AMENDMENTS TO THE SOCIAL SECURITY ACT 1969 – 1972

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

Volumes 1 – 6

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

Volumes 7, 8

Social Security Amendments of 1969 and Related Amendments

Volume 9

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Social Security Administration

AMENDMENTS TO THE SOCIAL SECURITY ACT 1969 – 1972

Social Security Amendments of 1972 and Related Amendments

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REPORTS, BILLS,
DEBATES, AND ACTS

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Social Security Administration
Office of Policy
Office of Legislative and Regulatory Policy

Social Security Amendments of 1969 and Related Amendments

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91st Congress, 2d Session - - - - - House Report No. 91-1096

SOCIAL SECURITY AMENDMENTS OF 1970

REPORT

OF THE

COMMITTEE ON WAYS AND MEANS

ON

H.R. 17550

TO AMEND THE SOCIAL SECURITY ACT TO PROVIDE INCREASES IN BENEFITS, TO IMPROVE COMPUTATION METHODS, AND TO RAISE THE EARNINGS BASE UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, TO MAKE IMPROVEMENTS IN THE MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAM WITH EMPHASIS UPON IMPROVEMENTS IN THE OPERATING EFFECTIVENESS OF SUCH PROGRAMS, AND FOR OTHER PURPOSES

MAY 14, 1970.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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91ST CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
2d Session } { No. 91-1096

SOCIAL SECURITY AMENDMENTS OF 1970

MAY 14, 1970.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. MILLS, from the Committee on Ways and Means, submitted the following

REPORT

[To accompany H.R. 17550]

The Committee on Ways and Means, to whom was referred the bill (H.R. 17550) to amend the Social Security Act to provide increases in benefits, to improve computation methods, and to raise the earnings base under the old-age, survivors, and disability insurance system, to make improvements in the medicare, medicaid, and maternal and child health programs with emphasis upon improvements in the operating effectiveness of such programs, and for other purposes, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

I. PRINCIPAL PURPOSES OF THE BILL

The general subject of social security has been the principal order of business before the Committee on Ways and Means for the past several months. On October 15, 1969, your committee commenced holding extensive public hearings on all aspects of the Social Security Act, including the old-age, survivors, and disability insurance program, the public assistance programs, and the medicare and medicaid programs.

The bill now being reported is the third separate bill relating to these programs recommended for action by your committee as a part of its recent deliberations. Last December, your committee recommended, and Congress enacted, an urgently needed 15-percent general increase in social security benefits, effective beginning January 1, 1970. In March of this year, your committee reported H.R. 16311, the proposed Family Assistance Act of 1970, which passed the House on April 16, and which related to the public assistance programs established under the Social Security Act.

The bill now being recommended by your committee contains amendments to the old-age, survivors, and disability insurance (OASDI) program, including a 5-percent benefit increase first applicable to benefits for the month of January 1971, and amendments to the medicare and medicaid and child health programs.

The provisions of the bill relating to the OASDI program are those which your committee believes are most urgently needed at the present time and which can be financed from the funds available under the financing provisions of the law as modified by the bill. In addition to an increase in social security benefits, the bill includes improvements in the provisions of the law relating to the social security retirement test; benefits for widows, widowers, and other dependents; the method of computing benefits; benefits for certain persons based on disability; and minor extensions of coverage.

The provisions of the bill relating to medicare, medicaid, and maternal and child health are designed primarily to improve the effectiveness of these programs.

Your committee conducted a thorough review of the operations of the two major health programs in the Social Security Act—medicare and medicaid. These programs taken together accounted for $9 billion of the total of $60 billion which was expended for health care in the United States in fiscal year 1969. Clearly, the impact which these programs have on the health industry is quite substantial. Clearly, too, developments in the health care field have a substantial impact on these programs.

Your committee became convinced, after hearing from many witnesses in both public and executive sessions, that there are many serious deficiencies in the operation and administration of the present programs which need correction. Some of these deficiencies can be attributed to inadequate planning and uneven performance by the Federal Government and its agents, and the States, particularly in the early stages of these programs. Your committee has received assurances from the Department of Health, Education, and Welfare that the strong efforts now being carried on to improve the operating effectiveness of these programs will continue.

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

The provisions in the bill dealing with the operating effectiveness of the programs should be viewed as a related set of provisions designed to accomplish that objective.

The cost of the changes relating to the OASDI program and of meeting the existing actuarial deficit in the hospital insurance program would be met by increasing the earnings base from $7,800 to $9,000 and by revising the contribution rate schedules.

II. SUMMARY OF PRINCIPAL PROVISIONS OF THE BILL

A. AMENDMENTS RELATED TO THE SOCIAL SECURITY CASH BENEFITS PROGRAM

Cash benefit increase

Social security payments to the 26.2 million beneficiaries on the rolls at the end of January, 1971, and to those who come on the rolls after that date would be increased by 5 percent. The benefit increase would be effective for the month of January 1971 (payable in February) and would mean additional benefit payments of $1.7 billion in the first 12 months.

Effective date—January 1, 1971.

Liberalization of the retirement test

The amount 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 level of $1,680 to $2,000. Then, similar to present law, for the next $1,200 of earnings (from $2,000 to $3,200 a year under the new provision) there would be a reduction of $1 in a recipient's social security benefits for each $2 of earnings. A reduction of $1 would be made for each $1 of annual earnings above $3,200. 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 in determining if his earnings in that year exceed $2,000. In 1971 about 900,000 beneficiaries would receive additional benefits and about 100,000 persons who would receive no benefits under present law would receive some benefits. Additional benefit payments for the first year would be about $475 million.

Effective date—Taxable years ending after 1970.

100 percent widow's and widower's benefit at age 65 and reduced benefits for widowers at age 60

Under present law, a widow's (or dependent widower's) benefit applied for at age 62 or later is equal to 82½ percent of the primary insurance amount of the wage earner. An actuarially reduced benefit may be received by a widow at age 60. Under the bill a widow or widower would be entitled to a benefit equal to 100 percent of the primary insurance amount, if first applied for at age 65 or later. Benefits applied for between age 62 and 65 would be proportionately increased over the present 82½ percent rate according to the age of the applicant at the time of application. In addition, widowers under age 62 would be granted the same privilege of applying for benefits on an actuarially reduced basis as now applies to widows.

About 3.3 million widows and widowers on the rolls at the end of January 1971 would receive additional benefits, and $700 million in additional benefit payments would be made in the first 12 months.

Effective date—January 1, 1971.

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 and up to age 62 for women. These differences which favor women over men, would be eliminated by applying the same rules to men as now apply to women.

In the first 12 months, an additional $925 million in benefits would be paid out; an estimated 10.2 million people on the rolls on the effective date would receive larger benefits under this provision; in addition 60,000 persons—workers and their dependents not eligible under present law—would be added to the rolls under the change in benefit eligibility requirements for men.

Effective date—January 1, 1971.

Eliminate reduction in benefits in certain cases

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

Approximately 100,000 beneficiaries would be immediately affected by this provision, which would result in additional benefit payments estimated at $10 million during the first 12 months.

Effective date.—Six months after the month of enactment.

Elimination of the support requirements for divorced women

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

Effective date.—January 1, 1971.

Disability insured status for individuals who are blind

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

Effective date.—January 1, 1971.

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 and the combined payments exceed 80 percent of average current earnings before disablement. Under the bill, social security disability benefits would be

reduced by the amount by which the combined payments under both programs exceed 100 percent of average current earnings before disability.

Effective date.—January 1, 1971.

Wage credits for members of the uniformed services

Present law provides for a social security wage credit of up to $100 a month, in addition to credit for basic pay, for military service performed after 1967. Under the bill, the additional wage credits would also be provided for service during the period from 1957 (when military service was covered under social security) through 1967. Approximately 130,000 beneficiaries would be affected immediately; $35 million in additional benefits would be paid out in the first 12 months.

Effective date.—January 1, 1971.

Childhood disability benefits for those disabled before age 22

Under present law, a person who becomes disabled before age 18 may qualify for childhood disability benefits which are payable to a qualified disabled adult son or daughter of an insured retired, deceased, or disabled worker. The bill would provide such childhood disability benefits when disability begins before age 22.

Effective date.—January 1, 1971.

Other OASDI amendments

Your committee also adopted other amendments relating to social security coverage of policemen and firemen in Idaho, the coverage of Federal Home Loan Bank employees, the coverage of certain public hospital employees in New Mexico, the payment of disability insurance benefits on the basis of applications filed after the death of the disabled person, the treatment of earnings of self-employed persons paying taxes on a fiscal year basis, a penalty for furnishing false information to obtain a social security account number, and the amount of a family's benefits when the worker's benefit is increased.

1ST-YEAR BENEFIT COSTS ANO NUMBER OF PERSONS AFFECTEO BY OLO-AGE, SURVIVORS, ANO OISABILITY INSURANCE PROVISIONS OF H.R. 17550

Provision	Additional benefit payments in 1st 12 months (in millions)	Present-law beneficiaries immediately affected [1] (in thousands)	Newly eligible persons [2] (in thousands)
5-percent benefit increase	$1,700	26,200	[3] 6
Modified retirement test [4]	475	900	100
Age 62 computation point	925	10,200	60
100 percent of PIA for widows and widowers	700	3,300	----------
Noncontributory credits for military service after 1956	35	130	----------
Election to receive larger future benefits by certain beneficiaries eligible for more than 1 actuarially reduced benefit	10	100	----------
Children disabled at ages 18 to 21	10	----------	13
Liberalized disability insured status requirement for the blind	25	----------	30
Liberalized workmen's compensation offset	7	55	5
Eliminate support requirement for divorced wives and surviving divorced wives	15	----------	10
Actuarially reduced benefits to widowers at age 60	(5)	----------	(5)

[1] Present-law beneficiaries whose benefit for the effective month would be increased under the provision.
[2] 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] Noninsured persons aged 72 and over.
[4] Additional benefit payments represent benefits for months in calendar year 1971. Some 900,000 persons who will receive some benefits for months in 1971 under present law would receive additional benefits under the provision; about 100,000 persons who will receive no benefits for mohths in 1971 under present law would receive some benefits under the provision.
[5] Less than $500,000 in additional payments; less than 500 newly eligible widowers.

Note: The above figures are not additive because the time periods are not uniform and because a person may be affected by more than 1 provision.

B. AMENDMENTS RELATED TO THE MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS

Coverage and benefit changes under medicare

Relationship between medicare and Federal employees benefits.—Your committee bill would require that effective with January 1, 1972, no payment would be made under medicare for the same services covered under a Federal employees health benefits plan, unless in the meantime the Secretary of Health, Education, and Welfare certifies that the Federal employees health benefits program has been modified to make available coverage supplementary to medicare benefits and that Federal employees and retirees age 65 and over will continue to have the benefit of a Government contribution toward their health insurance premiums.

Effective date.—January 1, 1972.

Hospital insurance for the uninsured.—People reaching age 65 who are ineligible for hospital insurance benefits under medicare would be able to enroll, on a voluntary basis, for hospital insurance coverage under the same conditions under which people can enroll under the supplementary medical insurance part of medicare. Enrollment for supplementary medical insurance is also required. Those who enroll would pay the full cost of the protection—$27 a month at the beginning of the program, rising as hospital costs rise. States and other organizations, through agreements with the Secretary would be permitted to purchase such protection on a group basis for their retired (or active) employees age 65 or over.

Effective date.—January 1, 1971.

Health maintenance organization option.—Individuals eligible for both part A and part B medicare coverage would be able to choose to have their care provided by a health maintenance organization (a prepaid group health or other capitation plan). The Government would pay for such coverage on a capitation basis not to exceed 95 percent of the cost of medicare benefits had the beneficiaries not been enrolled with the health maintenance organization.

Effective date.—January 1, 1971.

Improvements in the operating effectiveness of the medicare, medicaid, and maternal and child health programs

Limitation on Federal payment for disapproved expenditures.—Reimbursement amounts to providers of health services under the medicaid, medicare, and maternal and child health programs for capital costs, such as depreciation and interest, would not be made with respect to capital expenditures which are inconsistent with State or local health facility plans.

Effective date.—July 1, 1971 (or earlier if requested by a State).

Experiments and projects in prospective reimbursement and incentives for economy.—The Secretary of Health, Education, and Welfare would be required to develop experiments and demonstration projects de signed to test various methods of making payment to providers of services on a prospective basis under the medicare, medicaid and maternal and child health programs. In addition, the Secretary would be authorized to conduct experiments with methods of payment or reimbursement designed to increase efficiency and economy, and with community-wide utilization review mechanisms.

Effective date.—Enactment date.

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

Effective date.—Enactment date.

Limitation on recognition of physicians fee increases.—Charges determined to be reasonable under the present criteria in the medicare, medicaid, and maternal and child health law would be limited by providing: (*a*) that for fiscal year 1971 and thereafter medical charge levels recognized as prevailing may not be increased beyond the 75th percentile of actual charges in a locality during the previous elapsed calendar year; (*b*) that for fiscal year 1972 and thereafter the prevailing charge levels recognized for a locality may be increased, in the aggregate, only to the extent justified by indexes reflecting changes in costs of practice of physicians and in earnings levels; and (*c*) that for medical supplies, equipment, and services that, in the judgment of the Secretary, generally do not vary significantly in quality from one supplier to another, charges allowed as reasonable may not exceed the lowest levels at which such supplies, equipment and services are widley available in a locality.

Effective date.—Fiscal year 1971.

Payments for services of teaching physicians.—Medicare would pay for the services of teaching physicians on the basis of reasonable costs, rather than fee-for-service charges, unless other patients who have insurance or are able to pay are also charged for such services and the medicare deductibles and coinsurance amounts are regularly collected. Medicare payment would also be authorized for services provided to hospitals by staff of certain medical schools.

Effective date.—Enactment date.

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

Effective date.—Enactment date.

Government payment no higher than charges.—Payments for institutional services under the medicare, medicaid, and maternal and child health programs could not be higher than the charges regularly made for those services.

Effective date.—July 1, 1970.

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

Effective date.—Fifth month following month of enactment.

Guarantee of payment for extended care services.—The Secretary of Health, Education, and Welfare would be authorized to establish specific periods of time (by medical condition) after hospitalization during which a patient would be presumed, for payment purposes, to

require extended care level of services in an extended care facility. A similar provision would apply to posthospital home health services.

Effective date.—January 1, 1971.

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

Effective date.—Enactment date for medicare; July 1, 1971 (or earlier at the option of the State) for medicaid.

Stopping payment where hospital admission not necessary under medicare.—If the utilization review committee of a hospital or extended care facility, in its sample review of admissions, finds a case where institutionalization is no longer necessary, payment would be cut off after 3 days. This provision parallels the provision in present law under which long-stay cases are cut off after 3 days when the utilization review committee determines that institutionalization is no longer required.

Effective date.—Second month following the month of enactment.

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

Effective date.—January 1, 1971.

Changes in Federal matching percentages with respect to certain services.—The Federal medicaid matching for certain outpatient services would be increased and the Federal matching with respect to long-term institutional care would be decreased and certain other limitations would be imposed. Specifically, (1) the Federal matching percentage for outpatient hospital services, clinic services and home health services would be increased by 25 percent; (2) the Federal percentage after the first 60 days of care in a general or TB hospital would be reduced by one-third; (3) the Federal percentage after the first 90 days of care in a year in a skilled nursing home would be reduced by one-third; (4) the Federal matching for care in a mental hospital after 90 days of care would be reduced by one-third and no Federal matching would be available after an additional 275 days of such care during an individual's lifetime; and (5) the Secretary would be authorized to compute a reasonable cost differential for reimbursement purposes between skilled nursing homes and intermediate care facilities.

Effective date.—January 1, 1971.

Repeal of medicaid provision requiring expanded programs.—The requirement in present law that States have comprehensive medicaid programs by 1977 would be repealed.

Effective date.—Enactment date.

State determination of reasonable hospital costs.—States would be permitted to pay hospitals on the basis of their own determination of reasonable cost, provided there is assurance that the medicaid program would pay the actual cost of hospitalization of medicaid recipients.

Effective date.—July 1, 1971 (or earlier at the option of the State).

Federal matching for modern claims processing systems.—Federal matching at the 90-percent rate would be available under medicaid for the States to set up mechanized claims processing and informational retrieval systems. Federal matching for the continuing operation of such systems would be at the 75-percent rate.

Effective date.—July 1, 1970.

Utilization review in medicaid.—Hospitals and skilled nursing homes participating in the medicaid and maternal and child health programs would be required to have the same type of utilization review committee with the same functions as are required in the medicare program. (Any such committee actually performing such functions for medicare purposes would apply these to medicaid cases.)

Effective date.—July 1, 1971.

Medicaid deductibles for the medically indigent.—States would be permitted to impose cost sharing provisions with respect to people eligible under medicaid programs but not eligible for cash public assistance payments. (Present law requires such cost sharing provisions to vary directly with the amount of the recipient's income.)

Effective date.—January 1, 1971 (or earlier at the option at the State).

Role of State health agencies in medicaid.—State health agencies would be required to perform certain functions under the medicaid and maternal and child health programs relating to the quality of the health care furnished to recipients.

Effective date.—July 1, 1971.

Miscellaneous and technical provisions

Retroactive coverage under medicaid.—States would be required to cover under medicaid the cost of health care provided to an eligible individual during the 3-month period before the month in which he applied for medicaid.

Effective date.—July 1, 1971.

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

Effective date.—Second month after month of enactment.

Christian Science sanatoriums under medicaid.—Christian Science sanatoriums would be exempted from the medicaid requirement that they have a licensed nursing home administrator and from other inappropriate skilled nursing home requirements.

Effective date.—Enactment date.

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

Effective date.—Enactment date.

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

Effective date.—Enactment date.

Enrollment under medicare.—Eligible individuals would be permitted to enroll under medicare's supplementary medical insurance program during any prescribed enrollment period. Beneficiaries would no longer be required to enroll within 3 years following first eligibility or a previous withdrawal from the program. Relief would be provided where administrative error has prejudiced an individual's right to enroll in medicare's supplementary medical insurance program.

Effective date.—Enactment date.

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

Effective date.—Enactment date.

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

Effective date.—Enactment date.

Collection of medicare premium by the railroad retirement board.—Where a person is entitled to both railroad retirement and social security monthly benefits, his premium payment for supplementary medical insurance benefits would be deducted from his Railroad Retirement benefit in all cases.

Effective date.—Fifth month after month of enactment.

Medicare benefits for people living near U.S. border.—Medicare beneficiaries living in the United States close to the U.S. border would get covered care if the hospital they use is in Canada or Mexico and is closer to their residence than a comparable hospital in the U.S.

Effective date.—Admissions to a hospital after December 31, 1970.

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

C. FINANCING

In order to pay the additional cost of the new OASDI benefits provided and to meet the existing actuarial deficit in the hospital insurance (part A of medicare) program, the tax and benefit base would be increased from $7,800 a year to $9,000 a year, starting January 1, 1971, and a new schedule of tax rates would be provided as follows:

[Percent]

Period	OASDI		HI		Total	
	Present law	H.R. 17550	Present law	H.R. 17550	Present law	H.R. 17550
Contribution rates for employer-employee, each:						
1970	4.2	4.2	0.6	0.6	4.8	4.8
1971-72	4.6	4.2	0.6	1.0	5.2	5.2
1973-74	5.0	4.2	.65	1.0	5.65	5.2
1975	5.0	5.0	.65	1.0	5.65	6.0
1976-79	5.0	5.0	.7	1.0	5.7	6.0
1980-86	5.0	5.5	.8	1.0	5.8	6.5
1987 and after	5.0	5.5	.9	1.0	5.9	6.5
Self-employed contribution rates:						
1970	6.3	6.3	0.6	0.6	6.9	6.9
1971-72	6.9	6.3	.6	1.0	7.5	7.3
1973-74	7.0	6.3	.65	1.0	7.65	7.3
1975	7.0	7.0	.65	1.0	7.65	8.0
1976-79	7.0	7.0	.7	1.0	7.7	8.0
1980-86	7.0	7.0	.8	1.0	7.8	8.0
1987 and after	7.0	7.0	.9	1.0	7.9	8.0

The portion of social security contributions that is allocated to the disability insurance trust fund would be revised (as to the combined employer-employee rate) from 1.10 percent of taxable wages for 1970 and after (as in present law) to 0.90 of 1 percent for 1971 through 1974, to 1.05 percent for 1975 through 1979, and to 1.15 percent in 1980 and after, with corresponding changes in the allocation of the self-employed contribution rates.

III. GENERAL DISCUSSION OF THE BILL

A. GENERAL DISCUSSION OF PROVISIONS RELATING TO THE CASH BENEFITS PROGRAM

1. 5-percent increase in benefits

Over the years your committee has taken action to maintain social security benefits at realistic and adequate levels. From time to time these benefits have been increased to take into account changes in the national economy—particularly changes in living costs, earnings levels, and living standards. The most recent of these increases was the 15-percent increase provided under the Social Security Amendments of 1969, which, although effective with respect to the benefits payable for January 1970, was first paid to beneficiaries in April of this year.

Your committee recommends a general benefit increase of 5 percent effective with the benefits payable for January 1971. At the time your committee recommended the 15-percent benefit increase, it saw "a pressing and urgent need" for a benefit increase "as quickly as possible." As the result of further deliberations, your committee now sees a need for an additional increase in benefits starting next year. Without claiming prescience, your committee believes that economic changes in the shortrun future will warrant a further benefit increase.

Under the present law monthly benefits for workers who retire at age 65 in 1971 will range from $64 to $193.70; under the bill these amounts would range from $67.20 to $203.40. Additional illustrations of the effect of the benefit increase are shown in the table below. The table also reflects some of the effect of another provision in the bill which would increase the earnings base to $9,000, effective January 1,

1971. It should, however, be pointed out that in addition to the effects of the higher base reflected in the table, the higher creditable earnings under the new $9,000 base would also result in higher average monthly wages which would help maintain a reasonable relationship between benefits and earnings for people who have earnings of more than the present $7,800 maximum.

ILLUSTRATIVE MONTHLY BENEFITS PAYABLE UNDER PRESENT LAW AND UNDER H.R. 17550

Average monthly earnings [1]	Worker [2]		Man and wife [2 3]		Widow and 2 children	
	Present law	H.R. 17550	Present law	H.R. 17550	Present law	H.R. 17550 [4]
$76	$64.00	$67.20	$96.00	$100.80	$96.00	$100.80
150	101.70	106.80	152.60	160.20	152.60	160.20
250	132.30	139.00	198.50	208.50	202.40	208.50
350	161.50	169.60	242.30	254.40	280.80	280.80
450	189.80	199.30	284.70	299.00	354.40	354.40
550	218.40	229.40	327.60	344.10	395.60	395.60
650	250.70	[5] 263.30	376.10	395.00	434.40	434.40
750	([6])	[5] 283.00	([6])	424.50	([6])	474.40

[1] Figured generally over 5 less than the number of years elapsing after 1936 or 1950, or age 21, if later, and up to the year of death, disability, or attainment of age 65 for men (62 under the bill) and 62 for women.
[2] For a worker who is disabled or who is age 65 or older at the time of retirement and a wife age 65 or older at the time when she comes on the benefit rolls.
[3] Survivor benefit amounts for a widow and 1 child or for 2 parents would be the same as the benefits for a man and wife.
[4] For families already on the benefit rolls who are affected by the maximum benefit provisions, the amounts payable under the bill would in some cases be somewhat higher than those shown here.
[5] Generally payable to people who retire at age 65 in 2006.
[6] Not applicable, since the highest possible average earnings is $650.

Some 25.6 million beneficiaries on the rolls in January 1971 would have their benefits increased under this provision. An estimated $1.7 billion in additional benefits would be paid in the first 12 months.

2. Increase in special payments to certain people age 72 or older

The bill would also increase by 5 percent the special cash payments that are made under present law to people age 72 and older who are not insured for regular cash benefits under the social security system.

Under the 1965 amendments to the social security law, special monthly payments were provided for certain people who reached age 72 before 1969 on the basis of less work than is needed to qualify for regular cash benefits. The cost of the payments under this provision is met out of the old-age and survivors insurance trust fund.

Special monthly payments were also provided, under an amendment to the law enacted in 1966, for persons with no social security credits who reached age 72 before 1968 and for persons who reach age 72 after 1968 and before 1972 who have earned credit for some work but who do not qualify for payments under the 1965 amendments. Payments made under the 1966 amendments are reduced by the amount of any pension, retirement benefit, or annuity that a person is receiving under any other governmental pension system. Also, the payments are suspended for any month for which the person receives a payment under a federally aided public assistance program. Most of the cost of the payments to persons under this provision is met from general revenues.

Under the 5-percent increase provided in the bill, the payments under both of these special transitional provisions would be increased from $46 to $48.30 for an individual and from $69 to $72.50 for a couple, effective for January 1971. As a result, about 6,000 people who do not now get the special payments would qualify for some pay-

ments, and about 620,000 people would qualify for higher payments under this provision. An estimated $17 million in additional payments would be paid out in the first 12 months; about $15 million of this amount would be paid from general revenues.

3. Liberalization of the retirement test

Under present law, if a beneficiary under age 72 earns more than $1,680 in a year, $1 less in benefits is paid for each $2 of earnings between $1,680 and $2,880 and for each $1 of earnings above $2,880. However, full benefits are paid, regardless of the amount of annual earnings, for any month in which the beneficiary neither works for wages of more than $140 nor renders substantial services in self-employment. Under the bill, beginning 1971, a beneficiary would receive the full amount of his benefits each month if his annual earnings did not exceed $2,000; his benefit would be reduced by $1 for each $2 of earnings between $2,000 and $3,200 and for each $1 thereafter. The bill would increase from $140 to $166.66 the amount of wages a beneficiary may earn in a given month and still get full benefits for that month. These changes would update the retirement test to take into account the increase in earnings levels since the present $1,680 annual exempt amount became effective (beginning 1968) and make possible an increase in annual income for many of the beneficiaries who work.

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

4. Increase in widows' and widowers' insurance benefits

A factor which must be taken into account in considering whether the levels of social security benefits are adequate at any given time is the relationship of survivors' benefits to the worker's retirement benefit. In this connection your committee examined the benefits paid to older widows and found that the benefits paid to these people were not adequate because under the present law the most that can be paid to a widow is 82.5 percent of the retirement benefit which would be paid to her husband if he started getting benefits at or after age 65.

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 computation 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.

It is your committee's opinion that the reasons for setting widow's benefits at their present level are no longer valid and that in the light of present conditions there is no reason for paying aged widows less than the amount which would be paid to their husbands as retirement benefits. Currently, the average benefit for an aged widow is $101 a month, while the average benefit for a retired worker is $117. In addition, surveys of social security beneficiaries have shown that, on the average, women getting aged widow's benefits have less income other than social security than most other beneficiaries.

Your committee's bill would provide an increase in the benefits of widows and widowers who become entitled to benefits after reaching age 62. Under the bill, the benefit for a widow who becomes entitled to widow's benefits at or after age 65 would be increased from 82½ percent (payable under present law) to 100 percent of the amount her deceased husband would receive if his benefits started at or after age 65. For widows becoming entitled to widow's benefits between ages 62 and 65, the 100-percent amount would be reduced. For widows who start getting benefits before age 62, the amount would be approximately the same as, and in no case less than, is payable under present law.

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 not be less than the minimum benefit payable to a retired worker at age 65. The benefit for a widow who starts getting benefits before 62 and who is the only survivor getting benefits would be the minimum benefit reduced only because of the number of months before age 62 for which the benefit is paid.

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

ILLUSTRATIVE MONTHLY BENEFITS FOR WIDOWS AND WIDOWERS WHO BECOME ENTITLED AT OR AFTER AGE 65 UNDER PRESENT LAW AND UNDER H.R. 17550.

Average monthly earnings	Present law	H.R. 17550		
		Additional amount resulting from general benefit increase	Additional amount resulting from widow's benefit increase	Total benefit payable
$76.00	$64.00	$3.20	-------	$67.20
150.00	84.00	4.20	$18.60	106.80
250.00	109.20	5.50	24.30	139.00
350.00	133.30	6.70	29.60	169.60
450.00	156.60	7.90	34.80	199.30
550.00	180.20	9.10	40.10	229.40
650.00	206.90	10.40	46.00	263.30
750.00	(1)	(1)	(1)	283.00

[1] Not applicable, since the highest average earnings amount now possible is $650.

Your committee's intention is to provide the same amount—100 percent—for both the worker and the widow when the benefits start at or after age 65, and to provide reduced benefits in both cases when benefits begin before age 65. However, because of the necessity of gearing in the widow's benefits between the ages of 62 and 65 with the higher amount provided under present law for a widow at age 62, as

compared with the amount provided for a worker age 62, the reduction for widows and widowers who receive benefits beginning before age 65 is slightly different than the reduction for workers.

The increase in benefits for widows and dependent widowers would be effective for January 1971. Widows and widowers who are receiving benefits at that time and who would get higher amounts as a result of the provisions would have their benefits recomputed.

Some 3.3 million widows and widowers on the rolls at the end of January 1971 would receive higher benefits under this provision, and $700 million in additional benefit payments would be made in the first 12 months.

5. Dependent widowers' benefits at age 60

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

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

6. Age-62 computation point for men

Under present law, retirement benefits for men are figured differently, and less advantageously, than are the benefits for women. For a man the period for determining the number of years of earnings that are used in figuring the average monthly earnings on which his benefits are based ends with the beginning of the year in which he reaches age 65. For a woman the period ends with the beginning of the year in which she reaches age 62. Thus 3 more years are used for a man than are used for a woman of the same age.

This difference in the treatment of men and women under the program can result in significantly lower benefits being paid to a retired man than are paid to a retired woman with the same earnings. For example, a man and a woman each reach age 65 and retire in 1971. They each have maximum creditable earnings under the program in each year up to 1971. The woman's benefit beginning at age 65 would be $200.30 a month under present law while the man's benefit would be only $193.70 a month. If both workers reach age 62 in 1971, the woman's benefit would be $155 a month while the man's benefit would be only $148.80 a month.

The bill would change the way a man's retirement benefit is figured to make the computation the same as the computation of a woman's benefit. As a result the retirement benefits that a man would be paid would be the same as the benefits to a woman of the same age and with the same earnings. The change would result in higher retirement benefits for most men than are provided under present law. It would also result in higher benefits for dependents of retired workers and for the survivors of men who died after age 62.

The provision to shorten the computation period for men would be effective for benefits for January 1971. It would apply not only to those who come on the benefit rolls in and after January 1971 but also to those who are on the benefit rolls when the provision becomes effective. Benefits for those on the benefit rolls before 1971 would be recomputed under the new provision and, in many cases, the increased benefits would be paid beginning with payments for January 1971, payable in February. Some beneficiaries who have earnings in 1969 and whose benefits have to be refigured to take account of those additional earnings might not be paid their increased benefits until later in 1971 because of the time required to make the necessary computations but the payments would be made retroactive to January 1971.

The amount of social security credit that a worker must have to be insured for benefits is also determined differently, under present law, for men than for women. Again, the ending point for determining benefit eligibility for a man is the year in which he reaches age 65, while for a woman it is the year in which she reaches age 62. Your committee's bill would make the ending point age 62 for both men and women and allow men to become fully insured on the basis of fewer quarters of coverage than are now required. This change would be effective for January 1971.

An estimated 10.2 million people on the rolls on the effective date would receive larger benefits as a result of these changes, and in addition, 60,000 persons—workers and their dependents not eligible under present law—would be added to the rolls in the first 12 months. In the first 12 months an additional $925 million in benefits would be paid out.

7. Election to receive actuarially reduced benefits

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

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

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

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

Some examples showing the effect of these changes in the law are as follows:

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

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

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

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

Under the bill, she would get a benefit of $99 a month starting at age 65 notwithstanding the fact that she elected to take her reduced old-age benefit at age 62.

The new provisions would apply to people who become entitled to benefits for or after the sixth month after the month of enactment. People already on the benefit rolls when the provisions become effective could, upon request, have their benefits redetermined under the new provisions.

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

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

Consider the case discussed in the first example above. She could, under the provisions of the bill, request to have her benefit redetermined under the new provisions. As a result of this redetermination, her month of entitlement to wife's benefits could be changed from the month in which she reached age 62 to the month in which she reached age 65. With this change, the amount of her monthly benefit should have been $62.40 (instead of $78.20) a month from age 62 to age 65 and $99 (instead of $78.20) a month from age 65 on. She was paid $78.20 a month from age 62 on, or $15.80 a month too much from age 62 to age 65 and $20.80 a month too little from age 65 on. Assume she is age 66 when the redetermination is made. If the bill had been in effect she would have been paid, for the 48 months from age 62 to age 66 for which she has been paid benefits, $62.40 a month for the 36 months from age 62 to age 65, and $99 a month for the 12 months from age 65 to age 66, for a total of $3,434.40. She would actually have been paid $78.20 a month for all 48 months, for a total of $3,753.60. Thus she would have been paid a total of $319.20 too much—$3,753.60 that she did get paid less $3,434.40 that she should have been paid. The $20.80 increase in her benefit, from $78.20 to $99, would be withheld and not paid to her until the $319.20 has been recovered—in about 16 months. From that point on she would get a monthly benefit of $99. If she should die or become entitled to another benefit (for example, a widow's benefit based on her husband's earnings) before the $319.20 is entirely recovered, the amount not yet recovered would be waived.

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

Approximately 100,000 beneficiaries on the rolls would be immediately affected by this provision, which would result in additional benefit payments estimated at $10 million during the first 12 months.

8. Eliminate the support requirements for divorced women

Your committee is concerned that there are a number of divorced women who cannot qualify for social security benefits because they cannot meet the support requirement in the law. Benefits are payable to a divorced wife age 62 or older and a divorced widow age 60 or older if her marriage lasted 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. Your 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, effective January 1, 1971.

9. Disability insured status for individuals who are blind

To be insured for disability protection under present law, a worker must be fully insured and meet a requirement of substantial recent covered work. Generally, to meet the latter requirement, 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 that workers who are disabled while young may have been in the work force for a relatively short time.

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

The provision would be effective for January 1971. About 30,000 persons—blind workers and their dependents—would become immediately eligible for monthly benefits. About $25 million in additional benefits would be paid out during the first 12 months.

10. Wage credits for members of the uniformed services

Under present law, social security coverage is provided on a contributory basis for those serving in the uniformed services in years after 1956, but it is limited to a serviceman's basic pay and does not reflect the cash value of wages in kind, such as food and shelter, which is generally covered under social security with respect to other employment. The 1967 social security amendments therefore provided (in addition to the contributory coverage of basic pay) noncontributory wage credits, up to $100 for each month 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 assure realistic social security 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 some workers (and their families) whose benefits are based on only basic pay for years of military service during the period from 1957 through 1967.

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

11. Application for disability benefits after disabled worker's death

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

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

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

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

12. Disability benefits affected by the receipt of workmen's compensation

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

Under present law, when a disabled worker qualifies for both workmen's compensation and social security disability benefits, the social security benefits payable to him and his family are reduced by the amount, if any, that the total monthly benefits payable under the two programs exceed 80 percent of his average current earnings before he became disabled. A worker's average current earnings for this purpose are the larger of (a) the average monthly earnings used for computing his social security benefits, or (b) his average monthly earnings in employment or self-employment covered by social security

during the 5 consecutive years of highest covered earnings after 1950, computed without regard to the limitations which specify a maximum amount of earnings creditable and taxable under social security.

The objective of these provisions is to avoid the payment of combined amounts of social security benefits and workmen's compensation payments that would be excessive in comparison with the beneficiary's earnings before he became disabled. Your committee recognizes, however, that workmen's compensation is not solely a replacement of lost earnings but is, in part, compensation for pain and loss of function for which the disabled worker might otherwise secure recompense through legal action against his employer. It should, therefore, not be necessary to limit a worker's combined social security disability benefits and workmen's compensation payments to less than he earned before becoming disabled. Moreover, your committee has concluded that the present provisions are unduly restrictive and result in hardship for some disabled workers and their families. A worker's total disability will usually give rise to substantial expenses in addition to the family's continuing regular expenditures. Limiting the combined benefits that are payable to 80 percent of average current earnings has in many instances caused a significant reduction in the family's standard of living in comparison with the level attained by the worker at the time of disablement. A worker's average current earnings are calculated for purposes of these provisions on the basis of his earnings over a protracted period of time rather than his earnings just before disablement. Thus, restricting the family benefits to 80 percent of average current earnings may result in payment of an amount below 80 percent of the earnings level the worker had reached at the time he became disabled. Your committee believes that the allowable amount of combined workmen's compensation and social security disability benefits should be increased. The bill would therefore raise the combined payments allowable to 100 percent of the worker's average current earnings.

13. Coverage of Federal Home Loan Bank employees

The Social Security Amendments of 1956 provided for coverage of employees of the Federal Home Loan Banks on condition that their retirement system be coordinated with social security and that the plan for coordination be submitted to the Secretary of Health, Education, and Welfare and approved by him before July 1, 1957. This condition was not fulfilled within the prescribed time.

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

The bill would extend coverage to all current and future employees of the Federal Home Loan Banks for years after 1970. Persons who are Bank employees on January 1, 1971, would also have their service after 1965 covered, but only if the social security contributions on account of such service are paid by July 1, 1971, or by such later date as may be provided under an agreement entered into between the Banks and the Secretary of the Treasury.

14. Coverage of policemen and firemen in Idaho

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

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.

15. Coverage of certain hospital employees in New Mexico

Your committee's bill would permit the State of New Mexico, at any time prior to January 1, 1971, 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 the provisions of the Social Security Act which specify 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 presents a serious obstacle to obtaining social security coverage for the employees in question 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.

16. Childhood disability benefits for those disabled before age 22

Your committee's bill would improve disability protection for persons who become totally disabled before reaching an age at which they are likely to be self-supporting. Under present law, social security benefits are provided for the child of an insured deceased, disabled, or retired worker until the child attains age 18 or, if attending school, age 22. Also, a son or daughter of an insured worker can qualify for childhood disability benefits if he has been continuously totally disabled since before age 18 and is still disabled after the worker dies or becomes entitled to social security benefits. Your committee's bill would permit the payment of childhood disability benefits to such a son or daughter who becomes totally disabled before age 22.

When total disability arises between ages 18 and 22 the disabled son or daughter generally continues to be dependent on his parents. Your committee believes that it is appropriate and desirable to provide social security benefits in such cases should the insured parent die, become disabled, or retire.

The provision for benefits for people disabled since before age 22 would be applicable not only prospectively but also in the case of people who have already met the conditions proposed for entitlement to benefits and would be effective with respect to benefits for months after December 1970. About 13,000 people—disabled children and their mothers—would immediately become eligible for benefits. About $10 million in additional benefits would be paid out during the first 12 months.

17. Penalty for furnishing false information to obtain a social security number

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

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

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

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

A special provision was included in the 1969 amendments to prevent a decrease in total family benefits from occurring under the general benefit increase that was included in those amendments. But the provision was only temporary in effect—it applied only to the general benefit increase under the 1969 amendments, and did not apply to earnings recomputation cases. There is a need, therefore, for a permanent provision that would apply to future general benefit increases and also to increases resulting from earnings recomputations. Such a provision is included in your committee's bill.

Under the provision, no family would have its total family benefits decreased because of an increase in the worker's benefit resulting from the 5-percent general benefit increase that would be provided by the bill or from any general benefit increase that may be enacted in the future or from a recomputation of the worker's benefit to include additional earnings.

B. GENERAL DISCUSSION OF MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROVISIONS

1. Coverage under medicare program

(*a*) *Payment under the medicare program to individuals covered by Federal employees health benefits program.*—Under present law, Federal employees and retirees age 65 and over who are enrolled for Federal employees health benefits (FEHB) are also covered under the medicare hospital insurance plan (part A) if they have worked in employment covered by social security or railroad retirement and are eligible for monthly cash benefits under these programs. In addition, Federal employees, whether or not eligible for part A benefits, may enroll in the medicare voluntary supplementary medical insurance plan (part B) which is available to essentially all persons age 65 and over. Part A hospital insurance protection under medicare is earned during a 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. Part B medical insurance protection is available at 50 percent of cost, for which the enrollee pays a monthly premium—currently $4, and due to be $5.30 in July 1970—matched by the Federal Government.

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 as they did when they were active employees (although the coverage may be more valuable since older people use more medical services). The Federal Government currently pays about 24 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 duplicating the benefits.

Unlike most employers, the Federal Government has not arranged the health insurance protection it makes available to its employees age 65 and over (active or retired) so that such protection would be supplementary to medicare benefits.

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 retiree entitled under medicare cancels his enrollment under a FEHB plan because of the high total cost of his health care protection, he will lose the high level of protection he previously enjoyed under the FEHB program at an age where his health care costs can be expected to increase substantially.

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

In order to assure a better coordinated relationship between the FEHB program and medicare and to assure that Federal employees and retirees age 65 and over will eventually have the full value of the protection offered under medicare and FEHB, your committee's bill would provide that effective January 1, 1972, the medicare program (both parts A and B) would not pay for any otherwise covered service if such service is covered under a FEHB plan. 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 that there is available to each Federal employee or retiree age 65 and over one or more Federal health benefit plans which offer protection supplementing the combined protection of parts A and B of medicare, and the protection of part B alone and that the Government is making a contribution toward the health insurance of each Federal employee or retiree age 65 and over, which is at least equal to the contribution it makes for high option coverage under Government-wide FEHB plans. This contribution could be in the form of a Federal contribution toward the supplementary FEHB protection or a payment to or on behalf of such employee or retiree to offset the cost of his purchase of medicare protection, or a combination of the two. It is the hope and the intent of your committee that the Secretary will be able to make this certification before January 1972.

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(*b*) *Hospital insurance benefits for uninsured individuals not eligible under present transitional provision.*—Present law provides hospital insurance protection under the "special transitional provision" for people who are not qualified for cash benefits under the social security or railroad retirement program. (The provision excludes an active or retired Federal employee, or the spouse of such an employee, who is covered or could have been covered under the provisions of the Federal Employees Health Benefits Act of 1959; aliens residing in the United States for less than 5 years; and people who have been convicted of a crime against the security of the United States, including sabotage, espionage, treason, etc.) The "special transitional provision" covers people who are not qualified for cash benefits under the social security or railroad retirement program and who reached age 65 before 1968 even though they had no work under social security (or in 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.

Since the transitional provision is designed to provide hospital insurance coverage for only a part (though a large part) of the uninsured aged and to eventually phase out, a portion of the aged, though small in number (as of January 1, 1970, this portion numbered approximately 305,000 or 1½ percent of the aged population), are and will be, for one reason or another, excluded from hospital insurance coverage. (The 305,000 people include 55,000 recent immigrants, who would continue to be excluded from coverage; 145,000 active or retired Federal employees, who are not eligible for the transitional provisions; and 105,000 others.) Although these ineligibles include a substantial number of people who were eligible for social security coverage but who did not elect (or whose employers did not elect) to be covered (including employees of State and local governments), they also include several other groups: (1) wives who have never worked under covered employment and whose husbands are eligible for hospital insurance under the transitional provision, (2) women who are not insured on their own account and who cannot qualify for dependent's benefits (such as dependent aged sisters of insured workers and the dependents of uninsured workers), and (3) workers, such as agricultural and domestic workers, whose earnings may have been so low or sporadic they were unable to acquire insured status.

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

Your committee's bill 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 pro-

tection on a group basis for its retired or active employees age 65 and over. The intent is that the cost of such coverage would be fully financed by those who elect to enroll for this protection. Enrollees would pay a monthly premium based on the cost of hospital insurance protection for the uninsured group; such premium would be $27 a month beginning with January 1971 and up to and including June 1972, 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 convicted of certain subversive crimes would be excluded from participation under this provision, just as they are excluded from enrolling for supplementary medical insurance.

Your committee's bill also would require that in order for persons to be eligible to enroll for hospital insurance they must be enrolled 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 your 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 as his supplementary medical insurance termination. Your 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).

The effective date for coverage provided under this provision would be January 1, 1971.

2. Improvements in the operating effectiveness of the medicare, medicaid, and maternal and child health programs

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

There are few aspects of the health care system in the United States which have been so thoroughly explored as the need for comprehensive areawide planning for the development and utilization of all types of health care facilities. But the acceptance of the purposes of State and areawide health facility planning has not always been matched by purposeful application of the incentives required to achieve the end result of such planning. Thus, while a significant amount of Federal money

is currently being 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. Your committee believes that the connection between sound health facility planning and the prudent use of capital funds must be recognized if any significant gains in controlling health costs are to be made. Thus, your committee believes it is necessary to assure that medicare, medicaid, and the maternal and child health programs are consistent with State and local health facility planning efforts, in order to avoid paying higher costs unnecessarily in the future where these costs result from duplication or irrational growth of health care facilities.

At present, efforts are being made on the Federal, State, and local levels to assure that the need for the expansion and modernization of health facilities is evaluated, coordinated, and planned on a rational and controlled basis. At the Federal level, comprehensive health planning legislation provides for Federal grants for the establishment and funding of areawide and comprehensive State health care planning agencies. Currently, all 50 States, the District of Columbia, and five territories have State comprehensive health care planning agencies. On the areawide level, 106 planning agencies are receiving Federal grants: 10 of such agencies are operational. It is estimated that 113 areawide planning agencies will be receiving grants by the end of June and that 35 of such agencies will be operational.

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

The Secretary would be authorized to enter into agreements with the States under which designated planning agencies would submit

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

These limitations would be effective with respect to obligations for capital expenditures incurred after June 30, 1971, or earlier, if requested by the State.

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

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

However, your committee is well aware that in considering such a fundamental change in the present reimbursement method, possible disadvantages as well as the potential advantages must be taken into account. While it is clear for example, that prospective rate setting will provide incentives for health care institutions to keep costs at a level no higher than the rates set, it is not clear that the rates set would

result in government reimbursement at levels lower than, or even as low as, that which would result under the present retroactive cost finding approach. Providers could be expected to press for a rate that would cover all the costs, including research costs and bad debts, as well as margins of safety in the prospective rates that might result in reimbursement—if their requests were met—in excess of the costs that would have been reimbursed under the present approach. Moreover, any excess of reimbursement over costs to voluntary providers would probably be used to expand services, and the new level of expenditures might be reflected in setting higher prospective rates for future years.

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

In view of the far-ranging implications of such a change in the approach to reimbursement, your committee's bill provides for a period of experimentation under titles XVIII, XIX and V with various alternative methods and techniques of prospective reimbursement. It is the intent of your committee that experimentation be conducted with a view to developing and evaluating methods and techniques that will stimulate providers through positive financial incentives to use their facilities and personnel more 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 your committee's bill, the Secretary would be required to submit to the Congress no later than July 1, 1972, 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 your committee does not wish to preclude experimentation with other forms of reimbursement. Your committee believes that a solid foundation of experience is required with all possible alternative forms of reimbursement before permanent changes can be made. The bill therefore includes authorization for the Sec-

retary 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 experimental 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 offer the promise of program savings without any loss in the quality of care. The bill would also authorize experimentation with the use of areawide or communitywide utilization review and medical review mechanisms to determine whether they would bring about more effective controls over excessive utilization of services.

The Secretary is to submit to the Committee on Ways and Means and the Committee on Finance plans for each experiment or project, authorized under these provisions, a description, in detail, of its nature, methodology, and objectives. The intent is that there be an opportunity for congressional study before the experiment or project is put into operation.

These provisions will be effective upon enactment of the bill.

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

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

In commenting on the wide variations in per diem direct expenses for hospitals in New York City, J. Douglas Colman, president of the Associated Hospital Service of New York, noted in a paper prepared in connection with the National Conference on Medical Costs held on June 27–28, 1967; that:

> Some of the variations can be explained by varying characteristics of the patient census, by location, by scope of services offered, or by variations in the

efficiency of physical plant. But none of these, nor any combination of them, satisfactorily account for the range of variation shown. For example, the range for voluntary teaching hospitals in New York City alone is from 38 percent above to 20 percent below the median per diem cost for this group of hospitals. One must conclude that at least a part of this variation reflects variations in efficiency.

The data being cited by Mr. Colman indicated that direct costs of "hotel" services (food and room costs) in hospitals in New York City varied from $17 to $32 per patient day with a median of $23, but three hospitals were at the level of $30 or more, more than 25 percent above the median. Nursing service costs varied from $11 to $20 per patient day with a median of $12 and the hospital with the highest nursing costs had nursing costs almost $3 per day above the hospital with the next highest nursing costs.

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

Similarly, when the high costs flow from inefficiency in the delivery of needed 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. It is believed that they can only be accomplished by reimbursement mechanisms that limit reimbursement to the costs that would be incurred by a reasonably prudent and cost-conscious management.

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

The proposed new authority to set limits on costs recognized for certain classes of providers in various service areas differs from

existing authority in several ways and meets these problems. First, it would be exercised on a prospective, rather than retrospective, basis so that the provider would know in advance the limits to Government recognition of incurred costs and have the opportunity to act to avoid having costs that are not reimbursable. Second, the evaluation of the costs necessary in delivering covered services to beneficiaries would be exercised on a class and a presumptive basis—relatively high costs that cannot be justified by the provider as reasonable for the results obtained would not be reimbursable—so that implementation of the proposed authority would appear more feasible than present authority. Third, since the limits would be defined in advance, provision would be made for a provider to charge the beneficiary for the costs of of items or services in excess of or more expensive than those that are determined to be necessary in the efficient delivery of needed health services. Public notice would be provided where such charges are imposed by the institution and the beneficiary would be specifically advised of the nature and amount of such charges prior to admission so that there is opportunity for the public, doctors, and their medicare patients to know what additional payment would have to be made.

Your committee is aware of the magnitude of the task this proposal will impose on the Social Security Administration and on the other components of the Department of Health, Education, and Welfare that will be involved in implementing the authority it grants. Difficulties will be encountered as a result of deficiencies in the adequacy and timeliness of cost data and as a result of limitations in current methodology for comparing costs of health care institutions, measuring health care output and estimating the costs necessary to the efficient delivery of health care. On the other hand, your committee does not believe that the Congress should delay in enacting provisions controlling escalation of hospital and other health care costs until perfect methods of collecting and evaluating cost data are attained. What is intended by your committee's proposal is that limits on recognition of costs as reasonable under medicare, medicaid, and the child health programs be put into effect to the extent presently feasible and that these limits be refined and extended over time as developing cost data and methodology permits.

Your committee recognizes that the initial ceilings imposed will of necessity be imprecise in defining the actual cost of efficiently delivering needed health care. And your committee recognizes that these provisions will apply to a relatively quite small number of institutions. The data that is 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 night 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.

Providers will be permitted to collect costs in excess of the medicare ceilings from the beneficiary (except in the case of admission by a physician who has a direct or indirect financial interest in a facility) where these costs flow from items or services in excess of 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 determination of the cost of the excess items or services for which the beneficiary may be charged will be determined 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.

These provisions would be effective with respect to accounting periods beginning after the enactment of the bill.

(*d*) *Limits on prevailing charge levels.*—Under present administrative policies under medicare, the prevailing limit on the reasonable charge for a service is intended, over the long run, to be generally about the 83d percentile of customary charges for that service in the physician's locality. To illustrate, if customary charges for an appendectomy in a locality were at five levels, with 10 percent of the services rendered by physicians whose customary charge was $150, 40 percent rendered by physicians who charge $200, 40 percent rendered by physicians who charge $250 and 5 percent rendered by physicians who charge $300 and with the remaining 5 percent rendered by physicians charging in excess of $300, the prevailing limit would be $250, since this is the level that would cover at least 83 percent of the cases. However, if 15 percent, rather than 5 percent, of the services were rendered by physicians whose customary charge was at the $300 level with 5 percent charging above that level, the prevailing charge limit would be $300, since this would then be the level that would cover at least 83 percent of the cases.

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

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

Under your committee's bill, the prevailing charges recognized for a locality could be increased in fiscal year 1972 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.

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 1969. The increase in the indexes that occurs in a succeeding calendar year would constitute the maximum allowable aggregate increase in prevailing charges above the original base 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 ceilings for recognition of increases in prevailing fee limits on presently available indexes of changes in consumer prices and earnings 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 for 1966 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 in a carrier area would be 40 percent of the area increase in the BLS Consumer Price Index (all items less medical care) plus 60 percent of the area increase in the earnings reported to the social security program. The increase in the BLS Consumer Price Index (which includes a service component and other prices reflecting, to some degree, office salaries paid by physicians) would be considered to indicate the justifiable increase in fees to take account of increases in costs met by the physician in his practice and the increase in earnings would be considered to indicate the justifiable increase in fees to keep the physician's earnings in line with the earnings of others. Thus, if during calendar year 1970 the area increase in prices 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 1972 would be 4.2 percent:

$$(.40\times.03)+(.60\times.05)=.042$$

The carrier would apply the prevailing charge criteria now in the law (but setting the prevailing charge limit at the 75th percentile of customary charges rather than at the 83d percentile permitted under present policies) to data on charges in calendar year 1970 to determine the increases in prevailing charges that it would be appropriate to recognize during fiscal year 1972. In the illustration cited earlier, where 20 percent of appendectomies in a locality were rendered by physicians who customarily charged $300 or more and 80 percent of such services were rendered by physicians customarily charging at or below $250, the prevailing charge level for that service would be $250 (the level that would cover at least 75 percent of the cases), rather than the prevailing charge level of $300 (the level that would cover at least 83 percent of the cases) that would be set under present policies. If the aggregate increase in prevailing charges so determined was less than 4.2 percent, the adjustments' would be permitted and the portion of the allowable aggregate increase not used in that fiscal year could be carried forward and used in future fiscal years. However, if the aggregate increase in prevailing charges found otherwise appropriate exceeded 4.2 percent, such increases would be reduced to the extent necessary to bring the aggregate of all increases within the 4.2 ceiling—that is, if the new prevailing charge limits that were indicated for fiscal year 1972 by the 75th percentile of calendar year 1970 charges multiplied by the frequency of the related services in calendar year 1970 exceeded, in total, the prevailing charge limits indicated for fiscal year 1971 by the 75th percentile of calendar 1969 charges multiplied by the fre-

quency of the related services in calendar 1969 by 8.4 percent, then each of the prevailing charge increases indicated for fiscal year 1972 by the 75th percentile of calendar year 1970 charges would be reduced by one-half so that the aggregate increase allowed would be within the 4.2 ceiling.

It is, of course, contemplated under the bill that the Secretary would use, both initially and over the long run, the most refined indexes that can be developed. However, your committee believes that the viability of the proposal does not depend on a great deal of further refinement. The objectives of the proposal could be attained with equity through the use of an approach such as that described above. This is so because the indexes are not to be applied on a procedure-by-procedure basis that would raise serious questions of equity in absence of refinements to take account of variations in the mix of factors of production among various types of medical services and to take account of changes in productivity with respect to various services. Rather, the indexes will operate as overall ceilings on prevailing fee level increases recognized in a carrier area under which adjustments permitted by the present customary and prevailing charge criteria could be made to take account of the shifting patterns and levels of 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 prices and earnings, the rise in fees would be allowed in full.

Your committee believes it desirable to provide the Secretary with appropriate leadtime for implementation of the proposed ceilings on recognition of prevailing charge increases and to provide a conservative base for its application. For this reason, the committee bill includes an interim provision for fiscal year 1971 requiring, in effect, an extension of present policies to contain program costs that would be somewhat more restrictive than those presently anticipated. Under this interim provision the medical charge levels currently recognized as prevailing in a locality could be increased during fiscal year 1971 only to the extent found necessary, on the basis of statistical data and methodology acceptable to the Secretary, to bring the charge levels recognized as prevailing in a locality to the 75th percentile of the customary charges (weighted by frequency rendered) made for similar services in the same locality during calendar year 1969. However, if currently allowed charges exceed this 75th percentile, no decrease in charges would be required by the new legislation. And, as noted earlier, the prevailing charges calculated as representing the 75th percentile in calendar year 1969 will establish the base from which the rate increase in prevailing charge levels will be measured. The economic index that would go into effect starting with fiscal year 1972 would be applied to this base to establish limits in future years.

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

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

The effect of the new limits established under this provision would be extended to the medicaid and child health programs by providing that payments under these programs in fiscal year 1971 and thereafter may not be made with respect to any amount paid for items and services that exceeds these new limits. This would be consistent with the situation in the present medicaid program.

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

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

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

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

(*e*) *Establishment of incentives for States to emphasize outpatient care under medicaid programs.*—Your committee has been concerned that ways be developed to improve the utilization of services under the medicaid program and to encourage more effective and lower cost patterns of service. The present law has a uniform Federal matching percentage applied to all forms of health services covered under the State medicaid plan. In order to encourage States to make more efficient use of health services, your committee's bill would create incentives to encourage outpatient services and disincentives for long stays in institutional settings. Specifically, the bill would provide for: (1) an

increase in the Federal matching percentage by 25 percent for outpatient hospital services, clinic services and home health services; (2) a decrease in the Federal percentage by one-third after the first 60 days of care (in a fiscal year) in a general or TB hospital; (3) a reduction in the Federal percentage by one-third after the first 90 days of care in a skilled nursing home; (4) a decrease in Federal matching by one-third after 90 days of care in a mental hospital and provision for no Federal matching after an additional 275 days of such care during an individual's lifetime; and (5) authority for the Secretary to compute a reasonable cost differential for reimbursement purposes between skilled nursing homes and intermediate care facilities.

These changes would be effective with respect to services furnished after January 1, 1971.

The proposal to increase the Federal matching for outpatient, clinic, and home health services is directed at encouraging the States to provide early diagnosis and treatment of illness, preventive services, and alternatives to institutional care intended to reduce the need for and use of inpatient services.

The proposed limitations on length of stay in mental institutions reflect the assumption that medical treatment of mental disease inpatients generally does not exceed three months, and for patients over 65 rarely continues beyond a year.

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

The reduction in matching for skilled nursing homes is directed toward early transfer of patients to alternative facilities (such as intermediate care facilities), and the provision granting authority to the Secretary to compute for reimbursement purposes a reasonable cost differential between cost of skilled nursing home services and cost of intermediate care facilities is designed to assure that supporting care in these alternate institutions results in decreased costs. These provisions reflect the concern that many patients remain in skilled nursing homes longer than necessary and that as a result program costs are unnecessarily increasing.

The bill would also make clear in the present statute that an intermediate care facility shall not include an institution for mental diseases or mental defects.

(*f*) *Payment for physician's services in the teaching setting.*—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. 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. Early in 1969, onsite audits at a large midwestern county hospital staffed with many interns and residents disclosed a substantial overpayment. (The overpayment was later determined to be over $1 million—repayment is now being made.) It was also clear that the same problem existed in a number of other large hospitals and, in April 1969, instructions were issued by HEW to amplify and clarify the original regulations by spelling out in considerable detail the conditions under which medicare can recognize a charge for services to patients whose care involved residents and interns.

When onsite review and other information had indicated a widespread misunderstanding over the billing requirements, HEW asked carriers in June 1969 to suspend payment for services rendered to teaching patients in all major teaching institutions where the carrier was not assured that the payments it was making were proper. The suspensions were temporary and intended to last only so long as carriers had time to investigate and review any major billing discrepancies. In all, about 240 hospitals have been suspended, of which about 200 have been reinstated.

In the meantime, the Social Security Administration has undertaken a program of reviewing cases in the larger teaching hospitals which have primarily a service clientele to determine the extent to which the payments made to the physicians (or to billing organizations on their behalf) were not in accord with the law and regulations. Large overpayments have been discovered. In each situation the Social Security Administration is discussing the matter with the appropriate individuals who will be responsible for liquidating what it believes to be a fairly large indebtedness with the objective of, first determining the overpayment and second, making arrangements for repayment. Difficulties have been encountered in recouping the large overpayments involved in these cases—typically running into hundreds of thousands of dollars.

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

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

Therefore, the committee's bill would change the basis of reimbursement for teaching physicians' services from a fee-for-service basis to a cost-reimbursement basis where the services are furnished in a setting in which any one of the following circumstances exist: (1) the nonmedicare patients are not required to pay the reasonable charges for physicians' services even when they have private insurance or are otherwise able to pay for such services; or (2) medicare patients are not required to pay any charges for physicians' services; or (3) medicare patients are required to pay reasonable charges for physicians' services but payment of deductible and coinsurance amounts applicable to such services is not generally obtained from them or on their behalf. In determining whether these requirements are met, the arrangements under which the services are provided will be taken into account. For example, if patients in wards are charged or pay less than do patients in semi-private accommodations the determination of whether

medicare will pay cost or charges might be made separately by accommodation. If the charge is different when made by a physician during hours when he is donating his time than when he is treating his own private patients, that might be a basis for establishing whether cost or charges will be paid. If charges are paid by medicare, the amount paid will have to be set so that it is reasonable for the patient-care service rendered by physicians normally billing on a fee-for-service basis. In some cases hospitals that normally do not bill for physician services have special centers, such as a center for severly burned people, where patients able to pay are regularly admitted and pay charges. Medicare would follow the pattern of the private patient in such centers.

The Secretary would establish regulations under which the patient's ability to pay would be determined. The hospital's rules, which might be self-serving, would not be used. Your committee expects that the Secretary would test ability to pay by using the maximum income levels for a family for which Federal matching is available under the medicaid program. Under section 1903(f) of the medicaid law the maximum family income limits for Federal matching purposes are set at 1⅓ times the highest amount ordinarily paid to a family without other income under the aid to families with dependent children program.

To assure equitable payment, and no loss to the hospital on services to medicare patients, where the proposed cost-reimbursement approach is applicable, your committee's bill would exempt the payments from the deductible and coinsurance provisions. Institutions ordinarily cannot collect these copay amounts from the patients in question. The elimination of the patient's liability would also substantially simplify billing.

Your committee's bill would also amend the law so that a hospital could include costs that medical schools, public health departments, and other medical service organizations incur in paving physicians to provide patient care services to medicare patients in the hospital. Your committee's bill would also permit including in a hospital's costs for purposes of part, the reasonable cost to a medical school of providing services to the hospital which, if provided by the hospital, would have been covered under Part A. The hospital would be required to pay to the medical school the reasonable cost of the services of such physicians.

It is anticipated that when the reimbursement for the services of teaching physicians is on the basis of 100 percent of reasonable costs (with no cost-sharing payments required from the beneficiaries), the fiscal intermediary of the particular hospital would make the required benefit-cost determinations and would initially provide the resulting reimbursement to the hospital. Such reimbursement, although a liability of the supplementary medical insurance trust fund, would be initially paid from the hospital insurance trust fund (along with the other reimbursement payments made on an interim basis by the intermediary to the hospital). From time to time throughout the year, approximate adjustments (determined by actuarial techniques) would be made on an aggregate basis between the two trust funds, such adjustments re-

flecting the amounts which the hospital insurance trust fund paid and, accordingly, should be currently reimbursed by the supplementary medical insurance trust fund (so that there is no loss of interest by the former trust fund, at the expense of the latter trust fund). Final settlements of the respective liabilities of the two trust funds (taking into account the current adjustments previously mentioned and their timing) would be made on the basis of the annual audited cost findings required in connection with hospital reimbursement.

The provisions would be effective with respect to bills submitted after the date of enactment (accounting periods after the date of enactment in the case of reasonable cost determinations).

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

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

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

Program review teams would be established in each State by the Secretary, following consultation with groups representing consumers of health services, State and local professional societies, and the appropriate intermediaries and carriers utilized in the administration of title XVIII benefits. Both the professional and the nonprofessional members of the program review teams would be responsible for reviewing and reporting on statistical data on program utilization (which the Secretary would periodically provide). In addition, the

entire program review team would review cases involving overcharging; however, only the professional members of the program review teams would review cases involving the furnishing of excessive, inferior, or harmful services in order to assure that only professionals will review other professionals under this provision.

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

The provisions relating to title XVIII would be effective with respect to determinations made by the Secretary after enactment of the bill. The provisions relating to titles V and XIX would be effective with respect to items or services furnished after June 30, 1970.

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.

These provisions would be effective upon enactment of the bill.

(*h*) *Elimination of requirement that States move toward comprehensive medicaid programs.*—Section 1903(e) of the medicaid statute requires that each State make "a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance." Under an amendment adopted by the Congress in 1969 (Public Law 91-36, enacted August 9, 1969), the operation of this provision was suspended for two years, until July 1, 1971, and the date by which the States were to have comprehensive medicaid programs (applying to everyone who meets their eligibility standards with respect to income and resources) was changed from 1975 to 1977.

Your committee has been concerned with the burden of the medicaid program on State finances. For example, one State recently cut back on money going to medical schools in order to finance unexpected increases in the cost of medicaid. There is evidence that States have moved more rapidly in the direction of expanding their medicaid programs, and consequently increasing their costs, because of the influence of section 1903(e).

Your committee has taken action to remove section 1903(e) from the act. When the operations of the State medicaid programs have been substantially improved and there is assurance that program extensions will not merely result in more medical costs inflation, the question of required expansion of the program could then be reconsidered.

(*i*) *Determination of reasonable cost of inpatient hospital services under medicaid and maternal and child health programs.*—Under present law, as defined in regulations issued by the Secretary, States are required to reimburse hospitals for inpatient care under medicaid on the basis of the reasonable cost formula set forth in medicare. Several States have objected to this requirement, asserting that use of the medicare formula for medicaid reimbursement can result in

their paying more than the actual cost of providing inpatient care to those eligible for medicaid. There is nothing in the legislative history which requires that reasonable costs should be defined precisely the same way for both programs and there are reasons why they should not, such as the differing characteristics of the two populations served.

Your committee's bill retains the intent of the original provision—to avoid having hospitals or their private patients subsidize inpatient care for the poor—by providing for payment of actual and direct costs of inpatient care for medicaid eligibles. The bill would allow the States to develop their own methods and standards for reimbursement thereby giving them flexibility in working out satisfactory payment arrangements with their hospitals. The Secretary could disapprove a State's plan if it is shown to his satisfaction that the method developed by the State would not pay the actual and direct cost of providing care to medicaid eligibles. Reimbursement by the States would in no case exceed reasonable cost reimbursement as provided for under medicare.

The bill would apply the same determination of reasonable costs to maternal and child health program. The provisions would be effective July 1, 1971, or earlier if the State plan so provides.

(*j*) *Amount of payments where customary charges for services furnished are less than reasonable cost.*—Under present law, reimbursement under the medicare program is based on the reasonable costs incurred by providers of services (but only for inpatient hospital services under 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.

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

However, your committee believes that it would be undesirable to apply this provision in the case of 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 compensation for such services. In such cases fair compensation for a service could not exceed, but could be less than, the amount that would be paid under present law.

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

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

The provisions relating to medicare would be effective with respect to admissions to hospitals and extended care facilities after June 30, 1970, and with respect to services furnished by home health agencies for plans initiated after June 30, 1970. Provisions relating to medicaid and maternal and child health would be effective for calendar quarters beginning after June 30, 1970.

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

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

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

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

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

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

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

States would not be eligible to receive this increased Federal support until they have developed the capacity to provide basic information to recipients on services paid for by the program, including the names of the providers, the dates on which services were furnished, and the amount of payment made. Experience with the medicare program indicates that beneficiary complaints about discrepancies between

the "explanation of benefits" form they receive, and the care actually provided, has been the largest single source of information on possible abuse and fraud. It is appropriate to combine the requirement that States provide such explanations with the increased Federal matching which would support such an activity. Savings resulting from increased administrative efficiency would more than offset the costs of this provision.

This provision of the bill would be effective July 1, 1970.

(*m*) *Advance approval of extended care and home health coverage under medicare program.*—Posthospital extended care benefits and posthospital home health benefits are limited to medicare beneficiaries who, while no longer in need of inpatient hospital care, still require skilled nursing care or, in the case of home health benefits, 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 extended care facility or home health benefits cannot generally be made until some time after the services have been furnished. Your committee is aware that in many cases such benefits are being denied retroactively, with the harsh result that the patient is faced with a large bill he expected would be paid or the facility or agency has 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.

Your committee believes that to the extent that valid criteria can be established posthospital extended care and home health benefits should be more positively identified by type and duration of care which would be assured of reimbursement when furnished to a beneficiary but that no change should now be made to broaden the coverage of the extended care or home health benefits with resulting increased costs. To achieve its purpose, your committee's bill provides for determining in advance a minimum period of coverage in an extended care facility or under a home health plan for patients who, considering their medical conditions, age, or other pertinent factors, can be presumed to need the type of care necessary to qualify for benefits. Under the committee bill, the Secretary would be authorized to establish, by diagnosis and length of stay or number of visits, periods for which a patient would be presumed to be eligible for benefits; the periods would be related to such factors as the period generally needed for treatment of the patient's conditions, his medical history and other health factors affecting the nature and duration of the services to be provided. Appropriate procedural requirements for demonstrating compliance with the criteria would also be established.

For example, elderly patients suffering from a fractured hip ordinarily require a period of intensive skilled nursing and rehabilitative care following the initial reduction and stabilization of the injured limb. The Secretary, drawing on program experience and other data concerning the length of such intensive care ordinarily required for

the condition, would establish a minimum period of stay in an extended care facility during which the patient would be presumed to require the skilled nursing care on a continuing basis which is reimbursable under the program. The physician would be expected to certify the type of condition and related need for extended care and submit to the facility a plan for furnishing the care prior to the patient's admission. The period of coverage established by the Secretary could take into account such factors as the length of prior hospital stay and any surgical involvement required in effecting reduction of the fracture. If the patient suffered a setback or failed to convalesce as rapidly as expected, additional extended care payments could be approved by the intermediary beyond the initial period upon submission of appropriate medical evidence. On the other hand, if the facility's utilization review committee discovered in the course of regular case review that the patient was receiving only custodial services or had recuperated sufficiently to no longer require intensive skilled care, payment during the approved period could be terminated on a prospective basis under the same procedures used when such committees determine in review of a case of extended duration, that further inpatient stay is not medically necessary.

To prevent abuse of the advance approval procedure, intermediaries and facilities would be expected to monitor, through periodic review of a sample of paid stays, utilization review committee studies, and similar measures, the reliability of individual physicians in describing the patient's condition or certifying patients' need 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. Since there will be some instances in which the patient recovers sufficiently to no longer require an extended care level of services prior to expiration of the approved stay, extended care facility utilization review committees will be expected to continue to review approved cases at appropriate intervals and, where necessary, give notice that further payment is no longer justified.

This provision would be effective January 1, 1971.

(*n*) *Prohibition against reassignment of claims to benefits.*—Under present law, payment for services furnished by a physician or other person under the supplementary medical insurance program is made: (1) to the beneficiary on the basis of an itemized bill, or (2) to the physician or other person who provided the services on the basis of an 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 HEW makes such reassigned payments under medicare without specific legislative authority.

Experience with this practice under these programs shows that some physicians and other persons providing services reassign their rights to other organizations or groups under conditions whereby the organization or group submits claims and receives payment in its own name.

Such reassignments have been a source of incorrect and inflated claims for services and have created administrative problems with respect to determinations of reasonable charges and recovery of overpayments. Fraudulent operations of collection agencies have been identified in medicaid. Substantial overpayments to many such organizations have been identified in the medicare program, one involving over a million dollars.

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

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

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 July 1, 1971, or earlier if the State plan so provides.

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

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

This provision would be effective July 1, 1971.

(*p*) *Elimination of requirement that cost-sharing charges imposed on individuals other than cash recipients under medicaid be related to their income.*—Under present law, a State cannot impose deductibles or other cost-sharing devices on cash assistance recipients. In addition, while deductibles or copayments can be imposed with respect to the medically indigent, they must be "reasonably related to the recipient's income and resources."

Your committee's bill would remove the restriction relating to the medically indigent in order to allow States to explore the cost advan-

tages that may result from the direct savings and possible decrease in utilization that cost-sharing devices of a specified amount for all the medically indigent might create. Even a small charge gives the recipient a sense of participation and can reduce tendency to excessive use of services. Experience with many programs covering prescription drugs has shown that a modest copayment can control excessive utilization. Your committee believes that States should have the option of introducing copayment provisions for the purpose of reducing the overutilization of services.

It would be expected that States would impose flat deductibles or copayments primarily with respect to these items of health care or services which are provided in large part at the initiative of the patient. States would be permitted to have such a copayment for such services for all of its medically indigent.

The ban on use of deductibles or copayments for cash assistance recipients would be retained.

This provision would be effective January 1, 1971, or earlier if the State plan so provides.

(*q*) *Notification of unnecessary admission to a hospital or extended care facility under medicare program.*—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.

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

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

(*r*) *Use of State health agency to perform certain functions under medicaid and maternal and child health programs.*—Under present law, one State agency may have the responsibility for certifying health facilities for participation in the medicare program and another agency for certifying health facilities for participation in medicaid and maternal and child health programs. Your committee believes that this duplication of effort in the establishment and maintenance of health standards is unnecessary and inefficient. Your committee's bill would require the State to provide that the State health agency shall perform these functions for medicare, medicaid, and the maternal and child health programs.

Your committee also believes that the effectiveness and economy of the medicaid program would be enhanced through development of

capability in each State to perform utilization reviews, to establish standards relating to the quality of health care furnished to medicaid recipients, and to review the quality of the services provided. Activities such as these would provide information on the under- or over-utilization of resources and the quality and appropriateness of care.

To encourage the development of the capabilities upon which these improvements would be based, the committee bill provides that Federal participation in medicaid payments be contingent upon the establishment of a plan, acceptable to the Secretary, for utilization review, the establishment of standards relating to the quality of care furnished to medicaid recipients, and review of the quality of services provided. Federal matching at the 75-percent rate is 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 July 1, 1971.

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

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

Your committee believes it would be desirable for medicare to relate itself to health maintenance organizations in a way that conforms more nearly to their usual way of doing business. The objective is to provide,

in the cae of medicare beneficiaries, the same kind of financial incentives that health maintenance organizations have with respect to their other enrollees.

Accordingly, your committee's bill provides for medicare payment to such an organization with respect to beneficiaries enrolled with it to be made on a prospective per capita basis, encompassing services covered under both hospital insurance and supplementary medical insurance. (Group practice prepayment plans could, of course, choose to continue to be reimbursed under the provisions of existing law if they wished.) The payment would be determined annually in accordance with regulations of the Secretary, taking into account the organization's premiums with respect to nonmedicare enrollees (with appropriate actuarial adjustments to reflect the difference in utilization patterns between those under 65 and those over 65). This payment is to be no more than 95 percent of the estimated amount (with appropriate adjustments to assure actuarial equivalence) that would be payable if such covered medicare services were furnished outside of the framework of a health maintenance organization. Thus, the organization will be encouraged to manage its resources and provide a level of service within a predictable premium income; extensions and improvements in service could thus also be provided to beneficiaries from utilization and other savings that the organization may be able to make within resulting income. Payments to health maintenance organizations would be made from both the hospital insurance and supplementary medical insurance trust funds, with the portion from the supplementary medical insurance trust fund being the product of the total monthly premium (beneficiary and Federal Government amounts combined) times the number of medicare beneficiaries enrolled in the organization. The remainder of the payment would be made from the hospital insurance trust fund.

Under this new approach to payment of health maintenance organizations, there is expected to be a small increase in the first year or two in the amount of payment by the program. However, if additional beneficiaries enroll in either existing or newly established health maintenance organizations there is a likelihood of cost savings to the program.

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

To qualify to receive payment in this way, a health maintenance organization would have to be one which provides: (1) either directly or through arrangements with others, health services on a prospective per capita prepayment basis; (2) all the services and benefits of both the hospital and medical insurance parts of the program; (3) physi-

cian's services, either directly by physicians who are employees or partners of the organization, or under an arrangement with an organized group of physicians under which the group is reimbursed for its services on the basis of an aggregate fixed sum or on a per capita basis. (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.) At least half the enrolled members of a health maintenance organization must be under age 65, and the organization would have to have an open enrollment period at least once every 2 years under which it accepts enrollees on a nondiscriminatory basis up to the limits of its capacity. The 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 must have arrangements for assuring that the health services required by its enrollees are received promptly and appropriately and that they measure up to quality standards. The various elements of a health maintenance organization, such as the hospital, the extended care facility or clinical laboratory, would each continue to have to meet the conditions of participation or other quality standards which apply to such organizations under present law.

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

Beneficiaries enrolled with a health maintenance organization who are dissatisfied with decisions of the organization on this 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, generally, disenrollment would take effect at the same time after the disenrollment request as is the case now with respect to disenrollment under the supplementary medical insurance program.

Your committee notes that there is sufficient authority in the present medicaid program to permit States to arrange for medicaid coverage through a health maintenance organization. It would continue to be

necessary, as required under present law, to guarantee medicaid eligibles freedom of choice of health providers. Moreover, it is expected that the Department of Health, Education, and Welfare would use the provisions of medicare law and regulations for health maintenance organizations, to the extent appropriate, in regulations dealing with similar coverage under the medicaid program.

The health maintenance organization provisions in the bill would be effective with respect to services furnished on or after January 1, 1971.

3. Miscellaneous and technical provisions

(*a*) *Coverage prior to application for medicaid.*—Under present law a State may, at its own option, cover the cost of health care provided to an otherwise qualified recipient for the three months prior to his application for medicaid. Thirty-one States have elected to provide this coverage, thereby protecting persons who are eligible for medicaid but do not apply for assistance until after they have received care, either because they did not know about the medicaid eligibility requirements or because the sudden nature of their illness prevented their applying.

Your committee believes that such coverage is reasonable and desirable and recommends that the States be required to provide protection for that 3-month period. Therefore, your committee's bill requires all States to provide coverage for care and services furnished in or after the third month prior to application for those individuals who were otherwise eligible when the services were received.

This provision would be effective July 1, 1971.

(*b*) *Hospital admissions for dental services under the medicare program.*—Under present medicare procedures, when a patient is hospitalized in connection with the performance of noncovered dental procedures, payment may be made for inpatient hospital services if the patient has other impairments so severe that hospitalization is necessary. In some cases, intermediaries require that a physician certify to the medical necessity of dental admissions, since hospitalization is ordinarily not necessary for the provision of dental services. Where such a certification is required, the dentist who will be performing the dental procedures must arrange for a physician to make the necessary certification.

Your committee's bill would authorize the dentist who is caring for the patient to make the determination of the necessity for inpatient hospital admission for dental services without requiring a corroborating certification by a physician. Your committee believes that in these kinds of cases the dentist is in a better position to make the necessary evaluation of the patient's condition and probable reaction to dental surgery than is a physician who may not be familiar 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.

(*c*) *Exemption of Christian Science sanatoriums from certain nursing home requirements under medicaid.*—Under present law, Christian Science sanatoriums are permitted to participate in the medicaid program as skilled nursing homes, and as such, are required to meet the general requirements established for skilled nursing homes.

Your committee believes that Christian Science sanatoriums which do not actually provide medical care, should not be required to have

a skilled nursing home administrator licensed by the State, to maintain an organized nursing service under the direction of a registered nurse, to maintain detailed medical records, or to have diagnostic and other service arrangements with general hospitals. The bill would, therefore, exempt Christian Science sanatoriums from the requirements for a licensed nursing home administrator and other inappropriate requirements of the medicaid program. Such sanatoriums will be expected to continue to meet all applicable safety standards.

This provision would be effective upon enactment.

(*d*) *Physical therapy services under medicare.*—Under present law, physical therapy is covered as an inpatient hospital service, an inpatient extended care service, a home health service, and a service incident to physicians' services. Physical therapy is also covered when furnished under prescribed conditions by a participating hospital, extended care facility, home health agency, clinic, rehabilitation agency, or public health agency to its outpatients. The physical therapist may be either an employee of the participating facility or he may be self-employed and furnish his services under arrangements with and under the supervision of the facility.

The limitations imposed under present law on the coverage of physical therapy have been a source of some difficulty. For example, it has been difficult to explain why physical therapy services cannot be furnished in the therapist's office, especially in cases where the latter is more accessible than the facility to which the beneficiary must travel to obtain the service.

Your committee's bill would include as covered services under the supplementary medical insurance program the services of a physical therapist in independent practice, when furnished in his office or in the patient's home (including a place of residence used as his home other than an institution which is primarily engaged in furnishing skilled health care services). These services would be furnished under such licensing and other conditions relating to health and safety as the Secretary may find necessary, such as requiring that the services be furnished pursuant to a written plan of treatment established by a physician which prescribes the amount, type, and duration of services to be furnished, and setting out professional qualifications in addition to State licensure for the physical therapists participating under this provision. The bill would provide that the Secretary establish regulations governing other conditions under which the proposed services would be furnished. Your committee expects the Secretary to be guided by the conditions now in effect for providers of outpatient physical therapy services, taking into account the less elaborate facilities generally present in the office setting, but assuring that the regulations provide for the availability of an adequate program of physical therapy services in the therapist's office.

With respect to present law as it covers physical therapy services furnished to an inpatient of a hospital or an extended care facility, there are a few cases where an inpatient exhausts his inpatient benefits and can continue to receive payment for the physical therapy treatment (as a covered expense under the supplementary medical insurance program) only if the hospital or extended care facility is able to arrange for another participating facility to furnish the physical therapy treatment as an outpatient service. Your committee's bill would author-

ize a hospital or extended care facility to furnish outpatient physical therapy services to its inpatients. This would permit an inpatient of a participating hospital or extended care facility to continue to receive covered physical therapy services under the supplementary medical insurance program in those cases where he had exhausted his inpatient benefits through which physical therapy services were covered under the hospital insurance program or where he is otherwise ineligible for hospital insurance inpatient benefits.

Your committee is concerned over the increasing costs of physical therapy services furnished in hospitals and extended care facilities. Moreover, there is considerable evidence that physical therapy has been one of the areas in the present program most subject to abuse. Accordingly, the committee bill includes two provisions for controlling program expenditures for physical therapy services and for preventing abuse:

(1) Total charges on which payment may be made in a calendar year with respect to an individual for physical therapy services furnished to him in practitioners' offices or in his home by independently practicing physical therapists may not exceed $100 (such payment would be subject to the deductible and coinsurance provisions of the supplementary medical insurance program). Program reimbursement for the reasonable charges for the covered services would be made either to the beneficiary or, on assignment, directly to the physical therapist.

(2) With respect to physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency or by others under arrangements with such providers or other organizations, payment for the reasonable cost of such services may not exceed an amount equal to the salary which would have been payable to a qualified physical therapist if the services had been performed in an employment relationship.

The provisions for covering additional physical therapy services under supplementary medical insurance would be effective for services furnished on or after January 1, 1971. The provisions relating to physical therapy services furnished by a provider of services or other agency would be effective with respect to accounting periods beginning on or after January 1, 1971.

'(*e*) *Extension of grace period for termination of supplementary medical insurance coverage where failure to pay premiums is due to good cause.*—Under present law, an individual's coverage under the supplementary medical insurance part of medicare is terminated for nonpayment of premiums. The termination is effective on a date determined under regulations which may be established so as to provide a grace period (not in excess of 90 days) during which overdue premiums may be paid and coverage continued.

Several types of cases have arisen in which termination of an individual's supplementary medical insurance protection for failure to pay all premiums due within 90 days is clearly inequitable. For example, there have been cases where for reasons of physical or mental incapacity the enrollee was unable to make the premium payment within the allowed time limit and there was no one acting on his behalf to protect his interests. In other cases, coverage has been terminated because the enrollee mistakenly believed that payment had been made when actually it had not.

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Your committee's bill would extend the 90-day grace period for an additional 90 days where the Secretary finds that there was good cause for failure to pay the premium before the expiration of the initial 90-day grace period.

This provision would apply to such cases of nonpayment of premiums due within the 90-day period preceding the date of enactment.

(*f*) *Extension of time for filing claim for supplementary medical insurance benefits where delay is due to administrative error.*—Under present law, a claim for benefits under the supplementary medical insurance program must be filed by December 31 of the year following the year in which the services were provided. (For this purpose, services furnished in the last 3 months of a year are deemed to have been furnished in the following year.) The present time limit is adequate for the vast majority of supplementary medical insurance claims. In some few cases, however, beneficiaries have failed to file a timely claim due to a mistake or other action on the part of the Government or one of its agents. For example, misinformation from an official source or delay in establishing supplementary medical insurance entitlement has resulted in late filing of claims.

Your committee's bill would provide that where a claim under supplementary medical insurance is not filed timely due to error of the Government or one of its agents, the claim may nevertheless be honored if filed as soon as possible after the facts in the case have been established. This provision would assure that claimants would not be treated inequitably because of such an error.

This amendment would apply with respect to bills submitted and requests for payment made after March 1968.

(*g*) *Waiver of enrollment period requirements where individual's rights were prejudiced by administrative error or inaction.*—Under present law, an individual can enroll in the supplementary medical insurance program during his initial 7-month enrollment period, beginning with the third month before the month he attains age 65, or during any general enrollment period (during the first 3 months of each year), which begins within 3 years after the end of his initial enrollment period. (The committee's bill includes a provision which would eliminate the 3-year limit on enrollment. That provision is discussed immediately following discussion of this provision.)

There have been some relatively rare cases in which it has been discovered that due to an action, inaction, or error on the part of the Government an individual is in fact enrolled, or is in fact not enrolled, under supplementary medical insurance when both the individual and the Government had until then believed that the reverse was true. Such cases include instances where an individual filed an enrollment request timely 2, 3, or more years ago, but it was inadvertently misfiled and never acted upon. When the request is discovered, the individual, who did not know he had supplementary medical insurance coverage is presented with a substantial bill for premiums; or if he is a beneficiary, he may find that his benefit check is reduced or withheld altogether to pay premiums for supplementary medical insurance coverage which he never knew he had. Another type of case involves the person who enrolled in good faith and was allowed medical insurance on the basis of evidence showing that he had attained age 65; several years later new evidence is discovered which shows he was only age 64 at the time of

enrollment—that is, new evidence shows that he was not eligible to enroll when he did. In such situations the Government is forced to disallow the supplementary medical insurance coverage, refund all premiums received, recover any supplementary medical insurance benefits paid, and notify the person that if he wishes supplementary medical insurance coverage he may enroll in the next general enrollment period. Although these cases are rare, they can cause considerable hardship and distress to the individuals involved, and present law permits no relief to be given.

Your committee believes that where an individual's enrollment rights under supplementary medical insurance have been prejudiced because of the action, inaction or error on the part of the Government, he should not be penalized or caused hardship. The bill, therefore, authorizes the Secretary to provide such equitable relief as may be necessary to correct or eliminate the effects of these situations, including (but not limited to) the establishment of a special initial or subsequent enrollment period, with a coverage period determined on the basis thereof and with appropriate adjustments of premiums.

This provision would apply to all cases which have arisen since the beginning of the program.

(*h*) *Elimination of provisions preventing enrollment in supplementary medical insurance program more than 3 years after first opportunity.*—Under present law, an individual can enroll for the first time in the supplementary medical insurance program during his initial 7-month enrollment period, beginning with the third month before the month he attains age 65, or during any general enrollment period (during the first 3 months of each year) which begins within 3 years after the end of his initial 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.

Your committee's bill 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 under present law.

(*i*) *Waiver of recovery of incorrect payments from survivor who is without fault.*—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 defeat the purposes of the cash social security title (title II) of the Social Security Act or would be against equity and good conscience. If such individual dies, recovery action is initiated as necessary 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.

Your committee's bill would rectify this anomaly by permitting any individual who is liable for repayment of a medicare overpayment to qualify for waiver of recovery of the overpaid amount if he is without fault and if such recovery would defeat the purposes of title II or would be against equity and good conscience.

The provision would be effective upon enactment for overpayments outstanding at that time.

(*j*) *Requirement of minimum amount of claim to establish entitlement to hearing under supplementary medical insurance program.*—Under present law, people enrolled in the supplementary medical insurance program are assured an opportunity for a fair hearing by the carrier when requests for payment under supplementary medical insurance are denied or are not acted upon with reasonable promptness, or when the amount of the payment is in controversy, regardless of the dollar amount at issue. Experience under the program indicates that the holding of a full fair hearing is unwarranted in cases where the amount in controversy is relatively small. Carriers have reported cases involving $5 and $10 claims for which the cost of holding a fair hearing has exceeded $100. Approximately 45 percent of the hearings held since the beginning of the program have involved an amount less than $100. Further, regulations require carriers to have a reconsideration review of all denied claims. Such review involves different claims personnel than those who acted on the original claim and should be sufficient protection in small claims cases.

Your committee's bill would require that a minimum amount of $100 be at issue before an enrollee in the supplementary medical insurance program will be granted a fair hearing by the carrier.

The provision would be effective with respect to hearings requested after the enactment of the bill.

(*k*) *Collection of supplementary medical insurance premiums from individuals entitled to both social security and railroad retirement benefits.*—Under present law, the responsibility for collecting supplementary medical insurance premiums for enrollees entitled to both railroad retirement benefits and social security benefits is vested in either 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.

Your committee's bill provides that the Railroad Retirement Board shall be responsible for collection of supplementary medical insurance premiums for all enrollees who are entitled under that program. This change will eliminate the confusion, payment delay, and administrative expense deriving from the related provisions of present law.

This provision would be effective for premiums becoming due and payable after the fourth month after the month of enactment.

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

In connection with the Social Security Amendments of 1967, the Department of Health, Education, and Welfare and the Department of State were requested to explore the feasibility of entering into reciprocal arrangements between the United States and neighboring nations designed to make medicare benefits available to United States citizens who receive necessary hospital care in such neighboring nations. The report of the study indicated that such reciprocal arrangements are not feasible at the present time, but that unilateral extension of medicare, which could be limited to border residents, appears to be feasible.

Your committee's bill would include a provision which would expand Medicare coverage of services outside the United States to take account of the special problems of border residents. Medicare benefits would be payable, with respect to admissions after December 31, 1970, for inpatient hospital services furnished outside the United States if the beneficiary is a resident of the United States and the foreign hospital was closer to, or substantially more accessible from his residence than the nearest hospital in the United States which was suitable and available for his treatment. For such beneficiaries, benefits would be payable without regard to whether an emergency existed or where the illness or accident occurred. Only inpatient services furnished by a hospital which has been accredited by the Joint Commission on Accreditation of Hospitals or by a hospital approval program having essentially comparable standards would be covered.

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

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

This provision of the bill would be effective with respect to hospital admissions after December 31, 1970.

(*m*) *Study of chiropractic coverage.*—Your committee's bill would require the Secretary to conduct a study of chiropractic services covered under State plans approved under title XIX. The objectives of the study would be to determine whether and to what extent chiropractic services should be covered under the supplementary medical insurance program of title XVIII, giving particular attention to the limitations which should be placed on such coverage and on the amounts

to be paid for whatever services might be provided. The study would include one or more demonstration projects designed to assist in providing (under controlled conditions) the information necessary to achieve the objectives of the study. The Secretary would be required to report the results of the study to the Congress within 2 years after the date of enactment of this bill, together with his findings and recommendations based on the study, and on the information he obtains concerning the experience of public and private plans which now or did cover chiropractic services.

(*n*) *Extending health insurance protection to disabled beneficiaries.*—Your committee gave extensive consideration to a proposal to extend hospital insurance protection under title XVIII to disabled workers entitled to monthly cash disability benefits under the social security and railroad retirement programs. While your committee believes that extending hospital insurance protection to these beneficiaries would be most desirable, it has regretfully concluded that such an extension is not advisable at the present time.

A major factor in your committee's decision was that the per capita cost of providing hospital insurance for the disabled would be considerably higher than is the cost of providing the same coverage for the aged. The high cost (even if the proposal were limited to disabled worker beneficiaries), together with the need to bolster financing for the existing hospital insurance program for the aged (discussed elsewhere in this report), raised serious problems for which the committee found no immediately acceptable solution.

Your committee, therefore, has not included in the bill a provision to extend hospital insurance to disabled workers; rather it is directing the 1969 Advisory Council on Social Security to make a special study of the unmet need of the disabled for health insurance protection, the costs involved in providing this protection, and the ways of financing this protection. The Council would be required to include its findings in the report it will be submitting to the Secretary of Health, Education, and Welfare not later than January 1, 1971. The Council would also be required to make recommendations on the extent to which the cost of this protection could appropriately be met by the hospital insurance and supplementary medical insurance trust funds. The Council's report would be submitted to the boards of trustees of the trust funds and to the Congress.

(*o*) *Reimbursement of group practice prepayment plans.*—The Senate Committee on Finance in its consideration of the House enacted bill (H.R 6675) in 1965, recommended that supplementary medical insurance enrollees who received services covered thereunder as members of group practice prepayment plans be accommodated through the recognition of program liability on a cost basis for such services at the election of such a plan. This committee concurred in the recommendation.

It was the understanding of the Congress that the cost reimbursement of group practice prepayment plans would take into consideration the cost of the services made available to the members of such group practice plans who are medicare enrollees, to the end that costs with respect to medicare enrollees would not be borne by other members of the plan, and that the costs with respect to such other members would not be borne by the supplementary medical insurance program.

Thus, it was anticipated that the total allowable remuneration to plan physicians by the group practice plan would be allocated proportionately as between medicare members and other members of the plan with due recognition being given to time and utilization factors appropriate to the respective groups. To the extent that existing administrative procedures for reimbursing group practice plans on a cost basis are at variance with these principles or limit the right of such a plan to elect to be reimbursed on the basis of allocated costs, such procedures do not conform to the legislative intention with regard to the reimbursement for the services furnished by such plan.

(*p*) *Accelerated depreciation as part of cost reimbursement under medicare and medicaid in certain limited circumstances.*—The cost reimbursement provisions of the medicare and medicaid law do not specify whether accelerated depreciation should be allowed in computing the costs of a participating institution. When the original reimbursement regulations were developed, they specified that the then existing provisions for accelerated depreciation in the Federal income tax law that allowed the use of the sum of the years digits and double declining balance approaches could also be employed in medicare. Since that time, the income tax provisions have been modified. Also, difficulties have arisen under medicare in connection with the payment of accelerated depreciation during the early years of the life of an asset, particularly where the asset was sold by the original provider institution. In such cases, difficulty in recouping the additional medicare payments that had been allowed through the use of accelerated depreciation has been encountered.

In recognition of these developments, the Department has published a proposed regulation deleting the allowance of accelerated depreciation on assets that are acquired in the future. Hospitals and other institutional providers have expressed concern to your committee about hardships these proposed regulations would cause, and have noted that (1) a number of these institutions had made valid construction, acquisition, or permanent financial commitments before publication of the proposed regulations in connection with which they had assumed the availability of accelerated depreciation in accordance with existing regulations, and (2) there is an increasing necessity for health care institutions to finance capital additions and expansions of service through the use of mortgage loans under which, in the absence of accelerated depreciation allowances, they cannot meet the principal amortization schedules they have to pay on capital debts they incur.

With regard to the first problem, it seems reasonable to your committee to continue the application of the original regulations allowing accelerated depreciation on capital assets of participating providers where the financial commitment involved was entered into prior to February 5, 1970, and your committee has obtained the agreement of the Department of Health, Education, and Welfare to do so. February 5, 1970, is the date of the publication of the proposed regulations, so commitments could not have been entered into with knowledge of your committee's agreement with the Department.

Second, because health care institutions are undoubtedly required in many instances to rely on capital borrowing, your committee also recommends that, in the case of financial commitments entered into on or after February 5, 1970, the regulations allow 150 percent declining

balance depreciation to be paid on assets acquired in the future where the cash flow from depreciation on the total assets of the institution, including straight-line depreciation on the assets in question, is insufficient to supply the funds required to meet reasonable principal amortization schedules on the capital debts related to the provider's depreciable assets. Under this recommendation, the allowance of accelerated depreciation payments would be directly tied to the institution's problem of capital debt retirement. For the future, the allowance would be available only in those cases in which a demonstrable need exists. Further, the type of accelerated payment (150-percent declining balance) would be generally consistent with the formula that continues to be allowed in certain cases under the Federal income tax law.

(*q*) *Equivalency testing for personnel of independent clinical laboratories.*—In order to assure the accuracy and reliability of laboratory test results, present law requires the Secretary to establish health and safety criteria as conditions for medicare coverage of services furnished by independent laboratories. Among the standards found to be necessary safeguards by the Department of Health, Education, and Welfare were criteria for judging professional competency and qualifications of laboratory personnel. Since membership in or certification by professional organizations has long been one of the principal means of establishing professional qualifications in health fields, this approach was the one primarily relied on by the Secretary in developing medicare regulations. Medicare regulations also provide that individuals meeting certain formal and highly specialized educational and experience requirements may be found to qualify.

While your committee agrees that many of the present requirements for laboratory personnel have merit, it has concluded that the heavy reliance placed on private professional organizations has served to prevent experienced people either from entering the clinical laboratory field altogether or from making this their career—moving from a lower skilled job to a higher skilled one. What makes this such a critical problem is that laboratories are currently experiencing a sharp expansion in the demand for their services. As the services of laboratories have increased in scope and complexity, they have been faced with an ever-widening gap between their manpower requirements and the available supply of laboratory technologists and technicians.

Your committee believes that both recruitment and utilization of laboratory personnel would be greatly enhanced by the use of equivalency and proficiency examinations. The use of such examinations would greatly increase career mobility in the laboratory field, thereby making the profession more attractive generally, facilitating the recruitment and retention of laboratory workers, and encouraging reentry into the field by those who have left it. There is increased interest in and receptivity to the idea of equivalency testing among the professions—an interest recently emphasized in a report issued in March 1970 on "Equivalency and Proficiency Testing" by the National Committee for Careers in Medical Technology.

Your committee is aware that many ex-servicemen have received valuable training in the armed forces clinical laboratories. The change to proficiency and equivalency testing should provide assurances that many such individuals will be able to make their specialized training available in civilian clinical laboratories.

Your committee has received the assurances of the Department of Health, Education, and Welfare that it will immediately begin consultation with appropriate professional health organizations and educational institutions to develop proficiency testing and educational equivalency mechanisms for use in determining the qualifications of laboratory personnel under the medicare program.

The Department has been requested and has agreed to furnish a report to the Congress on or before July 1, 1971, indicating the progress it has made in carrying out such assurances.

(*r*) *Optometrists' services.*—Your committee believes that the medicare provisions as related to optometrists may need revision in that some optometric services when provided by a physician are covered, but may not be covered when provided by an optometrist. The Department of Health, Education, and Welfare should conduct a study of this problem and submit language to your committee designed to remove any existing inequity.

(*s*) *Homemakers' services under medicare.*—Your committee gave consideration to coverage of the services of home maintenance workers (homemakers) as part of home health services under both the hospital and medical insurance programs. Under present law, the home health benefit is designed for those beneficiaries whose conditions do not require the continuous medical and paramedical care provided in hospitals and extended care facilities, but nevertheless, are of such severity that the individuals are under the care of a physician, confined to their homes, and in need of active health care requiring skilled services. Care that is primarily custodial in nature, whether the care is provided in a nursing home or provided by a health aide in a private home, is not covered under the medicare program. Nor is the care covered when the patient needs only personal care or nonskilled health care.

Although home maintenance services as such are not covered under the home health benefit the covered services of a home health aide may include certain home maintenance services which are performed by the aide under professional supervision. These services may include keeping a safe environment in areas of the home used by the patient, such as changing the bed, light cleaning, laundering essential to the comfort and cleanliness of the patient and include seeing to it that the patient's nutritional needs are met, which may include purchase of food and assistance in preparation of meals. These services may be covered when they are only incidentally provided while the home health aide is fulfilling her primary function of providing health services.

Your committee believes that while financial assistance in maintaining one's home may be necessary and desirable for the well-being of an older person, it is not the purpose of the medicare program to cover all services an older person may need or use, particularly those which are not clearly a part of the person's health care. In view of these priorities, your committee is requesting the 1969 Advisory Council on Social Security to make a study of the unmet need of medicare beneficiaries for homemaker services.

C. STUDY OF THE SOCIAL SECURITY PROGRAM BY THE ADVISORY COUNCIL ON SOCIAL SECURITY

An Advisory Council on Social Security, authorized by the Congress in the Social Security Act and appointed under the provisions of the

Act by the Secretary of Health, Education, and Welfare, is currently conducting an overall review of the social security program. The Council is required by law to review all aspects of the social security program, including specifically the status of the social security trust funds in relation to the long-term commitments of the social security program, the scope of coverage and the adequacy of benefits under the program, and its impact on public assistance programs under the act. Under the law the Council is to report its findings and recommendations to the Secretary of Health, Education, and Welfare by January 1, 1971, who thereupon is to transmit the report to the Congress and to the boards of trustees of the social security trust funds.

In its deliberations your committee took note of the current study being made by the Advisory Council on Social Security. It is the view of your committee that it would be advisable to have the benefit of the study, findings, and recommendations of the Advisory Council before considering further two proposals for changes in the social security program: (1) extending the protection of the medicare program to disabled social security beneficiaries (discussed earlier in more detail on page 63) and (2) the computation of a married couple's social security benefits when both the husband and the wife have worked. Your committee is particularly interested in having the Advisory Council explore the difficult obstacles that must be overcome in order to achieve satisfactory results with respect to both of these issues. Your committee, therefore, requests the Council to include in its report specific recommendations on how the coverage of the medicare program may be extended to social security disability beneficiaries and how the benefits paid to a married couple may be equitably based on their combined earnings.

In addition, your committee requests the Council to make a special study of the unmet need of medicare beneficiaries for homemaker services, beyond those already provided to persons in need of skilled health services. The Council should include its findings in the report it will be submitting to the Secretary of Health, Education, and Welfare not later than January 1, 1971. The Council should also make recommendations on the extent to which the cost of this protection if deemed appropriate and necessary could be met by the hospital insurance and supplementary medical insurance trust funds.

D. FINANCING

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 bill would make provision for meeting the cost of the expanded program. At the present time, the social security cash benefits program is in close actuarial balance, while the hospital insurance program has an actuarial deficiency; that is, it is expected that over the long-range future the income to the hospital insurance program will be considerably less than the costs of the program. To meet the cost of the expanded cash benefits program and to bring the hospital insurance program into actuarial balance, the schedule of contribution rates would be revised and the contribution and benefit base—the maximum amount of annual earnings subject to contributions and used in computing benefits—would be increased.

(a) *Increase in the contribution and benefit base.*—The proposed increase in the contribution and benefit base from $7,800 to $9,000 would not only provide higher future benefits at higher earnings levels, but would also help to finance the changes made by the bill. An increase in the base results in a reduction in the overall cost of the social security program as a percent of taxable payroll. This occurs because the benefits provided are a higher percentage of earnings at the lower levels than at the higher levels, while the contribution rate is a flat percentage of earnings. When the base is increased, higher benefits are provided on the basis of the higher earnings that are taxed and credited, but the cost of providing these higher benefits is less than the additional income from the combined employee and employer contributions on earnings above the former maximum and up to the new maximum amount.

(b) *Changes in the contribution rates.*—Under the schedule of contribution rates for cash benefits that your committee recommends (shown below), the contribution rate scheduled for 1971–72 would be decreased from 4.6 percent each for employees and employers to 4.2 percent each. The rate scheduled for 1973–74 under present law would be decreased from 5 percent each to 4.2 percent each. The rate scheduled for 1975–79 would be 5.0 percent, the same as under present law. After 1979, the contribution rate would be 5.5 percent each, instead of 5 percent as under present law.

For the self-employed, the rate scheduled for 1971–72 for the cash benefits part of the program would be decreased from 6.9 percent to 6.3 percent. The rate scheduled for 1973–74 would be decreased from 7 percent to 6.3 percent. Thus the currently payable rate of 6.3 percent would remain in effect until 1975, at which time the increase to 7 percent, the highest rate scheduled under present law, would go into effect.

Your committee also recommends changes in the contribution rate schedule for the hospital insurance program. The contribution rate would be increased from 0.6 percent each for employees, employers, and the self-employed to 1 percent each beginning in 1971. The rate would be kept at 1 percent thereafter. Under present law the rate is scheduled to increase gradually from the present 0.6 percent to 0.9 percent for 1987 and after.

CONTRIBUTION RATE SCHEDULES UNDER PRESENT LAW AND H.R. 17550

[In percent]

Period	OASDI		HI		Total	
	Present law	H.R. 17550	Present law	H.R. 17550	Present law	H.R. 17559
Employer-employee, each:						
1970	4.2	4.2	0.6	0.6	4.8	4.8
1971–72	4.6	4.2	.6	1.0	5.2	5.2
1973–74	5.0	4.2	.65	1.0	5.65	5.2
1975	5.0	5.0	.65	1.0	5.65	6.0
1976–79	5.0	5.0	.7	1.0	5.7	6.0
1980–86	5.0	5.5	.8	1.0	5.8	6.5
1987 and after	5.0	5.5	.9	1.0	5.9	6.5
Self-employed:						
1970	6.3	6.3	0.6	0.6	6.9	6.0
1971–72	6.9	6.3	.6	1.0	7.5	7.3
1973–74	7.0	6.3	.65	1.0	7.65	7.3
1975	7.0	7.0	.65	1.0	7.65	8.0
1976–79	7.0	7.0	.7	1.0	7.7	8.0
1980–86	7.0	7.0	.8	1.0	7.8	8.0
1987 and after	7.0	7.0	.9	1.0	7.9	8.0

(c) *Change in allocation to the disability insurance trust fund.*—The bill would revise the allocation of contribution income to the disability insurance trust fund without significantly altering the long-range income of the fund. Under present law, 1.10 percent of taxable wages and 0.825 of 1 percent of self-employment income are allocated to the disability insurance trust fund. Under the committee's bill, the allocation to the disability insurance trust fund would be as follows:

[In percent]

Calendar year	Taxable wages	Self-employment income
1971–74	0.90	0.6750
1975–79	1.05	.7875
1980 and after	1.15	.8625

The revision in the allocation is necessary because, under present law, the size of the disability insurance trust fund is expected to grow rapidly over the next several years. Your committee believes that this growth is not necessary nor wise and that the allocation rate may be safely reduced below that specified in present law until 1980.

(d) *Effective date of increase in the contribution and benefit base for self-employed persons reporting on a fiscal year basis.*—In the past when increases in the contribution and benefit base have been enacted they have been effective, for self-employed people who report their income on a fiscal year basis, (i) with respect to contributions, for fiscal years ending in the calendar year in which the increase in the base became effective, and (ii) with respect to crediting for benefit purposes, at the beginning of the calendar year in which the increase in the base became effective. As a result, certain self-employed people were required to pay social security contributions on income that could not be credited for benefit purposes. For example, the last increase in the base, to $7,800, was effective for the calendar year 1968; for self-employed persons reporting their income on a fiscal year basis the increase was effective (i) with respect to contributions, for fiscal years ending in 1968, and (ii) with respect to crediting for benefit purposes, at the beginning of 1968. A fiscal year taxpayer whose fiscal year ended on June 30, 1968, for example, and who had self-employment income of $7,800 for that year would have had to pay contributions on the full $7,800 but could have had only $7,200 counted toward benefits ($3,300—one-half of the $6,600 base amount that was in effect in 1967—for the period July 1 through December 31, 1967, plus $3,900—one-half of the $7,800 base amount that was in effect in 1968—for the period January 1 through June 30, 1968).

Your committee believes that a taxpayer should not have to pay social security contributions on income that he cannot have credited for social security benefits. Accordingly, your committee's bill would provide that, for self-employed persons who report their income on a fiscal year basis, the increase in the base from $7,800 to $9,000 that would occur under the bill would be effective for contribution purposes for fiscal years beginning in 1971, the calendar year in which the increase in the base is effective, rather than for fiscal years ending in 1971, as would be the case if past practice were followed. Under this change no fiscal year taxpayer would have to pay social security contributions on income that he could not have credited for social security

benefits. On the other hand, he could not start having more than $7,800 a year counted toward his benefits until his fiscal year begins sometime after Jauary 1, 1971, the date on which the increase in the base to $9,000 becomes effective generally.

IV. ACTUARIAL COST ESTIMATES UNDER THE BILL

A. ACTUARIAL COST ESTIMATES FOR THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM

(a) *Summary of actuarial cost estimates*

The old-age, survivors, and disability insurance system, as modified by your committee's bill, has an estimated cost for benefit payments and administrative expenses that is closely in balance with contribution income. This also was the case for the 1950 and subsequent amendments at the time they were enacted.

The old-age and survivors insurance system as modified by your committee's bill shows an actuarial balance of −0.12 percent of taxable payroll under the intermediate-cost estimate. This is, of course, close to an exact balance, especially considering that a range of variation is necessarily present in the long-range actuarial cost estimates and, further, that rounded tax rates are used in actual practice. Accordingly, the old-age and survivors insurance program, as it would be changed by your committee's bill, is actuarially sound.

The separate disability insurance trust fund, established under the 1956 act, shows exact actuarial balance under the provisions that would be in effect after enactment of your committee's bill, because the contribution rates allocated to this fund are exactly the same as the cost of the disability benefits, based on the intermediate-cost estimate. Accordingly, the disability insurance program, as it would be modified by your committee's bill, is actuarially sound.

(b) *Financing policy*

(1) *Contribution rate schedule for old-age, survivors, and disability insurance in H.R. 17550*

The contribution schedule for old-age, survivors, and disability insurance contained in your committee's bill, as to the combined employer-employee rate, is lower than that under present law by 0.8 percent in 1971–72, and by 1.6 percent in 1973–74, is the same in 1975–79, and is 1.0 percent higher in 1980 and after. The maximum earnings base to which these tax rates are applied is $9,000 per year for 1971 and after under your committee's bill as compared with $7,800 under present law. These tax schedules are as follows:

[Percent]

Calendar year	Combined employer-employee rate		Self-employed rate	
	Present law	H.R. 17550	Present law	H.R. 17550
1970	8.4	8.4	6.3	6.3
1971–72	9.2	8.4	6.9	6.3
1973–74	10.0	8.4	7.0	6.3
1975–79	10.0	10.0	7.0	7.0
1980 and after	10.0	11.0	7.0	7.0

The allocated rates to the two trust funds that are applicable to the combined employer-employee contribution rate for your committee's bill, as compared with present law, are as follows:

[Percent]

Calendar year	Old-age and survivors insurance		Disability insurance	
	Present law	H.R. 17550	Present law	H.R. 17550
1970	7.3	7.30	1.1	1.10
1971–72	8.1	7.50	1.1	.90
1973–74	8.9	7.50	1.1	.90
1975–79	8.9	8.95	1.1	1.05
1980 and after	8.9	9.85	1.1	1.15

The corresponding allocated rates for the self-employed contribution rate are as follows:

[Percent]

Calendar year	Old-age and survivors insurance		Disability insurance	
	Present law	H.R. 17550	Present law	H.R. 17550
1970	5.475	5.4750	0.825	0.8250
1971–72	6.075	5.6250	.825	.6750
1973–74	6.175	5.6250	.825	.6750
1975–79	6.175	6.2125	.825	.7875
1980 and after	6.175	6.1375	.825	.8625

It should be remembered that the workers and employers contribute a combined, rounded rate for the two programs (old-age and survivors insurance and disability insurance), and not the above complex fractional rates separately. Such fractional rates are merely used by the Treasury Department to divide up the aggregate tax receipts between the two trust funds.

The schedule of allocation rates for the disability insurance trust fund in your committee's bill has been obtained in the following manner. For the combined employer-employee tax, the total rate for both old-age and survivors insurance and disability insurance was multiplied by the ratio of the level-cost of the disability insurance program (1.10 percent of taxable payroll) to the level-cost for both programs combined (10.51 percent of taxable payroll), and the result rounded to the nearest 0.05 percent. The allocation rate for the self-employed tax for disability insurance was then computed at 75 percent of the allocation rate for the combined employer-employee tax.

The allocation rates for the old-age and survivors insurance trust fund were obtained by merely subtracting the allocation rates for the disability insurance trust fund from the appropriate total tax rates.

(2) Self-supporting nature of system

The Congress has always carefully considered the cost aspects of the old-age, survivors, and disability insurance system when amendments to the program have been made. In connection with the 1950 amendments, the Congress stated the belief that the program should

be completely self-supporting from the contributions of covered individuals and employers. Accordingly, in that legislation the provision permitting appropriations to the system from general revenues of the Treasury was repealed. This policy has been continued in subsequent amendments. The Congress has very strongly believed that the tax schedule in the law should make the system self-supporting as nearly as can be foreseen and thus actuarially sound.

(*3*) *Actuarial soundness of system*

The concept of actuarial soundness as it applies to the old-age, survivors, and disability insurance system differs considerably from this concept as it applies to private insurance and private pension plans, although there are certain points of similarity with the latter. In connection with individual insurance, the insurance company or other administering institution must have sufficient funds on hand so that if operations are terminated, it will be in a position to pay off all the accrued liabilities. This, however, is not a necessary basis for a national compulsory social insurance system and, moreover, is frequently not the case for well-administered private pension plans, which may not, as of the present time, have funded all the liability for prior service benefits.

It can reasonably be presumed that, under Government auspices, such a social insurance system will continue indefinitely into the future. The test of financial soundness, then, is not a question of whether there are sufficient funds on hand to pay off all accrued liabilities. Rather, the test is whether the expected future income from tax contributions and from interest on invested assets will be sufficient to meet anticipated expenditures for benefits and administrative costs over the long-range period considered in the actuarial valuation. Thus, the concept of "unfunded accrued liability" does not by any means have the same significance for a social insurance system as it does for a plan established under private insurance principles, and it is quite proper to count both on receiving contributions from new entrants to the system in the future and on paying benefits to this group during the period considered in the valuation. The additional assets and liabilities must be considered in order to determine whether the system is in actuarial balance.

Accordingly, it may be said that the old-age, survivors, and disability insurance program is actuarially sound if it is in actuarial balance. This will be the case if the estimated future income from contributions and from interest earnings on the accumulated trust fund investments will, over the long-range period considered in the valuation, support the disbursements for benefits and administrative expenses. Obviously, future experience may be expected to vary from the actuarial cost estimates made now. Nonetheless, the intent that the system be self-supporting (and actuarially sound) can be expressed in law by utilizing a contribution schedule that, according to the intermediate-cost estimate, results in the system being in balance or substantially close thereto.

Your committee believes that it is a matter for concern if the old-age survivors, and disability insurance system shows any significant actuarial insufficiency. Traditionally, since 1965 (when the cost estimates were first made on a 75-year basis), the view has been held that, if such

actuarial insufficiency has been no greater than 0.10 percent of payroll, it is at the point where it is within the limits of permissible variation.

Furthermore, traditionally when there has been an actuarial insufficiency exceeding the limits indicated, any subsequent liberalizations in benefit provisions were fully financed by appropriate changes in the tax schedule or through raising the earnings base, and at the same time the actuarial status of the program was improved.

The changes provided in your committee's bill are in close conformity with these financing principles.

(*c*) *Basic assumptions for cost estimates*

(*1*) *General basis for long-range cost estimates*

Benefit disbursements may be expected to increase continuously for at least the next 50 to 70 years because of such factors as the aging of the population of the country and the slow but steady growth of the benefit roll. Similar factors are inherent in any retirement program, public or private, that has been in operation for a relatively short period. Estimates of the future cost of the old-age, survivors and disability insurance program are affected by many elements that are difficult to determine. Accordingly, the assumptions used in the actuarial cost estimates may differ widely and yet be reasonable.

The long-range cost estimates (shown for 1980 and after) have usually been presented on a range basis so as to indicate the plausible variation in future costs depending upon the actual trends developing for the various cost factors. It has not been possible, in the time available, to prepare such range estimates, but rather only an intermediate-cost estimate, which is used to indicate the basis for the financing provisions. This estimate is based on assumptions that are intended to represent close to full employment, with average annual earnings at about the level prevailing in 1970. The use of 1970 average earnings results in conservatism in the estimate since the trend is expected to be an increase in average earnings in future years (as will be discussed subsequently in item 5). In 1971, the aggregate amount of earnings taxable under the program with the proposed $9,000 earnings base is estimated at $469 billion. Of course, for future years the total taxable earnings are estimated to increase, because there will be larger numbers of covered workers.

The cost estimates are extended beyond the year 2000, since the aged population itself cannot mature by then. The reason for this is that the number of births in the 1930's was very low as compared with both prior and subsequent experience. As a result, there will be a dip in the relative proportion of the aged from 1995 to about 2015, which would tend to result in low benefit costs for the old-age, survivors, and disability insurance system during that period. For this reason the year 2000 is by no means a typical ultimate year insofar as costs are concerned.

(*2*) *Measurement of costs in relation to taxable payroll*

In general, the costs are shown as percentages of taxable payroll. This is the best measure of the financial cost of the program. Dollar figures taken alone are misleading. For example, a higher earnings level will increase not only the outgo of the system but also, and to a greater extent, its income. The result is that the cost relative to

payroll will decrease. As an illustration of the foregoing points, consider an individual who has covered earnings at a rate of $400 per month. Under your committee's bill such an individual would have a primary insurance amount of $185.60. If his earnings rate should be 50 percent higher (i.e. $600), his primary insurance amount would be $246.40. Under these conditions, the contributions payable with respect to his earnings would increase by 50 percent, but his benefit rate would increase by only 33 percent. Or to put it another way, when his earnings rate was $400 per month, his primary insurance amount represented 46.4 percent of his earnings, whereas, when his earnings increased to $600 per month, his primary insurance amount relative to his earnings decreased to 41.1 percent.

(3) General basis for short-range cost estimates

The short-range cost estimates (shown for the individual years 1970–75) are not presented on a range basis since—assuming a continuation of present economic conditions—it is believed that the demographic factors involved (such as mortality, fertility, retirement rates, etc.) can be reasonably closely forecast, so that only a single estimate is necessary. A gradual rise in the earnings level in the future (about 4–5 percent per year), somewhat below that which has occurred in the past few years, is assumed. As a result of this assumption, contribution income is somewhat higher than if level earnings were assumed, while benefit outgo is only slightly affected.

The cost estimates have, in general, been prepared on the basis of the same assumptions and methodology as those contained in the 1970 Annual Report of the Board of Trustees (H. Doc. No. 91–295).

(4) Level-cost concept

An important measure of long-range cost is the level-equivalent contribution rate required to support the system for the next 75 years (including not only meeting the benefit costs and administrative expenses, but also the maintenance of a reasonable contingency fund during the period, which at the end of the period amounts to 1 year's disbursements), based on discounting at interest. If such a level rate were adopted, relatively large accumulations in the trust funds would result, and in consequence there would be a sizable eventual income from interest. Even though such a method of financing is not followed, this concept may be used as a convenient measure of long-range costs. This is a valuable cost concept, especially in comparing various possible alternative plans and provisions, since it takes into account the heavy deferred benefit costs.

(5) Future earnings assumptions

The long-range estimates for the old-age, survivors, and disability insurance program are based on level-earnings assumptions, under which earnings levels of covered workers by age and sex will continue over the next 75 years at the levels estimated to be experienced in 1970. This does not mean covered payrolls are assumed to be the same each year; rather, they will rise steadily as the covered population at the working ages is estimated to increase. If in the future the earnings level should be considerably above that which now prevails, and if the benefits are adjusted upward so that the annual costs relative to payroll will remain the same as now estimated for the present system, then the increased dollar outgo resulting will offset the increased dollar income.

This is an important reason for considering costs relative to payroll rather than in dollars.

It should be noted that estimated 1970 earnings levels are used in the long-range cost estimates, even though the experience for the year is not yet completed. It is believed that this is appropriate procedure (under the accompanying assumption that the earnings base will be increased at times in the future to keep up to date with increases in the general level of earnings) for evaluating the costs of proposed benefit increases which will become effective after the current year.

The long-range cost estimates have not taken into account the possibility of a rise in earnings levels, although such a rise has characterized the past history of this country. If such an assumption were used in the cost estimates, along with the unlikely assumption that the benefits, nevertheless, would not be changed, the cost relative to payroll would, of course, be lower.

It is important to note that the possibility that a rise in earnings levels will produce lower costs of the old-age, survivors, and disability insurance program in relation to payroll is a very important safety factor in the financial operations of this system. The financing of the system is based essentially on the intermediate-cost estimate, along with the assumption of level earnings; if experience follows high-cost assumptions, additional financing will be necessary. However, if covered earnings increase in the future as in the past, the resulting reduction in the cost of the program (expressed as a percentage of taxable payroll) will more than offset the higher cost arising under experience following a high-cost estimate. If the latter condition prevails, the reduction in the relative cost of the program coming from rising earnings levels can be used to maintain the actuarial soundness of the system, and any remaining savings can be used to adjust benefits upward (to a lesser degree than the increase in the earnings level). However, the possibility of future increases in earnings levels should be considered only as a safety factor and not as a justification for adjusting benefits upward in anticipation of such increases.

If benefits are adjusted currently to keep pace fully with rising earnings as they occur, the year-by-year costs as a percentage of payroll would be unaffected. If benefits are increased in this manner, the level-cost of the program would be higher than now estimated, since under such circumstances, the relative importance of the interest receipts of the trust funds would gradually diminish with the passage of time. If earnings and benefit levels do consistently rise, thorough consideration will need to be given to the financing basis of the system because then the interest receipts of the trust funds will not meet as large a proportion of the benefit costs as would be anticipated if the earnings level had not risen.

(6) Interrelationship with railroad retirement system

An important element affecting old-age, survivors, and disability insurance costs arose through amendments made to the Railroad Retirement Act in 1951. These provide for a combination of railroad retirement compensation and old-age, survivors, and disability insurance covered earnings in determining benefits for those with less than 10 years of railroad service and also for all survivor cases.

Financial interchange provisions are established so that the old-age and survivors insurance trust fund and the disability insurance trust

fund are to be placed in the same financial position in which they would have been if railroad employment had always been covered under the program. It is estimated that, over the long range, the net effect of these provisions will be a relatively small loss to the old-age, survivors, and disability insurance system since the reimbursements from the railroad retirement system will be somewhat smaller than the net additional benefits paid on the basis of railroad earnings.

(7) Reimbursement for costs of pre-1957 military service wage credits

Another important element affecting the financing of the program arose through legislation in 1956 that provided for reimbursement from general revenues for past and future expenditures in respect to the noncontributory credits that had been granted for persons in military service before 1957. These financing provisions were modified by the 1965 amendments. The cost estimates contained here reflect the effect of these reimbursements (which are included as contributions), based on the assumption that the required appropriations will be made in the future in accordance with the relevant provisions of the law These reimbursements are intended to be made on the basis of a constant annual amount (as determined by the Secretary of Health, Education, and Welfare) for each trust fund payable over the period up to the year 2015 (with such amount subject to adjustment every 5 years).

In actual practice, the Secretary of Health, Education, and Welfare determined initially that the annual amount for the three trust funds involved (old-age and survivors insurance, disability insurance, and hospital insurance) was $120 million. However, the Budget Document of the United States has contained requests for appropriations for only $105 million and, to date, the appropriations have been made by the Congress on that basis.

(8) Reimbursement for costs of additional post-1956 military service wage credits

Under your committee's bill, individuals in active military service during 1957–67 will receive additional wage credits in excess of their cash pay (but within the maximum creditable earnings base) in recognition of their remuneration that is payable in kind (e.g., quarters and meals). These additional credits are at the rate of $100 per month. (Such credits for military service after 1967 is provided in present law—as a result of the 1967 amendments.) The additional costs that arise from these credits are to be financed from general revenues on an "actual disbursements cost" basis, with reimbursement to the trust funds on as prompt a basis as possible (and with interest adjustments to make up for any delay due to the time needed to make the necessary actuarial calculations from sample data and for the necessary appropriations to be made).

In many instances, the availability of these additional wage credits will not result in additional benefits because the individual will have maximum credited earnings without them or because the year in which such credits are granted will be a drop-out year in the computation of his average monthly wage. In the immediate-future years, the cost of these additional credits to the general fund will be relatively small (only about $35 million a year) since there will be relatively few cases arising, almost all due to death and disability.

(d) Actuarial balance of program in past years

(1) Actuarial balance of program after enactment of 1967 act [1]

The changes made by the 1967 amendments involved an increased cost that was fully met by the accompanying changes in the financing provisions (namely, an increase in the contribution rates in 1973 and after and an increase in the earnings base). After an increase in the allocation to the disability insurance system, both that portion of the program and the old-age and survivors insurance portion were estimated to be in close actuarial balance.

In 1968 the cost estimates were completely revised, based on the availability of new operating data. The new estimates showed significantly lower costs. The actuarial balance of the old-age, survivors, and disability insurance program increased from +0.01 percent of taxable payroll to +0.53 percent of taxable payroll. The factors contributing to lower costs were as follows: (1) use of 1968 earnings assumption (instead of 1966 earnings) +0.33 percent; (2) use of 4¼ percent interest assumption (instead of 3¾ percent), +0.11 percent; (3) use of higher female labor force participation rates, +0.06 percent; and (4) other factors, +0.02 percent.

Then, in 1969, another complete revision of the actuarial cost estimates was made. The estimated cost of the program was again significantly reduced. The actuarial balance of the old-age survivors, and disability insurance program was thereby increased from the figure of +0.53 percent of taxable payroll according to the 1968 estimate to +1.16 percent of taxable payroll. The factors contributing to lower costs were as follows: (1) use of 1969 earnings assumption (instead of 1968 earnings), +0.22 percent; (2) use of 4¾-percent interest assumption (instead of 4¼ percent), +0.11 percent; (3) use of higher labor force participation rates, for both men and women, +0.23 percent; and (4) other factors, +0.07 percent.

(2) Actuarial balance of program after enactment of 1969 act

According to the cost estimates for the 1967 act made in 1969, there was a very favorable actuarial balance for the combined old-age survivors, and disability insurance system, but that there was a deficit of 0.01 percent of taxable payroll for the disability insurance portion, and a favorable balance of 1.17 percent of taxable payroll for the old-age and survivors insurance portion.

Under the 1969 act, the benefit changes made were financed by utilizing the existing favorable actuarial balance, without any increases in the contribution rates and the earnings base. Accordingly, since the disability insurance system was in such close actuarial balance under the then-existing law, it was necessary to increase the portion of the combined contributions which were allocated to it, so as to finance the cost of the 15-percent benefit increase. Under the new allocation basis, both the old-age and survivors insurance system and the disability insurance system were in close actuarial balance.

(3) Actuarial balance of program under H.R. 17550

Table I traces through the change in the actuarial balance of the system from its situation under present law, according to the latest estimate, to that under your committee's bill, by type of major changes involved, determined as of January 1, 1970.

[1] For details of the actuarial balance of the program before the enactment of the 1967 act, see page 83, H. Rept. 544, 90th Cong.

TABLE 1.—CHANGES IN ACTUARIAL BALANCE OF OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, EXPRESSED IN TERMS OF ESTIMATED LEVEL-COST AS PERCENTAGE OF TAXABLE PAYROLL, BY TYPE OF CHANGE, INTERMEDIATE-COST ESTIMATE, PRESENT LAW AND H.R. 17550

[Percent]

Item	Old-age and survivors insurance	Disability insurance	Total system
Actuarial balance of present system	−0.08	0.00	−0.08
Effect of using 1970 earnings	+.25	+.03	+.28
Increase in earnings base	+.20	+.03	+.23
Age-62 computation point for men	−.12	(1)	−.12
Earnings test changes	−.10	(1)	−.10
Widow's benefits of 100 percent of PIA at 65	−.24	(2)	−.24
Elimination of actuarial reduction when shifting from one benfit to another	−.10	(1)	−.10
Miscellaneous changes [3]	−.01	−.01	−.02
Benefit increase of 5 percent	−.43	−.05	−.48
Revised contribution schedule	+.51	.00	+.51
Total effect of changes in bill	−.04	.00	−.04
Actuarial balance under bill	−.12	.00	−.12

[1] Less than 0.005 percent.
[2] Not applicable to this program.
[3] Includes the following: child's benefits for children disabled at ages 18 to 21; workmen's compensation offset based on 100 percent of "average current earnings" as maximum; elimination of support requirement for divorced wife's and widow's benefits; reduced widower's benefits at age 60, and liberalization of insured status requirements for disability benefits with respect to blind persons.

The changes made by your committee's bill would maintain the sound actuarial position of the old-age, survivors, and disability insurance system. The estimated actuarial balance of −0.12 percent of taxable payroll is not quite inside the established limit within which the system is considered substantially in actuarial balance (i.e. −0.10 percent of taxable payroll), but your committee believes that this small difference will readily be made up when the actuarial valuation is made in the latter part of 1971, when data on 1971 earnings become available.

It should be emphasized that in 1950 and in subsequent amendments, the Congress did not recommend that the system be financed by a high level tax rate in the future, but rather recommended an increasing schedule, which, of necessity, ultimately rises higher than such a level rate. Nonetheless, this graded tax schedule will produce a considerable excess of income over outgo for many years so that a sizable trust fund will develop, although not as large as would arise under an equivalent level tax rate. This fund will be invested in Government securities (just as is also the case for the trust funds of the civil service retirement, railroad retirement, national service life insurance, and U.S. Government life insurance systems). The resulting interest income will help to bear part of the higher benefit costs of the future.

(*e*) *Level-costs of benefit payments, by type*

The level-cost of the old-age and survivors insurance benefit payments (without considering administrative expenses, the railroad retirement financial interchange, and the effect of interest earnings on the existing trust fund) under the 1969 act, according to the latest intermediate-cost estimate, is 8.90 percent of taxable payroll, and the corresponding figure for the program as it would be modified by your committee's bill is 9.43 percent. The corresponding figures for the disability benefits are 1.10 percent for the 1969 act and also 1.10 percent for your committee's bill.

Table II presents the benefit costs for the old-age, survivors, and disability insurance system as it would be after enactment of your committee's bill, separately for each of the various types of benefits.

TABLE II.—ESTIMATED LEVEL-COST OF BENEFIT PAYMENTS, ADMINISTRATIVE EXPENSES, AND INTEREST EARNINGS ON EXISTING TRUST FUND UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, AFTER ENACTMENT OF COMMITTEE BILL, AS PERCENTAGE OF TAXABLE PAYROLL,[1] BY TYPE OF BENEFIT, INTERMEDIATE-COST ESTIMATE

[Percent]

Item	Old-age and survivors insurance	Disability insurance
Primary benefits	6.45	0.90
Wife's and husband's benefits	.50	06
Widow's and widower's benefits	1.54	(2)
Parent's benefits	.01	(2)
Child's benefits	.73	14
Mother's benefits	.13	(2)
Lump-sum death payments	.07	(2)
Total benefits	9.43	1.10
Administrative expenses	.13	.04
Railroad retirement financial interchange	.09	.00
Interest on existing trust fund[3]	−.24	−.04
Net total level-cost	9.41	1.10

[1] Including adjustment to reflect the lower contribution rate on self-employment income and on tips, as compared with the combined employer-employee rate.
[2] This type of benefit is not payable under this program.
[3] This item includes reimbursement for additional cost of noncontributory credit for military service and is taken as an offset to the benefit and administrative expense costs.

(*f*) *Income and outgo in near future*

Under your committee's bill, benefit disbursements under the old-age, survivors, and disability insurance system will increase, over present law, by about $3.9 billion for the first full year of operation of these changes.

The contribution income for the old-age, survivors, and disability system for 1971 is about $1.3 billion lower under your committee's bill than under present law (as a result of the tax rate under the bill being lower than under present law—which more than offsets the effect of the higher maximum taxable earnings base). However, when the contribution income for the old-age, survivors, and disability insurance system and the hospital insurance system are considered in combination, the contribution income for 1971 is $2.7 billion more under your committee's bill than under present law (due to the effect of the higher earnings base, since the combined employer-employee contribution rate for the two programs considered in combination is unchanged—although the self-employed contribution rate for the two programs combined is slightly lower).

Under the program as modified by your committee's bill, according to this estimate, the old-age and survivor's trust fund will increase slowly during 1970–74, rising from $32.1 billion at the end of 1970 to $38.3 billion at the end of 1974, or at a rate of $1–2 billion per year. Then, in 1975, when the contribution rates increase sharply (the combined employer-employee rate going from 8.4 percent to 10.0 percent), the trust fund increases by $10.4 billion; such large increases will also occur in the years immediately following 1975. The trust fund balance at the end of the year during the period 1970–74 closely approximates

1 year's outgo for benefit payments. Table III presents these short-range estimates.

TABLE III.—PROGRESS OF OLD-AGE AND SURVIVORS INSURANCE TRUST FUND, SHORT-RANGE ESTIMATE

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange [2]	Interest on fund [1]	Balance in fund at end of year [3]
Actual data:						
1951	$3,367	$1,885	$81	----------	$417	$15,540
1952	3,819	2,194	88	----------	365	17,442
1953	3,945	3,006	88	----------	414	18,707
1954	5,163	3,670	92	−$21	447	20,576
1955	5,713	4,968	119	−7	454	21,663
1956	6,172	5,715	132	−5	526	22,519
1957	6,825	7,347	162	−2	556	22,393
1958	7,566	8,327	194	124	552	21,864
1959	8,052	9,842	184	282	532	20,141
1960	10,866	10,677	203	318	516	20,324
1961	11,285	11,862	239	332	548	19,725
1962	12,059	13,356	256	361	526	18,337
1963	14,541	14,217	281	423	521	18,480
1964	15,689	14,914	296	403	569	19,125
1965	16,017	16,737	328	436	593	18,235
1966	20,658	18,267	256	444	644	20,570
1967	23,216	19,468	406	508	818	24,222
1968	24,101	22,643	476	438	939	25,704
1969	28,389	24,210	474	491	1,165	30,082
Estimated data (short-range estimate), committee bill:						
1970 [4]	30,440	28,799	503	523	1,396	32,093
1971	34,133	33,632	597	562	1,491	32,926
1972	36,269	35,263	571	679	1,583	34,265
1973	37,833	36,525	598	732	1,705	35,948
1974	39,574	37,827	625	730	1,928	38,268
1975	48,630	39,156	650	731	2,303	48,664

[1] An interest rate of 4.75 percent is used in determining the level costs, under the intermediate-cost long-range estimates, but in developing the progress of the trust fund a varying rate in the early years has been used.

[2] A negative figure indicates payment to the trust fund from the railroad retirement account, and a positive figure indicates the reverse.

[3] Not including amounts in the railroad retirement account to the credit of the old-age and survivors insurance trust fund. In millions of dollars, these amounted to $377 for 1953, $284 for 1954, $163 for 1955, $60 for 1956, and nothing for 1957 and thereafter.

[4] Estimated data for present law.

Note: Contributions include reimbursement for additional cost of noncontributory credit for military service and for the special benefits payable to certain noninsured persons aged 72 or over.

The disability insurance trust fund is estimated to increase by about $0.8 billion in 1971 under your committee's bill, and by somewhat larger amounts each year thereafter for the next few years. The balance in the disability insurance trust fund, under your committee's bill, would increase from $6.3 billion at the end of 1971 to $9.0 billion at the end of 1974, and then to $10.9 billion at the end of 1975. The trust fund balance at the end of the year during the period 1970–74 closely approximates 2 years' outgo for benefit payments. Table IV presents these short-range estimates.

TABLE IV.—PROGRESS OF DISABILITY INSURANCE TRUST FUND, SHORT-RANGE ESTIMATE

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange [1]	Interest on fund [2]	Balance in fund at end of year
Actual data:						
1957	$702	$57	$3	.....	$7	$649
1958	966	249	12	.....	25	1,379
1959	891	457	50	−$22	40	1,825
1960	1,010	568	36	−5	53	2,289
1961	1,038	887	64	5	66	2,437
1962	1,046	1,105	66	11	68	2,368
1963	1,099	1,210	68	20	66	2,235
1964	1,154	1,309	79	19	64	2,047
1965	1,188	1,573	90	24	59	1,606
1966	2,022	1,784	137	25	58	1,739
1967	2,302	1,950	109	31	78	2,029
1968	3,348	2,311	127	20	106	3,025
1969	3,615	2,557	138	21	177	4,100
Estimated data (short-range estimate), committee bill:						
1970 [3]	4,468	3,093	169	18	259	5,547
1971	4,154	3,480	184	17	321	6,341
1972	4,324	3,674	182	24	361	7,146
1973	4,517	3,824	192	30	411	8,028
1974	4,731	3,971	199	30	469	9,028
1975	5,716	4,113	208	30	547	10,940

[1] A negative figure indicates payment to the trust fund from the railroad retirement account, and a positive figure indicates the reverse.

[2] An interest rate of 4.75 percent is used in determining the level-costs under the intermediate-cost long-range estimates but in developing the progress of the trust fund a varying rate in the early years has been used.

[3] Estimated data for present law.

Note: Contributions include reimbursement for additional cost of noncontributory credit for military service.

(g) *Long-range operations of OASI trust fund*

Table V gives the estimated operations of the old-age and survivors insurance trust fund under the program as it would be changed by your committee's bill for the long-range future, based on the intermediate-cost estimate. It will, of course, be recognized that the figures for the next two or three decades are the most reliable (under the assumption of level-earnings trends in the future) since nearly all of the populations concerned—both covered workers and beneficiaries—are already born. As the estimates proceed further into the future, there is, of course, much more uncertainty.

In every year after 1969 for the next 25 years, contribution income under the system as it would be modified by your committee's bill is estimated to exceed old-age and survivors insurance benefit disbursements. Even after the benefit-outgo curve rises ahead of the contribution-income curve, the trust fund will nonetheless continue to increase because of the effect of interest earnings (which more than meet the administrative expense disbursements and any financial interchanges with the railroad retirement program). As a result, this trust fund is estimated to grow steadily under the intermediate long-range cost estimate (with a level-earnings assumption), reaching $69 billion in 1980 and about $188 billion at the end of this century. The trust fund is shown as being exhausted in about 65 years, which results from the small lack of actuarial balance, as indicated previously.

TABLE V.—ESTIMATED PROGRESS OF OLD-AGE AND SURVIVORS INSURANCE TRUST FUND UNDER SYSTEM AS MODIFIED BY H.R. 17550, LONG-RANGE INTERMEDIATE-COST ESTIMATE

[In millions]

Calendar year	Contributions	Benefit payments [1]	Administrative expenses	Interest on fund	Balance in fund at end of year
1980	$51,515	$44,215	$674	$2,755	$68,841
1985	54,149	51,198	728	4,639	108,462
1990	58,248	58,464	783	5,987	137,324
1995	62,723	64,633	831	7,038	160,256
2000	67,758	68,556	868	8,275	188,462
2025	88,162	114,090	1,276	10,873	237,590
2040	101,283	132,683	1,470	(2)	(2)

[1] Includes effect of financial interchange with railroad retirement system.
[2] Fund exhausted in 2035.

Note: Contributions include reimbursement for additional cost of noncontributory credit for military service before 1957. No account is taken in this table of the outgo for the special benefits payable to certain noninsured persons aged 72 or over or for the additional benefits payable on the basis of noncontributory credit for military service after 1956—or of the corresponding reimbursement therefor, which is exactly counterbalancing from a long-range cost standpoint.

(*h*) *Long-range operations of DI trust fund*

The disability insurance trust fund, under the program as it would be changed by your committee's bill, grows slowly but steadily after 1969, according to the intermediate long-range cost estimate, as shown by table VI. In 1980, it is shown as being $15 billion, while in 1990, the corresponding figure is $28 billion. There is a small excess of contribution income over benefit disbursements for every year after 1969 for the next 25 years.

TABLE VI.—ESTIMATED PROGRESS OF DISABILITY INSURANCE TRUST FUND UNDER SYSTEM AS MODIFIED BY H.R. 17550, LONG-RANGE INTERMEDIATE-COST ESTIMATE

[In millions]

Calendar year	Contributions	Benefit payments [1]	Administrative expenses	Interest on fund	Balance in fund at end of year
1980	$6,072	$5,058	$190	$618	$14,578
1985	6,465	5,877	199	938	21,455
1990	6,882	6,519	210	1,251	28,313
1995	7,412	7,293	227	1,581	35,532
2000	8,012	8,345	257	1,899	42,420
2025	10,390	12,118	369	2,182	48,279
2040	11,933	14,235	434	2,109	46,575

[1] Includes effect of financial interchange provision with railroad retirement system.

Note: Contributions include reimbursement for additional cost of noncontributory credit for military service before 1957. No account is taken in this table of the outgo for the additional benefits payable on the basis of noncontributory credit for military service after 1956—or of the corresponding reimbursement therefor, which is exactly counterbalancing from a long-range cost standpoint.

Table VII shows the estimated costs of the old-age and survivors insurance benefits and of the disability insurance benefits under the program as it would be changed by your committee's bill as a percentage of taxable payroll for various future years, through the year 2040, and also the level-costs of the two programs.

TABLE VII.—ESTIMATED COST OF BENEFIT PAYMENTS OF OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM AS PERCENT OF TAXABLE PAYROLL,[1] UNDER SYSTEM AS MODIFIED BY COMMITTEE BILL

Calendar year	Old-age and survivors insurance benefits	Disability insurance benefits	Total benefits
1980	8.32	0.96	9.28
1985	9.09	1.05	10.14
1990	9.78	1.10	10.88
1995	10.07	1.14	11.21
2000	9.91	1.21	11.12
2025	12.71	1.35	14.06
2040	12.87	1.38	14.25
Level-cost[2]	9.41	1.10	10.51

[1] Taking into account the lower contribution rate for self-employment income and tips, as compared with the combined employer-employee rate.

[2] Level contribution rate, at an interest rate of 4.75 percent benefits after 1969 taking into account interest on the trust fund on December 31, 1969, future administrative expenses, the railroad retirement financial interchange provisions, and the reimbursement of noncontributory military-wage-credits cost.

B. ACTUARIAL COST ESTIMATES FOR THE HOSPITAL INSURANCE SYSTEM

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

The hospital insurance system, as modified by your committee's bill, has an estimated cost for benefit payments and administrative expenses that is in close long-range balance with contribution income. It is recognized that the preparation of cost estimates for hospitalization and related benefits is much more difficult and is much more subject to variation than cost estimates for the cash benefits of the old-age, survivors, and disability insurance system. This is so not only because the hospital insurance program is relatively new, with little past operating experience, but also because of the greater number of variable factors involved in a service-benefit program than in a cash-benefit one. However, your committee believes that the present cost estimates are made under reasonable assumptions with respect to all foreseeable factors.

New long-range actuarial cost estimates for the hospital insurance system have recently been prepared. They show a significantly higher benefit cost than the previous estimates, which were used as the basis for the 1967 amendments.

These new cost estimates are based on revised assumptions as to the many factors involved in the hospital insurance program. Based on actual recent experience, the assumptions include higher unit costs in the future for hospital and other services covered by the program, an increasing trend in utilization of services, and somewhat higher increases in covered earnings that are subject to contributions. A detailed presentation of the new assumptions is contained in "Actuarial Study No. 71," issued by the Social Security Administration, Department of Health, Education, and Welfare, but some information on these matters is presented in the subsequent discussion here.

(*b*) *Financing policy*

(*1*) *Financing basis of H.R. 17550*

The contribution schedule contained in your committee's bill for the hospital insurance program, under a $9,000 taxable earnings base beginning in 1971, is as follows, as compared with that of present law:

[Percent]

Calendar year	Combined employer-employee rate		Self-employed rate	
	Present law	H.R. 17550	Present law	H.R. 17550
1970	1.2	1.2	0.60	0.6
1971–72	1.2	2.0	.60	1.0
1973–75	1.3	2.0	.65	1.0
1976–79	1.4	2.0	.70	1.0
1980–86	1.6	2.0	.80	1.0
1987 and after	1.8	2.0	.90	1.0

Your committee's bill has not changed the benefit protection provided by the hospital insurance program. However, the bill does contain a number of provisions which are intended to reduce the cost of the program. Among these provisions are the elimination of payments to certain providers of services who have abused the program, the limitation of the payments to certain providers of services who furnish services which are determined to be unduly expensive, certain limitations on financial participation for supporting unnecessary capital expenditures, the possibility of increased economy under prospective-reimbursement experiments and demonstration projects, the limitation of reimbursement to customary charges in certain instances when these are less than reasonable cost, and the requirement of reasonable institutional planning. No recognition of the effect of these cost-reduction changes has been made in the actuarial cost estimates, because it is not possible to quantify them; accordingly, any savings resulting represents a small safety margin in the cost estimates.

An important change made by your committee's bill would permit individuals to obtain their medicare coverage (both hospital insurance and supplementary medical insurance) through a health maintenance organization (a group practice prepayment plan or other capitation plan). In such instances, the medicare program would pay for such coverage on a capitation basis determined by actuarial methods, but not to exceed 95 percent of the amount that, according to actuarial estimates (which would take into account such factors as age and sex of the enrollees, geographical location of the organization, and selection and enrollment rules of the organization), would otherwise have been payable with respect to such persons if they had not been members of such organizations.

No valid experience under the medicare program is available for the purpose of making any cost estimates of the effect of this provision. To the extent that adequate actuarial analysis can be made in the future as to the actual operation of these health maintenance organizations, there could be a significant reduction in the long-run cost of the medicare program.

In the early years of operation, however, there might be slightly increased program costs, because the relatively few organizations of this type now in existence are being reimbursed only their actual costs. whereas under the provisions of your committee's bill, they would, in the future, be reimbursed somewhat more than costs (although possibly less than would have been paid with respect to the participating individuals if they had not belonged to such an organization). On the other hand, if such organizations can supply the covered services at

a lower cost than what would otherwise prevail, then in the future, if more of these organizations are formed, there could be a significant net savings to the program. Accordingly, the actuarial cost estimates have not been modified to reflect the possible cost aspects of this provision for a different reimbursement basis for health maintenance organizations.

Your committee's bill also contains a provision that would eliminate payments under the medicare program for services covered by the Federal employees health benefits plan, beginning in 1972, unless such plan is modified to make available coverage supplementary to that under the medicare program. For the purposes of the actuarial cost estimates, no account is taken of any possible reduction in benefit payments under the medicare program on this account, because of the likelihood that such modification will occur.

Your committee's bill provides an opportunity for persons who are not otherwise eligible under the hospital insurance program to enroll, on a voluntary basis, and then to pay the estimated full cost of the benefit protection thus made available. Such voluntary elective individual coverage can also be obtained by States and other organizations on a group basis for their retired employees aged 65 and over who are not otherwise protected under the hospital insurance program.

The actuarial cost estimates presented in this report do not take into account the effect of this provision for voluntary coverage of otherwise ineligible persons, since it is not possible to estimate how many of the approximately 250,000 persons eligible to so elect will actually do so; of these 250,000 persons, about 145,000 are covered under the Federal Employees Health Benefits plan and so are unlikely to elect the voluntary hospital insurance under the bill. Thus, approximately 100,000 persons are really potentially eligible to elect. Furthermore, if the premium rate, which has been actuarially estimated at $27 per month for the first 1½ years of operation, is adequate, there will be no net effect on the financial operations of the total program. In any event, whether or not such experience is favorable, there will be relatively little effect on the financial operations of the program, because of the small number of persons likely to be involved.

The hospital insurance program is completely separate from the old-age, survivors, and disability insurance system in several ways, although the earnings base is the same under both programs. *First*, the schedules of tax rates for old-age, survivors, and disability insurance and for hospital insurance are in separate subsections of the Internal Revenue Code (unlike the situation for old-age and survivors insurance as compared with disability insurance, where there is a single tax rate for both programs, but an allocation thereof into two portions). *Second*, the hospital insurance program has a separate trust fund (as is also the case for old-age and survivors insurance and for disability insurance) and, in addition, has a separate Board of Trustees from that of the old-age, survivors, and disability insurance system. *Third*, income tax withholding statements (forms W–2) show the proportion of the total contribution for old-age, survivors, and disability insurance and for hospital insurance that is with respect to the latter. *Fourth*, the hospital insurance program covers railroad employees directly in the same manner as other covered workers, and their benefit payments are paid directly from this trust fund (rather than

directly or indirectly through the railroad retirement system), whereas these employees are not covered by old-age, survivors, and disability insurance (except indirectly through the financial interchange provisions). *Fifth*, the financing basis for the hospital insurance system is determined under a different approach than that used for the old-age, survivors, and disability insurance system, reflecting the different natures of the two programs (by assuming rising earnings levels and rising hospitalization costs in future years, instead of level-earnings assumptions and by making the estimates for a 25-year period rather than a 75-year one). *Sixth*, the contribution rate for self-employed persons is the same as for employees, whereas under old-age, survivors, and disability insurance, the self-employed pay 50 percent more at the present time.

(*2*) *Self-supporting nature of system*

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

(*3*) *Actuarial soundness of system*

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

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

It seems desirable to your committee that the hospital insurance program should be in close actuarial balance. In order to accomplish this result, your committee has revised the contribution schedule to meet this requirement, according to the underlying cost estimates.

(*c*) *Hospitalization data and assumptions*

(*1*) *Past increases in hospital costs and in earnings*

Table A presents a summary comparison of the annual increases in hospital costs and the corresponding increases in wages that have occurred since 1955 and up through 1969.

TABLE A.—COMPARISON OF ANNUAL INCREASES IN HOSPITAL COSTS AND IN EARNINGS

[Percent]

Calendar year	Increase over previous year	
	Average wages in covered employment [1]	Average daily hospitalization costs [2]
1956	5.7	4.5
1957	5.5	7.7
1958	3.3	8.6
1959	3.3	6.8
1960	4.3	6.8
1961	3.1	8.5
1962	4.2	5.3
1963	2.4	5.6
1964	3.1	6.9
1965	1.6	7.0
1966	4.4	8.3
1967	6.3	12.3
1968	7.0	13.5
1969	6.0	[3] 14.0
Average for 1956–65	3.6	6.8
Average for 1966–69	5.9	12.0

[1] Data are for calendar years (based on experience in 1st quarter of year).
[2] Data are for fiscal years ending in September of year shown. Data are from American Hospital Association, and "hospitalization costs" represents total hospital expense per patient day.
[3] Preliminary estimate made by Social Security Administration.

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

The annual increases in earnings fluctuated somewhat over the period up through 1965, although there were not very large deviations from the average annual rate of 3.6 percent; no upward or downward trend over the period is discernible. The annual increases in hospital costs likewise fluctuated from year to year during this period, around the average annual rate of 6.8 percent.

During the period 1955–65, hospital costs increased at a faster rate than earnings. The differential between these two rates of increase fluctuated widely, being as high as somewhat more than 5 percent in some years and as low as a negative differential of about 1 percent in 1956 (with the next lowest differential being a positive one of about 1 percent in 1962). Over the entire 10-year period, the differential between the average annual rate of increase in hospital costs over the average annual rate of increase in earnings was 3.2 percent.

Following 1965, however, both earnings and hospital costs have risen sharply, the former at a rate of about 6 percent per year and the latter at about 12 percent per year. Thus, the differential rate

of increase of hospital costs as against earnings was about 6 percent per year during 1966–69, as compared with 3 percent in the preceding decade. Or, to put it another way, in the past 15 years, hospital costs have increased at double the rate that earnings in general have. No change in this relationship is evident currently, so that relatively high increases in hospital costs seem likely in at least the next few years.

Your committee was advised by the Department of Health, Education, and Welfare that, in the future, after the next few years, earnings are estimated to increase at a rate of about 4 percent per year. It is much more difficult to predict what the corresponding increase in hospital costs will be.

(2) Effect on cost estimates of rising hospital costs

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

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

Perhaps the major consideration in making actuarial cost estimates for hospital benefits is that—unlike the situation in regard to cost estimates for monthly cash benefits, where the result is the opposite—an unfavorable cost result is shown when total earnings levels rise, unless the financing provisions of the system are kept up to date (insofar as the maximum taxable earnings base is concerned). The reason for this result is that hospital costs rise at least at the same rate over the long run as the total earnings level, whereas the contribution income rises less rapidly, unless the earnings base is kept up to date, than the total earnings level.

For these reasons, the cost estimates were previously based on the assumption that both hospital costs and the general level of earnings will increase in the future for the entire 25-year period considered, while at the same time the earnings base will not change. The present cost estimates no longer assume that the maximum taxable earnings base will not change, but rather that it will be kept up to date, by periodic legislative revisions, with changes in the general level of earnings; such situation has been the case for the last two decades, and it seems reasonable that it will continue in the future.

Your committee believes that such a less conservative assumption, resulting in a reduced safety margin, is now justifiable and proper. Initially, such a safety factor was needed when there was no firm indication of what the actual near-future experience would be. Now, good data are available as to the actual current experience, and so such a margin is no longer necessary if adequately reasonable assumptions are adopted as to future trends of unit costs of services and of utilization of services. Quite obviously, if the earnings base is not changed in the future to keep it up to date in this manner, and if the actual experience develops in line with the assumptions made in the actuarial cost estimates, then higher contribution rates than now provided under your committee's bill would be necessary.

The fact that the cost-sharing provisions (the initial hospital deductible and the coinsurance features) are on a dynamic basis which varies with hospital costs is taken into account as not requiring a higher cost estimate than would be needed if static conditions were assumed.

(3) Assumptions as to relative trends of hospital costs and earnings underlying cost estimate for H.R. 17550

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

The assumptions as to the short-term trend of hospital costs for the cost estimates presented here are shown in table B.

Table B.—Assumptions as to future rates of increase in hospital costs

Calendar year:	*Rate of increase (in percent)*
1969	15.0
1970	14.0
1971	13.0
1972	11.5
1973	10.0
1974	8.5
1975	7.0
1976	6.0
1977	5.0
1978 and after	4.0

(4) Assumptions as to hospital utilization rates underlying cost estimates for H.R. 17550

The hospital utilization assumptions for the cost estimates in this report are founded on the hypothesis that current practices in this field will not change even more in the future than past experience

has indicated. In other words, no account is taken of the possibility that there will be a drastic change in philosophy as to the best medical practices, so as, for example, to utilize in-hospital care to a much greater extent than is now the case.

The hospital utilization rates used for the cost estimates for your committee's bill are based on the actual experience of the program in 1968, with assumed increases of 1 to 2 percent per year for the next decade.

(5) *Assumptions as to hospital per diem rates underlying cost estimates for H.R. 17550*

The average daily hospital reimbursement rate by the program for 1968 (i.e. not including the cost-sharing payments made by the beneficiaries) was about $48. This was projected for future years in the manner described previously.

(d) *Results of cost estimates*

(1) *Summary of cost estimate for H.R. 17550*

The level-cost of the benefits and administrative expenses under present law is estimated at 2.06 percent of taxable payroll under the assumption that the earnings base will be changed, after 1970, to keep up to date with the general level of earnings (as the increase to $9,000 in 1971 in your committee's bill does). Such level-cost would be 2.79 percent of taxable payroll if it were assumed that the earnings base would remain fixed at $7,800 over the entire 25-year valuation period—the assumption underlying previous actuarial evaluation of the program.

Under the rising-earnings-base assumption, the level-equivalent of the graded contribution schedule under present law is 1.56 percent of taxable payroll and the level-equivalent value of the existing trust fund is 0.02 percent of taxable payroll, so that there is a lack of actuarial balance under present law, using the revised estimates of hospital cost trends and the other revised cost factors, amounting to 0.48 percent of taxable payroll. Under the assumption that the earnings base remains level in the future at the $7,800 amount specified in present law (the assumption which has heretofore been made in setting the contribution schedule), the level-equivalent of the contribution schedule is 1.52 percent of taxable payroll, and the level-equivalent of the existing trust fund is 0.03 percent of taxable payroll, so that then the actuarial balance would be −1.24 percent of taxable payroll.

Under your committee's bill, there would be additional financing for the program, both through the increase in the earnings base to $9,000, effective in 1971, and through increasing the rates in the contribution schedule. Thus, the new contribution schedule (which has a level-equivalent value of 1.98 percent of taxable payroll) would, under the current cost estimate, adequately finance the program, whose actuarial balance would then be −0.06 percent of taxable payroll.

Table C traces through the actuarial balance of the hospital insurance system from its situation under present law, according to the latest estimate, to that under your committee's bill, determined as of January 1, 1970.

TABLE C.—CHANGES IN ACTUARIAL BALANCE OF HOSPITAL INSURANCE SYSTEM, EXPRESSED IN TERMS OF ESTIMATED LEVEL-COST AS PERCENTAGE OF TAXABLE PAYROLL, INTERMEDIATE-COST ESTIMATE, PRESENT LAW AND H.R. 17550

[Percent]

Item	Level-cost or level-equivalent			
	Contributions	Benefit payments[1]	Existing trust fund	Actuarial balance
Present law, level $7,800 earnings base	1.52	2.79	0.03	−1.24
Present law, increasing earnings base[2]	1.56	2.06	.02	−.48
Committee bill, increasing earnings base[2]	1.98	2.06	.02	−.06

[1] Including also the administrative expenses.

[2] The cost estimate is made under the assumption that the maximum taxable earnings base will be kept up to date after 1970, so that approximately the same proportion of the total payroll in covered employment will be taxable as was the case under the $7,800 base in 1968. This would produce a base of $9,000 in 1971 (as in your committee's bill) and, under the assumptions made as to future changes in earnings levels, $10,200 in 1973 (if changed then), and similarly $10,800 in 1975, $12,000 in 1977, etc., to $22,200 in 1993.

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

(2) *Future operations of hospital insurance trust fund*

Table D shows the estimated operation of the hospital insurance trust fund under present law (assuming no change in the $7,800 earnings (base), while table E gives similar figures for your committee's bill (under the assumption that the $9,000 earnings base effective in 1971 will be kept up to date with rising earnings levels in the future).

Under present law, outgo exceeds income for every year after 1969. As a result, the trust fund is shown as being exhausted in mid-1972. According to this estimate, under your committee's bill the balance in the trust fund would grow steadily in the future, increasing from about $2.2 billion at the end of 1970 to $14.2 billion 5 years later; over the long range, the trust fund would build up steadily, reaching a peak of $23 billion in 1985 and then decreasing to $13.8 billion in 1994 (at which time it represents somewhat less than 6 months' benefit outgo). The reason for the decrease in the trust-fund balance in the last decade of the 25-year valuation period and for the fund at the end of the period being less than 1 year's outgo is that the actuarial balance of the system is a small negative amount. If the experience were to follow exactly the underlying assumptions in the cost estimate, a small amount of additional financing would ultimately be necessary.

TABLE D.—ESTIMATED PROGRESS OF HI TRUST FUND UNDER PRESENT FINANCING PROVISIONS, INCURRED BASIS

[In millions]

Calendar year	Contributions [1]	Government payment for uninsured [2]	Benefit payments	Administrative expenses	Interest on fund [3]	Net income	Fund at end of year
1970	$4,973	$618	$5,820	$140	$139	−$230	$2,183
1971	5,231	656	6,894	150	101	−1,056	1,127
1972	5,482	685	8,031	161	8	−2,017	[4]

[1] Includes payments from general fund for military service wage credits.
[2] Cost for benefit payments and accompanying administrative expenses for uninsured persons for each fiscal year is assumed to be paid to the trust fund in the middle of the fiscal year (i.e., at the end of the corresponding calendar year).
[3] Over the long range, a 5-percent rate is assumed, with a somewhat higher rate in the early years.
[4] Fund exhausted in 1972.

Note: Fund balance at beginning of 1970 is $2,413 million on an incurred basis (as compared with $2,505 million on a cash basis).

TABLE E.—ESTIMATED PROGRESS OF HI TRUST FUND UNDER FINANCING PROVISIONS OF COMMITTEE BILL UNDER BASIS OF EARNINGS BASE BEING KEPT UP TO DATE WITH INCREASES IN EARNINGS,[1] INCURRED BASIS

[In millions]

Calendar year	Contributions [2]	Government payment for uninsured [3]	Benefit payments	Administrative expenses	Interest on fund [4]	Net income	Fund at end of year
1970	$4,973	$618	$5,820	$140	$139	−$230	$2,183
1971	9,252	656	6,894	150	226	3,090	5,273
1972	9,728	685	8,031	161	389	2,610	7,883
1973	10,721	701	9,204	172	534	2,580	10,463
1974	11,224	701	10,383	183	657	2,016	12,479
1975	11,997	688	11,477	195	753	1,766	14,245
1980	15,978	490	16,138	260	1,024	1,094	20,371
1985	20,860	282	21,462	345	1,109	444	22,955
1990	26,812	116	28,586	457	1,029	−1,086	20,552
1994	32,249	45	35,500	560	749	−3,017	13,842

[1] Maximum taxable earnings base would be $7,800 in 1970, $9,000 in 1971–72, $10,200 in 1973–74, $10,800 in 1975–76, $12,000 in 1977–78, increasing ultimately to $22,200 in 1993–94. Combined employer-employee contribution schedule would be 1.2 percent for 1970, and 2.0 percent for 1971 and after.
[2] Includes payment from general fund for military service wage credits.
[3] Cost for benefit payments and accompanying administrative expenses for uninsured persons for each fiscal year is assumed to be paid to the trust fund in the middle of the fiscal year (i.e., at the end of the corresponding calendar year).
[4] Over the long range, a 5-percent rate is assumed, with a somewhat higher rate in the early years.

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

Hospital and related benefits are provided not only for beneficiaries of the old-age, survivors, and disability insurance system and the railroad retirement system, but also on a "free" basis for most other persons who were aged 65 and over in 1966 (and for many of those attaining this age in the next few years) who are not insured under either of these two social insurance systems. The exceptions are noninsured persons who are active and retired Federal employees who are eligible (or had the opportunity of being eligible) for similar protection under the Federal Employees Health Benefits Act of 1959 or who are short-residence aliens.

Under present law, persons meeting such conditions who attain age 65 before 1968 qualify for the hospital benefits regardless of whether they have had any covered employment in the past, while those attaining age 65 after 1967 must have some such coverage to qualify—namely, 3 quarters of coverage (which can be acquired at any time after 1936) for each year elapsing after 1966 and before the year of attain-

ment of age 65 (e.g., 3 quarters of coverage for attainment of age 65 in 1968, 6 quarters for 1969, etc.). This transitional provision "washes out" under present law for men attaining age 65 in 1975 and for women attaining age 65 in 1974, since the fully-insured-status requirement for monthly benefits for such categories is then no greater than the special-insured status requirement.

Under your committee's bill, these requirements for noninsured men would "wash out" at the same time as for women (due to the "age-62 computation point for men" provision in your committee's bill).

The benefits for the noninsured group who receive hospital insurance benefits on a "free" basis is to be paid from the hospital insurance trust fund, but with financial reimbursement therefor from the general fund of the Treasury on a current basis, or with appropriate interest adjustment. The estimated cost to the general fund of the Treasury for the hospital and related benefits for this noninsured group (including the applicable additional administrative expenses) for various future years is shown in Table E. The estimated cost to the general fund of the Treasury for the closed group involved increases slowly to a peak of about $700 million per year in 1973–74 and then decreases steadily thereafter. Offsetting, in large part, the decline in the number of eligibles blanketed-in are the factors, the increasing hospital utilization per capita as the average age of the group rises and the increasing hospital costs in future years.

The foregoing discussion and cost estimates do not include the noninsured persons who, under the provisions of your committee's bill, can voluntarily buy into the hospital program on the basis of their paying the estimated full costs involved.

C. ACTUARIAL COST ESTIMATES FOR THE SUPPLEMENTAL MEDICAL INSURANCE SYSTEM

(a) *Summary of actuarial cost estimates*

Your committee's bill has broadened slightly the benefit protection provided by the supplementary medical insurance program. The only such changes that are significant from a cost standpoint are the provision of certain limited physical therapy services provided in the office of the physical therapist or in the patient's home which are not under the supervision of an institutional provider of services and making the deductible and coinsurance provisions inapplicable to the professional component of services performed by certain teaching physicians in hospitals.

Your committee's bill also contains a number of provisions which are intended to reduce the cost of the supplementary medical insurance program. Among these provisions are the establishment of limits on prevailing charge levels (using the 75th percentile for fiscal year 1971 and adjusting the levels thereafter by means of an appropriate economic index), tightening up the reimbursement provisions for teaching physicians who furnish inpatient services, and several provisions eliminating payments to certain providers of services who have abused the program and limiting the payments to certain providers of services who furnish services which are determined to be unduly expensive.

No account is taken in the actuarial cost estimates for the supplementary medical insurance program of the provisions of your commit-

tee's bill that provide for medicare coverage to be obtained from health maintenance organizations or for medicare benefits to be withheld (after 1971) if benefits are payable to the individual under the Federal employees health benefits plan, unless such plan is coordinated with medicare. The reasons for not considering such provisions are given in the section dealing with the actuarial cost estimates for the hospital insurance system.

The cost effects of these changes will be recognized by the Secretary of Health, Education, and Welfare in his determination of the standard premium rate for fiscal year 1972, which in accordance with the provisions of present law will be promulgated in December 1970.

(*b*) *Financing policy*

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

Coverage under supplementary medical insurance can be voluntarily elected, on an individual basis, by virtually all persons aged 65 and over in the United States. This program is intended to be completely self-supporting from the premiums of enrolled individuals and from the equal-matching contributions from the general fund of the Treasury. For the initial period, July 1966 through December 1967, the premium rate was established by law at $3 per month, so that the total income of the system per participant per month was $6. Persons who do not elect to come into the system at as early a time as possible generally have to pay a higher premium rate. The standard monthly premium rate is now adjusted annually by promulgation of the Secretary of Health, Education, and Welfare (using appropriate actuarial methods), so as to reflect the expected experience on an incurred-cost basis, including an allowance for a margin for contingencies. All financial operations for this program are handled through a separate fund, the supplementary medical insurance trust fund.

(*2*) *Actuarial soundness of system*

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

(*c*) *Results of cost estimates*

Your committee's bill makes a number of changes in the provisions of the supplementary medical insurance program, of which some expand its scope whereas several limit the scope or reduce costs. The only changes which have a significant cost effect are: (1) the elimination of the cost-sharing for the professional component of inpatient services

furnished by certain teaching physicians, effective on enactment; (2) the provision of benefits for certain additional physical therapy services, effective January 1, 1971; and (3) the establishment of limits on prevailing charge levels, effective July 1, 1970.

No significant cost effect is estimated for the higher reimbursement basis for certain teaching physicians, because payments for some of these services will be based on reasonable costs (rather than on reasonable charges) under your committee's bill.

The liberalized physical therapy benefits are estimated to have a cost of about $.03 per month per enrollee, or a total annual cost of about $7 million.

The lower limits established for the prevailing charge levels are estimated to reduce costs by about 1 to 2 percent in the first year of operation, or by about $20 to $40 million in fiscal year 1971. It is not possible to estimate the effect on in costs for subsequent years, because the appropriate economic index has yet to be prescribed by the Secretary of Health, Education, and Welfare.

The net effect of the changes that would be made by your committee's bill for the forthcoming premium period beginning July 1, 1970 (for which a standard premium rate of $5.30 per month has been promulgated by the Secretary of Health, Education, and Welfare), is a net reduction in benefit costs of about $17 to $37 million, resulting from an increased cost of $3 million for the additional physical therapy benefits (which are available beginning January 1, 1971) and a decreased cost of $20 to $40 million due to the lower limits on prevailing charge levels. As a result, the actuarial status of the program is slightly improved, and the premium rate will contain a somewhat larger margin for contingencies.

V. SECTION-BY-SECTION ANALYSIS OF THE BILL

The first section contains the short title of the bill—the "Social Security Amendments of 1970"—and the table of contents.

TITLE I—PROVISIONS RELATING TO OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE

SECTION 101. INCREASE IN OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

Section 101 of the bill provides a benefit increase of 5 percent, effective January 1, 1971, with new minimum and maximum benefit amounts.

Primary insurance amount; column IV of the revised benefit table

Section 101(a) of the bill amends section 215(a) of the Social Security Act to substitute a new table for the present benefit table. The new table effectuates the benefit increase for people who are on the benefit rolls prior to January 1971 and provides benefit amounts higher than those under present law for people who come on the benefit rolls in or after that month. The new primary insurance amounts, shown in column IV of the table, represent an increase of 5 percent over the primary insurance amounts provided in present law for average monthly earnings up to $650—the highest average monthly earnings possible under present law. (The primary insurance amount is the monthly benefit payable to a worker who retires at or after age 65 or to a disabled worker who had not previously been entitled to a reduced old-age benefit; it is also the amount on which all other benefits are based.)

An approximation of the benefits shown in the new benefit table can be arrived at by taking 85.92 percent of the first $110 of average monthly earnings, plus 31.25 percent of the next $290, plus 29.20 percent of the next $150, plus 34.32 percent of the next $100, plus 20 percent of the next $100. Benefits in the table in present law approximate 81.83 percent of the first $110 of average monthly earnings, plus 29.76 percent of the next $290, plus 27.81 percent of the next $150, plus 32.69 percent of the next $100.

The primary insurance amounts provided by the new table range from a minimum of $67.20 for people whose average monthly earnings are $76 or less to a maximum of $283 for people who have average monthly earnings of $750. Average monthly earnings as high as $750 will become possible in the future under the $9,000 contribution and benefit base which the bill (in sec. 120) provides. The primary insurance amounts of workers getting benefits based on present law (i.e., workers who will not have the advantage of the increased contribution and benefit base) are raised from $64 to $67.20 at the minimum and from $250.70 to $263.30 at the maximum payable in 1971.

The total monthly amount of benefits payable to a family on the basis of a single earnings record, shown in column V of the table, is 1½ times the worker's primary insurance amount up to the last point (average monthly earnings of $267) at which 1½ times the worker's primary insurance amount is greater than 80 percent of the worker's average monthly earnings. Above that point, the maximum family benefit is equal to the sum of 80 percent of the worker's average monthly earnings up to $436 (about 58 percent of the maximum possible average monthly earnings—$750 under a $9,000 contribution and benefit base) plus 40 percent of the worker's average monthly earnings above $436. This formula produces, at the maximum possible average monthly earnings of $750, a maximum family benefit of almost two-thirds of the average monthly earnings. Under the bill, the maximum amount of monthly benefits payable to a family will range from $100.80 to $474.40.

Maximum family benefits for people already on the rolls

Section 101(b) of the bill amends section 203(a)(2) of the act to assure an increase in family benefits for families with two or more members who are entitled to benefits for January 1971 if at least one of them was entitled to benefits in December 1970. Under the bill, the total of benefits payable to such families may not be reduced to less than the larger of (1) the family maximum specified in column V of the new table or (2) the sum of all the benefits of family members on the benefit rolls in December 1970 computed under present law, increased by 5 percent, and rounded to the next higher 10 cents if not already a multiple of 10 cents. Without such a provision, some families now on the rolls could receive little or no increase in benefits.

Section 101(b) of the bill also contains a provision affecting the amount of benefits for family members getting benefits in January 1971 on the basis of two or more earnings records. Under present law, when children are entitled to benefits on the earnings records of more than one worker, the total benefits payable to the family are not reduced to less than the smaller of the sum of the maximum family benefits payable on all the earnings records on which the family members could be entitled or the highest family maximum benefit shown in column V of the benefit table. Under the bill, in cases in which the combined-family-maximum provisions (sec. 202(k)(2)(A) of the act) are applicable, these provisions are applied before the provisions of section 203(a) which guarantee every beneficiary a 5-percent increase—that is, the provisions of the bill which guarantee a 5-percent increase to each member of the family (described above) are applied last. When the combined-family-maximum cases in which the combined family maximum provisions (sec. 202(k)(2)(A) of present law) are applicable, these provisions are applied before the provisions of section 203(a) which guarantee every beneficiary a 5-percent increase—that is, the provisions of the bill which guarantee a 5-percent increase to each member of the family (described above) are applied last. When the combined-family-maximum provisions are applicable in the effective month of the benefit increase, and later cease to apply because the benefits for the last family member entitled on more than one earnings record are terminated, the benefit amounts for the remaining family members, who are entitled on a single earnings record, will be determined under

section 203(a)(2), as amended by the bill, as if they had been getting benefits based on only one earnings record in January 1971.

Average monthly earnings: column III of the revised benefit table

Section 101(c) of the bill amends section 215(b)(4) of the act so that column III of the new benefit table will be applicable only in the case of an average monthly earnings computation for a person (1) who becomes entitled to old-age or disability insurance benefits in or after January 1971, or (2) who dies in or after that month without having been entitled to old-age or disability benefits, or (3) whose benefit is recomputed for months beginning with or after that month.

Primary insurance amount under 1969 act; column II of the revised benefit table

Section 101(d) of the bill amends section 215(c) of the act to provide that a person who becomes entitled to old-age or disability insurance benefits before January 1971, or who dies before that month, will have his primary insurance amount determined under the provisions of present law for purposes of column II of the revised table. Since benefit amounts appearing in column II of the revised table will be converted to the new benefit amounts in column IV of that table, the effect of this provision is that people already on the rolls will have their benefits converted to the higher primary insurance amount appearing on the same line in column IV of the new table. Under present law, column II of the benefit table shows the primary insurance amounts in effect prior to the Social Security Amendments of 1969, and column IV of the table shows the amounts to which the primary insurance amounts in column II were converted as a result of those amendments.

Effective date

Section 101(e) of the bill provides that the benefit increases under section 101 will be effective for monthly benefits for and after January 1971 and for lump-sum death payments where death occurs in or after that month.

Special provision for conversion of a disability insurance benefit to an old-age insurance benefit

Section 101(f) of the bill is a special transitional provision which applies to a person who is entitled to a disability insurance benefit for December 1970 and who becomes entitled to old-age insurance benefits (for example, by reason of attainment of age 65), or dies, in January 1971, to make certain that his primary insurance amount is increased. The general rule, provided in section 215(a)(4) of the act, that would otherwise apply in this situation is that an individual who was entitled to a disability insurance benefit for the month before the month for which he becomes entitled to an old-age insurance benefit will have as his primary insurance amount the amount in column IV of the table that is equal to the primary insurance amount on which his disability insurance benefit is based. In the above situation, the individual's disability insurance benefit, since it was derived from a primary insurance amount determined under present law, does not have any direct connection with column IV of the table included in the bill, which contains the new benefit amounts; thus, the general rule cannot be applied to him. Therefore, section 101(f) of the bill provides that his

primary insurance amount will be the amount in column IV of the table on the same line as that on which, in column II, appears his present primary insurance amount. (The primary insurance amount be applied to him. Therefore, section 101(f) of the bill provides that his disability insurance benefit under present law is based.)

SECTION 102. INCREASE IN BENEFITS FOR CERTAIN INDIVIDUALS AGE 72 AND OVER

Section 102 of the bill increases the amount of the special payments made to certain people age 72 and older who have never worked in covered jobs or who have had less covered work than is needed to qualify for the regular retirement benefits of the program.

Section 102(a) of the bill amends section 227 of the Social Security Act to increase from $46 to $48.30 the monthly amount payable to transitionally insured workers and widows who qualify for special payments under section 227 on the basis of 3, 4, or 5 quarters of coverage. (To qualify for regular retirement benefits, a worker has to have a minimum of 6 quarters of coverage.) It also raises from $23 to $24.20 the amount payable to the wives of men who qualify for benefits under that section.

Section 102(b) of the bill amends section 228 of the act to increase from $46 to $48.30 the monthly amount payable to people who qualify under section 228 on the basis of no quarters of coverage, or of some quarters of coverage but not enough to qualify for either regular retirement benefits or payments to transitionally insured people, and to increase from $23 to $24.20 the monthly amount payable to a wife when both husband and wife are entitled to benefits under that section.

Section 102(c) of the bill provides that these increases in the amounts of the special payments will be effective with respect to monthly payments for and after January 1971.

SECTION 103. INCREASED WIDOW'S AND WIDOWER'S INSURANCE BENEFITS

Section 103 of the bill provides increased widow's and widower's benefits for those who become entitled to such benefits after age 62. A widow or widower who first becomes entitled to benefits at or after age 65 can get a benefit equal to 100 percent of the primary insurance amount of the deceased worker. A widow's benefit amount is to be actuarially reduced by 57/120 per month for each month for which the benefit is paid before age 65, so that the benefit is 82.9 percent of the worker's primary insurance amount at age 62 and 71.5 percent at age 60.

Section 103(a)(1) of the bill amends section 202(e) of the Social Security Act to change the amount of an unreduced widow's benefit from 82½ percent of the worker's primary insurance amount to 100 percent.

Section 103(a)(2) of the bill amends section 202(e) of the act to provide that reduced wife's benefits and mother's benefits will be automatically converted to widow's benefits at age 65 rather than at age 62 so that a woman whose husband dies while she is between ages 62 and 65 can choose whether to take a reduced widow's benefit or wait until age 65 and get a full widow's benefit. It also provides that a disabled widow's benefit will be automatically converted to

an aged widow's benefit at age 65 rather than at age 62 so that a woman who recovers from a disability between ages 62 and 65 can choose whether to apply for reduced aged widow's benefits or wait until age 65.

Section 103(b)(1) of the bill amends section 202(f) of the act to change the amount of an unreduced widower's benefit from 82½ percent of the worker's primary insurance amount to 100 percent.

Section 103(b)(2) of the bill amends section 202(f) of the act to provide that reduced husband's benefits will be automatically converted to widower's benefits at age 65 rather than at age 62 so that a man whose wife dies while he is between ages 62 and 65 can choose whether to take a reduced widower's benefit or wait until age 65 and get a full widower's benefit.

Section 103(b)(3) amends section 202(f) of the act to provide that a disabled widower's benefit will be automatically converted to an aged widower's benefit at age 65 rather than at age 62 so that a man who recovers from a disability between ages 62 and 65 can choose whether to apply for reduced aged widower's benefits or wait until age 65.

Section 103(c)(1) and section 103(c)(2) of the bill amend section 203 of the act to eliminate the application of the retirement test to disabled widows and widowers until age 65 when the benefit based on a disability is converted to an aged widow's or widower's benefit.

Section 103(d)(1) of the bill amends section 202(q)(1) of the act to eliminate for widows and widowers the actuarial reduction factor of $\frac{5}{9}$ of 1 percent per month from age 60 to 62 and to substitute a new factor of $\frac{5}{12}$ of 1 percent from age 60 to 65. This change in the actuarial reduction factor for disabled widows and widowers is made in order to provide benefits between age 50 and 60 equal to those provided under present law. The benefit payable at age 50 equals 50 percent of the deceased worker's primary insurance amount.

Section 103(d)(2) of the bill amends section 202(q)(7) of the act to revise (in the light of the other amendments made by section 103) the description of the periods over which old-age, wife's, husband's, widow's, and widower's benefits are actuarially reduced, and to provide for a recomputation of benefits at age 62 and at age 65 to adjust the number of months in the period over which benefits are actuarially reduced. This adjustment is necessary to eliminate the reduction for months when actuarially reduced benefits were not received—for example, when benefits were withheld because of earnings from work. Under present law this recomputation is only provided for widows at age 62 and widowers at age 62 and for other beneficiaries at age 65.

Section 103(d)(3) of the bill amends section 202(q)(9) of the act to change the definition of retirement age for widows and widowers to age 65 as is now the case for old-age, wife's, and husband's insurance benefits.

Section 103(e)(1) of the bill amends section 202(m) of the act, which provides (in paragraph (1)) that the benefit of a sole surviving beneficiary will not be less than the minimum primary insurance amount.

Paragraph (2) of the amended section 202(m) deals specifically with benefits for a sole surviving widow or widower; it provides that such benefits when based upon an application filed between ages 62

and 65 will not be less than the minimum benefit, and when based upon an application filed between ages 60 and 62 will not be less than the minimum benefit reduced by the amount by which it would be reduced if the beneficiary had attained age 65 when he actually attained or would attain age 62. The maximum reduction that would apply to the minimum benefit in the latter case would be for 24 months.

Paragraph (3) of the amended section 202(m) provides that in determining the amount of a disabled widow's or widower's benefit when paragraph (2) applies, the amount of the reduction for months between ages 50 and 60 will be based on the person's actual age rather than the fictitious age used in determining the reduction applicable under paragraph (2). Thus the benefit for a 50-year-old disabled widow will be either a benefit equal to her husband's primary insurance amount reduced by $^{5}/_{12}$ of 1 percent per month for the 60 months between ages 60 and 65 and $^{43}/_{240}$ of 1 percent per month for the 120 months between ages 50 and 60 (as provided in section 202(q)(1) of the act as amended by section 103(d)(1) of the bill) or the minimum benefit reduced by $^{5}/_{12}$ of 1 percent per month for the 120 months between ages 50 and 60 based on the person's actual age, whichever is larger.

Section 103(f) of the bill directs the Secretary to redetermine the amount of the widow's and widower's benefits for those entitled in December 1970 as if the amendments made by section 103 had been available at the time of their initial entitlement; the redetermined amounts are to be effective for January 1971.

Section 103(g) of the bill provides that family members entitled on the same account as a widow or widower whose benefit is increased under the amendments made by section 103 will not have their benefits decreased as a result of the increase in the widow's or widower's benefit.

Section 103(h) of the bill provides that these amendments will be effective for monthly benefits beginning with January 1971.

SECTION 104. AGE-62 COMPUTATION POINT FOR MEN

Section 104 of the bill provides for determining the number of years to be used in figuring a man's insured status and the average monthly earnings on which his benefits are based by taking into account only the period up to age 62, as is the case for women, rather than up to age 65 as under present law.

Section 104(a) of the bill amends section 214(a)(1) of the Social Security Act to provide that benefit eligibility of a male worker will be based on the number of years up to the year in which he attains age 62, rather than up to the year in which he attains age 65 as under present law.

Section 104(b) of the bill amends section 215(b)(3) of the act to provide that, in determining the number of years to be used in figuring the average monthly earnings of a male worker, there will be taken into account only years up to the year in which he attains age 62 rather than up to the year in which he attains age 65 as under present law.

Section 104(c) of the bill provides that the primary insurance amount of an insured individual who, prior to January 1971, becomes entitled to an old-age insurance benefit, becomes entitled to a disability

insurance benefit after the year in which he attains age 62, or dies in a year after the year in which he attains age 62 will be recomputed using earnings only up to age 62 rather than up to age 65.

Section 104(d) of the bill amends section 223(a)(2) of the act to provide that the disability insurance benefit of a male worker will be computed as though he attained age 62 in the first month of his waiting period or, when the waiting period is waived, the first month of his entitlement to disability benefits. Elapsed years for the disability benefit computation will not include the year he attains age 62 or any year thereafter.

Section 104(e) of the bill amends section 223(c)(1)(A) of the act to make the reference to a fully insured individual therein applicable to any individual who had attained age 62 with no distinction between a man and a woman.

Sections 104(f) and (g) of the bill amend sections 227(a)(1) and 227(b) of the act to make conforming changes in the transitional insured status provisions.

Section 104(h) of the bill amends sections 209(i), 213(a)(2) and 216(i)(3)(A) of the act to make certain references therein applicable to an individual who attains age 62 with no distinction between a man and a woman.

Section 104(h) of the bill amends sections 209(i), 213(a)(2), and 303(g)(1) of the Social Security Amendments of 1960 to provide that the primary insurance amount of an individual age 62 before 1961 can continue to be computed under the provisions of the act before the amendments of 1960.

Section 104(j) of the bill amends section 3121(a) of the Internal Revenue Code of 1954 to provide that wages for social security tax purposes will not include any payment (other than sick or vacation pay) made to an employee after the month in which he attains age 62 with no distinction between a man and a woman, if the employee did not work for the employer in the period for which the payment is made.

Section 104(k) of the bill (a saving clause) provides that, if the monthly benefits of individuals entitled under section 202 or 223 of the act are redetermined in accordance with section 104 of the bill, the total benefits for the family will not be less than the amount to which they were entitled in January 1971 plus the amount of the increase in the insured individual's primary insurance amount.

Section 104(l) of the bill provides that these amendments will be effective for monthly benefits beginning with January 1971 and for lump-sum death payments in the case of insured individuals who die after December 1970.

SECTION 105. ELECTION TO RECEIVE ACTUARIALLY REDUCED BENEFITS IN ONE CATEGORY NOT TO BE APPLICABLE TO CERTAIN BENEFITS IN OTHER CATEGORIES

Section 105 of the bill eliminates the provision in present law under which a person who is eligible for both (1) an old-age insurance benefit and (2) a wife's or husband's insurance benefit and who files for either before age 65 is deemed to have filed for both. It also eliminates the provision in present law under which a person who gets a reduced benefit in one benefit category has any subsequent benefit he gets reduced to take account of the fact that he got the first benefit early.

Section 105(a)(1) of the bill amends section 202(q)(3)(A) of the Social Security Act to provide that the methods of figuring a reduction under section 202(q)(3)(B) (providing for reduced wife's or husband's benefits to take account of the receipt of an actuarially reduced old-age insurance benefit) or a reduction under section 202(q)(3)(C) (providing for reduced wife's, husband's, widow's, or widower's benefits to take account of the receipt of a reduced disability benefit) will only apply if they provide a higher benefit than would be payable if the receipt of the reduced old-age insurance benefit in section 202(q)(3)(B) or of the disability insurance benefit in section 202(q)(3)(C) were ignored. Present law will continue to be applied in cases where it would produce a higher benefit.

Section 105(a)(2) of the bill amends section 202(q)(3) of the act by striking out subparagraph (E) (providing for the reduction of an old-age insurance benefit to take account of the prior receipt of a reduced widow's or widower's benefit), subparagraph (F) (providing for the reduction in a disability benefit beginning with or after age 62 to take account of the receipt of a reduced widow's or widower's benefit), and subparagraph (G) (providing for a similar reduction in a disability benefit received before age 62). The effect of these changes is to eliminate the reduction in an old-age insurance benefit or a disability insurance benefit which would be made under present law to take account of receipt of reduced widow's or widower's benefits.

Section 105(b) of the bill repeals section 202(r) of the act, which provides that a person who is eligible in a given month for a benefit as a retired worker and as a spouse is deemed to have filed for both if he files for either.

Section 105(c)(1)(A) of the bill provides that (subject to the subsequent provisions of section 105) the amendments made by section 105(a) will be effective with respect to benefits for and after the sixth month after the month of enactment.

Section 105(c)(1)(B) of the bill provides that, in the case of a person who was on the rolls before the sixth month after the month of enactment, the amendments made by section 105(a) will be effective only if the person files a written request, which must take the form of a request for a redetermination of his benefit amount under section 105(c)(2) in the case of a person who is simultaneously entitled to two actuarially reduced benefits and who was deemed (or, except for the fact that an application was filed, would have been deemed) under section 202(r) of the act to have filed an application for the second such benefit; in the latter case the redetermination will apply unless the person who filed the request refuses to accept it. If the request is filed before the end of the sixth month after the month of enactment, the redetermination will be effective with respect to benefits for months beginning with such sixth month; if the request is not filed before the end of the sixth month after the month of enactment the redetermination will be effective with respect to benefits for and after the second month following the month in which the request is filed.

Section 105(c)(1)(C) of the bill provides that section 105(b) (eliminating the deemed filing provisions) will be effective on the basis of applications filed on or after the date of enactment of the bill.

Section 105(c)(2)(A) of the bill provides that where a person entitled to reduced benefits in the fifth month following the month of enact-

ment was deemed (or, except for the fact that an application was filed, would have been deemed) to have filed an application for benefits in another category, and files a written request for a redetermination, the Secretary will redetermine both benefits as though there had been no deemed filing requirement at the time the person applied for benefits.

Section 105(c)(2)(B) of the bill provides the method for redetermining benefits in cases where the person was deemed (or, except for the fact that he filed an application, would have been deemed) to have filed for one of the benefits. The smaller benefit is assumed to have been taken in the first month of the simultaneous entitlement. The larger benefit is assumed to have been taken in the month in which the redetermination is effective (or at age 65, if earlier). The amount of total benefits actually received prior to the effective month of the redetermination will be measured against the amount of total benefits which would have been received if the amendments had always been in effect. The excess of the former (if any) over the latter will be recovered to the extent and in the manner provided in section 105(c)(2)(C) and (E), discussed below.

Section 105(c)(2)(C) of the bill provides that an individual who requests a redetermination will be notified by the Secretary of the amount of the benefits as redetermined, the amount of the excess to be recovered, and the extent of the period over which recovery will be made. The individual will have 30 days after notification is mailed to reject the redetermination.

Section 105(c)(2)(D) of the bill provides that if the request for a redetermination is filed before the end of the sixth month following the month of enactment and the redetermination is not refused, it will be effective with respect to benefits for and after the sixth month after the month of enactment. If the request is filed after the sixth month after the month of enactment and the redetermination is not refused, it will be effective with respect to benefits for and after the second month after the month in which the redetermination is requested.

Section 105(c)(2)(E) of the bill provides that the Secretary will recover any excess in benefits paid to a person to which a redetermination applies only by withholding the amount of the monthly increase in such person's benefits resulting from the amendment, made by section 105 (a) and (b); the person can receive no less in total monthly benefits after the redetermination than he was receiving before the redetermination was effective. (If the beneficiary dies recovery will be considered complete, and no recovery will be made from any benefit that is not increased as a result of this section or these amendments).

Section 105(d) of the bill (a saving clause) prevents any reduction in benefits for other members of a family when benefits are increased under this section for someone getting benefits on the same earnings record.

SECTION 106. LIBERALIZATION OF EARNINGS TEST

Section 106(a) of the bill amends paragraphs (1), (3), and (4)(B) of section 203(f) of the Social Security Act to increase the amount of earnings a beneficiary may have in a year and still be paid full benefits for the year. It also makes a conforming amendment in paragraph (1)(A) of section 203(h) of the act, which requires beneficiaries to report if their earnings exceed the permissible amount in a year.

Paragraph (1) of the amended section 203(f) provides that, for purposes of the retirement test (the provision in the law under which some or all benefits are withheld when a beneficiary under age 72 has exceeded a specified amount of earnings), any earnings of a beneficiary in excess of the amount he may earn and still get full benefits for the year (the annual exempt amount) will not be charged to any month in which he did not engage in self-employment and render services for wages of more than $166.66⅔ (instead of $140 as in present law). The effect of this change is that regardless of a beneficiary's total earnings in a year his benefits may not be withheld for any month in which he did not have wages of more than $166.66⅔ (and did not engage in self-employment).

Paragraph (3) of the amended section 203(f) provides that a person's "excess earnings" for any taxable year will be his earnings in excess of $166.66⅔ (instead of $140 as in present law) times the number of months in his taxable year. The effect of this change is that a beneficiary will get benefit each month of a year if his earnings for the year do not exceed $2,000 (instead of $1,680 as under present law), and that the provision under which benefits are reduced by $1 for each $2 of the first $1,200 of excess earnings will apply to earnings between $2,000 and $3,200 (instead of between $1,680 and $2,880).

Paragraph (4)(B) of the amended section 203(f) provides that in determining whether a beneficiary earned more in a month than $166.66⅔ (instead of $140 as under present law) for purposes of applying the monthly exemption under paragraph (1) of such section, he will be presumed to have earned more than that amount until it is shown to the satisfaction of the Secretary that he did not do so.

Paragraph (1)(A) of the amended section 203(h) requires a beneficiary to report his earnings to the Secretary of Health, Education, and Welfare whenever he has excess earnings as defined in the amended section 203(f).

Section 106(b) of the bill provides that these amendments will be effective for taxable years ending after December 1970.

SECTION 107. EXCLUSION OF CERTAIN EARNINGS IN YEAR OF ATTAINING AGE 72

Section 107(a) of the bill amends section 203(f)(3) of the Social Security Act by adding a new clause (B) which provides that, in the year in which an individual attains age 72, earnings in and after the month in which he attains age 72 will not be counted in determining his excess earnings for such year.

Section 107(b) provides that this change will be effective for taxable years ending after December 1970.

SECTION 108. REDUCED BENEFITS FOR WIDOWERS AT AGE 60

Section 108 of the bill provides for actuarially reduced benefits for nondisabled widowers as early as age 60, as is now the case for widows. The benefit amount is to be reduced by 57/120 of 1 percent per month for each month the benefit is taken before age 65. (See section 103 of the bill explaining benefit amounts from age 62 to 65 as provided by the bill.) The benefit amount at age 65 will equal 100 percent of the

worker's primary insurance amount; at age 62 it will equal 82.9 percent and at age 60 it will equal 71.5 percent.

Section 108(a) of the bill amends section 202(f) of the Social Security Act to provide for widowers' benefits for nondisabled widowers at age 60 as is now the case for widows.

Section 108(b)(1) and section 108(b)(2) of the bill amend section 203(c) of the act to provide that the retirement test is inapplicable to widowers between age 60 and 65 only if they became entitled to benefits before age 60 (i.e., on the basis of a disability) rather than before age 62 as under present law. This makes the application of the retirement test to widowers consistent with its application to widows.

Section 108(b)(3) of the bill amends section 222(b)(1) of the act to provide for deductions from widowers' benefits for refusal to accept rehabilitation services when the widower has not attained age 60, rather than if he has not attained age 62 as under present law, reflecting the fact that under these amendments nondisabled widowers' benefits will be available as early as age 60.

Section 108(b)(4) of the bill amends section 222(d)(1)(D) of the act to provide for funding of rehabilitation services for widowers entitled before age 60, rather than age 62 as under present law, reflecting the the fact that under these amendments nondisabled widowers' benefits will be available as early as age 60.

Section 108(b)(5) of the bill amends section 225 of the act to provide for the suspension of widowers' benefits before age 60, rather than before age 62 as under present law, where the Secretary of Health, Education, and Welfare has information indicating that the widower has ceased to be under a disability, reflecting the availability of nondisabled widowers' benefits as early as age 60.

Section 108(c) of the bill provides that these amendments will be effective for monthly benefits payable for months beginning with January 1971.

ENTITLEMENT TO CHILD'S INSURANCE BENEFITS BASED ON DISABILITY WHICH BEGAN BETWEEN 18 AND 22

Section 109 of the bill provides child's insurance benefits to an otherwise qualified adult son or daughter if his disability has been continuous since before age 22 (rather than only if it was continuous since before age 18 as under present law).

Section 109(a) of the bill amends clause (ii) of section 202(d)(1)(B) of the Social Security Act to permit the payment of child's insurance benefits to an individual under a disability which began before he attained age 22 (rather than age 18).

Section 109(b) of the bill amends subparagraphs (F) and (G) of section 202(d)(1) of the act to provide that entitlement to child's insurance benefits will end, for a child who is over age 18 and disabled, with the second month following the month in which he ceases to be under a disability unless he is entitled as a full-time student under age 22.

Section 109(c) of the bill further amends section 202(d)(1) of the act by adding at the end a new sentence which provides that child's insurance benefits will not be payable to an individual in any month in which the individual engages in substantial gainful activity if his continuing entitlement to such benefits is solely by reason of disability as defined in section 223(d)(1)(B) of the act.

Section 109(d) of the bill amends subsection 202(d)(6) of the act to provide that (1) a child whose benefits are terminated at or after age 18 can be re-entitled to child's benefits if he is disabled (as defined in section 223(d) of the act) before age 22, and (2) such re-entitlement will end with the month preceding the month in which the child dies, marries, or (in certain cases) is adopted, or with the second month following the month disability ceases unless the child is entitled as a full-time student and has not attained age 22.

Section 109(e) of the bill makes two changes in section 202(s) of the act. Section 109(e)(1) amends paragraph (1) of section 202(s) to exclude persons entitled to child's insurance benefits by reason of becoming disabled after attaining age 18 but before age 22 from the category of children aged 18–21 whose mothers are ineligible for benefits on the basis of having entitled children aged 18–21 in their care. Section 109(e)(2) amends paragraph (2) of section 202(s) to extend to persons entitled to child's insurance benefits by reason of becoming disabled after attaining age 18 but before age 22 the provisions that permit a childhood disability beneficiary to continue to get benefits when he marries another beneficiary, and which permit such other beneficiary to continue to get benefits when he marries such childhood disability beneficiary. Section 109(e)(2) also amends paragraph (3) of section 202(s) to extend to the child entitled on the basis of a disability that began after age 18 but before age 22 (1) the exemption from the dependency requirements in present law for husband's and widower's benefits, (2) the provisions of existing law for terminating, in the case of a male childhood disability beneficiary, benefits payable to his spouse if his benefits as a disabled child terminate because he is no longer disabled, (3) the provisions of present law that exempt a disabled child from having his benefits withheld on account of work, and (4) the provisions of present law under which a disabled child can, upon marriage, become eligible as a wife, widow, husband, or widower beneficiary.

Section 109(f) of the bill (a saving clause) protects beneficiaries on the old-age, survivors, and disability insurance benefit rolls in December 1970 in certain cases where an individual is made eligible for benefits by this section of the bill. If an individual who is made eligible by this section becomes entitled to benefits for January 1971, then each member of the family who was entitled to benefits for December 1970 will get an amount no less than he would have gotten if the newly eligible person had not become entitled to benefits, in spite of the provisions of section 203(a) (relating to the limit on the total amount of benefits payable to a family). The benefit amount of the newly entitled person would be determined without regard to the saving clause.

Section 109(g) of the bill provides that these amendments will apply with respect to monthly benefits for months after December 1970, except that in the case of an individual who is not entitled to benefits under section 202 of the act for December 1970 they will apply only on the basis of an application filed after September 30, 1970.

SECTION 110. ELIMINATION OF SUPPORT REQUIREMENT AS CONDITION OF BENEFITS FOR DIVORCED AND SURVIVING DIVORCED MOTHERS

Section 110(a) of the bill amends section 202(b)(1) of the Social Security Act by removing the requirement that to get wife's benefits

an otherwise qualified divorced wife must have been receiving one-half of her support from her former husband or receiving substantial contributions from him pursuant to a written agreement unless there is a court order in effect for substantial contributions to her support from him.

Section 110(b)(1) of the bill amends section 202(e)(1) of the act by removing the requirement that to get widow's insurance benefits an otherwise qualified surviving divorced wife must have been receiving one-half of her support from her former husband or receiving substantial contributions from him pursuant to a written agreement unless there is a court order in effect for substantial contributions to her support from him.

Section 110(b)(2) of the bill makes a conforming change in section 202(e)(6) of the act.

Section 110(c) of the bill amends section 202(g)(1) of the act removing the requirement in subparagraph (F) that to get mother's insurance benefits an otherwise qualified surviving divorced mother must have been receiving one-half of her support from her former husband or receiving substantial contributions from him pursuant to a written agreement unless there is a court order in effect for substantial contributions to her support from him.

Section 110(d) of the bill makes these amendments effective for and after January 1971 on the basis of applications filed on and after the date of enactment of the bill.

ELIMINATION OF DISABILITY INSURED-STATUS REQUIREMENT OF SUBSTANTIAL RECENT COVERED WORK IN CASES OF INDIVIDUALS WHO ARE BLIND

Section 111 of the bill provides that a blind individual can be insured for disability insurance benefits and establish a period of disability (disability freeze) without meeting a requirement of substantial recent covered work. Under present law, to meet this requirement a disabled worker (including a blind worker) generally needs 20 quarters of coverage during the period of 40 calendar quarters ending with the quarter in which he became disabled. (An alternative provision takes into account that workers who are disabled while young may have been in the work force for a relatively short time.)

Section 111(a) of the bill amends section 216(i)(3) of the Social Security Act by excepting an individual whose disability is blindness (as defined in section 216(i)(1) of the act) from the requirement of substantial recent covered work for purposes of qualifying for a period of disability.

Section 111(b) of the bill amends section 223(c)(1) of the act by excepting an individual whose disability is blindness from the requirement of substantial recent covered work for purposes of qualifying for disability insurance benefits.

Section 111(c) of the bill provides that these amendments will be effective with respect to applications for disability insurance benefits, and for disability determinations for purposes of establishing a period of disability, that are filed in or after the month of enactment, or before such month if the applicant has not died before such month and if either (1) notice of the final decision of the Secretary has not been given to the applicant before such month, or (2) such notice has been given before such month but a civil action thereon is com-

menced (whether before, in, or after such month) under section 205(g) of the Social Security Act and the decision in such civil action has not become final before such month; except that no monthly benefits would be payable or increased by reason of these amendments for months before January 1971.

SECTION 112. WAGE CREDITS FOR MEMBERS OF THE UNIFORMED SERVICES

Section 112(a) of the bill amends section 229(a) of the Social Security Act to provide noncontributory wage credits for service in the uniformed services of the United States after 1956 and before 1968. (The noncontributory wage credits are in addition to credits for the serviceman's covered wages, i.e., his basic service pay.) The amount of the noncontributory wage credits will be determined in the same way as noncontributory wage credits for years after 1967 are determined under present law. Ordinarily, this amount is $300 for each calendar quarter in which the serviceman received covered wages on a contributory basis for his service, but it is limited to $100 for any calendar quarter in which his service pay was $100 or less, and $200 for any calendar quarter in which his service pay was more than $100 but not more than $200. (As under present law, additional benefits paid as a result of these additional credits will be financed from general revenues.)

Section 112(b) of the bill provides that the amendments made by section 112(a) will apply with respect to monthly benefits payable under title II of the act for months after December 1970 and to lump-sum death payments in the case of deaths after December 1970. Any person on the benefit rolls in December 1970 whose monthly benefits can be increased as a result of the noncontributory wage credits provided under section 112(a) can have his benefits increased if he or any other person entitled to monthly benefits on the same earnings record files an application for a recomputation of benefits. The recomputed benefit amount will be effective for months beginning with January 1971, or, if later, the twelfth month before the month in which the application for a recomputation of benefits is filed. Recomputation of benefits to take into account the wage credits provided under section 112(a) will be made notwithstanding the limitations on recomputations contained in section 215(f)(1) of the act (in general, benefits cannot be recomputed unless there were earnings after 1965), and no such recomputation will be regarded as a recomputation for purposes of section 215(f).

APPLICATIONS FOR DISABILITY INSURANCE BENEFITS FILED AFTER DEATH OF INSURED INDIVIDUAL

Section 113 of the bill provides that a period of disability (disability freeze) can be established and disability insurance benefits (and related dependents' benefits) can be paid on the basis of an application filed within 3 months after the month of the death of the disabled individual.

Section 113(a)(1) of the bill amends section 223(a)(1) of the Social Security Act by adding at the end a new sentence which provides that entitlement to disability insurance benefits, in the case of a deceased individual, may be based upon an application filed within 3 months after the month in which he died.

Sections 113(a)(2), (3), and (4) of the bill make conforming changes in sections 223(a), (b), and (c) of the act.

Section 113(b) of the bill amends section 216(i)(2)(B) of the act by adding at the end a new sentence which provides that a period of disability may begin on the basis of an application for a disability determination filed with respect to a deceased individual within 3 months after the month in which he died.

Section 113(c) of the bill provides that these amendments will apply in cases of deaths occurring in and after the year of enactment. In addition it provides that where a death occurred prior to the date of enactment but in the year of enactment, an application filed in accordance with such amendments within 3 months after the date of enactment will, for purposes of sections 202(j)(1) (relating to the retroactive life of an application for dependents' benefits) and 223(b) (relating to the retroactive life of an application for disability insurance benefits) of the act, be deemed to have been filed in the month such death occurred.

WORKMEN'S COMPENSATION OFFSET FOR DISABILITY INSURANCE BENEFICIARIES

Section 114(a) of the bill amends paragraph (5) of section 224(a) of the Social Security Act to provide that, where workmen's compensation is payable, social security disability benefits will be reduced only by the amount by which the combined workmen's compensation and social security payments exceed 100 percent of the workers' average current earnings (as defined in section 224(a)) before he became disabled. (Under present law, the reduction applies to the amount exceeding 80 percent of such earnings.)

Section 114(b) of the bill provides that this amendment will apply with respect to monthly benefits for months after December 1970.

SECTION 115, COVERAGE OF FEDERAL HOME LOAN BANK EMPLOYEES

Section 115(a) of the bill provides social security coverage for service performed in the employ of a Federal Home Loan Bank. The Social Security Amendments of 1956 amended section 210(a)(6)(B)(ii) of the Social Security Act and section 3121(b)(6)(B)(ii) of the Internal Revenue Code of 1954 to provide such coverage subject to the condition that the Banks coordinate their retirement systems with social security and that the plan for coordination be submitted to and approved by the Secretary of Health, Education, and Welfare by July 1, 1957. This condition was not met, and service for Federal Home Loan Banks has never been covered for social security purposes. Under section 115(a), coverage is effective for all service performed in the employ of a Federal Home Loan Bank after December 1970, and, for persons in the employ of such a bank on January 1, 1971, is effective for service performed in the employ of such a Bank after December 1965 but only if both the employee and the employer contributions as specified in the Federal Insurance Contributions Act for all such persons are paid (as provided in section 3122 of such act) by July 1, 1971, or later if agreed to before such date by the banks and the Secretary of the Treasury or his delegate.

Section 115(b) of the bill repeals subparagraphs (A)(i) and (B) of section 104(i)(2) of the Social Security Amendments of 1956, which

contained the condition that the FHLB retirement systems must be coordinated with social security and approved by the Secretary of Health, Education, and Welfare by July 1, 1957.

SECTION 116. POLICEMEN AND FIREMEN IN IDAHO

Section 116 of the bill amends section 218(p)(1) of the Social Security Act to add the State of Idaho to the list of States specifically named in the law as States which may modify their section 218 agreement to provide coverage under the social security program for policemen and firemen who are in positions under a State or local retirement system. (Section 218(p)(2) of the Social Security Act, added by the Social Security Amendments of 1967, makes social security coverage available to firemen who are members of a retirement system in States not listed in section 218(p)(1), but only if special conditions are met.) The effective date of such coverage would be whatever date is specified by the State of Idaho in the modification of its agreement, but could not be earlier than the beginning of the fifth year before the year in which the coverage is arranged.

SECTION 117. COVERAGE OF CERTAIN HOSPITAL EMPLOYEES IN NEW MEXICO

Section 117 of the bill permits the State of New Mexico, notwithstanding the provisions of section 218 of the Social Security Act, to modify its coverage agreement with the Secretary of Health, Education, and Welfare at any time before January 1, 1971, to provide coverage for services of employees of a hospital which is an integral part of a political subdivision to which the coverage agreement has not been made applicable. The employees of such hospital would be covered as a separate coverage group as defined in section 218(b)(5) of the act; and such coverage can apply only to service performed for a hospital which has, prior to 1966, withdrawn from a retirement system which had been applicable to the employees of such hospital.

SECTION 118. PENALTY FOR FURNISHING FALSE INFORMATION TO OBTAIN A SOCIAL SECURITY ACCOUNT NUMBER

Section 118(a) of the bill amends section 208 of the Social Security Act by adding a new subsection (f) to provide that the penalties in present law for certain fraudulent representations to the Secretary of Health, Education, and Welfare will apply to an individual who willfully, knowingly, and with the intent of deceiving the Secretary as to his true identity (or the true identity of any other person) furnishes false information with respect to any information required by the Secretary in connection with the establishment and maintenance of the social security records of wages and self-employment income.

Section 118(b) of the bill provides that this amendment will apply in the case of information furnished to the Secretary after the date of enactment of the bill.

SECTION 119. GUARANTEE OF NO DECREASE IN TOTAL FAMILY BENEFITS

Section 119(a) of the bill amends section 203(a) of the Social Security Act (as otherwise amended by the bill) to add a permanent saving clause to guarantee that when a worker is getting an actuarially reduced benefit and his primary insurance amount is increased, the total benefits payable to the family on his earnings record will not be decreased. In some such cases, if the benefits payable to a family are subject to the maximum limitation on the total amount of benefits payable on one earnings record, the family might, without such a saving clause, get less in total benefits after the worker's primary insurance amount is increased than they were getting before.

Section 119(b) makes permanent a special temporary saving clause provided by section 1002(b)(2) of the Social Security Amendments of 1969. Section 1002(b)(2) provided that where a person was on the benefit rolls in 1970 he, or his family, will never get less than he or they would have gotten prior to the 15-percent benefit increase provided by the 1969 amendments as long as the person on he rolls in 1970 remains on the rolls. Under the change, the no-loss guarantee will apply permanently; i.e., it will apply without regard to whether the person on the benefit rolls in 1970 remains on the rolls.

SECTION 120. INCREASE OF EARNINGS COUNTED FOR BENEFIT AND TAX PURPOSES

Section 120 of the bill raises the amount of annual earnings that is subject to social security contributions and counted toward social security benefits (the contribution and benefit base) from $7,800 to $9,000 beginning with 1971.

Amendments to Title II of the Social Security Act

Definition of wages

Section 120(a)(1) of the bill amends section 209(a) of the Social Security Act (defining "wages" for benefit purposes) to make the $9,000 contribution and benefit base applicable to wages paid after 1970.

Definition of self-employment income

Section 120(a)(2) of the bill amends section 211(b)(1) of the act (defining "self-employment income" for benefit purposes) to make the $9,000 contribution and benefit base applicable for taxable years beginning after 1970.

Quarter of coverage

Section 120(a)(3) of the bill amends clauses (ii) and (iii) of section 213(a)(2) of the act (defining "quarter of coverage") to provide that an individual will be credited with a quarter of coverage for each quarter of a calendar year after 1970 in which his wages for such year equal $9,000 (rather than $7,800 as in present law). An individual will also be credited with a quarter of coverage for each quarter any part of which falls within a taxable year beginning after 1970 in which the sum of his wages and self-employment equals $9,000.

Average monthly wage

Section 120(a)(4) of the bill amends section 215(e)(1) of the act (relating to the amount of annual earnings that can be counted in computing a person's average monthly wage) to increase from $7,800 to $9,000, effective for calendar years after 1970, the maximum amount of annual earnings that may be counted in the computation of a person's average monthly wage for purposes of determining benefit amounts.

Amendments to the Internal Revenue Code of 1954

Definition of self-employment income

Section 120(b)(1) of the bill amends section 1402(b)(1) of the Internal Revenue Code of 1954 (defining "self-employment income" for social security tax purposes) by increasing from $7,800 to $9,000 the amount of annual self-employment income subject to social security contributions for taxable years beginning after 1970.

Definition of wages

Section 120(b)(2) of the bill amends section 3121(a)(1) of the code (defining "wages" for social security tax purposes) by increasing from $7,800 to $9,000 the amount of annual wages subject to contributions for calendar years after 1970.

Federal service

Section 120(b)(3) of the bill amends section 3122 of the code (relating to Federal service) to conform its provisions to the increase in the contribution and benefit base from $7,800 to $9,000.

Returns in the case of certain governmental employees

Section 120(b)(4) of the bill amends section 3125 of the code (relating to returns in the case of governmental employees in Guam, American Samoa, and the District of Columbia) to conform its provisions to the increase in the contribution and benefit base from $7,800 to $9,000.

Special refunds of employee contributions

Sections 120(b)(5) and 120(b)(6) of the bill amend section 6413(c) of the code (relating to special refunds of social security contributions paid by an employee who in any calendar year had more than one employer and had total wages in excess of the maximum which may be counted) to conform the special refund provisions to the $9,000 contribution and benefit base for calendar years after 1970.

Estimated tax on self-employment income

Section 120(b)(7) of the bill amends section 6654(d)(2)(B)(ii) of the code (relating to failure to pay estimated income tax on adjusted self-employment income) to conform to the increase in the contribution and benefit base to $9,000.

Effective dates

Section 120(c) provides effective dates for the changes made by the section. The amendments (relating to wages) made by sections 120(a)(1), 120(a)(3)(A), and 120(b) (except paragraphs (1) and (7) thereof) are applicable with respect to remuneration paid after December 1970; the amendments (relating to self-employment in-

come) made by sections 120(a)(2), 120(a)(3)(B), 120(b)(1) and 120(b)(7) are applicable with respect to taxable years beginning after 1970; and the amendment made by section 120(a)(4) (relating to average monthly wage) is applicable with respect to calendar years after 1970.

SECTION 121. CHANGES IN TAX SCHEDULES

Section 121 of the bill provides new schedules of social security tax rates for old-age, survivors, and disability insurance and for hospital insurance.

Old-age, survivors, and disability insurance rates

Section 121(a) of the bill amends sections 1401(a), 3101(a), and 3111(a) of the Internal Revenue Code of 1954 to provide new schedules of old-age, survivors, and disability insurance tax rates for the self-employed and for employees and employers.

Subsection (a) of the amended section 1401 provides a new schedule of tax rates on self-employment income for purposes of old-age, survivors, and disability insurance. Under present law, these tax rates are as follows:

Taxable years beginning after:	*Percent*
1968 (and before 1971)	6.3
1970 (and before 1973)	6.9
1972	7.0

Under the bill, the tax rates on self-employment income for old-age, survivors, and disability insurance are as follows:

Taxable years beginning after:	*Percent*
1968 (and before 1975)	6.3
1974	7.0

Subsection (a) of the amended section 3101 and subsection (a) of the amended section 3111 provide new schedules of tax rates on wages for purposes of old-age, survivors, and disability insurance. Under present law, these tax rates for employees and employers are as follows:

Calendar years:	*Percent*
1969 to 1970, inclusive	4.2
1971 to 1972, inclusive	4.6
1973 and after	5.0

Under the bill, the tax rates on wages for both employees and employers for old-age, survivors, and disability insurance are as follows:

Calendar years:	*Percent*
1969 to 1974, inclusive	4.2
1975 to 1979, inclusive	5.0
1980 and after	5.5

Hospital insurance rates

Section 121(b) of the bill amends sections 1401(b), 3101(b), and 3111(b) of the code to provide new schedules of hospital insurance tax rates for the self-employed and for employees and employers.

Subsection (b) of the amended section 1401 provides a new schedule of tax rates on self-employment income for purposes of hospital insurance. Under present law, these tax rates are as follows:

Taxable years beginning after:	Percent
1967 (and before 1973)	0. 60
1972 (and before 1976)	. 65
1975 (and before 1980)	. 70
1979 (and before 1987)	. 80
1986	. 90

Under the bill, the tax rates on self-employment income for hospital insurance are as follows:

Taxable years beginning after:	Percent
1967 (and before 1971)	0. 6
1970	1. 0

Subsection (b) of the amended section 3101 and subsection (b) of the amended section 3111 provide new schedules of tax rates on wages for purposes of hospital insurance. Under present law, these tax rates are as follows:

Calendar years:	Percent
1968 to 1972, inclusive	0. 60
1973 to 1975, inclusive	. 65
1976 to 1979, inclusive	. 70
1980 to 1986, inclusive	. 80
1987 and after	. 90

Under the bill, the tax rates on wages for both employees and employers for hospital insurance are as follows:

Calendar years:	Percent
1968 to 1970, inclusive	0. 6
1971 and after	1. 0

Effective dates

Section 121(c) of the bill provides that the amendments made by sections 121(a)(1) and 121(b)(1) are to apply with respect to taxable years which begin after December 31, 1970, and that the remaining amendments made by section 121 are to apply with respect to remuneration paid after December 31, 1970.

SECTION 122. ALLOCATION TO DISABILITY INSURANCE TRUST FUND

Section 122(a) of the bill amends section 201(b)(1) of the Social Security Act, which deals with the amount to be allocated and appropriated to the Federal Disability Insurance Trust Fund each year with respect to wages and presently provides that such amount with respect to any wages paid after 1969 is to be 1.10 percent of such wages. Under the amended section 201(b)(1), the amount so allocated and appropriated will be 0.90 percent of the wages paid during 1971, 1972, 1973, and 1974, 1.05 percent of the wages paid during 1975, 1976, 1977, 1978, and 1979, and 1.15 percent of the wages paid after 1979.

Section 122(b) of the bill amends section 201(b)(2) of the act, which deals with the amount to be allocated and appropriated to the Federal Disability Insurance Trust Fund each year with respect to self-employment income and presently provides that the amount to be so allocated and appropriated with respect to any self-employment income reported for taxable years beginning after 1969 is to be 0.825 percent of the amount of such self-employment income. Under the amended section 201(b)(2), the amount so allocated and appropriated will be 0.675 percent of the self-employment income so re-

ported for any taxable year beginning after 1970 and before 1975, 0.7875 percent of the self-employment income so reported for any taxable year beginning after 1974 and before 1980, and 0.8625 percent of the self-employment income so reported for any taxable year beginning after 1979.

TITLE II—PROVISIONS RELATING TO MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH

PART A—COVERAGE UNDER MEDICARE PROGRAM

SECTION 201. PAYMENT UNDER MEDICARE PROGRAM TO INDIVIDUALS COVERED BY FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Section 201 of the bill amends section 1862 of the Social Security Act (relating to exclusions from coverage) by adding a new subsection (c) which provides that no payment may be made under either part A or part B of the medicare program for any item or service furnished to or on behalf of an individual on or after January 1, 1972, if such item or service is covered under a Federal employees health benefits plan in which the individual is enrolled, unless the Secretary has determined and certified prior to the date such item or service is furnished that the Federal employees health benefits program has been modified to assure that——

(1) there is available to each Federal employee or annuitant age 65 and over one or more health benefits plans which supplement the combined protection provided under parts A and B of title XVIII, and one or more health benefits plans which supplement the protection provided under part B alone; and

(2) the Government will make a contribution toward the cost of the supplementary protection which is at least equal to the contribution it makes for high option coverage under the Government-wide Federal employees health benefits plans; such contribution could be in the form of a contribution toward the supplementary protection, a payment to offset the cost of title XVIII coverage, or some combination of the two.

SECTION 202. HOSPITAL INSURANCE BENEFITS FOR UNINSURED INDIVIDUALS NOT ELIGIBLE UNDER PRESENT TRANSITIONAL PROVISION

Section 202 of the bill substantially rewrites section 103 of the Social Security Amendments of 1965, which permits certain persons not entitled to social security or railroad retirement cash benefits to qualify for hospital insurance benefits, in order to permit additional uninsured individuals to qualify for such benefits.

Section 202(a) of the bill amends section 103(a) of the 1965 amendments to provide that, in addition to persons meeting the present requirements of such section, a person who (1) is a resident citizen or resident alien age 65 or over but not eligible for cash benefits, (2) does not otherwise qualify for hospital insurance coverage, (3) has filed an application for hospital insurance coverage under this section as required by regulations, and (4) has enrolled for supplementary medical insurance as provided in section 1837 of such Act as modified by the new section 103(d) (discussed below) will be entitled to benefits

under part A of title XVIII. Such entitlement will begin with the day on which such person's coverage period (as provided in the new section 103(d)) begins and will end with the month in which he dies or, if earlier, the month before the month in which he becomes entitled to hospital insurance benefits under section 226 or certifiable as a railroad retirement beneficiary. The amended section 103(a) limits the 12-month retroactivity of hospital insurance coverage provided for under such section 103(a) to those people who are eligible for hospital insurance coverage as a result of their meeting the section's regular requirements.

Section 202(b) of the bill amends section 103(b) of the 1965 amendments to provide that a Federal employee, previously excluded by paragraph (3) of such section 103(b), may enroll for hospital insurance benefits provided for under section 103(a)(2) (as amended by the bill), if he meets the eligibility requirements for enrolling for such coverage as provided in section 103(d)(1) (as amended by section 202(d) of the bill).

Section 202(c) of the bill limits the provisions of section 103(c) of the 1965 amendments to payments made with respect to people who are entitled to hospital insurance benefits under section 226 of the act solely by reason of the existing provisions of section 103(a) of such amendments (as redesignated section 103(a)(1) by the bill).

Section 202(d) of the bill amends section 103 of the 1965 amendments by adding a new subsection (d) to provide that a person meeting the preceding eligibility requirements (as provided in the new section 103(a)(2)) may enroll for the hospital insurance benefits provided under section 103(a).

The new section 103(d) makes the provisions of sections 1837, 1838, 1839, and 1840 of the Social Security Act (relating to enrollment, coverage, premium amount, and premium payment, respectively, under the supplementary medical insurance part of title XVIII of the act) applicable for purposes of hospital insurance coverage under the amended section 103 with the following modifications:

(1) section 1837(c) of the act (relating to supplementary medical insurance enrollment) is modified to provide that an initial general enrollment period is to begin the first day of the second month which begins after the date of enactment of the bill and is to end March 31, 1971, with this initial general enrollment period being open to people who meet the eligibility requirements of the new section 103(a)(2);

(2) section 1837(d) of the act is modified to provide that for people first meeting the eligibility requirements for enrolling for hospital insurance benefits provided in such section 103(a)(2) on or after March 31, 1971, there will be an initial enrollment period as otherwise provided in such section 1837(d);

(3) section 1838(a)(1) of the act (relating to supplementary medical insurance coverage period) is modified to provide that for people enrolling for hospital insurance benefits under the new section 103(d)(1) during the initial general enrollment period described above, the hospital insurance coverage period will begin January 1, 1971, or the first day of the month following the month of enrollment, whichever is the latest;

(4) section 1838(b) of the act is modified to provide that a person's coverage period for hospital insurance benefits under the

new section 103(a)(2) will terminate when he becomes entitled to hospital insurance benefits under the existing provisions of section 103(a) (as redesignated section 103(a)(1) by the bill), and that if a person's supplementary medical insurance enrollment is terminated his enrollment and coverage for hospital insurance under the new section 103(a)(2) will be terminated as of the same month his supplementary medical insurance enrollment and coverage terminate;

(5) section 1839(a) of the act is modified to provide that each person enrolling for hospital insurance benefits as provided under the new section 103(a)(2) will pay a $27 monthly premium for each month he is covered for such hospital benefits before July 1972;

(6) section 1839(b)(1) of the act (relating to premium amounts) is modified to provide that the premium amount to be paid by each enrollee for each month after June 1972 will be an amount (as determined and promulgated by the Secretary in December of the preceding year, and rounded to the nearest $1) equal to $27 multiplied by the ratio of (1) the inpatient hospital deductible for the current year, as promulgated under section 1813(b)(2) of the act, to (2) such deductible promulgated for 1971; and

(7) section 1840 of the act is modified by substituting "Federal Hospital Insurance Trust Fund" for "Federal Supplementary Medical Insurance Trust Fund".

Section 202(d) of the bill further amends section 103 of the 1965 amendments by adding a new subsection (e) to provide that a State or any other public or private agency or organization will be permitted to pay monthly premiums on behalf of retired age-65-and-over employees who are eligible for and have enrolled for the hospital insurance protection provided by the new section 103(a)(2). Such group premium payment will be under a contract or other arrangement entered into between the agency or organization and the Secretary, and will be permitted only where the Secretary determines that such a method of premium payments is administratively feasible.

PART B—IMPROVEMENTS IN THE OPERATING EFFECTIVENESS OF THE MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS

SECTION 221. LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

Section 221(a) of the bill adds a new section 1122 at the end of title XI of the Social Security Act.

Subsection (a) of the new section 1122 expresses the congressional intent that funds appropriated under titles V, XVIII, and XIX of the act should not be used to support unnecessary capital expenditures and that reimbursement under such titles should support State health planning activities.

Subsection (b) of the new section 1122 provides that the Secretary, after consultation with the State executive officer and local public officials, is to make an agreement with any State under which a designated planning agency (which has a governing body or advisory body at least one-half of whose members represent consumer interests)

will (1) make findings and recommendations with respect to capital expenditures proposed by or on behalf of any health care facility in its jurisdiction, (2) receive the findings and recommendations of other qualified planning agencies with respect to proposed capital expenditures of health care facilities in their jurisdiction, and (3) submit to the Secretary any such finding which indicates that any such expenditure is inconsistent with the standards, criteria, or plans developed pursuant to the Public Health Service Act (or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963) to meet the need for adequate health care facilities in the area covered by the plan or plans.

Subsection (c) of the new section 1122 provides that the Secretary will pay from the Federal Hospital Insurance Trust Fund to any State with which he makes an agreement the reasonable costs incurred by the planning agencies involved in preparing and forwarding findings and recommendations with respect to proposed capital expenditures.

Subsection (d)(1) of the new section 1122 provides that in determining reimbursement under titles V, XVIII, and XIX of the act the Secretary will disallow, for such periods as he finds necessary, expenses with respect to capital expenditures which are attributable to depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary facilities), or other expenses related to such capital expenditure if he determines (A) that neither the designated planning agency nor any other qualified planning agency had been notified of the proposed capital expenditure at least 60 days before it was made, or (B) that the agency had given notice to the facility within a reasonable period of time after receipt of notice of the proposed expenditure and prior to such expenditure that it would not be in conformity with the standards, criteria, or plans developed by such agency or any other qualified planning agency for adequate health care facilities in such jurisdiction, and prior to reporting its findings to the Secretary had consulted and taken into consideration the findings and recommendations of other planning agencies or organizations performing similar functions with respect to the area in which the health facility is located.

Subsection (d)(2) of the new section 1122 provides that if after submitting the matter to the national advisory council (discussed below) the Secretary determines that disallowance of any expense relating to a capital expenditure would be inconsistent with effective organization and delivery of health services or effective administration of title V, XVIII, or XIX, he shall not disallow such expense.

Subsection (e) of the new section 1122 provides that in determining reimbursement under titles V, XVIII, and XIX in cases where facilities or equipment are obtained under lease that would have been subject to a disallowance if purchased, the Secretary shall deduct from the facility's rental expenses an amount reasonably equivalent to that which would have been disallowed if the facilities or equipment had been purchased.

Subsection (f) of the new section 1122 provides that any person dissatisfied with a determination under the section may request reconsideration by the Secretary up to 6 months after notification; such determinations are not subject to other administrative or judicial review.

Subsection (g) of the new section 1122 defines the term "capital expenditure" as an expenditure which, under generally accepted

accounting principles, is not properly chargeable as an expense of operation and maintenance and exceeds $100,000, changes the facility's bed capacity, or substantially changes the facility's services.

Subsection (h) of the new section 1122 provides that the section is not applicable to Christian Science sanatoriums.

Subsection (i)(1) of the new section 1122 directs the Secretary to establish or designate a national advisory council to assist and advise him in the preparation of regulations and on policy matters in the administration of the section.

Subsection (i)(2) of the new section 1122 provides that any council so established or designated is to consult and coordinate its activities with other appropriate national advisory councils and coordinate the activities under the section with related Federal health programs.

Subsection (i)(3) of the new section 1122 provides that if an advisory council is newly established by the Secretary its members are not to be in the regular full-time employ of the United States and are to be chosen from among leaders in the fundamental sciences, the medical sciences, or the organization, delivery, and financing of health care, or from among persons who are State or local officials or are active in community affairs or public or civic affairs or who are representative of minority groups. Members of such advisory council will be entitled to compensation at rates to be determined by the Secretary but not to exceed the maximum rate paid to a GS–18.

Section 221(b) of the bill provides that the amendment made by section 221(a) will apply with respect to capital expenditures the obligation for which is incurred after June 30, 1971, or (with respect to any State or part thereof) earlier if the State so requests.

Section 221(c) of the bill amends various provisions of titles V, XVIII, and XIX of the act to make conforming changes and to require that standards applied under those provisions be consistent with the new section 1122.

SECTION 222. REPORT ON PLAN FOR PROSPECTIVE REIMBURSEMENT; EXPERIMENTS AND DEMONSTRATION PROJECTS TO DEVELOP INCENTIVES FOR ECONOMY IN THE PROVISION OF HEALTH SERVICES

Section 222(a)(1) of the bill authorizes the Secretary of Health, Education, and Welfare to develop and engage in experiments and demonstration projects designed to determine the advantages and disadvantages of various alternative methods of prospective reimbursement to hospitals, extended care facilities, and other providers of services under title XVIII of the act and under State plans approved under titles XIX and V of the act in order to stimulate providers through financial incentives to use their facilities and personnel more efficiently and thereby reduce program costs.

Section 222(a)(2) of the bill provides that such experiments and demonstration projects are to be of sufficient scope and applicability to permit evaluation of alternative methods of prospective reimbursement without committing the programs involved to the adoption of any prospective payment system either locally or nationally.

Section 222(a)(3) of the bill provides that the Secretary may waive payment requirements of titles V, XVIII, and XIX with respect to such experiments and demonstration projects. Any costs incurred in such experiments or projects in excess of amounts which would

normally be paid under such titles will be borne by the Secretary. The Secretary will obtain the advice and recommendations of competent specialists prior to instituting any such experiment or project, and will furnish to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate

prior to placing an experiment or project in operation a written report containing a full description of the experiment or project.

Section 222(a)(4) of the bill provides that grants and payments for experiments and demonstration projects are to be made from the Federal trust funds established for the hospital and supplementary medical insurance programs under title XVIII of the act.

Section 222(a)(5) of the bill provides that the Secretary is to submit a report to the Congress no later than July 1, 1972, on the experiments and projects carried out. Such report is to include detailed recommendations with respect to program-wide implementation of a system of prospective reimbursement.

Section 222(a)(6) of the bill amends section 1875(b) of the Social Security Act to provide that the Secretary's annual report to the Congress concerning the operation of the health insurance program will include a report of the experiments and demonstration projects authorized by section 222(a).

Section 222(b)(1) of the bill amends section 402(a) of the Social Security Amendments of 1967 to provide authorization for the Secretary to develop and engage in experiments and demonstration projects for the following purposes: to determine whether changes in methods of payment (other than those authorized in section 222(a) of the bill) would create incentives for increasing efficiency and economy for health care and services under health programs established by the Social Security Act; to determine whether payments to organizations and institutions providing comprehensive health care services for noncovered services incidental to covered services would result in a more economical provision and effective utilization of covered services; to determine whether use of rates of payment approved by a State for purposes of administering one or more of its laws would reduce the costs of health programs established by the act; to determine whether payments based on a single, combined rate of reimbursement for teaching activities and patient care rendered by residents, interns, and supervisory physicians connected with a graduate medical education program would result in more equitable and economical patient care arrangements; and to determine whether areawide or community-wide utilization review and medical review mechanisms would more effectively control use of services. Grants and payments for these experiments and demonstration projects are to be made from the Federal trust funds established for the hospital and supplementary medical insurance programs under title XVIII of the act.

Section 222(b)(2) of the bill amends section 402(b) of the 1967 amendments to make conforming changes which permit demonstration projects as well as experiments and to require the Secretary to furnish to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate

to placing an experiment or project in operation a written report containing a full description of the experiment or project.

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Section 222(b)(3) of the bill amends section 1875(b) of the act to provide that the Secretary's annual report to the Congress concerning the operation of the health insurance program will include a report on the experiments and demonstration projects authorized under the amendments made by section 222(b) of the bill.

SECTION 223. LIMITATIONS ON COVERAGE OF COSTS UNDER MEDICARE PROGRAM

Section 223(a) of the bill amends section 1861(v)(1) of the act (defining reasonable cost for purposes of provider reimbursement) by excluding from recognition as reasonable any part of incurred cost found to be unnecessary in the efficient delivery of needed health services.

Section 223(b) of the bill amends section 1861(v)(1) of the act to provide for the establishment of limits on costs which will be recognized as reasonable based on estimates of the costs necessary in efficient delivery of services.

Section 223(c) and section 223(d) of the bill further amend section 1861(v)(1) of the act to make it clear that the medicare objective of meeting all direct and indirect costs of providing covered services to covered individuals does not extend to those costs determined to be unnecessary in the efficient delivery of covered services.

Section 223(e) of the bill amends section 1866(a)(2)(B) of the act to permit a provider to impose charges for items or services in excess of or more expensive than items or services for which reimbursement may be made under title XVIII even where not requested by the patient provided that (A) such charges are customarily imposed by such provider, do not exceed the excess cost of such items or services in the provider's previous fiscal period, and are identified (to the person to whom the items or services are furnished) as costs in excess of those determined to be necessary, and (B) the Secretary provides public notice that such charges may be imposed.

Section 223(f) of the bill amends section 1861(v) of the act (as otherwise amended by the bill) to provide for reduction of program reimbursement to providers of services in those instances where the provider imposes charges in excess of or more expensive than those determined to be necessary in the efficient delivery of health services to the extent that such charges exceed the cost actually incurred for such items or services.

Section 223(g) of the bill amends section 1866(a)(2) of the act to provide that a provider of services may not impose additional charges upon a patient as otherwise permitted under the amendments made by section 223 if the admitting physician has a direct or indirect financial interest in such provider.

Section 223(h) of the bill provides that these amendments will be effective upon the enactment of the bill.

SECTION 224. LIMITS ON PREVAILING CHARGE LEVELS

Section 224(a) of the bill amends section 1842(b)(3) of the Social Security Act with respect to the determination of the reasonable charge for services furnished under the supplementary medical insurance program. Under the amendment, no charge for services

rendered after June 30, 1970, and before July 1, 1971, may be determined to be reasonable if it exceeds the higher of (1) the prevailing charge recognized by the carrier for similar services in the same locality in administering the supplementary medical insurance program under part B of title XVIII on June 30, 1970, or (2) the prevailing charge level that would cover 75 percent of the customary charges made for similar services in the same locality during the calendar year 1969 on the basis of statistical data and methodology acceptable to the Secretary.

With respect to services rendered after June 30, 1971, the charges recognized as prevailing within a locality may be increased in any fiscal year only to the extent found necessary to cover 75 percent of the customary charges made for similar services in the same locality during the last preceding elapsed calendar year, on the basis of statistical data and methodology acceptable to the Secretary; in no case may they be increased (in the aggregate) beyond the levels that would cover 75 percent of the customary charges made for similar services in the same locality during the calendar year 1969, except to the extent that the Secretary finds that such adjustments are justified by economic changes on the basis of appropriate economic index data.

In the case of medical services, supplies, and equipment that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after June 30, 1970, and determined to be reasonable may exceed the lowest charge levels at which such services, supplies, and equipment are widely available in a locality only to the extent and under the circumstances specified by the Secretary.

Section 224(b) of the bill amends section 1903 of the act by adding a new subsection (g) providing that payment to States under the medicaid program may not be made with respect to any amount paid for items or services furnished under a State plan after June 30, 1970, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under the amendments made by section 224(a) of the bill.

Section 224(c) of the bill amends section 506 of the act by adding a new subsection (f) providing that payment to States under the maternal and child health program may not be made with respect to any amount paid for items or services furnished under a State plan after June 30, 1970, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under the amendments made by section 224(a) of the bill.

SECTION 225. ESTABLISHMENT OF INCENTIVES FOR STATES TO EMPHASIZE OUTPATIENT CARE UNDER MEDICAID PROGRAMS

Section 225(a) of the bill amends section 1903 of the Social Security Act (as otherwise amended by the bill) by adding a new subsection (e) to provide variable Federal matching rates for certain services provided under State medicaid plans. Under the amendment, with respect to services provided after December 1970 there will be (1) an increase of 25 percent in the matching rate (up to a maximum of 95 percent) for outpatient hospital services, clinic services, and home health services (other than physical therapy services); (2) a decrease of 33⅓ percent in the matching rate after the first 60 days of inpatient

hospital services furnished an individual in any fiscal year in a general or tuberculosis hospital; (3) a decrease of 33⅓ percent in the matching rate after the first 90 days of a patient's care in any fiscal year in a skilled nursing home; and (4) a decrease of 33⅓ percent in the matching rate after 90 days of a patient's care (occurring after December 1970) in a mental hospital, with the complete elimination of Federal matching after the patient has received an additional 275 days of such care during his lifetime.

Section 225(b)(1) of the bill amends section 1121 of the act by adding a new subsection (f), providing the Secretary with authority to reduce the amount of expenditures for which Federal matching will be available in the case of intermediate care facilities in a State (for calendar quarters after 1970), where he determines that a reasonable cost differential does not exist between the cost of skilled nursing home services and the cost of intermediate care facility services in such State, by the reasonable equivalent of the increased amount paid because of the lack of such differential.

Section 225(b)(2) of the bill amends section 1121(e) of the act to eliminate public mental institutions from the definition of "intermediate care facility".

SECTION 226. PAYMENT FOR SERVICES OF TEACHING PHYSICIANS UNDER MEDICARE PROGRAM

Section 226 of the bill amends section 1833 of the Social Security Act with respect to the basis and amount of reimbursement for certain services performed by physicians in hospitals.

Section 226(a)(1) of the bill adds to section 1833(a)(1) of the act a new clause (C) describing two circumstances under which payment for services performed by a physician in a hospital and covered under the supplementary medical insurance program established under part B of title XVIII will be equal to 100 percent of the reasonable cost of the services to the hospital or other medical service organization which incurs the costs (instead of 80 percent of the charges for the services as in present law). Such payment on a reasonable cost basis will be applicable with respect to the physician's services to hospital patients if (1) the services are similar to services furnished in comparable circumstances to all patients (or all members of a class of patients) who are not covered under the insurance program under part B of title XVIII or under medicaid and such patients are not required to pay the reasonable charge for the services even when they have private insurance covering the services or (as defined in regulations) are otherwise able to pay, or (2) patients covered under part B of title XVIII are not required to pay any charges for the services, or are required to pay reasonable charges but without obtaining from them or on their behalf the applicable deductible and coinsurance amounts in addition to the part B payments.

Section 226(a)(2) of the bill adds to section 1833(d) of the act a new clause (3) to provide that expenses incurred under the supplementary medical insurance program for physicians' services which are reimbursed on the basis of 100 percent of reasonable cost to the hospital or medical service organization incurring such cost will not be taken into account for purposes of meeting the annual $50 deductible under that program.

Section 226(b) of the bill provides that where the faculty of a medical school provides services in a hospital which would be reimbursable under part A of title XVIII if furnished directly by the hospital and the hospital pays to the medical school on account of such services less than the reasonable cost of such services to the school, the reasonable cost of such services to the medical school will be included in determining the reasonable cost to the hospital of furnishing services covered under part A.

Section 226(c) of the bill provides that the amendments made by section 226 (a) will apply to bills submitted and requests for payment made after the date of enactment of the bill, and that the amendments made by section 226(b) will be effective for accounting periods beginning after such date.

SECTION 227. AUTHORITY OF SECRETARY TO TERMINATE PAYMENTS TO SUPPLIERS OF SERVICES

Section 227(a) of the bill amends section 1862 of the Social Security Act (as otherwise amended by the bill) by adding a new subsection (d) which provides that no payment may be made under either part A or part B of title XVIII for items or services furnished by a person whom the Secretary determines (1) has made or caused to be made false statements or misrepresentations of fact for use in applying for payment or determining the right to a payment under the medicare program; (2) has submitted or caused to be submitted bills or requests for payment containing charges (or costs) which the Secretary, with the concurrence of the program review team (discussed below), finds to be substantially in excess of such person's customary charges (or costs) unless there is good cause for such charges (or costs); or (3) has furnished services or supplies which the Secretary, with the concurrence of the physicians or other professional health personnel of the program review team, determines are substantially in excess of the needs of or are harmful to individuals, or are of grossly inferior quality. The determinations of the Secretary pursuant to these provisions are to be effective after there has been given such reasonable notice to the public and the person involved as may be specified in regulations. The stoppage of payment is to be effective with respect to services furnished on or after the effective date of the determination (except in the case of a hospital, extended care facility, and home health agency, for which the determination would be effective in the manner provided for terminations of agreements under section 1866(b) (3) and (4)) and will continue until the Secretary finds that the abuses which led to the decision have ceased and there is reasonable assurance that they will not recur. Any person furnishing services who is dissatisfied with the Secretary's decision is entitled to a hearing by the Secretary and to judicial review of the Secretary's decision.

The new section 1862(d) also provides for the establishment by the Secretary, in each State, of one or more program review teams. In appointing these teams the Secretary will consult with State and local professional societies, carriers and intermediaries, and consumer representatives. The duties of the teams will include (1) the review of statistical data on program utilization furnished by the Secretary; (2) the submission of periodic reports to the Secretary concerning this review together with any recommendations they may have concerning

it; (3) the review of particular cases where there is a likelihood of abuse; and (4) the submission to the Secretary of periodic reports concerning such review, together with their analyses and recommendations.

Section 227(b) of the bill amends section 1866(b)(2) of the act to provide that the Secretary may terminate an agreement with a provider of services under the medicare program if he determines that the provider (1) has made or caused to be made false statements or misrepresentations of fact for use in applying for payment or determining the right to a payment under that program; (2) has submitted or caused to be submitted requests for payment for services which are substantially in excess of the costs incurred in rendering such services; or (3) has furnished services or supplies which the Secretary, with the concurrence of the physicians or other professional health personnel of the program review team, determines are substantially in excess of the needs of or are harmful to individuals, or are of grossly inferior quality.

Section 227(c) of the bill amends section 1903(g) of the act (as added by section 224(b) of the bill) to provide that no payment may be made by the Federal Government to a State for amounts paid for items or services furnished after June 1970 under a State plan for medical assistance which are (1) in excess of the reasonable charge as determined under the third, fourth, and fifth sentences of section 1842(b)(3) (as added by the bill), or (2) precluded from payment under title XVIII because of a determination of the Secretary pursuant to the new section 1862(d)(1) or under the new clause (D), (E), or (F) of section 1866(b)(2).

Section 227(d) of the bill amends section 506(f) of the act to provide that no payment may be made by the Federal Government to a State for amounts paid for items or services furnished under a State plan for maternal and child health services and services for crippled children which are (1) in excess of the reasonable charge as determined under the third, fourth, and fifth sentences of section 1842(b)(3) (as added by the bill), or (2) precluded from payment under title XVIII because of a determination by the Secretary pursuant to the new section 1862(d)(1) or under the new clause (D), (E), or (F) of section 1866(b)(2).

SECTION 228. ELIMINATION OF REQUIREMENT THAT STATES MOVE TOWARD COMPREHENSIVE MEDICAID PROGRAMS

Section 228 of the bill repeals section 1903(e) of the Social Security Act (and section 2(b) of Public Law 91–36) so as to remove the requirement that each State make "a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards".

SECTION 229. DETERMINATION OF REASONABLE COST OF INPATIENT HOSPITAL SERVICES UNDER MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

Section 229(a) of the bill amends section 1902(a)(13) of the Social Security Act to authorize States to develop their own methods and standards for determining the reasonable cost of inpatient hospital care for medicaid eligibles, subject to the condition that (1) hospitals and private patients may not be required to bear the cost of care for those under the plan nor may the plan be required to pay for services to those not covered by the plan, and (2) reimbursement by the States may in no case exceed the amount which would be determined to be the reasonable cost of the inpatient hospital services under title XVIII.

Section 229(b) of the bill amends section 505(a)(6) of the act to give States the same authority (to develop their own methods and standards for determining the reasonable cost of inpatient hospital care, subject to the specified conditions) under their maternal and child health plans.

Section 229(c) provides that these amendments will be effective July 1, 1971 (or earlier if the State plan so provides).

SECTION 230. AMOUNT OF PAYMENTS WHERE CUSTOMARY CHARGES FOR SERVICES FURNISHED ARE LESS THAN REASONABLE COST

Section 230(a) of the bill amends section 1814(b) of the Social Security Act to provide that payments to nonpublic providers of services under the hospital insurance program will, subject to the applicable deductible and coinsurance provisions, be the lesser of the reasonable cost of the services as determined under section 1861(v) of the act or the customary charges for the services. If the services are furnished free or at only nominal charge by a public provider of services, such payments will be determined on the basis of those items (specified in regulations) included in the determination of the reasonable cost which the Secretary finds will provide fair compensation for the services.

Section 230(b) of the bill amends section 1833(a)(2) of the act to provide that payments under the medical insurance program to nonpublic providers of services will be 80 percent of the lesser of the reasonable cost of the services as determined under section 1861(v) or the customary charges for the services. Public providers which furnish services free or at nominal charge will be reimbursed at 80 percent of reasonable cost as determined under section 1814(b)(2) of the act.

Section 1833(c) of the bill amends section 1903(g) of the act (as otherwise amended by the bill) to provide a similar basis for payments to States under their plans established and approved under title XIX of the act.

Sections 230(d) and 230(e) of the bill amend section 506(f) and section 509(a) of the act (as otherwise amended by the bill) to provide a similar basis for payments to States for items and services reimbursable under title V of the act.

Section 230(f) of the bill provides that the amendments made by section 230 (a) and (b) will apply to services furnished by hospitals, extended care facilities, and home health agencies in accounting pe-

riods beginning after June 30, 1970, and that the amendments made by section 230 (c), (d), and (e) will apply to services furnished in calendar quarters beginning after June 30, 1970.

SECTION 231. INSTITUTIONAL PLANNING UNDER MEDICARE PROGRAM

Section 231(a) of the bill amends section 1861(e) of the Social Security Act to require an institution to have in effect an overall plan and budget in order to qualify as a hospital under the medicare program.

Section 231(b) of the bill amends section 1861(f)(2) of the act to impose a similar requirement with respect to psychiatric hospitals.

Section 231(c) of the bill amends section 1861(g)(2) of the act to impose a similar requirement with respect to tuberculosis hospitals.

Section 231(d) of the bill amends section 1861(j) of the act to impose a similar requirement with respect to extended care facilities.

Section 231(e) of the bill amends section 1861(o) of the act to impose a similar requirement with respect to home health agencies.

Section 231(f) of the bill further amends section 1861 of the act by adding a new subsection (z), which defines an overall plan and budget as one that provides for a detailed annual operating budget, provides for a capital expenditure plan for at least a 3-year period which includes all anticipated capital expenditures in excess of $100,000, is reviewed and updated annually, and is prepared by a committee consisting of representatives of the administrative staff, the medical staff, and the governing body of the institution involved.

Section 231(g) of the bill amends sections 1814(a)(2)(C), 1814(a)(2)(D), and 1863 of the act to make conforming changes.

Section 231(h) of the bill amends section 1865 of the act to provide that if the Joint Commission on Accreditation of Hospitals requires hospitals to have institutional plans as defined in the new section 1861(z) as a condition of accreditation, all hospitals accredited by the Commission may be considered as satisfying the new section 1861(e)(8).

Section 231(i) of the bill provides that these amendments will apply with respect to any provider of services for its fiscal years beginning after the fifth month following the month in which this act is enacted.

SECTION 232. PAYMENTS TO STATES UNDER MEDICAID PROGRAMS FOR INSTALLATION AND OPERATION OF CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS

Section 232(a) of the bill amends section 1903(a) of the Social Security Act by inserting a new paragraph (3) which authorizes 90-percent Federal matching to enable States to design, develop, and install mechanized claims processing and information retrieval systems deemed necessary by the Secretary to provide efficient and economical administration of their medicaid plans and to be compatible with claims processing and retrieval systems utilized in the administration of title XVIII, including matching of the State's share of the cost of installing such a system to be used jointly in the administration of such State's plan and that of any other State approved under title XIX.

The new section 1903(a)(3) also authorizes 75-percent Federal matching of administrative expenses incurred in the operation of such systems if they are approved by the Secretary and have the capacity to provide basic information to recipients on services paid for by the program, including the names of the providers furnishing services to such recipients, the dates on which such services were furnished, and the amount of the payment made.

Section 232(b) of the bill provides that this amendment will apply to medicaid expenditures made after June 30, 1970.

SECTION 233. ADVANCE APPROVAL OF EXTENDED CARE AND HOME HEALTH COVERAGE UNDER MEDICARE PROGRAM

Section 233(a) of the bill amends section 1862 of the Social Security Act (as otherwise amended by the bill) by adding a new subsection (e). Paragraph (1) of the new subsection (e) provides that (1) where a patient's physician completes the certification for post-hospital extended care services or post-hospital home health services (which is required by subpar. (C) or (D) of sec. 1814(a)(2) of the act) for a condition which is designated in regulations, and (2) such physician submits to the extended care facility prior to the patient's admission a plan for furnishing the services or to the home health agency prior to the first visit a plan specifying the type and frequency of the services required, and (3) there is compliance with such additional procedures and requirements as may be prescribed in regulations, then the provisions of section 1862(a)(1) (excluding coverage for services which are not reasonable and necessary for diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member) and section 1862(a)(9) (excluding coverage for custodial care) will not apply for the conditions and related periods of time prescribed in regulations. An exception to this rule is made where, in the case of extended care services, a finding is made by the facility's utilization review committee (under sec. 1814(a)(7) of the act) that further stay in the facility is not medically necessary.

Paragraph (2) of the new section 1862(e) provides that, in specifying the conditions and periods of time described above, the Secretary will take into account the medical severity of such conditions, the periods for which such conditions generally require extended care or home health services, the length of stay in an institution generally needed for treatment, and other pertinent factors affecting the type of care to be provided.

Paragraph (3) of the new section 1862(e) provides that if the Secretary determines that a physician is submitting with some frequency erroneous certifications of conditions prescribed in regulations or inappropriate plans of treatment, the provisions of sections 1862(a)(1) and 1862(a)(9) of the act will, after the date of such determination, apply to patients for whom such physician submits certifications or plans notwithstanding paragraph (1) of the new section 1862(e).

Section 233(b) provides that this amendment will be effective with respect to admissions to extended care facilities, and home health plans initiated, on and after January 1, 1971.

SECTION 234. PROHIBITION AGAINST REASSIGNMENT OF CLAIMS TO BENEFITS

Section 234(a) of the bill amends section 1842(b) of the Social Security Act so as to prohibit payment for services provided under the supplementary medical insurance program to anyone other than the individual to whom the services were provided or the physician or other person providing the services. However, payment may be made to the employer of the physician or other person providing the services if such physician or other person is required as a condition of his employment to turn over his fee for such services to his employer; and where the service is provided in a hospital, clinic, or other facility payment may be made to the facility if there is a contractual arrangement between the physician or other person and the facility under which the facility submits the bill for such services.

Section 234(b) amends section 1902(a) of the act so as to prohibit payment for services provided under approved State medicaid programs to anyone other than the physician, dentist, or other independent practitioner who provided the services. However, payment may be made to the employer of such physician, dentist, or other independent practitioner if he is required as a condition of his employment to turn over his fees to the employer; and where the care or service to turn over his fee for such services to the employer; and where the care or service is provided in a hospital, clinic, or other facility payment may be made to the facility if there is a contractual arrangement between the practitioner and the facility under which the facility submits the bill for such services.

Section 234(c) of the bill provides that the amendment made by section 234(a) will apply with respect to bills submitted and requests for payment made after the date of enactment of the bill, and that the amendment made by section 234(b) will be effective July 1, 1971, or earlier if the State plan so provides.

SECTION 235. UTILIZATION REVIEW REQUIREMENTS FOR HOSPITALS AND SKILLED NURSING HOMES UNDER MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

Section 235(a)(1) of the bill amends section 1903(g) of the Social Security Act (as added and otherwise amended by the bill) to require as a condition of payment under the medicaid program that hospitals and skilled nursing homes participating in such program have their medicaid cases reviewed by the same utilization review committee which already reviews their medicare cases or, if such a committee does not exist, by a committee which meets the requirements imposed by section 1861(k) of the act for purposes of the medicare program.

Section 235(a)(2) of the bill amends section 1902(a)(30) of the act to make a conforming change.

Section 235(b) of the bill amends section 506(f) of the act (as added and otherwise amended by the bill) to impose with respect to services provided by hospitals and skilled nursing homes under the maternal and child health program (title V of the act) the same utilization review requirement as is imposed with respect to services under the medicaid program under the amendment made by section 235(a)(1).

Section 235(c) of the bill provides that the amendments made by section 235(a)(1) and (b) will apply to services furnished after June 30, 1971, and that the amendment made by section 235(a)(2) will be effective July 1, 1971.

SECTION 236. ELIMINATION OF REQUIREMENT THAT COST-SHARING CHARGES IMPOSED ON INDIVIDUALS OTHER THAN CASH RECIPIENTS UNDER MEDICAID BE RELATED TO THEIR INCOME

Section 236(a) of the bill amends section 1902(a)(14) of the Social Security Act to eliminate the requirement that any deductible or cost-sharing charge which is imposed under a State medicaid plan upon a medically indigent recipient must be related to such recipient's income or his income and resources. (The imposition of deductibles or cost-sharing charges upon cash assistance recipients continues to be prohibited.)

Section 236(b) of the bill provides that this amendment will be effective January 1, 1971 (or earlier if the State plan so provides).

SECTION 237. NOTIFICATION OF UNNECESSARY ADMISSION TO A HOSPITAL OR EXTENDED CARE FACILITY UNDER MEDICARE PROGRAM

Section 237(a) of the bill amends section 1814(a)(7) of the Social Security Act to include among the cases where medicare payments are to be terminated for medically unnecessary services those cases where the services involved are found to be medically unnecessary by a utilization review committee or group in the course of its sample or other review of admissions to a hospital or extended care facility.

Section 237(b) of the bill provides that this amendment will be effective with respect to services furnished after the second month following the month in which the bill is enacted.

SECTION 238. USE OF STATE HEALTH AGENCY TO PERFORM CERTAIN FUNCTIONS UNDER MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

Section 238(a) of the bill amends section 1902(a)(9) of the Social Security Act to require State medicaid plans to provide that the State health agency will have responsibility for establishing and maintaining health standards for institutions in which medicaid recipients may receive care or services (with the State authority or authorities presently referred to in sec. 1902(a)(9) retaining responsibility for establishing and maintaining standards other than those relating to health for such institutions).

Section 238(b) of the bill amends section 1902(a) of the act by adding (in a new par. (32)) a new plan requirement under which the State health agency is given responsibility for establishing a plan for the review by professional health personnel of the quality and appropriateness of care and services furnished to medicaid recipients in order to provide guidance to the State medicaid agency, and (in most cases) is given responsibility for determining whether institutions and agencies meet the applicable requirements for participation in the medicaid program.

Section 238(c) of the bill amends section 505(a) of the act by adding (in a new par. (15)) substantially the same new plan require-

ment for maternal and child health purposes as the requirement added for medicaid purposes by section 238(b).

Section 238(d) of the bill provides that these amendments will be effective July 1, 1971.

SECTION 239. PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

Section 239 (a) of the bill adds to title XVIII of the Social Security Act a new section 1876 providing for payments to health maintenance organizations.

Paragraph (1) of the new section 1876(a) authorizes the Secretary to determine by actuarial methods a combined part A and B prospective per capita rate of payment to health maintenance organizations. Payments are to be made for services provided to individuals who are enrolled in such organizations and are also entitled to hospital insurance benefits under part A and enrolled for medical insurance benefits under part B. These payments are in lieu of amounts that would otherwise be payable with respect to such individuals under sections 1814(b) and 1833(a) of the act.

Paragraph (2) of the new section 1876(a) provides that the rate of payment to such an organization is to be determined annually in accordance with regulations established by the Secretary. This rate will take into account the health maintenance organization's premiums for its other enrollees and other pertinent factors which the Secretary may prescribe. (Actuarial adjustments are to be made reflecting the difference in utilization between a health maintenance organization's members who are under age 65 and its members age 65 and over.) The rate of payment is not to exceed 95 percent of the amount the Secretary estimates would be paid if the services were furnished by sources other than a health maintenance organization.

Paragraph (3) of the new section 1876(a) provides that the payment to health maintenance organizations is to be made from the Federal hospital insurance trust fund and the Federal supplementary medical insurance trust fund. The portion of such payment to be made from the supplementary medical insurance trust fund to a health maintenance organization for a month will be equal to 200 percent of the product of (A) the number of covered enrollees in the organization in such month and (B) the monthly premium rate for supplementary medical insurance for that month. The remainder of the monthly payment will be paid from the hospital insurance trust fund.

The new section 1876(b) defines a "health maintenance organization" as a public or private organization which—

(1) provides, directly or through arrangements with others, health services to enrolled individuals on a per capita prepayment basis;

(2) provides to enrolled individuals, through qualified providers of services, all of the services and benefits covered under parts A and B of title XVIII;

(3) provides physicians' services directly through physicians who are either employees or partners of the organization or under an arrangement with an organized group (or groups) of physicians which is (or are) reimbursed for services on the basis of an aggregate fixed sum or on a per capita basis;

(4) demonstrates to the satisfaction of the Secretary proof of financial responsibility and capability to provide comprehensive

health care services (including institutional services) efficiently, effectively, and economically;

(5) has enrolled members at least half of whom are under age 65;

(6) has arrangements that assure that the health services required by its members are received promptly and appropriately and that the services received measure up to quality standards established under regulations prescribed by the Secretary; and

(7) has an open enrollment period at least once every 2 years under which it accepts eligible individuals, without underwriting restrictions, on a first-come first-accepted basis up to the limit of its capacity.

The new section 1876(c) provides that the benefits provided to an individual through a health maintenance organization will consist of—

(1) services described in sections 1812 and 1832 which are furnished by such organization in accordance with the new section 1876(e);

(2) emergency services (as defined in regulations) furnished to him by a physician, supplier, or provider of services other than the health maintenance organization, with payment being made by the organization on the individual's behalf.

The new section 1876(d) provides that (subject to the provisions of section 1876(e)) every individual who is entitled to hospital insurance benefits under part A and who is enrolled for medical insurance benefits under part B will be eligible to enroll with a health maintenance organization which serves the geographic area in which he resides.

The new section 1876(e) provides that regulations are to be prescribed to govern enrollment and termination of enrollment with a health maintenance organization.

The new section 1876(f) provides that an individual enrolled with a health maintenance organization is entitled to a hearing before the Secretary (to the same extent as is provided in section 205(b) of the act) if the amount in controversy is $100 or more and the individual is dissatisfied because of his failure to receive without additional cost any health service to which he believes he is entitled. In any such hearing the Secretary will make the health maintenance organization a party thereto. If the amount in controversy is $1,000 or more, the individual or the health maintenance organization will be entitled to judicial review of the Secretary's final decision.

Paragraph (1) of the new section 1876(g) provides that if the health maintenance organization provides only the services described in section 1876(c), its premium rate may not exceed the actuarial value of the cost-sharing provisions applicable under part A and part B.

Paragraph (2) of the new section 1876(g) provides that if the health maintenance organization provides additional services it will furnish its enrollees with information as to the division of its premium rate between the portion for the additional services and the portion for the services described in section 1876(c); the latter portion may not exceed the actuarial value of the cost-sharing provisions applicable under part A and part B.

Section 239(b) of the bill amends section 1866 of the act by adding at the end a new subsection (f) which provides that the term "provider of services" is to include a health maintenance organization if it meets the requirements of the new section 1876.

Section 239(c) of the bill provides that any health maintenance organization which has entered into an agreement with the Secretary pursuant to section 1866 of the act will be entitled to payment only as provided in the new section 1876; the provisions of section 1833 of the act do not apply.

Section 239(d) of the bill provides that the effective date of any agreement with a health maintenance organization will be specified in the agreement pursuant to regulations.

Section 239(e) of the bill amends sections 1814(a), 1833(a), and 1866(b)(2) of the act to make conforming changes.

Section 239(f) of the bill provides that these amendments will be effective with respect to services provided on or after January 1, 1971.

PART C—MISCELLANEOUS AND TECHNICAL PROVISIONS

SECTION 251. COVERAGE PRIOR TO APPLICATION FOR MEDICAL ASSISTANCE

Section 251(a) of the bill amends section 1902(a) of the Social Security Act by adding (in a new paragraph (33)) a new requirement under which State medicaid plans must provide for payments of medical assistance where care or services included under the plan were furnished in or after the third month prior to the month of application for individuals who were otherwise eligible when the care or services were received.

Section 251(b) of the bill provides that this amendment will be effective July 1, 1971.

SECTION 252. HOSPITAL ADMISSIONS FOR DENTAL SERVICES UNDER THE MEDICARE PROGRAM

Section 252(a) of the bill amends section 1814(a)(2) of the Social Security Act by adding a new subparagraph (E) which provides that, in order to receive payment for inpatient hospital services in connection with a dental procedure, a physician must certify that the patient suffers from impairments which are of such severity that he requires hospitalization.

Section 252(b) of the bill amends section 1861(r) of the act to provide that a doctor of dentistry or of dental or oral surgery may make the certification described in the new subparagraph (E) of section 1814(a)(2).

Section 252(c) of the bill amends section 1862(a)(12) of the act to make it clear that payment under part A for inpatient hospital services in connection with dental procedures will not be excluded from coverage when the patient suffers from severe impairments which require that he be hospitalized.

Section 252(d) of the bill provides that these amendments will be effective with respect to admissions occurring after the second month following the month of enactment.

SECTION 253. EXEMPTION OF CHRISTIAN SCIENCE SANATORIUMS FROM CERTAIN NURSING HOME REQUIREMENTS UNDER MEDICAID PROGRAMS

Section 253(a) of the bill amends section 1902(a) of the Social Security Act to exclude Christian Science sanatoriums from the terms "skilled nursing home" and "nursing home" for specified medicaid

purposes and thereby to exempt them from the requirements established for skilled nursing homes which relate to medical practices and activities such as maintaining an organized nursing service under the direction of a registered nurse, maintaining detailed medical records, having diagnostic and other service arrangements with general hospitals, and having a skilled nursing home administrator licensed by the State. States are relieved of the requirement that they provide regular medical review and periodic inspections of the care provided in Christian Science sanatoriums.

Section 253(b) of the bill amends section 1908(g)(1) of the act (relating to State programs for licensing nursing home administrators) to provide that the term "nursing home" contained therein does not include Christian Science sanatoriums.

Section 253(c) of the bill provides that these amendments will be effective upon the enactment of the bill.

SECTION 254. PHYSICAL THERAPY SERVICES UNDER MEDICARE PROGRAM

Section 254(a)(1) of the bill amends section 1861(p) of the Social Security Act to include, as part of "outpatient physical therapy services," physical therapy services furnished by a licensed physical therapist in his office or in the patient's home if such services are furnished in accordance with regulations including such conditions relating to health and safety as the Secretary finds necessary.

Section 254(a) (2) and (3) amend section 1833 of the act (as otherwise amended by the bill) to provide that no more than $100 in any calendar year may be considered as incurred expenses for purposes of payments for the physical therapy services described in the amendment made by section 254(a)(1), and that reimbursement will be on the basis of the reasonable charges for such services.

Section 254(a)(4) amends section 1832(a)(2)(C) of the act to provide that the services described in the amendment made by section 254(a)(1) will not be considered as outpatient physical therapy services benefit for which reimbursement may only be made on behalf of the entitled beneficiary; thus reimbursement may either be made directly to the beneficiary for the incurred expenses or on his behalf (upon assignment by him) to the physical therapist who furnished the services.

Section 254(b) of the bill amends section 1861(p) of the act (as otherwise amended by the bill) to provide that "outpatient physical therapy services" include physical therapy services furnished by a hospital or extended care facility to an inpatient of such institution.

Section 254(c) of the bill amends section 1861(v) of the act by adding a new paragraph providing that the payment for physical therapy services furnished by a provider of services, or by a clinic, rehabilitation agency, or public health agency, or by others under arrangements with such a provider, agency, or organization, may not exceed the amount that would reasonably have been paid as salary if the services had been performed by an employee.

Section 254(d) of the bill provides that the amendments made by sections 254(a) and 254(b) will apply with respect to services furnished after December 31, 1970, and that the amendments made by section 254(c) will apply with respect to provider accounting periods beginning after the enactment of the bill.

SECTION 255. EXTENSION OF GRACE PERIOD FOR TERMINATION OF SUPPLEMENTARY MEDICAL INSURANCE COVERAGE WHERE FAILURE TO PAY PREMIUMS IS DUE TO GOOD CAUSE

Section 255(a) of the bill amends section 1838(b) of the Social Security Act (which presently provides that termination of coverage under the supplementary medical insurance program for nonpayment of premiums shall be deferred for a grace period not in excess of 90 days during which overdue premiums may be paid and coverage continued) to authorize the extension of the grace period for an additional 90 days where the Secretary determines that there was good cause for failure to pay the overdue premiums within the initial 90-day period.

Section 255(b) provides that this amendment will apply with respect to nonpayment of premiums becoming due and payable on or after the date of enactment of the bill. For purposes of the amendment any premium which became due and payable within the 90-day period immediately preceding the date of enactment is considered as becoming due and payable as of such date.

SECTION 256. EXTENSION OF TIME FOR FILING CLAIM FOR SUPPLEMENTARY MEDICAL INSURANCE BENEFITS WHERE DELAY IS DUE TO ADMINISTRATIVE ERROR

Section 256(a) of the bill amends section 1842(b)(3) of the Social Security Act to provide that a bill submitted or a request for payment made after the close of the calendar year following the year in which the related service was furnished may be honored notwithstanding the lapse of time if the delay in submitting the bill or in requesting the payment is due to error or misrepresentation of the Government or one of its agents and if the bill is submitted or the request for payment is made as soon as possible after the fact of such error or misrepresentation is established.

Section 256(b) of the bill provides that this amendment will apply with respect to bills submitted and requests for payment made after March 1968.

SECTION 257. WAIVER OF ENROLLMENT PERIOD REQUIREMENTS WHERE INDIVIDUAL'S RIGHTS WERE PREJUDICED BY ADMINISTRATIVE ERROR OR INACTION

Section 257(a) of the bill amends section 1837 of the Social Security Act by adding a new subsection (f), providing that where the Secretary finds that an individual's enrollment or nonenrollment in the supplementary medical insurance program is unintentional, inadvertent, or erroneous because of the error, misrepresentation, or inaction of a departmental officer, employee, or agent, the Secretary may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction (including the designation for such individual of a special initial or subsequent enrollment period, with a coverage period determined on the basis thereof and with appropriate adjustments of premiums).

Section 257(b) of the bill provides that this amendment will be effective as of July 1, 1966.

SECTION 258. ELIMINATION OF PROVISIONS PREVENTING ENROLLMENT IN SUPPLEMENTAL MEDICAL INSURANCE PROGRAM MORE THAN THREE YEARS AFTER FIRST OPPORTUNITY

Section 258 of the bill amends section 1837(b) of the Social Security Act to permit eligible individuals to enroll or reenroll in the supplementary medical insurance program during any prescribed general enrollment period by eliminating the requirement that an individual must enroll (or reenroll after termination of a previous enrollment) within 3 years following the close of his initial enrollment period (or following the effective date of such termination). The restriction that no individual may enroll in the supplementary medical insurance program more than twice is retained.

SECTION 259. WAIVER OF RECOVERY OF INCORRECT PAYMENTS FROM SURVIVOR WHO IS WITHOUT FAULT UNDER MEDICARE PROGRAM

Section 259(a) of the bill amends section 1870(c) of the Social Security Act (which presently provides that with respect to an overpayment there will be no adjustment as required under section 1870(b) of the act (or recovery) in any case in which the individual to whom the incorrect payment was made is without fault and where such adjustment (or recovery) would defeat the purpose of title II of the act or would be against equity and good conscience) to make its provisions applicable to any person who is without fault and subject to adjustment as provided for in section 1870(b)(4) of the act.

Section 259(b) of the bill provides that this amendment will apply with respect to waiver actions considered after the date of enactment of the bill.

SECTION 260. REQUIREMENT OF MINIMUM AMOUNT OF CLAIM TO ESTABLISH ENTITLEMENT TO HEARING UNDER SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

Section 260(a) of the bill amends section 1842(b)(3)(C) of the Social Security Act (which presently provides that enrollees in the supplementary medical insurance program will be granted fair hearings by the carrier in cases where requests for payment are denied or are not acted upon with reasonable promptness or when the amount of payment is in controversy) to provide that a minimum amount of $100 must be at issue before such a hearing will be granted.

Section 260(b) of the bill provides that this amendment will apply with respect to hearings requested after the date of enactment of the bill.

SECTION 261. COLLECTION OF SUPPLEMENTARY MEDICAL INSURANCE PREMIUMS FROM INDIVIDUALS ENTITLED TO BOTH SOCIAL SECURITY AND RAILROAD RETIREMENT BENEFITS

Sections 261 (a), (b), (c), and (d) of the bill amend sections 1840 and 1841 of the Social Security Act to provide that a railroad retirement beneficiary's monthly supplementary medical insurance premiums will be deducted from his railroad retirement pension regardless

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of any entitlement he may have to monthly benefits under title II of the act.

Section 261(e) of the bill amends section 1841 of the act by adding a new subsection (i) providing that the Managing Trustee of the Supplementary Medical Insurance Trust Fund is to reimburse the Railroad Retirement Board from the trust fund in such amounts as the Secretary of Health, Education, and Welfare determines to be equal to the costs incurred by the Board in making the premium deductions.

Section 261(f) of the bill provides that these amendments will apply with respect to premiums becoming due and payable after the fourth month following the month of enactment of the bill.

SECTION 262. PAYMENT FOR CERTAIN INPATIENT HOSPITAL SERVICES FURNISHED OUTSIDE THE UNITED STATES

Section 262(a) of the bill amends section 1814(f) of the Social Security Act to make medicare benefits payable for inpatient hospital services furnished outside the United States in cases where the beneficiary is a resident of the United States and the foreign hospital is closer to, or substantially more accessible from, his residence than the nearest hospital in the United States which was suitable and available for his treatment. Such benefits are to be payable without regard to whether an emergency existed or where the illness or accident occurred. (In present law section 1814(f) limits payment to emergencies occurring within the United States.) Payment for covered hospital services furnished outside the United States would be made essentially on the same basis as payment for emergency services furnished by a nonparticipating hospital within the United States.

Section 262(b) of the bill amends section 1861(e) of the act to provide that medicare benefits payable under the amended section 1814(f) will be payable only with respect to inpatient services furnished by a hospital which has been accredited by the Joint Commission on Accreditation of Hospitals or by a hospital-approval program having essentially comparable standards.

Section 262(c) of the bill makes a conforming change in section 1862(a)(4) of the act.

Section 262(d) of the bill provides that these amendments will be applicable to services furnished with respect to admissions occurring after December 31, 1970.

SECTION 263. STUDY OF CHIROPRACTIC COVERAGE

Section 263 of the bill directs the Secretary of Health, Education, and Welfare (utilizing his authority under section 1110 of the Social Security Act) to conduct a study of the coverage of services performed by chiropractors under State medicaid plans approved under title XIX of the Social Security Act to determine whether, and to what extent, chiropractic services should be covered under part B of title XVIII. The study is to focus on the limitations which should be placed upon such coverage (including payment limitations) and is to include one or more experimental, pilot, or demonstration projects designed to assist in providing under controlled conditions the information necessary to achieve the objectives of the study. The Secretary

is to report the results of the study to the Congress within 2 years after the date of enactment of the bill, together with his findings and recommendations based on the study, and on other relevant informations.

TITLE III—MISCELLANEOUS

SECTION 301. MEANING OF TERM "SECRETARY"

Section 301 of the bill makes it clear that the term "Secretary" (unless the context otherwise requires) means the Secretary of Health, Education, and Welfare when it is used in the bill and in the amendments made by the bill.

VI. SEPARATE VIEWS OF HON. CHARLES A. VANIK, OF OHIO

Although this bill provides some long-needed improvements in the social security system, I am distressed with the decision to reduce the old-age and disability insurance fund by $30.2 billion in the next 4 years with a compounded loss including interest totaling $54.9 billion by January 1, 1980.

The reduction of the old-age and disability tax rate was achieved by deferring the scheduled increase in the employer-employee combined contribution rate to 10 percent until January 1, 1975. Present law would have increased the combined 8.4-percent rate to 9.2 percent on January 1, 1971, and to 10 percent on January 1, 1973.

I cannot agree with the Social Security authorities who deplore the healthy growth of the social security fund. Those who criticize and question the soundness of this program are given comfort by our legislative action which diverts almost $62.6 billion from the fund over the next 40 years.

Under regular insurance actuarial standards, the social security trust fund is far below accepted reserve requirements. The tax stretchout further reduces the strength of the trust fund at a time of uncertainties beyond projection or prophecy.

Our action in reducing the tax rate on the old age, survivors', and disability insurance fund is an inflationary action which comes simultaneously with income tax reductions. It would seem provident to place some of the tax reduction into the retirement reserve.

Furthermore, the trust funds are becoming more substantial investors in the Federal debt. The time is not far distant when 40 percent of the Federal debt will be held by trust fund accounts. The trust fund contributions constitute the only investment in the Federal debt of millions of American taxpayers. Incredible as it may seem, the substantial investment of the trust funds in the Federal debt have served to keep the Federal interest rate and the public interest rate from reaching even greater heights.

Those who oppose the increased reserves in the social security trust fund are also those who oppose increased benefits. They are willing to shortchange the trust funds in order to reduce pressures for increased benefits and services needed by retired Americans. The worker-contributor will save a few pennies but the corporations of America will have a windfall of $15 billion in 4 years at the expense of a stronger social security fund and a better program. This proposal is penny wise but pound foolish.

CHARLES A. VANIK.

VII. SUPPLEMENTAL REPUBLICAN VIEWS

We believe the committee did a commendable job in adopting a series of structural changes that will produce greater equity in our social security program. We are particularly pleased that the committee has acted favorably on the administration's proposals to improve benefits for widows and increase the amount that an individual may earn without losing benefits. We also support the provisions of the bill designed to improve the effectiveness and hold down the costs of the medicare, medicaid, and maternal and child health programs.

However, we must express concern about several of the actions taken by the committee. First, we are concerned about the manner and timing of the 5-percent benefit increase provided in the committee bill. Second, we are concerned about the implications of the actuarial imbalance that will exist in the fund for the immediate future, even though this imbalance is admittedly small. Finally, we deeply regret the partisan rejection of the administration's recommendation for automatically adjusting benefits in the future as the cost of living increases.

I. POOR TIMING OF THE BENEFIT INCREASE

At the outset, we want to firmly state our belief that social security beneficiaries are entitled to benefit increases to replace purchasing power lost to inflation. Additionally, we feel that Congress should periodically review the benefit schedule in the light of overall advances in economic activity. Congress has enacted benefit increases in the past in accordance with these essential principles and will continue to do so in the future.

Since 1965, Congress has increased cash benefits by 39 percent, and has also enacted the medicare program which for the aged is today equivalent to about a 30-percent increase in benefits. This record certainly reflects our sincere desire to be fair toward those relying on social security benefits.

We believe it is equally important to be fair to those who are bearing the tax burden necessary to provide these benefits. When the tax increases provided by this bill are fully effective, social security employee taxes will exceed the income taxes payable by a working man with a wife and two children (taking the higher of the standard deduction or low-income allowance) at all wage levels below $7,170. This does not include the employer's share of the tax, although most economists agree that the economic incidence of the employer's share of the tax falls on the employee. It is also important to note that social security taxes are applied to the worker's wages without allowing any deductions or exemptions.

We simply must remember that the income that a worker can currently devote to future contingencies is limited by his ability to meet the immediate needs of his family. If the cost of social security

cuts too deeply into daily living requirements, people will begin to make unfavorable comparisons between current costs and distant benefits. If the time ever comes that current workers are unwilling to bear the cost of providing benefits to current retirees, the social security system will be in real danger and those who will stand to lose most will be the current beneficiaries.

We are concerned that the timing of the 5-percent benefit increase included in this bill, coming on top of a 15-percent increase that social security beneficiaries began receiving only last month, fails to give sufficient weight to both the benefits that should be payable and the burdens that may be reasonably imposed on today's workers.

We wholeheartedly supported the 15-percent increase enacted into law on December 30 of last year. It must be recognized, however, that in doing so Congress provided benefits nearly half again as large as was necessary to make up for increases in the cost of living. Realizing that the war against a deeply entrenched inflation resulting from years of fiscal irresponsibility could not be won overnight, we provided a cushion against further increases in the cost of living on a prospective basis. Despite this, the committee has, only 4 months after we provided a 15-percent increase, voted an additional 5-percent benefit increase payable next January 1. This results in combined increases of nearly 21 percent within a 1-year period, which is substantially above the erosion in benefits that has resulted from inflation since the last increase in 1968.

Under the proposal for automatically adjusting benefits to increases in the cost of living, which we support, it is estimated that an increase in benefits of around 5 percent would be payable at the end of 1971. It is therefore not the benefit increase that concerns us, but its timing. The practice of bunching increases of this magnitude back to back will in the long run lead to further substantial increases in the tax burdens that must be imposed.

Additionally, the timing of this increase will result in an increase in spending in the unified budget of around $700 million in fiscal 1971. Coming on top of other increases in Federal spending and possible shortfalls in Federal revenue, the timing of this increase may seriously impair public confidence in our Government's determination to win the battle against inflation. Social security beneficiaries living on fixed incomes suffer the most from inflation. They should not be made the scapegoat for governmental programs to deal with inflation, as we recognized in supporting the recent 15 percent benefit increase. But by the same token, they will suffer the most if our determination to control inflation is seriously impaired.

II. ACTUARIAL IMBALANCE IN THE OASDI FUND DURING THE IMMEDIATE FUTURE

During the history of the social security program, tolerances have been established to determine when the social security funds are actuarially in balance. Since 1965, when estimates were placed on a 75-year basis, the fund has been considered to be actuarially in balance only when long-term level costs are financed within one-tenth of 1 percent of covered payroll. We must express our concern about action taken by the committee which provides long-term level costs that exceed income over the estimating period by 0.12 percent of covered payroll.

While the OASDI trust funds are only out of balance by 0.02 percent of payroll and should be in balance again sometime in 1971, we must express a strong word of caution. In the past, the committee has insisted that the criteria for determining actuarial soundness be strictly adhered to. We trust that the action taken by the committee in this bill does not reflect a disregard for the practice of insisting on the soundest financing, and will not provide a precedent for any changes in this policy in the future.

III. PARTISAN REJECTION OF ADMINISTRATION'S RECOMMENDATION FOR AUTOMATICALLY ADJUSTING BENEFITS

In his message to the Congress on social security, President Nixon recommended that benefits "be adjusted automatically to reflect increases in the cost of living. The uncertainty of adjustment under present laws and the delay often encountered when the needs are already apparent is unnecessarily harsh to those who must depend on social security benefits to live."

Recommendations for automatic benefit adjustments were included in both major party platforms in the last election, advocated by both presidential candidates, and have been included in legislation introduced by four Democrat members on the Ways and Means Committee.

The rejection of President Nixon's proposal on a completely partisan basis is therefore surprising and disappointing. It is a complete departure from the policies the Democratic Party pledged the American people they would work for. It was certainly anomalous for four Democrat members of the committee to vote against an escalator clause when they have introduced legislation to enact such a provision.

More than this, the partisan rejection of this constructive proposal is a disservice to all current and future beneficiaries of our social security program. The proposal would extend to social security beneficiaries for the first time the same protection against inflation that our civil service retirees have enjoyed since 1962, and that our military retirees have enjoyed since 1958.

Prompt adjustment of benefits would enable our citizens to plan their retirement with the assurance that a specified amount of real income would be consistently provided. Studies indicate that the total amount of benefit increases provided between 1954 and the end of last year was nearly identical with increases that would have been provided under a provision automatically increasing benefits. However, since Congress enacted increases on only three different occasions during this period, long delays were experienced by beneficiaries, with no increase at all being provided during the 6-year period between 1959 and 1965. Under the President's proposal for automatic benefit adjustments, benefits would have been increased six times during this period, avoiding unnecessary delay and hardship. Justice to our senior citizens requires that benefits be promptly updated.

Additionally, a provision automatically adjusting benefits would enable a busy Congress to devote time to considering solely on their merits structural improvements in the program to improve equity, facilitate administration, and increase the basic efficiency of the

program. Proposals of dubious merit having little support in the Congress have too often in the past been enacted because they were attached to legislation providing benefit adjustments that were vitally needed by social security beneficiaries. In considering structural improvements in the program, Congress would, of course, periodically review the entire benefit structure to provide adjustments over and above the automatic increases when increases in general economic productivity make such adjustments desirable.

We want to make it clear that the provision for automatic benefit adjustments does not in any way delegate to the executive branch discretion to increase taxes. In order to finance the automatic benefit increases tied to increases in the cost of living, provisions are included in the bill for periodic adjustments in the wage base to reflect increases in earnings. However, the increase in the wage base is not left to the discretion of any executive official, but is specifically tied to actual increases in the earnings of workers in covered employment.

Under the provisions for automatic benefit adjustments recommended by the administration, which the Democrat members of the committee rejected, the average wages actually paid to workers in covered employment during the first quarter of each even-numbered year would be compared with the average wages actually paid to covered workers in the first quarter of 1971. The wage base would be automatically increased by an amount equal to the increase in the earnings of covered workers that has occurred, rounded to the nearest multiple of $600. It cannot be alleged that this leaves to anyone's discretion the right to raise or lower taxes. Changes in tax rates would continue to require specific legislation. Changes in the wage base could only result when wages increase in accordance with a very specific formula spelled out in the legislation or as a result of specific legislation. The circumstances under which taxes are payable would continue to remain where they belong, under the complete control of the Congress.

CONCLUSION

We strongly support the constructive amendments included in this bill providing structural improvements to the OASDI program, the medicare program, and the child and maternal health program. We commend the administration for making sound recommendations and working with the committee in developing needed improvements in these areas.

We have reservations concerning the timing of the 5-percent increase, the growing burden of payroll taxes on our working population, and the actuarial imbalance, though small, that will exist in the fund during the immediate future. We strongly object to the partisan rejection of the administration's constructive recommendation to provide for automatic increases in benefits commensurate with increases in the cost of living.

John W. Byrnes, Jackson E. Betts, Herman T. Schneebeli, Harold R. Collier, Joel T. Broyhill, Barber B. Conable, Jr., George Bush, Rogers C. B. Morton, Charles E. Chamberlain, Jerry L. Pettis.

○

Union Calendar No. 508

91ST CONGRESS
2D SESSION

H. R. 17550

[Report No. 91–1096]

IN THE HOUSE OF REPRESENTATIVES

MAY 11, 1970

Mr. MILLS (for himself and Mr. BYRNES of Wisconsin) introduced the following bill; which was referred to the Committee on Ways and Means

MAY 14, 1970

Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

A BILL

To amend the Social Security Act to provide increases in benefits, to improve computation methods, and to raise the earnings base under the old-age, survivors, and disability insurance system, to make improvements in the medicare, medicaid, and maternal and child health programs with emphasis upon improvements in the operating effectiveness of such programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act, with the following table of contents, may be cited as the "Social Security Amendments of 1970".

TABLE OF CONTENTS

TITLE II—PROVISIONS RELATING TO MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH—Continued

PART B—IMPROVEMENTS IN THE OPERATING EFFECTIVENESS OF THE MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS—Con.

PART C—MISCELLANEOUS AND TECHNICAL PROVISIONS

TABLE OF CONTENTS—Continued

TITLE I—PROVISIONS RELATING TO OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE

INCREASE IN OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

SEC. 101. (a) Section 215(a) of the Social Security Act is amended by striking out the table and inserting in lieu thereof the following:

"TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS

"I (Primary insurance benefit under 1939 Act, as modified)		II (Primary insurance amount under 1960 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—		
----------	$16.20	$64.00	----------	$76	$67.20	$100.80
$16.21	16.84	65.00	$77	78	68.30	102.50
16.85	17.60	66.40	79	80	69.80	104.70
17.61	18.40	67.70	81	81	71.10	106.70
18.41	19.24	68.90	82	83	72.40	108.60
19.25	20.00	70.30	84	85	73.90	110.90
20.01	20.64	71.60	86	87	75.20	112.80
20.65	21.28	72.80	88	89	76.50	114.80
21.29	21.88	74.20	90	90	78.00	117.00
21.89	22.28	75.50	91	92	79.30	119.00
22.29	22.68	76.80	93	94	80.70	121.10
22.69	23.08	78.00	95	96	81.90	122.90
23.09	23.44	79.40	97	97	83.40	125.10
23.45	23.76	80.80	98	99	84.90	127.40
23.77	24.20	82.30	100	101	86.50	129.80
24.21	24.60	83.50	102	102	87.70	131.60
24.61	25.00	84.90	103	104	89.20	133.80
25.01	25.48	86.40	105	106	90.80	136.20
25.49	25.92	87.80	107	107	92.20	138.30
25.93	26.40	89.20	108	109	93.70	140.60

"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 1969 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—		
$26.41	$26.94	$90.60	$110	$113	$95.20	$142.80
26.95	27.46	91.90	114	118	96.50	144.80
27.47	28.00	93.30	119	122	98.00	147.00
28.01	28.68	94.70	123	127	99.50	149.30
28.69	29.25	96.20	128	132	101.10	151.70
29.26	29.68	97.50	133	136	102.40	153.60
29.69	30.36	98.80	137	141	103.80	155.70
30.37	30.92	100.30	142	146	105.40	158.10
30.93	31.36	101.70	147	150	106.80	160.20
31.37	32.00	103.00	151	155	108.20	162.30
32.01	32.60	104.50	156	160	109.80	164.70
32.61	33.20	105.80	161	164	111.10	166.70
33.21	33.88	107.20	165	169	112.60	168.90
33.89	34.50	108.60	170	174	114.10	171.20
34.51	35.00	110.00	175	178	115.50	173.30
35.01	35.80	111.40	179	183	117.00	175.50
35.81	36.40	112.70	184	188	118.40	177.60
36.41	37.08	114.20	189	193	120.00	180.00
37.09	37.60	115.60	194	197	121.40	182.10
37.61	38.20	116.90	198	202	122.80	184.20
38.21	39.12	118.40	203	207	124.40	186.60
39.13	39.68	119.80	208	211	125.80	188.70
39.69	40.33	121.00	212	216	127.10	190.70
40.34	41.12	122.50	217	221	128.70	193.10
41.13	41.76	123.90	222	225	130.10	195.20
41.77	42.44	125.30	226	230	131.60	197.40
42.45	43.20	126.70	231	235	133.10	199.70
43.21	43.76	128.20	236	239	134.70	202.10
43.77	44.44	129.50	240	244	136.00	204.00
44.45	44.88	130.80	245	249	137.40	206.10
44.89	45.60	132.30	250	253	139.00	208.50
		133.70	254	258	140.40	210.60
		134.90	259	263	141.70	212.60
		136.40	264	267	143.30	215.00
		137.80	268	272	144.70	217.60
		139.20	273	277	146.20	221.60
		140.60	278	281	147.70	224.80
		142.00	282	286	149.10	228.80
		143.50	287	291	150.70	232.80
		144.70	292	295	152.00	236.00
		146.20	296	300	153.60	240.00
		147.60	301	305	155.00	244.00
		148.90	306	309	156.40	247.20
		150.40	310	314	158.00	251.20
		151.70	315	319	159.30	255.20
		153.00	320	323	160.70	258.40
		154.50	324	328	162.30	262.40
		155.90	329	333	163.70	266.40
		157.40	334	337	165.30	269.60
		158.60	338	342	166.60	273.60
		160.00	343	347	168.00	277.60
		161.50	348	351	169.60	280.80
		162.80	352	356	171.00	284.80
		164.30	357	361	172.60	288.80
		165.60	362	365	173.90	292.00
		166.90	366	370	175.30	296.00
		168.40	371	375	176.90	300.00
		169.80	376	379	178.30	303.20
		171.30	380	384	179.90	307.20
		172.50	385	389	181.20	311.20
		173.90	390	393	182.60	314.40
		175.40	394	398	184.20	318.40
		176.70	399	403	185.60	322.40
		178.20	404	407	187.20	325.60
		179.40	408	412	188.40	329.60
		180.70	413	417	189.80	333.60
		182.00	418	421	191.10	336.80
		183.40	422	426	192.60	340.80
		184.60	427	431	193.90	344.80
		185.90	432	436	195.20	348.80
		187.30	437	440	196.70	350.40
		188.50	441	445	198.00	352.40
		189.80	446	450	199.30	354.40
		191.20	451	454	200.80	356.00
		192.40	455	459	202.10	358.00
		193.70	460	464	203.40	360.00
		195.00	465	468	204.80	361.60
		196.40	469	473	206.30	363.60
		197.60	474	478	207.80	365.60

"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 1969 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—		
		$198.90	$479	$482	$208.90	$367.20
		200.30	483	487	210.40	369.20
		201.50	488	492	211.60	371.20
		202.80	493	496	213.00	372.80
		204.20	497	501	214.50	374.80
		205.40	502	506	215.70	376.80
		206.70	507	510	217.10	378.40
		208.00	511	515	218.40	380.40
		209.30	516	520	219.80	382.40
		210.60	521	524	221.20	384.00
		211.90	525	529	222.50	386.00
		213.30	530	534	224.00	388.00
		214.50	535	538	225.30	389.60
		215.80	539	543	226.60	391.60
		217.20	544	548	228.10	393.60
		218.40	549	553	229.40	395.60
		219.70	554	556	230.70	396.80
		220.80	557	560	231.90	398.40
		222.00	561	563	233.10	399.60
		223.10	564	567	234.30	401.20
		224.30	568	570	235.60	402.40
		225.40	571	574	236.70	404.00
		226.60	575	577	238.00	405.20
		227.70	578	581	239.10	406.80
		228.90	582	584	240.40	408.00
		230.00	585	588	241.50	409.60
		231.20	589	591	242.80	410.80
		232.30	592	595	244.00	412.40
		233.50	596	598	245.20	413.60
		234.60	599	602	246.40	415.20
		235.80	603	605	247.60	416.40
		236.90	606	609	248.80	418.00
		238.10	610	612	250.10	419.20
		239.20	613	616	251.20	420.80
		240.40	617	620	252.50	422.40
		241.50	621	623	253.60	423.60
		242.70	624	627	254.90	425.20
		243.80	628	630	256.00	426.40
		245.00	631	634	257.30	428.00
		246.10	635	637	258.50	429.20
		247.30	638	641	259.70	430.80
		248.40	642	644	260.90	432.00
		249.60	645	648	262.10	433.60
		250.70	649	650	263.30	434.40
			651	655	264.00	436.40
			656	660	265.00	438.40
			661	665	266.00	440.40
			666	670	267.00	442.40
			671	675	268.00	444.40
			676	680	269.00	446.40
			681	685	270.00	448.40
			686	690	271.00	450.40
			691	695	272.00	452.40
			696	700	273.00	454.40
			701	705	274.00	456.40
			706	710	275.00	458.40
			711	715	276.00	460.40
			716	720	277.00	462.40
			721	725	278.00	464.40
			726	730	279.00	466.40
			731	735	280.00	468.40
			736	740	281.00	470.40
			741	745	282.00	472.40
			746	750	283.00	474.40".

(b) Section 203 (a) of such Act is amended by striking out paragraph (2) and inserting in lieu thereof the following:

"(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 on the basis of the wages and self-employment income of such insured individual and at least one such person was so entitled for December 1970 on the basis of such wages and self-employment income, such total of benefits for January 1971 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 (including this subsection, but without the application of section 222 (b), section 202 (q), and subsections (b), (c), and (d) of this section), as in effect prior to the enactment of the Social Security Amendments of 1970, for each such person for such month, by 105

percent and raising each such increased amount, if it is not a multiple of $0.10, to the next higher multiple of $0.10;

but in any such case (i) paragraph (1) of this subsection shall not be applied to such total of benefits after the application of subparagraph (B), and (ii) if section 202 (k) (2) (A) was applicable in the case of any such benefits for January 1971, 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 January 1971, or".

(c) Section 215 (b) (4) of such Act is amended by striking out "December 1969" each time it appears and inserting in lieu thereof "December 1970".

(d) Section 215 (c) of such Act is amended to read as follows:

"Primary Insurance Amount Under 1969 Act

"(c) (1) For the purposes of column II of the table appearing in subsection (a) of this section, an individual's primary insurance amount shall be computed on the basis of the law in effect prior to the enactment of the Social Security Amendments of 1970.

"(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 January 1971, or who died before such month."

(e) The amendments made by this section shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970 and with respect to lump-sum death payments under such title in the case of deaths occurring after December 1970.

(f) If an individual was entitled to a disability insurance benefit under section 223 of the Social Security Act for December 1970 and became entitled to old-age insurance benefits under section 202 (a) of such Act for January 1971, or he died in such month, then, for purposes of section 215 (a) (4) of the Social Security Act (if applicable), the amount in column IV of the table appearing in such section 215 (a) for such individual shall be the amount in such column on the line on which in column II appears his primary insurance amount (as determined under section 215 (c) of such Act) instead of the amount in column IV equal to the primary insurance amount on which his disability insurance benefit is based.

INCREASE IN BENEFITS FOR CERTAIN INDIVIDUALS AGE 72 AND OVER

SEC. 102. (a) (1) Section 227 (a) of the Social Security Act is amended by striking out "$46" and inserting in

lieu thereof "$48.30", and by striking out "$23" and inserting in lieu thereof "$24.20".

(2) Section 227(b) of such Act is amended by striking out "$46" and inserting in lieu thereof "$48.30".

(b) (1) Section 228(b) (1) of such Act is amended by striking out "$46" and inserting in lieu thereof "$48.30".

(2) Section 228(b) (2) of such Act is amended by striking out "$46" and inserting in lieu thereof "$48.30", and by striking out "$23" and inserting in lieu thereof "$24.20".

(3) Section 228(c) (2) of such Act is amended by striking out "$23" and inserting in lieu thereof "$24.20".

(4) Section 228(c) (3) (A) of such Act is amended by striking out "$46" and inserting in lieu thereof "$48.30".

(5) Section 228(c) (3) (B) of such Act is amended by striking out "$23" and inserting in lieu thereof "$24.20".

(c) The amendments made by subsections (a) and (b) shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970.

INCREASED WIDOW'S AND WIDOWER'S INSURANCE BENEFITS

SEC. 103. (a) Section 202(e) of the Social Security Act is amended—

(1) by striking out "82½ percent of" wherever it appears in paragraphs (1) and (2); and

(2) by striking out "age 62" in subparagraphs (C) (i) and (C) (ii) of paragraph (1), and in the matter following subparagraph (G) in paragraph (1), and inserting in lieu thereof in each instance "age 65".

(b) Section 202 (f) of such Act is amended—

(1) by striking out "82½ percent of" wherever it appears in paragraphs (1) and (3);

(2) by inserting ", after attainment of age 65," after "was entitled" in paragraph (1) (C); and

(3) by striking out "age 62" in the matter following subparagraph (G) in paragraph (1) and inserting in lieu thereof "age 65".

(c) (1) The last sentence of section 203 (c) of such Act is amended by striking out all that follows the semicolon and inserting in lieu thereof the following: "nor shall any deduction be made under this subsection from any widow's insurance benefit for any month in which the widow or surviving divorced wife is entitled and has not attained age 65 (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 65 (but only if he became so entitled prior to attaining age 62)."

(2) Clause (D) of section 203 (f) (1) of such Act is amended to read as follows; "(D) for which such individual

is entitled to widow's insurance benefits and has not attained age 65 (but only if she became so entitled prior to attaining age 60), or widower's insurance benefits and has not attained age 65 (but only if he became so entitled prior to attaining age 62), or".

(d) (1) Section 202 (q) (1) of such Act is amended to read as follows:

"(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 such month and for any subsequent month shall, subject to the succeeding paragraphs of this subsection, be reduced by—

"(A) 5/9 of 1 percent of such amount if such benefit is an old-age insurance benefit, 25/36 of 1 percent of such amount if such benefit is a wife's or husband's insurance benefit, or 5 7/120 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 the 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;

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) $^{43}/_{240}$ 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 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 age 62."

(2) Section 202 (q) (7) of such Act is amended—

(A) by striking out everything that precedes sub-

paragraph (A) and inserting in lieu thereof the following:

"(7) For purposes of this subsection the 'adjusted reduction period' for an individual's old-age, wife's, husband's, widow's, or widower's insurance benefit is the reduction period 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, excluding from each such period—";

and

(B) by striking out "attained retirement age" in subparagraph (E) and inserting in lieu thereof "attained age 62, and also for any month before the month in which he attained retirement age,".

(3) Section 202 (q) (9) of such Act is amended to read as follows:

"(9) For purposes of this subsection, the term 'retirement age' means age 65."

(e) Section 202 (m) of such Act is amended to read as follows:

"Minimum Survivor's Benefit

"(m) (1) In any case in which an individual is entitled to a monthly benefit under this section (other than under subsection (a)) for any month and no other person is (with-

out the application of subsection (j) (1) and section 223 (b)) entitled to a monthly benefit under this section or section 223 for such month on the basis of the same wages and self-employment income, such individual's benefit amount for such month, prior to reduction under subsections (k) (3) and (q) (1), shall be not less than the first amount appearing in column IV of the table in section 215 (a).

"(2) In the case of such an individual who is entitled to a monthly benefit under subsection (e) or (f) and whose benefit is subject to reduction under subsection (q) (1), such benefit amount, after reduction under subsection (q) (1), shall not be less than the amount it would be under paragraph (1) after such reduction if such individual had attained (or would attain) retirement age (as defined in subsection (q) (9)) in the month in which he attained (or would attain) age 62.

"(3) In the case of an individual to whom paragraph (2) applies but whose first month of entitlement to benefits under subsection (e) or (f) was before the month in which he attained age 60, such paragraph (2) shall be applied, for purposes of determining the number of months to be used in computing the reduction under subparagraphs (A) and (B) of subsection (q) (1) (but not for purposes of determining the number of months to be used in computing the reduction under subparagraphs (C) and (D) of such subsection), as

though such first month of entitlement had been the month in which he attained such age."

(f) In the case of an individual who is entitled (without the application of section 202 (j) (1) and 223 (b) of the Social Security Act) to widow's or widower's insurance benefits for the month of December 1970, the Secretary shall redetermine the amount of such benefits under title II of such Act as if the amendments made by this section had been in effect for the first month of such individual's entitlement to such benefits.

(g) Where—

(1) two or more persons are entitled (without the application of section 202 (j) (1) of the Social Security Act) to monthly benefits under section 202 of such Act for December 1970 on the basis of the wages and self-employment income of a deceased individual, and one or more of such persons is so entitled under subsection (e) or (f) of such section 202, and

(2) one or more of such persons is entitled on the basis of such wages and self-employment income to increased monthly benefits under subsection (e) or (f) of such section 202 (as amended by this section) for January 1971, and

(3) the total of benefits to which all persons are entitled under section 202 of such Act on the basis of

such wages and self-employment income for January 1971 is reduced by reason of section 203(a) of such Act, as amended by this Act (or would, but for the penultimate sentence of such section 203(a), be so reduced),

then the amount of the benefit to which each such person referred to in paragraph (1), other than a person entitled under subsection (e) or (f) of such section 202, is entitled for months after December 1970 shall be adjusted, after the application of such section 203(a), to an amount no less than the amount it would have been if the person or persons referred to in paragraph (2) had not become entitled to an increased benefit referred to in such paragraph.

(h) The amendments made by this section shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970.

AGE-62 COMPUTATION POINT FOR MEN

SEC. 104. (a) Section 214(a)(1) of the Social Security Act is amended by striking out "before—" and all that follows down through "except" and inserting in lieu thereof "before the year in which he died or (if earlier) the year in which he attained age 62, except".

(b) Section 215(b)(3) of such Act is amended by striking out "before—" and all that follows down through

"For" and inserting in lieu thereof "before the year in which he died or, if it occurred earlier but after 1960, the year in which he attained age 62. For".

(c) In the case of an individual who is entitled to monthly benefits under section 202 or 223 of the Social Security Act for a month after December 1970, on the basis of the wages and self-employment income of an insured individual who prior to January 1971 became entitled to benefits under section 202 (a), or who prior to January 1971 became entitled to benefits under section 223 after the year in which he attained age 62, or who died prior to January 1971 in a year after the year in which he attained age 62, the Secretary shall, notwithstanding paragraphs (1) and (2) of section 215 (f) of such Act, recompute the primary insurance amount of such insured individual. Such recomputation shall be made under whichever of the following alternative computation methods yields the higher primary insurance amount:

(1) the computation methods in section 215 (b) and (d) of such Act, as amended by this Act, as such methods would apply in the case of an insured individual who attained age 62 in 1971, except that the provisions of section 215 (d) (3) of such Act shall not apply; or

(2) the computation methods specified in paragraph (1) without regard to the limitation "but after 1960"

contained in section 215 (b) (3) of such Act, except that for any such recomputation, when the number of an individual's benefit computation years is less than 5, his average monthly wage shall, if it is in excess of $400, be reduced to such amount.

(d) Section 223 (a) (2) of such Act is amended—

(1) by striking out "(if a woman) or age 65 (if a man)",

(2) by striking out "in the case of a woman" and inserting in lieu thereof "in the case of an individual", and

(3) by striking out "she" and inserting in lieu thereof "he".

(e) Section 223 (c) (1) (A) of such Act is amended by striking out "(if a woman) or age 65 (if a man)".

(f) Section 227 (a) of such Act is amended by striking out "so much of paragraph (1) of section 214 (a) as follows clause (C)" and inserting in lieu thereof "paragraph (1) of section 214 (a)".

(g) Section 227 (b) of such Act is amended by striking out "so much of paragraph (1) thereof as follows clause (C)" and inserting in lieu thereof "paragraph (1) thereof".

(h) Sections 209 (i), 213 (a) (2), and 216 (i) (3) (A), of such Act are amended by striking out "(if a woman) or age 65 (if a man)".

(i) (1) Section 303 (g) (1) of the Social Security Amendments of 1960 is amended—

(A) by striking out "Amendments of 1965 and 1967" and inserting in lieu thereof "Amendments of 1965, 1967, 1969, and 1970";

(B) by striking out "Amendments of 1967" wherever it appears and inserting in lieu thereof "Amendments of 1970"; and

(C) by inserting "(subject to section 104 (i) (2) of the Social Security Amendments of 1970)" after "except that" in the last sentence.

(2) For purposes of monthly benefits payable after December 1970, or a lump-sum death payment in the case of an insured individual who dies after December 1970, "retirement age" as referred to in section 303 (g) (1) of the Social Security Amendments of 1960 shall mean age 62.

(j) Paragraph (9) of section 3121 (a) of the Internal Revenue Code of 1954 (relating to definition of wages) is amended to read as follows:

"(9) any payment (other than vacation or sick pay) made to an employee after the month in which he attains age 62, if such employee did not work for the employer in the period for which such payment is made;".

(k) When two or more persons are entitled (without the application of sections 202 (j) (1) and 223 (b) of the Social Security Act) to monthly benefits under section 202 or 223 of such Act for December 1970, on the basis of the wages and self-employment income of an insured individual, and the total of benefits for such persons is reduced under section 203 (a) of such Act (or would, but for the penultimate sentence of such section 203 (a), be so reduced) for the month of January 1971 and such individual's primary insurance amount is increased for such month under the amendments made by this section, then the total of benefits for such persons for and after January 1971 shall not be reduced to less than the sum of—

(1) the amount determined under section 203 (a) (2) of such Act for January 1971, and

(2) an amount equal to the excess of (A) such individual's primary insurance amount for January 1971, as determined under section 215 of such Act (as amended by section 101 of this Act) and in accordance with the amendments made by this section, over (B) his primary insurance amount for January 1971 as determined under such section 215 without regard to such amendments.

(l) The amendments made by this section shall apply

with respect to monthly benefits under title II of the Social Security Act for months after December 1970 and with respect to lump-sum death payments made under such title in the case of deaths occurring after December 1970, except that in the case of an individual who was not entitled to a monthly benefit under title II of such Act for December 1970 such amendments shall apply only on the basis of an application filed in or after the month in which this Act is enacted.

ELECTION TO RECEIVE ACTUARIALLY REDUCED BENEFITS IN ONE CATEGORY NOT TO BE APPLICABLE TO CERTAIN BENEFITS IN OTHER CATEGORIES

SEC. 105. (a) (1) Section 202 (q) (3) (A) of the Social Security Act is amended by striking out all that follows clause (ii) and inserting in lieu thereof the following: "then (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) of this paragraph, in lieu of any reduction under paragraph (1), if the amount of the reduction in such benefit under this paragraph is less than the amount of the reduction in such benefit would be under paragraph (1)."

(2) Section 202 (q) (3) of such Act is further amended by striking out subparagraphs (E), (F), and (G).

(b) Section 202 (r) of such Act is repealed.

(c) (1) (A) Subject to subparagraph (B), subsection (a) of this section and the amendments made thereby shall apply with respect to benefits for months commencing with the sixth month after the month in which this Act is enacted.

(B) Subsection (a) of this section and the amendments made thereby shall apply in the case of an individual whose entitlement to benefits under section 202 of the Social Security Act began (without regard to sections 202 (j) (1) and 223 (b) of such Act) before the sixth month after the month in which this Act is enacted only if such individual files with the Secretary of Health, Education, and Welfare, in such manner and form as the Secretary shall by regulations prescribe, a written request that such subsection and such amendments apply. In the case of such an individual who is described in paragraph (2) (A) (i) of this subsection, the request for a redetermination under paragraph (2) shall constitute the request required by this subparagraph, and subsection (a) of this section and the amendments made thereby shall apply pursuant to such request with respect to such individual's benefits as redetermined in accordance with paragraph (2) (B) (i) (but only if he does not refuse to accept such redetermination). In the case of any individual with respect to whose benefits subsection (a) of this section and the amendments made thereby may apply only pursuant

to a request made under this subparagraph, such subsection and such amendments shall be effective (subject to paragraph (2) (D)) with respect to benefits for months commencing with the sixth month after the month in which this Act is enacted or, if the request required by this subparagraph is not filed before the end of such sixth month, with the second month following the month in which the request is filed.

(C) Subsection (b) of this section shall apply with respect to benefits payable pursuant to applications filed on or after the date of the enactment of this Act.

(2) (A) In any case where an individual—

(i) is entitled, for the fifth month following the month in which this Act is enacted, to a monthly insurance benefit under section 202 of the Social Security Act (I) which was reduced under subsection (q) (3) of such section, and (II) the application for which was deemed (or, except for the fact that an application had been filed, would have been deemed) to have been filed by such individual under subsection (r) (1) or (2) of such section, and

(ii) files a written request for a redetermination under this subsection, on or after the date of the enactment of this Act and in such manner and form as the Secretary of Health, Education, and Welfare shall by regulations prescribe,

the Secretary shall redetermine the amount of such benefit, and the amount of the other benefit (reduced under subsection (q) (1) or (2) of such section) which was taken into account in computing the reduction in such benefit under such subsection (q) (3), in the manner provided in subparagraph (B) of this paragraph.

(B) Upon receiving a written request for the redetermination under this paragraph of a benefit which was reduced under subsection (q) (3) of section 202 of the Social Security Act and of the other benefit which was taken into account in computing such reduction, filed by an individual as provided in subparagraph (A) of this paragraph, the Secretary shall—

(i) determine the highest monthly benefit amount which such individual could receive under the subsections of such section 202 which are involved (or under section 223 of such Act and the subsection of such section 202 which is involved) for the month with which the redetermination is to be effective under subparagraph (D) of this subsection (without regard to sections 202 (k), 203 (a), and 203 (b) through (l)) if—

(I) such individual's application for one of such two benefits had been filed in the month in which it was actually filed or was deemed under

subsection (r) of such section 202 to have been filed, and his application for the other such benefit had been filed in a later month, and

(II) the amendments made by this section had been in effect at the time each such application was filed; and

(ii) determine whether the amounts which were actually received by such individual in the form of such two benefits during the period prior to the month with which the redetermination under this paragraph is to be effective were in excess of the amounts which would have been received during such period if the applications for such benefits had actually been filed at the times fixed under clause (i) (I) of this subparagraph, and, if so, the total amount by which benefits otherwise payable to such individual under such section 202 (and section 223) would have to be reduced in order to compensate the Federal Old-Age and Survivors Insurance Trust Fund (and the Federal Disability Insurance Trust Fund) for such excess.

(C) The Secretary shall then notify such individual of the amount of each such benefit as computed in accordance with the amendments made by subsections (a) and (b) of this section and as redetermined in accordance with subparagraph (B) (i) of this paragraph, specifying (i) the

amount (if any) of the excess determined under subparagraph (B) (ii) of this paragraph, and (ii) the period during which payment of any increase in such individual's benefits resulting from the application of the amendments made by subsections (a) and (b) of this section would under designated circumstances have to be withheld in order to effect the reduction described in subparagraph (B) (ii). Such individual may at any time within thirty days after such notification is mailed to him refuse (in such manner and form as the Secretary shall by regulations prescribe) to accept the redetermination under this paragraph.

(D) Unless the last sentence of subparagraph (C) applies, a redetermination under this paragraph shall be effective (but subject to the reduction described in subparagraph (B) (ii) over the period specified pursuant to clause (ii) of the first sentence of subparagraph (C)) beginning with the sixth month following the month in which this Act is enacted, or, if the request for such redetermination is not filed before the end of such sixth month, with the second month following the month in which the request for such redetermination is filed.

(E) The Secretary, by withholding amounts from benefits otherwise payable to an individual under title II of the Social Security Act as specified in clause (ii) of the first sentence of subparagraph (C) (and in no other manner), shall

recover the amounts necessary to compensate the Federal Old-Age and Survivors Insurance Trust Fund (and the Federal Disability Insurance Trust Fund) for the excess (described in subparagraph (B) (ii)) attributable to benefits which were paid such individual and to which a redetermination under this subsection applies.

(d) Where—

(1) two or more persons are entitled on the basis of the wages and self-employment income of an individual (without the application of sections 202 (j) (1) and 223 (b) of the Social Security Act) to monthly benefits under section 202 of such Act for the month preceding the month with which (A) a redetermination under subsection (c) of this section becomes effective with respect to the benefits of any one of them and (B) such benefits are accordingly increased by reason of the amendments made by subsections (a) and (b) of this section, and

(2) the total of benefits to which all persons are entitled under such section 202 on the basis of such wages and self-employment income for the month with which such redetermination and increase becomes effective is reduced by reason of section 203 (a) of such Act as amended by this Act (or would, but for the penultimate sentence of such section 203 (a), be so reduced),

then the amount of the benefit to which each of the persons referred to in paragraph (1), other than the person with respect to whose benefits such redetermination and increase is applicable, is entitled for months beginning with the month with which such redetermination and increase becomes effective shall be adjusted, after the application of such section 203 (a), to an amount no less than the amount it would have been if such redetermination and increase had not become effective.

LIBERALIZATION OF EARNINGS TEST

SEC. 106. (a) (1) Paragraphs (1), (3), and (4) (B) of section 203 (f) of the Social Security Act are each amended by striking out "$140" and inserting in lieu thereof "$166.66⅔".

(2) Paragraph (1) (A) of section 203 (h) of such Act is amended by striking out "$140" and inserting in lieu thereof "$166.66⅔".

(b) The amendments made by subsection (a) shall apply with respect to taxable years ending after December 1970.

EXCLUSION OF CERTAIN EARNINGS IN YEAR OF ATTAINING AGE 72

SEC. 107. (a) The first sentence of section 203 (f) (3) of the Social Security Act is amended by inserting "(A)" after "except that", and by inserting before the period at the

end thereof the following: ", and (B) 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 equitable manner under regulations of the Secretary)".

(b) The amendment made by subsection (a) shall apply with respect to taxable years ending after December 1970.

REDUCED BENEFITS FOR WIDOWERS AT AGE 60

SEC. 108. (a) Section 202(f) of the Social Security Act (as amended by section 103(b)(2) of this Act) is further amended—

(1) by striking out "age 62" each place it appears and inserting in lieu thereof "age 60"; and

(2) by striking out "or the third month" in the matter following subparagraph (G) in paragraph (1) and inserting in lieu thereof "or, if he became entitled to such benefits before he attained age 60, the third month".

(b)(1) The last sentence of section 203(c) of such Act (as amended by section 103(c)(1) of this Act) is further amended by striking out "age 62" and inserting in lieu thereof "age 60".

(2) Clause (D) of section 203(f)(1) of such Act (as

amended by section 103(c)(2) of this Act) is further amended by striking out "age 62" and inserting in lieu thereof "age 60".

(3) Section 222(b)(1) of such Act is amended by striking out "a widow or surviving divorced wife who has not attained age 60, a widower who has not attained age 62" and inserting in lieu thereof "a widow, widower or surviving divorced wife who has not attained age 60".

(4) Section 222(d)(1)(D) of such Act is amended by striking out "age 62" each place it appears and inserting in lieu thereof "age 60".

(5) Section 225 of such Act is amended by striking out "age 62" and inserting in lieu thereof "age 60".

(c) The amendments made by this section shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970, except that in the case of an individual who was not entitled to a monthly benefit under title II of such Act for December 1970 such amendments shall apply only on the basis of an application filed in or after the month in which this Act is enacted.

ENTITLEMENT TO CHILD'S INSURANCE BENEFITS BASED ON DISABILITY WHICH BEGAN BETWEEN 18 AND 22

SEC. 109. (a) Clause (ii) of section 202(d)(1)(B) of the Social Security Act is amended by striking out "which began before he attained the age of eighteen" and inserting

in lieu thereof "which began before he attained the age of 22".

(b) Subparagraphs (F) and (G) of section 202(d)(1) of such Act are amended to read as follows:

"(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; 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, 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."

(c) Section 202 (d) (1) of such Act is further amended by adding at the end thereof the following new sentence: "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."

(d) Section 202 (d) (6) of such Act is amended by striking out "in which he is a full-time student and has not attained the age of 22" and all that follows and inserting in lieu thereof "in which he—

"(A) (i) is a full-time student or (ii) is under a disability (as defined in section 223 (d)), and

"(B) had not attained the age of 22, 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."

(e) Section 202 (s) of such Act is amended—

(1) by striking out "which began before he attained such age" in paragraph (1); and

(2) by striking out "which began before such child attained the age of 18" in paragraphs (2) and (3).

(f) Where—

(1) one or more persons are entitled (without the application of sections 202 (j) (1) and 223 (b) of the Social Security Act) to monthly benefits under section 202 or 223 of such Act for December 1970 on the basis of the wages and self-employment income of an individual, and

(2) one or more persons (not included in paragraph (1)) are entitled to monthly benefits under such section 202 or 223 for January 1971 solely by reason of the amendments made by this section on the basis of such wages and self-employment income, and

(3) the total of benefits to which all persons are entitled under such section 202 or 223 on the basis of

such wages and self-employment income for January 1971 is reduced by reason of section 203 (a) of such Act as amended by this Act (or would, but for the penultimate sentence of such section 203 (a), be so reduced),

then the amount of the benefit to which each person referred to in paragraph (1) of this subsection is entitled for months after December 1970 shall be adjusted, after the application of such section 203 (a), to an amount no less than the amount it would have been if the person or persons referred to in paragraph (2) were not entitled to a benefit referred to in such paragraph (2).

(g) The amendments made by this section shall apply only with respect to monthly benefits under section 202 of the Social Security Act for months after December 1970, except that in the case of an individual who was not entitled to a monthly benefit under such section 202 for December 1970 such amendments shall apply only on the basis of an application filed after September 30, 1970.

ELIMINATION OF SUPPORT REQUIREMENT AS CONDITION OF BENEFITS FOR DIVORCED AND SURVIVING DIVORCED WIVES

SEC. 110. (a) Section 202 (b) (1) of the Social Security Act is amended—

(1) by adding "and" at the end of subparagraph (C),

(2) by striking out subparagraph (D), and

(3) by redesignating subparagraphs (E) through (L) as subparagraphs (D) through (K), respectively.

(b) (1) Section 202 (e) (1) of such Act is amended—

(A) by adding "and" at the end of subparagraph (C),

(B) by striking out subparagraph (D), and

(C) by redesignating subparagraphs (E) through (G) as subparagraphs (D) through (F), respectively.

(2) Section 202 (e) (6) of such Act is amended by striking out "paragraph (1) (G)" and inserting in lieu thereof "paragraph (1) (F)".

(c) Section 202 (g) (1) (F) of such Act is amended by striking out clause (i), and by redesignating clauses (ii) and (iii) as clauses (i) and (ii), respectively.

(d) The amendments made by this section shall apply only with respect to benefits payable under title II of the Social Security Act for months after December 1970 on the basis of applications filed on or after the date of the enactment of this Act.

ELIMINATION OF DISABILITY INSURED-STATUS REQUIREMENT OF SUBSTANTIAL RECENT COVERED WORK IN CASES OF INDIVIDUALS WHO ARE BLIND

SEC. 111. (a) The first sentence of section 216 (i) (3) of the Social Security Act is amended by inserting before the period at the end thereof the following: ", and 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))".

(b) Section 223 (c) (1) of such Act is amended by striking out "coverage." in subparagraph (B) (ii) and inserting in lieu thereof "coverage;", and by striking out "For purposes" and inserting in lieu thereof the following:

"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 section 216 (i) (1)). For purposes"

(c) The amendments made by this section shall be 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 in which this Act is enacted, or

(2) before the month in which this Act is enacted if the applicant has not died before such month and if—

(A) notice of the final decision of the Secretary of Health, Education, and Welfare has not been given to the applicant before such month; or

(B) the notice referred to in subparagraph (A) has been so given before such month 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 such month) and the decision in such civil action has not become final before such month;

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 months before January 1971.

WAGE CREDITS FOR MEMBERS OF THE UNIFORMED SERVICES

SEC. 112. (a) Subsection 229(a) of the Social Security Act is amended—

(1) by striking out "after December 1967" and inserting in lieu thereof "after December 1970"; and

(2) by striking out "after 1967" and inserting in lieu thereof "after 1956".

(b) The amendments made by subsection (a) shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970 and with respect to lump-sum death payments under such title in the case of deaths occurring after December 1970, except that, in the case of any individual who is entitled, on the basis of the wages and self-employment income of any individual to whom section 229 of such Act applies, to monthly benefits under title II of such Act for December 1970, such amendments shall apply (1) only if an application for recomputation by reason of such amendments 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 1971 or the twelfth month before the month in which such application was filed. Recomputations of benefits as required to carry out the provisions of this paragraph shall be made notwithstanding the provisions of section 215 (f) (1) of the Social Security Act, and no such recomputation shall

be regarded as a recomputation for purposes of section 215 (f) of such Act.

APPLICATIONS FOR DISABILITY INSURANCE BENEFITS FILED AFTER DEATH OF INSURED INDIVIDUAL

SEC. 113. (a) (1) Section 223 (a) (1) of the Social Security Act is amended by adding at the end thereof the following new sentence: "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."

(2) Section 223 (a) (2) of such Act is amended by striking out "he filed his application for disability insurance benefits and was" and inserting in lieu thereof "the application for disability insurance benefits was filed and he was".

(3) The third sentence of section 223 (b) of such Act is amended by striking out "if he files such application" and inserting in lieu thereof "if such application is filed".

(4) Section 223 (c) (2) (A) of such Act is amended by striking out "who files such application" and inserting in lieu thereof "with respect to whom such application is filed".

(b) Section 216 (i) (2) (B) of such Act is amended by adding at the end thereof the following new sentence: "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 re-

spect to such individual within 3 months after the month in which he died."

(c) The amendments made by this section shall apply in the case of deaths occurring in and after the year in which this Act is enacted. For purposes of such amendments (and for purposes of sections 202 (j) (1) and 223 (b) of the Social Security Act), any application with respect to an individual whose death occurred in such year but before the date of the enactment of this Act which is filed within 3 months after the date of the enactment of this Act shall be deemed to have been filed in the month in which such death occurred).

WORKMEN'S COMPENSATION OFFSET FOR DISABILITY INSURANCE BENEFICIARIES

SEC. 114. (a) Section 224 (a) (5) of the Social Security Act is amended by striking out "80 per centum of".

(b) The amendment made by subsection (a) shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970.

COVERAGE OF FEDERAL HOME LOAN BANK EMPLOYEES

SEC. 115. (a) The provisions of section 210 (a) (6) (B) (ii) of the Social Security Act and section 3121 (b) (6) (B) (ii) of the Internal Revenue Code of 1954, insofar as they relate to service performed in the employ of a Federal Home Loan Bank, shall be effective—

(1) with respect to all service performed in the

employ of a Federal Home Loan Bank after December 1970; and

(2) in the case of individuals who are in the employ of a Federal Home Loan Bank on January 1, 1971, with respect to any service performed in the employ of a Federal Home Loan Bank after December 1965; but this paragraph shall be effective only if an amount equal to the taxes imposed by sections 3101 and 3111 of such Code with respect to the services of all such individuals performed in the employ of Federal Home Loan Banks after December 1965 are paid under the provisions of section 3122 of such Code by July 1, 1971, or by such later date as may be provided in an agreement entered into before such date with the Secretary of the Treasury or his delegate for purposes of this paragraph.

(b) Subparagraphs (A) (i) and (B) of section 104 (i) (2) of the Social Security Amendments of 1956 are repealed.

POLICEMEN AND FIREMEN IN IDAHO

SEC. 116. Section 218 (p) (1) of the Social Security Act is amended by inserting "Idaho," after "Hawaii,".

COVERAGE OF CERTAIN HOSPITAL EMPLOYEES IN NEW MEXICO

SEC. 117. Notwithstanding any provisions of section 218 of the Social Security Act, the agreement with the State of

New Mexico heretofore entered into pursuant to such section may at the option of such State be modified at any time prior to January 1, 1971, so as to apply to the services of employees of a hospital which is an integral part of a political subdivision to which an agreement under this section has not been made applicable, as a separate coverage group within the meaning of section 218 (b) (5) of such Act, but only if such hospital has prior to 1966 withdrawn from a retirement system which had been applicable to the employees of such hospital.

PENALTY FOR FURNISHING FALSE INFORMATION TO OBTAIN SOCIAL SECURITY ACCOUNT NUMBER

SEC. 118. (a) Section 208 of the Social Security Act is amended by adding "or" after the semicolon at the end of subsection (e), and by inserting after subsection (e) the following new subsection:

"(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);".

(b) The amendments made by subsection (a) shall

apply with respect to information furnished to the Secretary after the date of the enactment of this Act.

GUARANTEE OF NO DECREASE IN TOTAL FAMILY BENEFITS

SEC. 119. (a) Section 203 (a) of the Social Security Act (as amended by section 101 (b) of this Act) is amended by striking out "or" at the end of paragraph (2), by striking out the period at the end of paragraph (3), and inserting in lieu therof ", or", and by inserting after paragraph (3) the following new paragraph:

"(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 determin-

ing the total of monthly benefits for all persons on the basis of such wages and self-employment income for months subsequent to such particular month 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 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."

(b) In any case in which the provisions of section 1002 (b) (2) of the Social Security Amendments of 1969 apply, the total of monthly benefits as determined under section 203 (a) of the Social Security Act shall, for months after 1970, be increased to the amount that would be required in order to assure that the total of such monthly benefits (after the application of section 202 (q) of such Act) will not be less than the total of monthly benefits that was applicable (after the application of such sections 203 (a) and 202 (q)) for the first month for which the provisions of such section 1002 (b) (2) applied.

INCREASE OF EARNINGS COUNTED FOR BENEFIT AND TAX PURPOSES

SEC. 120. (a) (1) (A) Section 209 (a) (5) of the Social Security Act is amended by inserting "and prior to 1971" after "1967".

(B) Section 209 (a) of such Act is further amended by adding at the end thereof the following new paragraph:

"(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 1970, is paid to such individual during any such calendar year;".

(2) (A) Section 211 (b) (1) (E) of such Act is amended by inserting "and beginning prior to 1971" after "1967", and by striking out "; or" and inserting in lieu thereof "; and".

(B) Section 211 (b) (1) of such Act is further amended by adding at the end thereof the following new subparagraph:

"(F) For any taxable year beginning after 1970, (i) $9,000, minus (ii) the amount of the wages paid to such individual during the taxable year; or".

(3) (A) Section 213 (a) (2) (ii) of such Act is

amended by striking out "after 1967" and inserting in lieu thereof "after 1967 and before 1971, or $9,000 in the case of a calendar year after 1970".

(B) Section 213(a)(2)(iii) of such Act is amended by striking out "after 1967" and inserting in lieu thereof "after 1967 and beginning before 1971, or $9,000 in the case of a taxable year beginning after 1970".

(4) Section 215(e)(1) of such Act is amended by striking out "and the excess over $7,800 in the case of any calendar year after 1967" and inserting in lieu thereof "the excess over $7,800 in the case of any calendar year after 1967 and before 1971, and the excess over $9,000 in the case of any calendar year after 1970".

(b)(1)(A) Section 1402(b)(1)(E) of the Internal Revenue Code of 1954 (relating to definition of self-employment income) is amended by inserting "and beginning before 1971" after "1967", and by striking out "; or" and inserting in lieu thereof "; and".

(B) Section 1402(b)(1) of such Code is further amended by adding at the end thereof the following new subparagraph:

"(F) for any taxable year beginning after 1970, (i) $9,000, minus (ii) the amount of the wages paid to such individual during the taxable year; or".

(2) Section 3121 (a) (1) of such Code (relating to definition of wages) is amended by striking out "$7,800" each place it appears and inserting in lieu thereof "$9,000".

(3) The second sentence of section 3122 of such Code (relating to Federal service) is amended by striking out "$7,800" and inserting in lieu thereof "$9,000".

(4) Section 3125 of such Code (relating to returns in the case of governmental employees in Guam, American Samoa, and the District of Columbia) is amended by striking out "$7,800" where it appears in subsections (a), (b), and (c) and inserting in lieu thereof "$9,000".

(5) Section 6413 (c) (1) of such Code (relating to special refunds of employment taxes) is amended—

(A) by inserting "and prior to the calendar year 1971" after "after the calendar year 1967";

(B) by inserting after "exceed $7,800," the following: "or (E) during any calendar year after the calendar year 1970, the wages received by him during such year exceed $9,000,"; and

(C) by inserting before the period at the end thereof the following: "and before 1971, or which exceeds the tax with respect to the first $9,000 of such wages received in such calendar year after 1970".

(6) Section 6413 (c) (2) (A) of such Code (relating to refunds of employment taxes in the case of Federal em-

ployees) is amended by striking out "or $7,800 for any calendar year after 1967" and inserting in lieu thereof "$7,800 for the calendar year 1968, 1969, or 1970, or $9,000 for any calendar year after 1970".

(7) Section 6654(d)(2)(B)(ii) of such Code (relating to failure by individual to pay estimated income tax) is amended by striking out "$6,600" and inserting in lieu thereof "$9,000".

(c) The amendments made by subsections (a)(1) and (a)(3)(A), and the amendments made by subsection (b) (except paragraphs (1) and (7) thereof), shall apply only with respect to remuneration paid after December 1970. The amendments made by subsections (a)(2), (a)(3)(B), (b)(1), and (b)(7) shall apply only with respect to taxable years beginning after 1970. The amendment made by subsection (a)(4) shall apply only with respect to calendar years after 1970.

CHANGES IN TAX SCHEDULES

SEC. 121. (a)(1) Section 1401(a) of the Internal Revenue Code of 1954 (relating to rate of tax on self-employment income for purposes of old-age, survivors, and disability insurance) is amended by striking out paragraphs (2), (3), and (4) and inserting in lieu thereof the following:

"(2) in the case of any taxable year beginning after December 31, 1968, and before January 1, 1975, the tax shall be equal to 6.3 percent of the amount of the self-employment income for such taxable year; and

"(3) in the case of any taxable year beginning after December 31, 1974, the tax shall be equal to 7.0 percent of the amount of the self-employment income for such taxable year."

(2) Section 3101 (a) of such Code (relating to rate of tax on employees for purposes of old-age, survivors, and disability insurance) is amended by striking out paragraphs (2), (3), and (4) and inserting in lieu thereof the following:

"(2) with respect to wages received during the calendar years 1969, 1970, 1971, 1972, 1973, and 1974, the rate shall be 4.2 percent;

"(3) with respect to wages received during the calendar years 1975, 1976, 1977, 1978, and 1979, the rate shall be 5.0 percent; and

"(4) with respect to wages received after December 31, 1979, the rate shall be 5.5 percent."

(3) Section 3111 (a) of such Code (relating to rate of tax on employers for purposes of old-age, survivors, and disability insurance) is amended by striking out paragraphs (2), (3), and (4) and inserting in lieu thereof the following:

"(2) with respect to wages paid during the calendar years 1969, 1970, 1971, 1972, 1973, and 1974, the rate shall be 4.2 percent;

"(3) with respect to wages paid during the calendar years 1975, 1976, 1977, 1978, and 1979, the rate shall be 5.0 percent; and

"(4) with respect to wages paid after December 31, 1979, the rate shall be 5.5 percent."

(b) (1) Section 1401 (b) of such Code (relating to rate of tax on self-employment income for purposes of hospital insurance) is amended by striking out paragraphs (1) through (5) and inserting in lieu thereof the following:

"(1) in the case of any taxable year beginning after December 31, 1967, and before January 1, 1971, the tax shall be equal to 0.6 percent of the amount of the self-employment income for such taxable year; and

"(2) in the case of any taxable year beginning after December 31, 1970, the tax shall be equal to 1.0 percent of the amount of the self-employment income for such taxable year."

(2) Section 3101 (b) of such Code (relating to rate of tax on employees for purposes of hospital insurance) is

amended by striking out paragraphs (1) through (5) and inserting in lieu thereof the following:

"(1) with respect to wages received during the calendar years 1968, 1969, and 1970, the rate shall be 0.6 percent; and

"(2) with respect to wages received after December 31, 1970, the rate shall be 1.0 percent."

(3) Section 3111(b) of such Code (relating to rate of tax on employers for purposes of hospital insurance) is amended by striking out paragraphs (1) through (5) and inserting in lieu thereof the following:

"(1) with respect to wages paid during the calendar years 1968, 1969, and 1970, the rate shall be 0.6 percent; and

"(2) with respect to wages paid after December 31, 1970, the rate shall be 1.0 percent."

(c) The amendments made by subsections (a) (1) and (b) (1) shall apply only with respect to taxable years beginning after December 31, 1970. The remaining amendments made by this section shall apply only with respect to remuneration paid after December 31, 1970.

ALLOCATION TO DISABILITY INSURANCE TRUST FUND

SEC. 122. (a) Section 201(b)(1) of the Social Security Act is amended—

(1) by striking out "and (D)" and inserting in lieu thereof "(D)"; and

(2) by striking out "after December 31, 1969, and so reported," and inserting in lieu thereof the following: "after December 31, 1969, and before January 1, 1971, and so reported, (E) 0.90 of 1 per centum of the wages (as so defined) paid after December 31, 1970, and before January 1, 1975, and so reported, (F) 1.05 per centum of the wages (as so defined) paid after December 31, 1974, and before January 1, 1980, and so reported, and (G) 1.15 per centum of the wages (as so defined) paid after December 31, 1979, and so reported,".

(b) Section 201(b)(2) of such Act is amended—

(1) by striking out "and (D)" and inserting in lieu thereof "(D)"; and

(2) by inserting after "December 31, 1969," the following: "and before January 1, 1971, (E) 0.675 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1970, and before January 1,

1975, (F) 0.7875 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1974, and before January 1, 1980, and (G) 0.8625 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1979,".

TITLE II—PROVISIONS RELATING TO MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH

PART A—COVERAGE UNDER MEDICARE PROGRAM

PAYMENT UNDER MEDICARE PROGRAM TO INDIVIDUALS COVERED BY FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

SEC. 201. Section 1862 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(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, 1972, 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 the Federal employees health benefits pro-

gram 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 upon or after attaining age 65, in addition to the health benefits plans available before he attains such age, one or more health benefits plans which offer protection supplementing the combined protection provided under parts A and B of this title and one or more health benefits plans which offer protection supplementing the protection provided under part B of this title alone, and

"(2) the Government 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 coverage under parts A and B (or part B alone) of this title, or (C) a combination of such contribution and such payment."

HOSPITAL INSURANCE BENEFITS FOR UNINSURED INDIVIDUALS NOT ELIGIBLE UNDER PRESENT TRANSITIONAL PROVISION

SEC. 202. (a) Section 103 (a) of the Social Security Amendments of 1965 is amended—

(1) by redesignating clauses (A) and (B) in paragraphs (2) and (4) as clauses (i) and (ii), respectively, and by redesignating paragraphs (1), (2), (3), (4), and (5) as subparagraphs (A), (B), (C), (D), and (E), respectively;

(2) by striking out all that follows "Anyone who—" and precedes subparagraph (B) (as redesignated by paragraph (1) of this subsection) and inserting in lieu thereof the following:

"(1) (A) has attained the age of 65,";

(3) by adding "or" at the end of subparagraph (E) (as so redesignated);

(4) by striking out "shall (subject to the limitations in this section)" and all that follows down through the period at the end of the first sentence and inserting in lieu thereof the following:

"(2) (A) meets the provisions of subparagraphs (A), (C), and (D) of paragraph (1),

"(B) does not meet the provisions of subparagraph (B) of paragraph (1), and

"(C) has enrolled (i) under section 1837 of the Social Security Act and (ii) under subsection (d) of this section,

shall (subject to the limitations in this section) be deemed, solely for purposes of section 226 of the Social Security Act, to be entitled to monthly insurance benefits under such section 202 for each month, beginning—

"(i) in the case of an individual who meets the provisions of paragraph (1), with the first month in which he meets the requirements of such paragraph, or

"(ii) in the case of an individual who meets the provisions of paragraph (2), with the day on which his coverage period (as provided in subsection (d)) begins,

and ending with the month in which he dies, or, if earlier, the month before the month in which he becomes (or upon filing application for monthly insurance benefits under section 202 of such Act would become) entitled to hospital insurance benefits under section 226 or becomes certifiable as a qualified railroad retirement beneficiary.";

(5) (A) by striking out "the preceding requirements of this subsection" in the second sentence and inserting in lieu thereof "the requirements of paragraph (1) of this subsection" and (B) by striking out "para-

graph (5) hereof" and inserting in lieu thereof "subparagraph (E) of such paragraph"; and

(6) by striking out "paragraphs (1), (2), (3), and (4)" in the third sentence and inserting in lieu thereof "subparagraphs (A), (B), (C), and (D) of paragraph (1)".

(b) Section 103(b) of such Amendments is amended (1) by inserting "(i)" after "individual" in the second sentence, and (2) by adding before the period at the end thereof the following: ", or (ii) (with respect to an enrollment under subsection (d)(1)) for any month during his coverage period (as provided in subsection (d))".

(c) Section 103(c)(1) of such Amendments is amended by striking out "this section" and inserting in lieu thereof "paragraph (1) of subsection (a) of this section".

(d) Section 103 of such Amendments is further amended by adding at the end thereof the following new subsections:

"(d)(1) An individual who meets the conditions of subparagraphs (A) and (B) of paragraph (2) of subsection (a) and has enrolled under section 1837 of the Social Security Act may enroll for the hospital insurance benefits provided under subsection (a).

"(2) The provisions of sections 1837, 1838, 1839, and 1840 (relating to enrollments under part B of title XVIII

of the Social Security Act) shall be applicable to the enrollment authorized by paragraph (1) in the same manner, to the same extent, and under the same conditions as such sections are applicable to enrollments under such part B, except that for purposes of this subsection such sections 1837, 1838, 1839, and 1840 are modified as follows:

"(A) the term 'paragraphs (1) and (2) of section 1836' shall be considered to read 'subparagraphs (A) and (B) of paragraph (2) of section 103 (a) of the Social Security Amendments of 1965';

"(B) the term 'March 1, 1966' shall be considered to read 'March 31, 1971';

"(C) the term 'May 31, 1966' shall be considered to read 'March 31, 1971';

"(D) the term '1969' shall be considered to read '1972';

"(E) subsection (a) (1) of such section 1838 shall be considered to read as follows:

"'(1) in the case of an individual who enrolls for benefits under subsection (a) of section 103 of the Social Security Amendments of 1965 pursuant to subsection (c) of section 1837 (as made applicable by section 103 (d) (2) of such Amendments), January 1, 1971, or, if later, the first day of the month following the month in which he so enrolls; or';

"(F) subsection (b) of such section 1838 shall be considered amended by adding at the end thereof the following new sentence: 'An individual's enrollment under subsection (d) of section 103 of the Social Security Amendments of 1965 shall also terminate (i) when he satisfies subparagraghs (B) and (E) of paragraph (1) of subsection (a) of such section, with such termination taking effect on the first day of the month in which he satisfies such subparagraphs, or (ii) when his enrollment under section 1837 terminates, with such termination taking effect as provided in the second sentence of this subsection.';

"(G) subsection (a) of such section 1839 shall be considered to read as follows:

"'(a) The monthly premium of each individual for each month in his coverage period before July 1972 shall be $27.';

"(H) the term '1967' when used in subsection (b) (1) of such section 1839 shall be considered to read 'June 1972';

"(I) subsection (b) (2) of such section 1839 shall be considered to read as follows:

"'(2) The Secretary shall, during December of 1971

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 for months occurring in the 12-month period commencing July 1 of the next year. Such amount shall be equal to $27 multiplied by the ratio of (1) the inpatient hospital deductible for such next year, as promulgated under section 1813(b)(2), to (2) such deductible promulgated for 1971. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1.'; and

"(J) the term 'Federal Supplementary Medical Insurance Trust Fund' shall be considered to read 'Federal Hospital Insurance Trust Fund'.

"(e) Payment of the monthly premiums on behalf of any individual who meets the conditions of subparagraphs (A) and (B) of paragraph (2) of subsection (a) and has enrolled for the hospital insurance benefits provided under 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."

PART B—IMPROVEMENTS IN THE OPERATING EFFECTIVENESS OF THE MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS

LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

SEC. 221. (a) Title XI of the Social Security Act is amended by adding at the end thereof the following new section:

"LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

"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 health care facilities 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 body 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 in such State within the field of its responsibilities, and

"(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 in such State within the fields of their respective responsibilities, 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 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 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), 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 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;

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.

"(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 would not be consistent with the effective organization and delivery of health services or the effective administration 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 follow-

ing 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, the Medical Assistance 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 ad-

visory 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."

(b) The amendment made by subsection (a) shall apply only with respect to a capital expenditure the obligation for which is incurred by or on behalf of a health care facility subsequent to whichever of the following is earlier: (A) June 30, 1971, 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.

(c) (1) Section 505 (a) (6) of such Act (as amended by section 229 (b) of this Act) is further amended by inserting ", consistent with section 1122," after "standards" where it first appears.

(2) Section 506 of such Act (as amended by sections

224(c), 227(d), 230(d), and 235(b) of this Act) is further amended by adding at the end thereof the following new subsection:

"(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."

(3) Clause (2) of the second sentence of section 509(a) of such Act is amended by inserting ", consistent with section 1122," after "standards"

(4) Section 1861(v) of such Act is amended by adding at the end thereof the following new paragraph:

"(5) 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."

(5) Section 1902(a)(13)(D) of such Act (as amended by section 229(a) of this Act) is further amended by inserting ", consistent with section 1122," after "standards" where it first appears.

(6) Section 1903(b) of such Act is amended by adding at the end thereof the following new paragraph:

"(3) 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."

REPORT ON PLAN FOR PROSPECTIVE REIMBURSEMENT; EXPERIMENTS AND DEMONSTRATION PROJECTS TO DEVELOP INCENTIVES FOR ECONOMY IN THE PROVISION OF HEALTH SERVICES

SEC. 222. (a) (1) The Secretary of Health, Education, and Welfare, directly or through contracts with public or private agencies or organizations, shall develop and carry out experiments and demonstration projects designed to determine the relative advantages and disadvantages of various alternative methods of making payment on a prospective basis to hospitals, extended care facilities, and other providers of services for care and services provided by them under title XVIII of the Social Security Act and under State plans approved under titles XIX and V of such Act, including alternative methods for classifying providers, for establishing prospective rates of payment, and for implementing on a gradual, selective, or other basis the establishment of a prospective payment system, in order to stimulate such providers through positive financial incentives to use their facilities and personnel more efficiently and thereby to reduce the total costs of the health programs involved without adversely affecting the quality of services by containing or lowering the rate of increase in provider costs that has been and is being experienced under the existing system of retroactive cost reimbursement.

(2) The experiments and demonstration projects developed under paragraph (1) shall be of sufficient scope and shall be carried out on a wide enough scale to permit a thorough evaluation of the alternative methods of prospective payment under consideration while giving assurance that the results derived from the experiments and projects will obtain generally in the operation of the programs involved (without committing such programs to the adoption of any prospective payment system either locally or nationally).

(3) In the case of any experiment or demonstration project under paragraph (1), 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 methods of payment for services provided; and costs incurred in such experiment or project in excess of those which would otherwise be reimbursed or paid under such titles may be reimbursed or paid to the extent that such waiver applies to them (with such excess being borne by the Secretary). No experiment or demonstration project shall be developed or carried out under paragraph (1) until the Secretary obtains the advice and recommendations of specialists who are competent to evaluate the proposed experiment or project as to the soundness of its objectives, the possibilities of securing productive results, the adequacy of resources to conduct it, and its relationship to other similar experiments or projects

already completed or in process; and no such experiment or project shall be actually placed in operation until a written report containing a full and complete description thereof has been transmitted to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate.

(4) Grants, payments under contracts, and other expenditures made for experiments and demonstration projects under this subsection shall be made 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). 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 subsection. With respect to any such grant, payment, or other expenditure, the amount to be paid from each of such trust funds shall be determined by the Secretary, giving due regard to the purposes of the experiment or project involved.

(5) The Secretary shall submit to the Congress no later than July 1, 1972, a full report on the experiments and demonstration projects carried out under this subsection and on the experience of other programs with respect to pros-

pective reimbursement together with any related data and materials which he may consider appropriate. Such report shall include detailed recommendations with respect to the specific methods which could be used in the full implementation of a system of prospective payment to providers of services under the programs involved.

(6) Section 1875(b) of the Social Security Act is amended by inserting "and the experiments and demonstration projects authorized by section 222(a) of the Social Security Amendments of 1970" after "1967".

(b) (1) Section 402(a) of the Social Security Amendments of 1967 is amended to read as follows:

"(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 1970) 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 to organizations and institutions which have the capability of providing comprehensive health care services or 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 programs;

"(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; and

"(E) to determine whether utilization review and medical review mechanisms established on an areawide or communitywide basis would have the effect of providing more effective controls under such programs over excessive utilization of services.

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 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). 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 shall be determined by the Secretary, giving due regard to the purposes of the experiment or project involved."

(2) Section 402 (b) of such Amendments is amended—

(A) by striking out "experiment" each time it appears and inserting in lieu thereof "experiment or demonstration project";

(B) by striking out "experiments" and inserting in lieu thereof "experiments and projects";

(C) by striking out "reasonable charge" and inserting in lieu thereof "reasonable charge, or to reimbursement or payment only for such services or items as may be specified in the experiment"; and

(D) by inserting before the period at the end thereof the following: "; and no such experiment or project shall be actually placed in operation until a written report containing a full and complete description thereof has been transmitted to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate".

(3) Section 1875 (b) of the Social Security Act is

amended by striking out "experimentation" and inserting in lieu thereof "experiments and demonstration projects".

LIMITATIONS ON COVERAGE OF COSTS UNDER MEDICARE PROGRAM

SEC. 223. (a) The first sentence of section 1861 (v) (1) of the Social Security Act is amended by inserting immediately before "determined" where it first appears the following: "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".

(b) The third sentence of section 1861 (v) (1) of such Act is amended by striking out the comma after "services" where it last appears and inserting in lieu thereof the following: ", 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,".

(c) The fourth sentence of section 1861 (v) (1) of such Act is amended by inserting after "services" where it first appears the following: " (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)".

(d) The fourth sentence of section 1861 (v) (1) of such Act is further amended by striking out "costs with respect" where they first appear and inserting in lieu thereof the following: "necessary costs of efficiently delivering covered services".

(e) Section 1866 (a) (2) (B) of such Act is amended (1) by inserting "(i)" after "(B)", and (2) by adding at the end thereof the following new clause:

"(ii) Where a provider of services customarily furnishes an individual items or services which are 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 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 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 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 in excess of the cost determined to be necessary in the efficient delivery of needed health services under this title."

(f) Section 1861(v) of such Act (as amended by section 221(c)(4) of this Act) is further amended by redesignating paragraphs (4) and (5) as paragraphs (5) and (6), respectively, and by inserting after paragraph (3) the following new paragraph:

"(4) If a provider of services furnishes items or services to an individual which are 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 re-

duced 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."

(g) Section 1866(a)(2) of such Act is amended by adding at the end thereof the following new subparagraph:

"(D) Where a provider of services customarily furnishes 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, 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."

(h) The amendments made by this section shall be effective with respect to accounting periods beginning after the date of the enactment of this Act.

LIMITS ON PREVAILING CHARGE LEVELS

SEC. 224. (a) Section 1842(b)(3) of the Social Security Act is amended by adding at the end thereof the following new sentences: "No charge may be determined to be reason-

able under this part for services rendered after June 30, 1970, and before July 1, 1971, if it exceeds the higher of (i) the prevailing charge recognized by the carrier for similar services in the same locality in administering this part on June 30, 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 calendar year 1969. With respect to services rendered after June 30, 1971, the charges recognized as prevailing within a locality may be increased in any fiscal year only to the extent found necessary, on the basis of statistical data and methodology acceptable to the Secretary, to cover 75 percent of the customary charges made for similar services in the same locality during the last preceding elapsed calendar year but may not be increased (in the aggregate) beyond the levels described in clause (ii) of the preceding sentence except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such adjustments are justified by economic changes. In the case of medical services, supplies, and equipment that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after June 30, 1970, determined to be reasonable may exceed the lowest charge levels at which such services, supplies, and equipment

are widely available in a locality only to the extent and under the circumstances specified by the Secretary."

(b) Section 1903 of such Act is amended by adding at the end thereof the following new subsection:

"(g) Payment under the preceding provisions of this section shall not be made with respect to any amount paid for items or services furnished under the plan after June 30, 1970, 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)."

(c) Section 506 of such Act is amended by adding at the end thereof the following new subsection:

"(f) Notwithstanding the preceding provisions of this section, no payment shall be made to any State thereunder with respect to any amount paid for items or services furnished under the plan after June 30, 1970, 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)."

ESTABLISHMENT OF INCENTIVES FOR STATES TO EMPHASIZE OUTPATIENT CARE UNDER MEDICAID PROGRAMS

SEC. 225. (a) (1) Section 1903 of the Social Security Act (as amended by section 228 of this Act) is further

amended by inserting after subsection (d) the following new subsection:

"(e) The amount determined under subsection (a)(1) for any State shall be adjusted as follows:

"(1) With respect to the following services furnished under the State plan after January 1, 1971, the Federal medical assistance percentage shall be increased by 25 per centum thereof, except that the Federal medical assistance percentage as so increased may not exceed 95 per centum:

"(A) outpatient hospital services and clinic services (other than physical therapy services); and

"(B) home health care services (other than physical therapy services); and

"(2) with respect to the following services furnished under the State plan after January 1, 1971, the Federal medical assistance percentage shall be decreased as follows:

"(A) after an individual has received inpatient hospital services (including services furnished in an institution for tuberculosis) on sixty 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 any such services furnished thereafter to such individual in the same fiscal year shall be decreased by 33⅓ per centum thereof;

"(B) after an individual has received care as an inpatient in a skilled nursing home on ninety days (whether or not such days are consecutive) during any fiscal year, the Federal medical assistance percentage with respect to any such care furnished thereafter to such individual in the same fiscal year shall be decreased by 33⅓ per centum thereof; and

"(C) after an individual has received inpatient services in a hospital for mental diseases on ninety days occurring after December 31, 1970 (whether or not such days are consecutive), the Federal medical assistance percentage with respect to any such services furnished to such individual on an additional two hundred and seventy-five days (whether or not such days are consecutive) shall be decreased by 33⅓ per centum thereof and no payment may be made under this title for any such services furnished to such individual on any day after such two hundred and seventy-five days.

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) Section 1903 (a) (1) of such Act is amended by inserting ", subject to subsection (e) of this section" after "section 1905 (b)".

(b) (1) Section 1121 of such Act is amended by adding at the end thereof the following new subsection:

"(f) (1) If the Secretary determines for any calendar quarter beginning after December 31, 1970, with respect to any State that there does not exist a reasonable cost differential between the cost of skilled nursing home services and the cost of intermediate care facility services in such State, the Secretary may reduce the amount which would otherwise be considered as expenditures for which payment may be made under subsection (c) 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 cost of skilled nursing home services and the 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."

(2) Section 1121 (e) of such Act is amended by adding at the end thereof the following new sentence: "Effective July 1, 1970, the term 'intermediate care facility' shall not include any public institution (or distinct part thereof) for mental diseases or mental defects."

PAYMENT FOR SERVICES OF TEACHING PHYSICIANS UNDER MEDICARE PROGRAM

SEC. 226. (a) (1) Section 1833 (a) (1) of the Social Security Act is amended by striking out "and" before "(B)", and by inserting before the semicolon at the end thereof the following: ", and (C) with respect to expenses incurred for services which are furnished to a patient of a hospital by a physician and for which payment may be made under this part, the amounts paid shall be equal to 100 percent of the

reasonable cost, to the hospital or other medical service organization incurring such cost, of such services if (i) (I) such services are furnished under circumstances comparable to the circumstances under which similar services are furnished to all persons, or all members of a class of persons, who are patients in such hospital and who are not covered by the insurance program established by this part (and not covered under a State plan approved under title XIX), and (II) none of such persons, or members of such class of persons, are required to pay the reasonable charges for such similar services even when they have private insurance covering such similar services (or are otherwise able to pay reasonable charges for all such similar services as determined in accordance with regulations), or (ii) (I) none of the patients in such hospital who are covered by such program are required to pay any charges for services furnished by physicians, or (II) they are required to pay reasonable charges for such services but payment of the deductible and coinsurance applicable to such services is not generally obtained from them or on their behalf in addition to the portion of such charges payable as insurance benefits under this part".

(2) The first sentence of section 1833(b) of such Act is amended by striking out "and" before "(2)", and by inserting before the period at the end thereof the following: ", and (3) such total amount shall not include expenses in-

curred for services to which clause (C) of subsection (a) (1) applies."

(b) Section 1861 (v) (1) of such Act is amended—

(1) by inserting "(A)" after "(1)";

(2) by striking out "(A) take" and "(B) provide" and inserting in lieu thereof "(i) take" and "(ii) provide", respectively.

(3) by inserting "(B)" immediately preceding "Such regulations in the case of extended care services"; and

(4) by adding at the end thereof the following new subparagraph:

"(C) Where a hospital has an arrangement with a medical school under which the faculty of such school provides services at such hospital and under which reimbursement to such school by such hospital is less than the reasonable cost of such services to the medical school, the reasonable cost of such services to the medical school shall be included in determining the reasonable cost to the hospital of furnishing services 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 if such services were furnished by the hospital, and

"(ii) such hospital pays to the medical school the reasonable cost of such services to the medical school."

(c) (1) The amendments made by subsection (a) shall apply with respect to bills submitted and requests for payment made after the date of the enactment of this Act.

(2) The amendments made by subsection (b) shall be effective with respect to accounting periods beginning after the date of the enactment of this Act.

AUTHORITY OF SECRETARY TO TERMINATE PAYMENTS TO SUPPLIERS OF SERVICES

SEC. 227. (a) Section 1862 of the Social Security Act (as amended by section 201 of this Act) is further amended by adding at the end thereof the following new subsection:

"(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 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, 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 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, posthospital 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."

(b) Section 1866(b) (2) of such Act is amended by striking out the period at the end thereof and inserting in lieu thereof the following: ", 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."

(c) Section 1903 (g) of such Act (as added by section 224 (b) of this Act) is further amended by striking out "shall not be made" and all that follows and inserting in lieu thereof the following: "shall not be made—

"(1) with respect to any amount paid for items or services furnished under the plan after June 30, 1970, 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 June 30, 1970, 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)."

(d) Section 506 (f) of such Act (as added by section

224(c) of this Act) is further amended by striking out "no payment shall be made" and all that follows and inserting in lieu thereof the following: "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 June 30, 1970, 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 June 30, 1970, 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)."

ELIMINATION OF REQUIREMENT THAT STATES MOVE TOWARD COMPREHENSIVE MEDICAID PROGRAMS

SEC. 228. Section 1903(e) of the Social Security Act, and section 2(b) of Public Law 91-56 (approved August 9, 1969), are repealed.

DETERMINATION OF REASONABLE COST OF INPATIENT HOSPITAL SERVICES UNDER MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

SEC. 229. (a) Section 1902 (a) (13) (D) of the Social Security Act is amended to read as follows:

"(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards which shall be developed by the State and included in the plan and shall not result in any part of the cost of any such services provided to individuals covered by the plan being borne by individuals not so covered or in any part of the cost of any such services provided to individuals not so covered being borne by the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861 (v) as the reasonable cost of such services for purposes of title XVIII;".

(b) Section 505 (a) (6) of such Act is amended to read as follows:

"(6) provides for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards

which shall be developed by the State and included in the plan and shall not result in any part of the cost of any such services provided to individuals covered by the plan being borne by individuals not so covered or in any part of the costs of any such services provided to individuals not so covered being borne by the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861 (v) as the reasonable cost of such services for purposes of title XVIII;".

(c) The amendments made by this section shall be effective July 1, 1971 (or earlier if the State plan so provides).

AMOUNT OF PAYMENTS WHERE CUSTOMARY CHARGES FOR SERVICES FURNISHED ARE LESS THAN REASONABLE COST

SEC. 230. (a) Section 1814 (b) of the Social Security Act is amended to read as follows:

"Amount Paid to Providers

"(b) The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1813, be—

"(1) the lesser of (A) the reasonable cost of such services, as determined under section 1861(v), or (B) the customary charges with respect to such services; or

"(2) 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 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."

(b) Section 1833(a)(2) of such Act is amended to read as follows:

"(2) in the case of services described in section 1832(a)(2)—80 percent of—

"(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)."

(c) Section 1903(g) of such Act (as added by section 224(b) and amended by section 227(c) of this Act) is further amended by striking out the period at the end of para-

graph (2) and inserting in lieu thereof "; or", and by adding after paragraph (2) the following new paragraph:

"(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."

(d) Section 506(f) of such Act (as added by section 224(c) and amended by section 227(d) of this Act) is further amended by striking out the period at the end of paragraph (2) and inserting in lieu thereof "; or", and by adding after paragraph (2) the following new paragraph:

"(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 (speci-

fied 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."

(e) Clause (2) of the second sentence of section 509 (a) of such Act (as amended by section 221 (c) (3) of this Act) is further amended by inserting "(A)" before "the reasonable cost", and by inserting after "under the project," the following: "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".

(f) The amendments made by subsections (a) and (b) shall apply to services furnished by hospitals and extended care facilities in accounting periods beginning after June 30, 1970, and to services furnished by home health agencies in accounting periods beginning after June 30, 1970. The amendments made by subsections (c), (d), and (e) shall apply with respect to services furnished in calendar quarters beginning after June 30, 1970.

INSTITUTIONAL PLANNING UNDER MEDICARE PROGRAM

SEC. 231. (a) The first sentence of section 1861 (e) of the Social Security Act is amended—

(1) by striking out "and" at the end of paragraph (7);

(2) by redesignating paragraph (8) as paragraph (9); and

(3) by inserting after paragraph (7) the following new paragraph:

"(8) has in effect an overall plan and budget that meets the requirements of subsection (z); and".

(b) Section 1861 (f) (2) of such Act is amended to read as follows:

"(2) satisfies the requirements of paragraphs (3) through (9) of subsection (e);".

(c) Section 1861 (g) (2) of such Act is amended to read as follows:

"(2) satisfies the requirements of paragraphs (3) through (9) of subsection (e);".

(d) The first sentence of section 1861 (j) of such Act is amended—

(1) by striking out "and" at the end of paragraph (9);

(2) by redesignating paragraph (10) as paragraph (11); and

(3) by inserting after paragraph (9) the following new paragraph:

"(10) has in effect an overall plan and budget that meets the requirements of subsection (z); and".

(e) Section 1861(o) of such Act is amended—

(1) by striking out "and" at the end of paragraph (4);

(2) by redesignating paragraph (5) as paragraph (6); and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) has in effect an overall plan and budget that meets the requirements of subsection (z); and".

(f) Section 1861 of such Act is further amended by adding at the end thereof the following new subsection:

"Institutional Planning

"(z) An overall plan and budget of a hospital, extended care 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;

"(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."

(g) (1) Section 1814(a) (2) (C) and section 1814 (a) (2) (D) of such Act are each amended by striking out "and (8)" and inserting in lieu thereof "and (9)".

(2) Section 1863 of such Act is amended by striking out "subsections (e) (8), (f) (4), (g) (4), (j) 10), and (o) (5)" and inserting in lieu thereof "subsections (e) (9), (f) (4), (g) (4), (j) (11), and (o) (6)".

(h) Section 1865 of such Act is amended—

(1) by striking out "(except paragraph (6) thereof)" in the first sentence and inserting in lieu thereof "(except paragraphs (6) and (8) thereof)", and

(2) by striking out the second sentence and inserting in lieu thereof the following: "If such Commission, as a condition for accreditation of a hospital, (1) requires a utilization review plan as defined in section 1861(k) or imposes another requirement which serves substantially the same purpose, or (2) requires institutional plans as defined in section 1861(z) 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) or 1861(e)(8), as the case may be."

(i) The amendments made by this section shall apply with respect to any provider of services for fiscal years (of such provider) beginning after the fifth month following the month in which this Act is enacted.

PAYMENTS TO STATES UNDER MEDICAID PROGRAMS FOR INSTALLATION AND OPERATION OF CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS

SEC. 232. (a) Section 1903(a) of the Social Security Act is amended by redesignating paragraph (3) as para-

graph (4), and by inserting after paragraph (2) the following new paragraph:

"(3) an amount equal to—

"(A) 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such mechanized claims processing and information retrieval systems as the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of title XVIII, including the State's share of the cost of installing such a system to be used jointly in the administration of such State's plan and the plan of any other State approved under this title, and

"(B) 75 per centum of so much of the sums expended during such quarter as are attributable to the operation of systems of the type described in subparagraph (A) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by the plan of the specific services so cov-

ered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services; plus".

(b) The amendments made by subsection (a) shall apply with respect to expenditures under State plans approved under title XIX of the Social Security Act made after June 30, 1970.

ADVANCE APPROVAL OF EXTENDED CARE AND HOME HEALTH COVERAGE UNDER MEDICARE PROGRAM

SEC. 233. (a) Section 1862 of the Social Security Act (as amended by sections 201 and 227(a) of this Act) is further amended by adding at the end thereof the following new subsection:

"(e) (1) In any case where post-hospital extended care services or post-hospital home health services are furnished to an individual and—

"(A) a physician provides the certification referred to in subparagraph (C) or (D) of section 1814(a)(2), as the case may be, and the condition of the individual with respect to which such certification is made is a condition designated in regulations,

"(B) such physician (in the case of such extended care services) submitted to the extended care facility

which is to provide such services, prior to the admission of such individual to such facility, a plan for the furnishing of such services, or (in the case of such home health services) submitted to the home health agency which is to furnish such services, prior to the first visit to such individual, a plan specifying the type and frequency of the services required, and

"(C) there is compliance with such other requirements and procedures as may be specified in regulations,

the provisions of paragraphs (1) and (9) of subsection (a) shall not apply (except as may be provided in section 1814 (a) (7)) for such periods of time, with respect to such conditions of the individual, as may be prescribed in regulations.

"(2) In specifying the conditions included under paragraph (1) and the periods for which paragraphs (1) and (9) of subsection (a) shall not apply, the Secretary shall take into account the medical severity of such conditions, the period over which such conditions generally require the services specified in subparagraphs (C) and (D) of section 1814 (a) (2), the length of stay in an institution generally needed for the treatment of such conditions, and such other factors affecting the type of care to be provided as the Secretary deems pertinent.

"(3) 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 such paragraph."

(b) The amendments made by this section shall be effective with respect to admissions to extended care facilities, and home health plans initiated, on or after January 1, 1971.

PROHIBITION AGAINST REASSIGNMENT OF CLAIMS TO BENEFITS

SEC. 234. (a) Section 1842 (b) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

"(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 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."

(b) Section 1902 (a) of such Act is amended—

(1) by striking out "and" at the end of paragraph (29);

(2) by striking out the period at the end of paragraph (30) and inserting in lieu thereof "; and"; and

(3) by inserting after paragraph (30) the following new paragraph:

"(31) 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 arrange-

ment between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service."

(c) The amendment made by subsection (a) shall apply with respect to bills submitted and requests for payments made after the date of the enactment of this Act. The amendments made by subsection (b) shall be effective July 1, 1971 (or earlier if the State plan so provides).

UTILIZATION REVIEW REQUIREMENTS FOR HOSPITALS AND SKILLED NURSING HOMES UNDER MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

SEC. 235. (a) (1) Section 1903 (g) of the Social Security Act (as added by section 224 (b) and amended by sections 227 (c) and 230 (c) of this Act) is further amended by striking out the period at the end of paragraph (3) and inserting in lieu thereof "; or", and by adding after paragraph (3) the following new paragraph:

"(4) with respect to any amount expended for care or services furnished under the plan by a hospital or skilled nursing home unless such hospital or skilled nursing home 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 procedures and the same review committee or group) as a condition of payment under this title."

(2) Section 1902(a)(30) of such Act is amended by inserting "(including but not limited to utilization review plans as provided for in section 1903(g)(4))" after "plan" where it first appears.

(b) Section 506(f) of such Act (as added by section 224(c) and amended by sections 227(d) and 230(d) of this Act) is further amended by striking out the period at the end of paragraph (3) and inserting in lieu thereof "; or", and by adding after paragraph (3) the following new paragraph:

"(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."

(c)(1) The amendments made by subsections (a)(1)

and (b) shall apply with respect to services furnished in calendar quarters beginning after June 30, 1971.

(2) The amendment made by subsection (a) (2) shall be effective July 1, 1971.

ELIMINATION OF REQUIREMENT THAT COST-SHARING CHARGES IMPOSED ON INDIVIDUALS OTHER THAN CASH RECIPIENTS UNDER MEDICAID BE RELATED TO THEIR INCOME

SEC. 236. (a) Section 1902 (a) (14) of the Social Security Act is amended to read as follows:

"(14) provide that in the case of individuals receiving aid or assistance under State plans approved under titles I, X, XIV, and 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 services furnished him under the plan;".

(b) The amendment made by subsection (a) shall be effective January 1, 1971 (or earlier if the State plan so provides).

NOTIFICATION OF UNNECESSARY ADMISSION TO A HOSPITAL OR EXTENDED CARE FACILITY UNDER MEDICARE PROGRAM

SEC. 237. (a) Section 1814 (a) (7) of the Social Security Act is amended by striking out "as described in section 1861 (k) (4)" and inserting in lieu thereof "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".

(b) The amendment made by subsection (a) shall apply with respect to services furnished after the second month following the month in which this Act is enacted.

USE OF STATE HEALTH AGENCY TO PERFORM CERTAIN FUNCTIONS UNDER MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

SEC. 238. (a) Section 1902 (a) (9) of the Social Security Act is amended to read as follows:

"(9) provide—

"(A) that the State health agency 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;".

(b) Section 1902 (a) of such Act (as amended by section 234 (b) of this Act) is further amended—

(1) by striking out "and" at the end of paragraph (30);

(2) by striking out the period at the end of paragraph (31) and inserting in lieu thereof "; and"; and

(3) by inserting after paragraph (31) the following new paragraph:

"(32) provide—

"(A) that the State health 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 health agency, or, if the services of another State or local agency are being utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), such other agency, 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 require-

ments for participation in the program under such plan."

(c) Section 505(a) of such Act is amended—

(1) by striking out "and" at the end of paragraph (13);

(2) by striking out the period at the end of paragraph (14) and inserting in lieu thereof "; and"; and

(3) by adding after paragraph (14) the following new paragraph:

"(15) provides—

"(A) that the State health 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 health agency, or, if the services of another State or local agency are being utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), such other agency, will perform the function of determining whether institutions and agencies meet the require-

ments for participation in the program under the plan under this title."

(d) The amendments made by this section shall be effective July 1, 1971.

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

SEC. 239. (a) Title XVIII of the Social Security Act is amended by adding after section 1875 the following new section:

"PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

"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, with respect to any health maintenance organization, a combined part A and part B, prospective, per capita rate of payment for services provided for enrollees in such organization who are entitled to hospital insurance benefits under part A and enrolled for medical insurance benefits under part B.

"(2) Such rate of payment shall be determined annually in accordance with regulations, taking into account the health maintenance organization's premiums with respect to its other enrollees (with appropriate actuarial adjustments to reflect the difference in utilization between its members who are under age 65 and its members who are age 65 and over) and such other pertinent factors as the Secretary may

prescribe in regulations, and shall be designed to provide payment at a level not to exceed 95 per centum of the amount that the Secretary estimates (with appropriate adjustments to assure actuarial equivalence) would be payable for services covered under this title if such services were to be furnished by other than health maintenance organizations.

"(3) The payments to health maintenance organizations under this subparagraph 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 product of (A) the number of covered enrollees of such organization for such month, and (B) the monthly premium rate for supplementary medical insurance for such month as has been determined and promulgated under section 1839 (b) (2). The remainder of such payment shall be paid by the former trust fund.

"(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 enrollees on a per capita prepayment basis;

"(2) provides with respect to enrollees to whom this section applies (through institutions, entities, and

persons meeting the applicable requirements of section 1861) all of the services and benefits covered under parts A and B of this title;

"(3) provides physicians' services directly through physicians who are either employees or partners of such organization or under an arrangement with an organized group or groups of physicians which is or are reimbursed for services on the basis of an aggregate fixed sum or on a per capita basis;

"(4) 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;

"(5) has enrolled members at least half of whom consist of individuals under age 65;

"(6) has arrangements for assuring 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

"(7) has an open enrollment period at least once every two years, under which it accepts eligible persons (as defined under subsection (d)) without underwriting restrictions and on a first-come first-accepted

basis up to the limit of its capacity (unless to do so would result in failure to meet the requirement of paragraph (5)).

"(c) The benefits provided to an individual under this section shall consist of—

"(1) 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

"(2) entitlement to have payment made by such health maintenance organization to him or on his behalf for such emergency services (as defined in regulations) 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.

"(d) Subject to the provisions of subsection (e), every individual who is entitled to hospital insurance benefits under part A and is enrolled for medical insurance benefits under part B shall be eligible to enroll with a 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 for such enrollees shall not exceed the actuarial value of the cost-sharing provisions applicable under part A and part B.

"(2) If the health maintenance organization provides its enrollees under this section with additional services over those described in subsection (c), it shall furnish such enrollees with information as to the division of its premium rate between the portion applicable to such additional services and the portion applicable to the services described in subsection (c), subject to the limitation that the latter portion may not exceed the actuarial value of the cost-sharing provisions applicable under part A and part B."

(b) Section 1866 of such Act is amended by adding at the end thereof the following new subsection:

"(f) For purposes of this section, the term 'provider of services' shall include a health maintenance organization if such organization meets the requirements of section 1876."

(c) Notwithstanding the provisions of section 1833 of the Social Security Act, any health maintenance organization which has entered into an agreement with the Secretary pursuant to section 1866 of such Act shall, for the duration of such agreement, be entitled to reimbursement only as provided in section 1876 of such Act.

(d) The effective date of any agreement with any health maintenance organization pursuant to section 1866 of such Act shall be specified in such agreement pursuant to regulations.

(e) (1) Section 1814(a) of such Act is amended by striking out "Except as provided in subsection (d)," and inserting in lieu thereof the following: "Except as provided in subsection (d) or in section 1876,".

(2) Section 1833 (a) of such Act is amended by striking out "Subject to" and inserting in lieu thereof the following: "Except as provided in section 1876, and subject to".

(3) Section 1866(b) (2) of such Act is amended by inserting after "1861" in clause (B) the following: "(or of section 1876 in the case of a health maintenance organization)".

(f) The amendments made by this section shall be effective with respect to services provided on or after January 1, 1971.

PART C—MISCELLANEOUS AND TECHNICAL PROVISIONS

COVERAGE PRIOR TO APPLICATION FOR MEDICAL ASSISTANCE

SEC. 251. (a) Section 1902(a) of the Social Security Act (as amended by sections 234(b) and 238(b) of this Act) is further amended—

(1) by striking out "and" at the end of paragraph (31);

(2) by striking out the period at the end of paragraph (32) and inserting in lieu thereof "; and"; and

(3) by inserting after paragraph (32) the following new paragraph:

"(33) 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."

(b) The amendments made by subsection (a) shall be effective July 1, 1971.

HOSPITAL ADMISSIONS FOR DENTAL SERVICES UNDER MEDICARE PROGRAM

SEC. 252. (a) Section 1814 (a) (2) of the Social Security Act is amended by striking out "or" at the end of subparagraph (C), by adding "or" after the semicolon at the end of subparagraph (D), and by inserting after subparagraph (D) the following new subparagraph:

"(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;".

(b) Section 1861 (r) of such Act is amended by inserting after "or any facial bone" the following: ", or (C) the certification required by section 1814 (a) (2) (E) of this Act,".

(c) Section 1862 (a) (12) of such Act is amended by inserting before the semicolon the following: ", 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".

(d) The amendments made by this section shall apply

with respect to admissions occurring after the second month following the month in which this Act is enacted.

EXEMPTION OF CHRISTIAN SCIENCE SANATORIUMS FROM CERTAIN NURSING HOME REQUIREMENTS UNDER MEDICAID PROGRAMS

SEC. 253. (a) Section 1902(a) of the Social Security Act is amended by adding at the end thereof the following new sentence: "For purposes of paragraphs (26), (28)(B), (D), and (E), and (29), and of section 1903(g)(4), the terms 'skilled nursing home' and 'nursing home' do not include a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts."

(b) Section 1908(g)(1) of such Act is amended by inserting after "Secretary" the following: ", but does not include a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts".

(c) The amendments made by this section shall be effective on the date of the enactment of this Act.

PHYSICAL THERAPY SERVICES UNDER MEDICARE PROGRAM

SEC. 254. (a)(1) Section 1861(p) of the Social Security Act is amended by adding at the end thereof (after and below paragraph (4)(B)) the following new sentence:

"Under regulations, the term 'outpatient physical therapy services' also includes physical therapy services furnished an individual by a physical therapist (in his office or in such individual's home) who meets licensing and other standards prescribed by the Secretary in regulations, otherwise than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health agency, if the furnishing of such services meets such conditions relating to health and safety as the Secretary may find necessary."

(2) Section 1833 of such Act is amended by adding at the end thereof the following new subsection:

"(g) In the case of services described in the next to last sentence of section 1861(p), with respect to expenses incurred in any calendar year, no more than $100 shall be considered as incurred expenses for purposes of subsections (a) and (b)."

(3) Section 1833(a)(2) of such Act (as amended by section 230(b) of this Act) is further amended by striking out the period at the end of subparagraph (B) and inserting in lieu thereof "; or", and by adding after subparagraph (B) the following new subparagraph:

"(C) if such services are services to which the next to last sentence of section 1861(p) applies, the reasonable charges for such services."

(4) Section 1832 (a) (2) (C) of such Act is amended by striking out "services." and inserting in lieu thereof "services, other than services to which the next to last sentence of section 1861 (p) applies."

(b) (1) Section 1861 (p) of such Act (as amended by subsection (a) (1) of this section) is further amended by adding at the end thereof the following new sentence: "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 extended care facility."

(2) Section 1835 (a) (2) (C) of such Act is amended by striking out "on an outpatient basis".

(c) Section 1861 (v) of such Act (as amended by sections 221 (c) (4) and 223 (f) of this Act) is further amended by redesignating paragraphs (5) and (6) as paragraphs (6) and (7), respectively, and by inserting after paragraph (4) the following new paragraph:

"(5) Where physical therapy services are furnished by a provider of services or other organization specified in the first sentence of section 1861 (p), or by others under an arrangement with such a provider or other organization, the amount included in any payment to such provider or organization under this title as the reasonable cost of such services shall not exceed an amount equal to the salary which would

reasonably have been paid for such services to the person performing them if they had been performed in an employment relationship with such provider or organization rather than under such arrangement."

(d) (1) The amendments made by subsections (a) and (b) shall apply with respect to services furnished on or after January 1, 1971.

(2) The amendments made by subsection (c) shall be effective with respect to accounting periods beginning on or after January 1, 1971.

EXTENSION OF GRACE PERIOD FOR TERMINATION OF SUPPLEMENTARY MEDICAL INSURANCE COVERAGE WHERE FAILURE TO PAY PREMIUMS IS DUE TO GOOD CAUSE

SEC. 255. (a) Section 1838 (b) of the Social Security Act is amended by striking out "(not in excess of 90 days)" in the third sentence, and by adding at the end thereof the following new sentence: "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 tc pay the overdue premiums within such 90-day period."

(b) The amendments made by subsection (a) shall apply with respect to nonpayment of premiums which become due and payable on or after the date of the enact-

ment of this Act or which became payable within the 90-day period immediately preceding such date; and for purposes of such amendments 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 the enactment of this Act.

EXTENSION OF TIME FOR FILING CLAIM FOR SUPPLEMENTARY MEDICAL INSURANCE BENEFITS WHERE DELAY IS DUE TO ADMINISTRATIVE ERROR

SEC. 256. (a) Section 1842(b)(3) of the Social Security Act (as amended by section 224(a) of this Act) is further amended by adding at the end thereof the following new sentence: "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."

(b) The amendment made by subsection (a) shall 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. 257. (a) Section 1837 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(f) In any case where the Secretary finds that an individual's enrollment or nonenrollment in the insurance program established by this part is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Department of Health, Education, and Welfare, 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."

(b) The amendment made by subsection (a) shall be effective as of July 1, 1966.

ELIMINATION OF PROVISIONS PREVENTING ENROLLMENT IN SUPPLEMENTARY MEDICAL INSURANCE PROGRAM MORE THAN THREE YEARS AFTER FIRST OPPORTUNITY

SEC. 258. Section 1837(b) of the Social Security Act is amended to read as follows:

"(b) No individual may enroll under this part more than twice."

WAIVER OF RECOVERY OF INCORRECT PAYMENTS FROM SURVIVOR WHO IS WITHOUT FAULT UNDER MEDICARE PROGRAM

SEC. 259. (a) Section 1870(c) of the Social Security Act is amended by striking out "and where" and inserting in lieu thereof the following: "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".

(b) The amendment made by subsection (a) shall apply with respect to waiver actions considered after the date of the enactment of this Act.

REQUIREMENT OF MINIMUM AMOUNT OF CLAIM TO ESTABLISH ENTITLEMENT TO HEARING UNDER SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

SEC. 260. (a) Section 1842(b)(3)(C) of the Social Security Act is amended by inserting after "a fair hearing by the carrier" the following: ", in any case where the amount in controversy is $100 or more,".

(b) The amendment made by subsection (a) shall apply with respect to hearings requested (under the procedures established under section 1842(b)(3)(C) of the Social Security Act) after the date of the enactment of this Act.

COLLECTION OF SUPPLEMENTARY MEDICAL INSURANCE PREMIUMS FROM INDIVIDUALS ENTITLED TO BOTH SOCIAL SECURITY AND RAILROAD RETIREMENT BENEFITS

SEC. 261. (a) Section 1840(a)(1) of the Social Security Act is amended by striking out "subsection (d)" and inserting in lieu thereof "subsections (b)(1) and (c)".

(b) Section 1840(b)(1) of such Act is amended by inserting "(whether or not such individual is also entitled for such month to a monthly insurance benefit under section 202)" after "1937", and by striking out "subsection (d)" and inserting in lieu thereof "subsection (c)".

(c) Section 1840 of such Act is further amended by striking out subsection (c), and by redesignating subsections (d) through (i) as subsections (c) through (h), respectively.

(d)(1) Section 1840(e) of such Act (as so redesignated) is amended by striking out "subsection (d)" and inserting in lieu thereof "subsection (c)".

(2) Section 1840(f) of such Act (as so redesignated) is amended by striking out "subsection (d) or (f)" and inserting in lieu thereof "subsection (c) or (e)".

(3) Section 1840(h) of such Act (as so redesignated) is amended by striking out "(c), (d), and (e)" and inserting in lieu thereof "(c), and (d)".

(4) Section 1841 (h) of such Act is amended by striking out "1840 (e)" and inserting in lieu thereof "1840 (d)".

(e) Section 1841 of such Act is amended by adding at the end thereof the following new subsection:

"(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 in making deductions 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 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."

(f) The amendments made by this section shall apply with respect to premiums becoming due and payable after the fourth month following the month in which this Act is enacted.

PAYMENT FOR CERTAIN INPATIENT HOSPITAL SERVICES FURNISHED OUTSIDE THE UNITED STATES

SEC. 262. (a) Section 1814 (f) of the Social Security Act is amended to read as follows:

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

"(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 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 in a place within the United States 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)."

(b) Section 1861 (e) of such Act is amended—

(1) by striking out "except for purposes of sections 1814 (d) and 1835 (b)" and inserting in lieu thereof "except for purposes of sections 1814 (d), 1814 (f), and 1835 (b)";

(2) by inserting ", section 1814 (f) (2)," immediately after "For purposes of sections 1814 (d) and 1835 (b) (including determinations of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections)"; and

(3) by inserting after the third sentence the following new sentence: "For purposes of section 1814 (f) (1), such term includes an institution which (i) is a hospital for purposes of section 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."

(c) Section 1862 (a) (4) of such Act is amended by striking out "emergency".

(d) The amendments made by this section shall apply to services furnished with respect to admissions occurring after December 31, 1970.

STUDY OF CHIROPRACTIC COVERAGE

SEC. 263. The Secretary, utilizing the authority conferred by section 1110 of the Social Security Act, shall conduct a study of the coverage of services performed by chiropractors under State plans approved under title XIX of such Act in order to determine whether and to what extent such services should be covered under the supplementary medical insurance program under part B of title XVIII of such Act, giving particular attention to the limitations which should be placed upon any such coverage and upon payment therefor. Such study shall include one or more experimental, pilot, or demonstration projects designed to assist in providing under controlled conditions the information necessary to achieve the objectives of the study. The Secretary shall report the results of such study to the Congress within two years after the date of the enactment of this Act, together with his findings and recommendations based on such study (and on such other information as he may consider relevant concerning experience with the coverage of chiropractors by public and private plans).

MISCELLANEOUS TECHNICAL AND CLERICAL AMENDMENTS

SEC. 264. (a) Clause (A) of section 1902(a)(26) of the Social Security Act is amended by striking out "evaluation" and inserting in lieu thereof "evaluation)", and by striking out "care)" and inserting in lieu thereof "care".

(b) Section 1908(d) of such Act is amended by striking out "subsection (b)(1)" and inserting in lieu thereof "subsection (c)(1)".

(c) Section 408(f) of such Act is amended by striking out "522(a)" and inserting in lieu thereof "422(a)".

TITLE III—MISCELLANEOUS PROVISIONS

MEANING OF TERM "SECRETARY"

SEC. 301. As used in this Act, and in the provisions of the Social Security Act amended by this Act, the term "Secretary," unless the context otherwise requires, means the Secretary of Health, Education, and Welfare.

Union Calendar No. 508

91ST CONGRESS
2D SESSION

H. R. 17550

[Report No. 91–1096]

A BILL

To amend the Social Security Act to provide increases in benefits, to improve computation methods, and to raise the earnings base under the old-age, survivors, and disability insurance system, to make improvements in the medicare, medicaid, and maternal and child health programs with emphasis upon improvements in the operating effectiveness of such programs, and for other purposes.

By Mr. MILLS and Mr. BYRNES of Wisconsin

MAY 11, 1970
Referred to the Committee on Ways and Means

MAY 14, 1970
Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Commissioner's Bulletin

SOCIAL SECURITY ADMINISTRATION

Number 106 May 15, 1970

SOCIAL SECURITY AMENDMENTS OF 1970

To Administrative, Supervisory,
and Technical Employees

The Committee on Ways and Means has completed its consideration of the President's social security proposals, which were contained in H. R. 14080 (summarized in Commissioner's Bulletin No. 94, dated October 8, 1969). A new bill, H. R. 17550, reflecting the Committee's decisions was introduced on May 11 in the House of Representatives by Wilbur D. Mills, Chairman of the Committee, and by John W. Byrnes, the ranking minority member of the Committee.

The major proposals made by the President are included in H. R. 17550 except that the bill departs from the President's recommendations on benefit increases and the retirement test.

As you know, the President recommended a 10-percent increase in social security benefits effective for March 1970 and automatic adjustment of benefits in the future. The Congress subsequently enacted a 15-percent increase in benefits effective for January 1970, and the Committee's bill provides for an additional 5-percent increase in benefits to be effective for next January. The bill does not include the President's proposal for automatic adjustments of benefits (and of the contribution and benefit base).

Under the retirement test provisions of H. R. 17550, the annual exempt amount of earnings would be increased from the present $1680 to $2000, with $1 in benefits withheld for each $2 of earnings between $2000 and $3200 and by $1 for each $1 of earnings above $3200. The President had recommended an annual exempt amount of $1800, with $1 in benefits to be withheld for each $2 of all annual earnings above $1800; the exempt amount would have been adjusted automatically every two years to keep pace with any increases in earnings levels.

As recommended by the President, the contribution and benefit base is increased from $7800 to $9000. Also, the contribution rates approved by the Committee, although different in detail from those recommended by President Nixon last year, are in accord with the President's basic

recommendation that increases in the contribution rates for cash benefits now scheduled for 1971 and 1973 be postponed. Under the bill, as recommended by President Nixon, the current rate of 4.2 percent, each, for employees and employers will remain in effect until 1975, when the rate would go to 5 percent, each. The bill establishes a new ultimate rate for cash benefits of 5.5 percent, each, to go into effect in 1980.

Significant changes in the financing of the hospital insurance program, including the method of estimating costs, are provided for. Under the bill the contribution rates for hospital insurance would be increased to 1 percent, each, for employees, employers, and the self-employed for 1971 and after, as recommended by the Administration, instead of increasing gradually (as under present law) from 0.6 percent, each, in 1970 to an ultimate rate of 0.9 percent, each, in 1987. The changed financing would put the hospital insurance program into acceptable actuarial balance.

H. R. 17550 includes a number of changes in the cash benefits program in addition to those recommended by the President. Among these are provisions for the payment of actuarially reduced benefits to dependent widowers at age 60, elimination of the support requirement as a condition for benefits for divorced wives and widows, changes in the disability insured status requirement for the blind, and a change in the workmen's compensation offset for disability beneficiaries.

The provisions in the Committee bill dealing with the Medicare and Medicaid programs reflect, for the most part, changes recommended by the Department. In his testimony before the Senate Committee on Finance in February, Under Secretary Veneman recommended a change in the method of reimbursing institutional providers under Medicare and the introduction of additional limitations on the recognition of physicians' fee increases. These recommendations are embodied in provisions of the Committee bill under which (1) the Secretary is directed to develop large-scale experiments and demonstration projects to test various methods of making payments to providers of services on a prospective, rather than retroactive cost basis, and (2) recognition of increases in physician fee levels are to be related to indexes reflecting changes in costs of practice for physicians and in earnings levels. The bill also provides authority for the Secretary to establish limits on "reasonable" provider costs based on comparisons of the cost of covered services by various classes of providers in the same geographical area.

The Administration's proposal to stimulate the development of health maintenance organizations, announced by Secretary Finch in March, is also incorporated into the bill. Under this proposal, Medicare beneficiaries who live in an area served by such organizations would have the option of receiving their covered services through the organization rather than in the usual way from individual doctors and hospitals. The organization would receive its Medicare payment not in the form of reimbursement for physician visits or hospital stays, but in the form of a prospective, per capita payment determined for each organization on an annual basis.

All of the Administration's recommendations included in the "Health Cost Effectiveness Amendments" sent to the Committee late last year are embodied in the provisions of the Committee's bill. These include authority for the Secretary to terminate or suspend Medicare payments to suppliers of health services found guilty of program abuses and authority to withhold or reduce reimbursement amounts for depreciation, interest and other expenses related to capital expenditures in excess of $100,000 that are determined to be inconsistent with State or local health facility plans.

The Committee's bill also includes a number of other changes designed to improve the operating effectiveness of the Medicare program as well as changes to improve the operation of the Medicaid, and maternal and child health programs.

Enclosed is explanatory material on the major provisions of H. R. 17550.

Robert M. Ball
Commissioner

Enclosure

SUMMARY OF PRINCIPAL SOCIAL SECURITY PROVISIONS OF H.R. 17550
AS APPROVED BY THE COMMITTEE ON WAYS AND MEANS OF THE HOUSE OF REPRESENTATIVES

1. CASH BENEFIT CHANGES

(a) Increase in benefits for current and future beneficiaries

The bill would provide an across-the-board benefit increase of 5 percent for people on the benefit rolls, and for those who come on the rolls in the future, effective for January 1971.

The minimum monthly benefit would be increased from $64 to $67.20. The $250.70 maximum benefit (based on average monthly earnings of $650--$7800 a year) eventually payable under present law would be increased to $263.30. Creditable earnings higher than $7800 a year would result from an increase in the contribution and benefit base to $9000 a year that would also occur under the bill. These higher earnings would make possible higher benefit amounts up to an ultimate maximum of $283 (based on average monthly earnings of $750--$9000 a year). The ultimate maximum family benefit would be $474.40, as compared with $434.40 under present law.

(b) Increase in special payments to certain uninsured people age 72 and over

The special payments made to people age 72 and over who have not worked long enough in covered employment to be insured for regular retirement benefits would also be increased by 5 percent--from $46 to $48.30 a month for an individual and from $69 to $72.50 a month for a couple, effective for January 1971.

(c) Liberalization of the retirement test

The amount a beneficiary under age 72 may earn in a year and still receive full benefits for the year would be increased from $1680 to $2000. The amount of annual earnings to which the $1-for-$2 reduction would apply would range from $2000 to $3200, rather than from $1680 to $2880 as under current law. The amount a beneficiary may earn in wages in a month and still get full benefits for that month (regardless of his total annual earnings)

would be increased from $140 to $166.66. The bill would also change the application of the retirement test in the year a worker reaches age 72. In determining annual earnings, only amounts earned before the month in which the worker attains age 72 (rather than earnings for the entire year) would be counted; net earnings from self-employment would be prorated equitably among all months of the year. The provisions would be effective with respect to taxable years ending after 1970.

(d) Increase in widows' and widowers' benefits

The bill would increase benefits for widows and widowers who become entitled to benefits at or after age 65 from 82 1/2 percent to 100 percent of the deceased worker's primary insurance amount. For those who become entitled to benefits before 65, the 100-percent amount would be reduced in a way similar to the way in which a worker's benefit is reduced under present law if he becomes entitled before age 65. For example, a widow coming on the rolls at age 64 would get 94.3 percent; at age 63 she would get 88.6 percent; 82.9 percent would be payable at age 62, 77.2 percent at age 61, and 71.5 percent, the same as under present law, at age 60.

The provision would be effective for January 1971, and widows and widowers on the rolls in December 1970 would have their benefits increased effective for January as if this change had been in effect when they first became entitled to benefits.

(e) Age-62 computation point for men

The bill would shorten by 3 the number of years over which a man's average monthly earnings are figured in retirement cases by making the ending point for determining the number of years to be used in figuring his average the beginning of the year in which he reaches age 62, rather than age 65 as under present law. The bill would also make the ending point for determining a man's insured status the beginning of the year in which he reaches age 62, rather than age 65. As a result, these provisions would be the same for men as they are under present law for women.

These changes would be effective for January 1971. Benefits for those coming on the rolls in January 1971 or after would be figured under the new provision and would be paid beginning in February 1971. Benefits for those on the benefit rolls before 1971 would be refigured under the new provision and, in many cases, the increased benefits would be paid beginning in February. Some beneficiaries who have earnings in 1969 and whose benefits have to be refigured to take account of those additional earnings, as well as under the new method, might not be paid their increased benefits until later in 1971, but the payments will be retroactive to January 1971.

(f) Election to receive actuarially reduced benefits

Under the bill, a person who is eligible for both an old-age insurance benefit and a wife's or husband's insurance benefit would not have to apply for both benefits, as he must do under present law. He would be able to apply for only one of the benefits and wait until later to apply for the other.

Also under the bill, the actuarial reduction that is made in one benefit would not lower the amount of a benefit that is taken later; the amount of the benefit taken later would be the same as if no other benefit had been paid. For example, a woman who takes a reduced old-age insurance benefit of $62.40, based on a primary insurance amount of $78, at age 62, and who at age 65 becomes eligible for a wife's benefit of $99 (before taking her old-age insurance benefit into consideration) would, under the bill, be able to get a combined old-age and wife's insurance benefit of $99 starting at age 65. Under present law she can get only $83.40.

The new provisions would apply to people who come on the benefit rolls in or after the sixth month after the month of enactment. People already on the rolls when the provisions become effective could, upon request, have their benefits redetermined under the new provisions.

In some cases a change to a month of entitlement later than was originally established for a beneficiary could result in higher monthly benefits for him, but it would also mean that he would no longer be entitled to have received some of the benefits he did receive between his original entitlement month and the more advantageous, later entitlement month (generally age 65) that could have been established if these provisions had been effective at that time. Under the bill the payment of the amount of the increase in benefits that would occur under the provision would be withheld until recovery is made of the excess of the amount the beneficiary was actually paid over the amount he would have been paid if the provision had been in effect at the time of his original application.

(g) Age of eligibility for dependent widowers' benefits

The bill would lower the age of eligibility for dependent widowers' benefits from age 62 to age 60, making it the same as that for widows under present law. Benefits payable beginning before age 62 would be actuarially reduced, as are the benefits for widows who come on the rolls before age 62. The provision would be effective for January 1971.

(h) Elimination of the support requirements for divorced women

The bill would eliminate the provision in the law that a divorced wife, divorced widow, or surviving divorced mother must meet one of the following support requirements: (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 20-year duration-of-marriage requirement for divorced wife's and divorced widow's benefits would not be affected by this change. The change would be effective with respect to benefits for months after December 1970.

(i) Amendments to the disability program

(1) Childhood disability benefits for those disabled before age 22

Childhood disability benefits would be made available for an otherwise qualified disabled adult son or daughter whose disability began after attainment of age 18 and before age 22. Under present law, a person must have become disabled before age 18 to qualify for childhood disability benefits. Benefits under this provision would be payable for months after December 1970.

(2) Disability benefits for blind persons

A blind person would be insured for disability insurance benefits if he is fully insured--i.e., has as many quarters of coverage as the number of calendar years that elapsed after 1950 (or the year he reached age 21, if later) and up to the year in which he became disabled. He would no longer have to meet a requirement of substantial recent covered work (generally 20 quarters of coverage in the period of 40 calendar quarters preceding disablement). Benefits under this provision would be payable for months beginning with January 1971.

(3) Disability benefits affected by receipt of workmen's compensation

The bill would modify the provisions under which social security disability benefits are reduced where workmen's compensation is also payable. Present law permits the disabled worker and his family to receive combined payments not exceeding 80 percent of the worker's average earnings before he became disabled. Under the bill, the disabled worker and his family would be able to receive combined benefits equaling 100 percent of his average earnings. The provision would be effective for benefits for months after December 1970.

(4) Payment of disability insurance benefits on the basis of applications filed after death

The bill would permit disability insurance benefits (and dependents' benefits based on the worker's entitlement to disability benefits) to be paid if application is filed within 3 months after the disabled worker's death. The provision would apply in cases of deaths occurring in or after the year of enactment.

(j) Other changes

(1) Guarantee that no family will have their total family benefits decreased as a result of an increase in the worker's benefit

The bill includes a provision under which no family would have their total family benefits decreased because of an increase in the worker's benefit resulting from the 5-percent general benefit increase that would be provided by the bill or any general benefit increase that may be enacted in the future or from a recomputation of the worker's benefit to include additional earnings. Without the provision, such a decrease could occur in cases where the family maximum provision applies and the worker's benefit is actuarially reduced and, in the case of a general benefit increase, in situations where a family comes on the benefit rolls after the increase is effective (so that it does not qualify for the general benefit increase saving clause, which applies to people who are on the rolls at the time the increase is effective and assures that each of them will have his benefit increased by the amount of the increase) but is entitled retroactively to benefits before the increase is effective.

(2) Wage credits for military service

Noncontributory social security wage credits of $100 a month would be provided, in addition to credit for basic pay, for military service after 1956 (rather than after 1967 as provided in present law). Beneficiaries on the rolls could receive increased benefits based on the additional credits after December 1970, provided an application for a recomputation is filed.

(3) Penalty for furnishing false information to obtain a social security number

Criminal penalties would be provided if an individual, with intent to deceive the Secretary of Health, Education, and

Welfare as to his true identity, knowingly and willfully furnishes false information on an application for a social security number for the purpose of obtaining more than one number or of establishing a social security record under a false name.

(4) Effective date of increase in the contribution and benefit base for self-employed people reporting on a fiscal year basis

The bill would provide that, for self-employed people who report their income on a fiscal year basis, the increase in the base from $7800 to $9000 that would occur under the bill would be effective for contribution purposes for fiscal years beginning in 1971, rather than for fiscal years ending in 1971, as would be the case if past practices had been followed. Under this change no fiscal year taxpayer would have to pay social security contributions on income that he could not have credited for social security benefits. On the other hand, he could not start having more than $7800 a year counted toward his benefits until his fiscal year begins sometime after January 1, 1971, the date on which the increase in the base to $9000 becomes effective generally.

(5) Coverage of Federal Home Loan Bank employees

Social security coverage would be provided for employees of the Federal Home Loan Banks beginning January 1, 1971. People who are in the employ of one of the banks on January 1, 1971, would have their services for a bank covered for years after 1965, but only if the social security contributions on account of such service are paid by July 1, 1971, or by such later date as may be provided under an agreement with the Secretary of the Treasury.

(6) Coverage of certain hospital employees in New Mexico

The State of New Mexico would be permitted prior to January 1, 1971, to provide social security coverage under its coverage agreement for employees of certain hospitals without regard to the provisions of law which specify the conditions under which State and local employees may be covered under social security.

(7) Coverage of policemen and firemen in Idaho

Idaho would be added to the list of States in the law (now 19) which may cover policemen and firemen who are in positions covered under a State or local retirement system.

2. HEALTH INSURANCE CHANGES

(a) Payment for services covered by FEHB program

The bill would provide that effective January 1, 1972, no payment would be made under the Medicare program for any service covered under a Federal employees health benefits plan. This provision would not go into effect if the Secretary certifies, before January 1, 1972, that the Federal employees health benefits program has been modified to make available Federal employee plans which offer protection supplementing Medicare (both parts A and B, as well as part B alone) and to assure that the Government is making a contribution toward such supplementary insurance which is at least equal to the contribution it makes for high option coverage under the Government-wide Federal employee plans.

(b) Hospital insurance benefits for uninsured individuals

The bill would provide hospital insurance coverage on a voluntary basis, for uninsured persons aged 65 and over who are (1) not eligible for such coverage under existing law, (2) residents of the United States, and (3) either citizens or aliens admitted for permanent residence. Persons electing to enroll for this protection would be required to pay a premium of $27 a month for each month up to and including June 1972. The premium rate would be recomputed each year to take account of expected increased costs during the subsequent year. States and other organizations, through agreements with the Secretary, would be permitted to purchase this coverage on a group basis for their retired employees age 65 or over. The same restrictions on enrollment and reenrollment (including a 10-percent-per-year charge for late enrollment) would apply as apply to enrollment for supplementary medical insurance. Only those persons enrolled for supplementary medical insurance would be eligible to enroll for hospital insurance under this provision, with termination of supplementary medical insurance coverage automatically terminating hospital insurance coverage obtained under this provision. Hospital insurance coverage under this provision would be effective in accordance with enrollment provisions but in no case before January 1, 1971.

(c) Limitation on Federal participation for capital expenditures

The bill would authorize the Secretary to withhold or reduce reimbursement amounts to providers of services under title XVIII for depreciation, interest, and, in the case of proprietary providers, a return on equity capital, or other expenses related to capital expenditures for plant and equipment in excess of $100,000 which 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.) The Secretary would take such action on the basis of findings and recommendations submitted to him by various planning agencies. However, if after consultation with a national advisory council the Secretary determines that a disallowance of 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 an agreement with States under which designated health facility and health services planning agencies would submit their findings and recommendations (along with those of other qualified planning agencies) with respect to proposed capital expenditures. Payment would be authorized from the Federal Hospital Insurance Trust Fund for the reasonable costs incurred by the planning agencies in preparing and forwarding findings and recommendations. Adverse determinations by the Secretary would be subject to reconsideration by the Secretary. This provision would be effective with respect to obligations for capital expenditures incurred after June 30, 1971, or earlier if a State so requests.

(d) Report on plan for prospective reimbursement; experiments and demonstration projects to develop incentives for economy in the provision of health services

The bill would require the Secretary to develop experiments and demonstration projects designed to test various methods of making Medicare payments to providers of services on a prospective basis and to report to the Congress, no later than July 1, 1972, the results of such experiments and demonstration projects, along with a discussion of experiences of other programs with respect to prospective reimbursement. The report shall also include recommendations with respect to specific methods which could be used in the full implementation of prospective reimbursement on a program-wide basis. In addition,

the Secretary is authorized 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 for the services of residents, interns, and supervisory physicians in teaching settings. Also authorized are experiments and demonstration projects designed to determine whether payments to organizations and institutions for services which are not currently covered under titles V, XVIII, or XIX and which are incidental to services covered under the programs would offer the promise of program savings without any loss in the quality of care, and whether use of areawide or community-wide utilization review and medical review mechanisms would bring about more effective controls over excessive utilization of services. A description of each proposed experiment and project must be submitted to the House Ways and Means Committee and Senate Finance Committee prior to implementation.

(e) Limitations on coverage of costs under Medicare

The bill provides authority for the Secretary to set prospective limits on costs to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to Medicare beneficiaries. Since the limits would be defined in advance, provision would be made for a provider to charge the beneficiary, after appropriate public notice, for the costs of items or services in excess of or more expensive than those that are determined to be necessary in the efficient delivery of needed health services. (No such charges may be made, however, in the case of admission by a physician who has a direct or indirect financial interest in the facility.) It is expected that reasonable limits would be set sufficiently above average costs per patient day previously experienced by a class of institutions so that only institutions with extraordinary expenses would be subject to the limits imposed. In addition, providers would have the right to appeal 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 that the Secretary finds compelling.

(f) Limits on prevailing charge levels

The bill would limit charges determined to be reasonable under the Medicare and Medicaid law by providing (1) that medical charge levels currently recognized as prevailing in a locality could be increased during fiscal year 1971 only to the extent necessary, on the basis of statistical data and methodology acceptable to the Secretary, to bring the prevailing charge levels to the 75th percentile of the customary charges made for similar services in the same locality

during calendar year 1969; (2) that prevailing charges recognized for a locality could be increased in fiscal year 1972 and in later years only to the extent justified by an economic index reflecting changes in the operating expenses of physicians and in physicians' earnings levels; and (3) that for medical supplies, equipment, and services that, in the judgment of the Secretary, generally do not vary significantly in quality from one supplier to another, charges incurred during fiscal year 1971 and later years and determined as reasonable would not exceed the lowest levels at which such supplies, equipment, and services are widely available in a locality, except to the extent specified by the Secretary. The indexes would not be applied on a procedure-by-procedure basis but would operate as overall ceilings on prevailing fee level increases recognized in a carrier area. Payments under titles V and XIX would also be subject to these limitations.

(g) Payment of services for teaching physicians under Medicare program

The bill would change the basis of reimbursement for teaching physicians' services from a fee-for-service basis to a cost-reimbursement basis where the services are furnished in a setting in which any one of the following circumstances exist: (1) the non-Medicare patients, even when able to pay, are not obligated to pay the billed charges for physicians' services; or (2) not all Medicare patients are obligated to pay the medical insurance deductible and coinsurance amounts related to the established charges; or (3) all the Medicare patients are obligated to pay the deductible and coinsurance amounts but such amounts are not generally collected. Medicare payment would also be authorized for services to hospital patients by staff of certain medical schools.

(h) Authority to terminate payments to suppliers of services

The bill provides authority for the Secretary to terminate or suspend payments under the Medicare program for services rendered by any supplier of health and medical services found guilty of program abuses. The Secretary would be required to make the names of such persons or organizations public so that beneficiaries would be informed about which providers cannot participate in the program. The situations for which termination of payment would 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 to furnish professional advice to the Secretary in carrying out this authority.

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.

(i) Amount of payment where customary charges for services furnished are less than reasonable cost

The bill provides authority for the Secretary to limit reimbursement under titles V, XVIII, and XIX to a provider's customary charges so that total reimbursement paid under the various programs would not exceed what would have been paid if the facility's customary charges to the general public had been paid. However, where the provider is a public institution which furnishes services free of charge or at nominal charges to the public, reimbursement would be based on reasonable costs determined so as to provide fair compensation for the services. This provision would be effective with respect to services furnished in accounting periods beginning after June 30, 1970.

(j) Institutional planning

The bill would require each provider of services, as a condition of participation under Medicare, to have a written plan reflecting an operating budget and a capital expenditures budget covering the immediate subsequent one and three accounting years. The plan, which would be reviewed and updated annually, 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 or improvement of land, buildings, and equipment and replacement, modernization, and expansion of the buildings and equipment), and proposed methods of financing the costs. This provision would be effective for a provider of services for any fiscal year beginning after the fifth month following the month of enactment.

(k) Advance approval of extended care and home health coverage

The bill would authorize the Secretary to establish, by medical condition, specific periods of time after hospitalization during which a patient would be presumed to require an extended care level of services. Where a patient's physician certifies to the need for such care and submits to the extended care facility, in advance of admission, a plan for carrying out the services, the care furnished would be assumed to be the type of care which is covered as extended care. Comparable provisions applying to posthospital home health services are also included. However, the advance approval provisions can be declared inapplicable to patients of any physician who is found to be unreliable in certifying patients' need for such care. Also, an extended care facility's utilization review committee could terminate payment to a patient during the approved period if it determined that further inpatient stay was no longer medically necessary.

(l) Prohibition against reassignment of claims to benefits

The bill would prohibit payment for physician and other medical services provided under Medicare and Medicaid to anyone other than the physician or other person providing the services unless the physician or other person is required as a condition of his employment to turn over his fees to his employer or unless there is a contractual arrangement between a physician or other person and the facility in which the services were provided under which the facility bills for all such services.

(m) Notification of unnecessary admission to a hospital or extended care facility

The bill expands the responsibility of hospital and extended care facility utilization review committees to require notification in any case which, in the course of a review of a current sample of admissions, it is determined that admission to or further stay in the institution is not medically necessary. Payment would be terminated under the same procedures now applied to cases of extended duration where the committee determines that further stay is not medically necessary.

(n) Health maintenance organization option

The bill provides that individuals eligible for both part A and part B Medicare coverage would be able to choose to have their care provided by a health maintenance organization (a prepaid group health or other capitation plan). The rate of payment to such organizations by the program would be set each year by the Secretary, taking into account the organization's premium to

nonmedicare enrollees, and is not to exceed 95 percent of the estimated amount that would be payable for covered Medicare services furnished outside the framework of a health maintenance organization.

Medicare beneficiaries who exercise this option would receive covered services only through the health maintenance organization with which they are enrolled, except for emergency services (generally, services required by the beneficiary while he is outside of the area served by the organization). The health maintenance organization would be responsible for the cost of such emergency services, but the Medicare beneficiary would be responsible for the full cost of any nonemergency services he received outside the organization.

A health maintenance organization is defined as an organization which provides, either directly or by arrangement with others, health services, including physicians' services on a per capita prepayment basis. At least half its members must be under 65 years of age and it must hold open enrollment periods at least once every 2 years. Among the additional requirements is a requirement that the organization must have arrangements for assuring that the health services required by its enrollees are received promptly and appropriately and that they meet quality standards. Present arrangements for reimbursing group practice prepayment plans would remain in effect. Plans that qualify could choose to be reimbursed as health maintenance organizations or to continue to be reimbursed under existing law.

(o) Hospital admissions for dental services under the Medicare program

The bill would require a certification of medical necessity to be made where a patient must be hospitalized in connection with a dental procedure for management of other severe impairments. The dentist who is caring for the patient may make the determination that such hospitalization is necessary without the need for a corroborating certification by a physician.

(p) Physical therapy services

The bill would cover under the supplementary medical insurance program the services of a physical therapist in independent practice, when furnished in his office or in the patient's home. These services would be furnished under such licensing and other conditions relating to health and safety as the Secretary may find necessary. The reimbursable charges on which payment would be made for such services furnished to an individual could not exceed $100 in a calendar year. Coverage of these services would be effective January 1, 1971.

The bill would also make two changes with respect to physical therapy services furnished by a provider of services: (1) the existing provision for covering "outpatient physical therapy services" would be broadened to permit a hospital or extended care facility to furnish these services to their inpatients who can now receive these services only as "outpatients" of another provider of services (this change would be effective upon enactment of this legislation); and (2) where the services are provided under an arrangement with a physical therapist the program payment could not exceed an amount equal to the salary which would have been payable if the services had been performed in an employment relationship (this change would be effective with respect to services provided in accounting periods of the respective providers of services beginning after enactment of this legislation).

(q) Extension of grace period for termination of SMI coverage

The bill would authorize an additional 90-day grace period (over and above the 90-day grace period authorized under present law) before termination of supplementary medical insurance coverage. Such additional grace period would be authorized only in cases where it can be demonstrated that there was good cause for failure to pay the overdue premiums within the initial 90-day grace period. The provision would be effective with respect to nonpayment of premiums which become due and payable on or after date of enactment or which become payable within the 90-day period immediately preceding enactment.

(r) Extension of time for filing SMI claims

The bill would provide that where a claim under supplementary medical insurance is not filed before the close of the calendar year following the year in which the service was furnished (as prescribed under present law) and where such late filing is due to an error on the part of the Government or one of its agents, the claim would be honored if filed as soon as possible after the facts in the case are established. This provision would apply with respect to bills submitted and requests for payment made after March 1968.

(s) Waiver of enrollment period requirements

The bill would authorize the Secretary to provide equitable relief (including the designation of special enrollment and coverage periods as appropriate) in situations where an individual's enrollment or nonenrollment in the supplementary medical insurance program is other than it should be because of administrative error or inaction. This provision would be effective as of July 1, 1966.

(t) Elimination of 3-year enrollment limit

The bill would eliminate the 3-year deadlines on enrollment and reenrollment in the supplementary medical insurance program. As under present law, individuals who terminate enrollment would be allowed to reenroll only once. The present enrollment periods would be retained.

(u) Waiver of recovery of overpayments

The bill would permit an individual entitled to cash social security or railroad retirement benefits on the earnings of a deceased beneficiary to whom or on whose behalf a Medicare overpayment has been made 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.

(v) Minimum amount required for hearing

The bill would require that a minimum amount of $100 must be at issue before an enrollee in the supplementary medical insurance program will be granted a fair hearing by the carrier.

(w) Collection of SMI premiums by Railroad Retirement Board

The bill would require that for all annuitants or pensioners under the railroad retirement program (including those who are entitled to monthly social security benefits), the monthly premiums for supplementary medical insurance be collected by the Railroad Retirement Board. The provision would become effective with premiums becoming due and payable after the fourth month following enactment of the bill.

(x) Payment for inpatient hospital services furnished to border residents

The bill would provide for coverage of inpatient hospital services furnished outside the United States where the beneficiary is a resident of the United States and where 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 and only with respect to inpatient services furnished by a hospital which has been accredited by the Joint Commission on Accreditation of Hospitals or by a hospital-approval program having essentially comparable standards. This amendment would apply with respect to admissions occurring after December 31, 1970.

Present law provisions covering emergency inpatient hospital services furnished outside the United States to beneficiaries other than those who would be affected by the above change would be retained. Payment for all covered hospital services furnished outside the United States would be made on essentially the same basis as payment for emergency services furnished by a nonparticipating hospital within the United States.

(y) Study of chiropractic services

The bill would provide for a study of chiropractic services furnished under title XIX to determine whether, and to what extent, chiropractic services should be covered under part B of title XVIII. The study would be conducted by the Secretary, who would report his findings and recommendations to the Congress within 2 years after enactment of the bill.

3. FINANCING OF SOCIAL SECURITY BILL

To meet the cost of the proposed changes in the cash benefits program and to meet the present actuarial deficit in the hospital insurance program, the contribution and benefit base would be increased from $7800 to $9000 (effective January 1, 1971), and the contribution rate schedules for the cash benefits and hospital insurance parts of the program would be revised. For employers and employees, the combined rates for cash benefits and hospital insurance would be the same as present law for 1971 and 1972 and slightly less than present law for 1973 and 1974. For the self-employed, the combined contribution rate would be less than under present law for 1971 through 1974. The ultimate contribution rate for cash benefits and hospital insurance would be 6.5 percent each for employers and employees, effective for 1980 and after, and 8.0 percent for the self-employed, effective for 1975 and after.

The contribution rate schedules under present law and under the Committee Bill are as follows:

Period	OASDI		HI		Total	
	Present Law	Committee Bill	Present Law	Committee Bill	Present Law	Committee Bill
	Employer-Employee, Each					
1971-72	4.6%	4.2%	.6%	1.0%	5.2%	5.2%
1973-74	5.0	4.2	.65	1.0	5.65	5.2
1975	5.0	5.0	.65	1.0	5.65	6.0
1976-79	5.0	5.0	.7	1.0	5.7	6.0
1980-86	5.0	5.5	.8	1.0	5.8	6.5
1987 and after	5.0	5.5	.9	1.0	5.9	6.5
	Self-Employed					
1971-72	6.9%	6.3%	.6%	1.0%	7.5%	7.3%
1973-74	7.0	6.3	.65	1.0	7.65	7.3
1975	7.0	7.0	.65	1.0	7.65	8.0
1976-79	7.0	7.0	.7	1.0	7.7	8.0
1980-86	7.0	7.0	.8	1.0	7.8	8.0
1987 and after	7.0	7.0	.9	1.0	7.9	8.0

Disability Insurance Trust Fund

The bill would revise the allocation of contribution income between the old-age and survivors insurance and disability insurance trust fund. Under present law, 1.10 percent of taxable wages and 0.825 of 1 percent of self-employment income are allocated to the disability insurance trust fund. The allocation under the bill would be as follows:

Calendar Year	Percent of Taxable Wages	Percent of Self-Employment Income
1971-74	0.90	0.6750
1975-79	1.05	0.7875
1980 and after	1.15	0.8625

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE

Ways and Means Committee Bill

First-year benefit costs and number of persons affected, by provision

Provision	Additional benefit payments in first 12 months (in millions)	Present-law beneficiaries immediately affected 1/ (in thousands)	Newly eligible persons 2/ (in thousands)
5% benefit increase	$1,700	26,200	3/ 6
Modified retirement test 4/	475	900	100
Age 62 computation point	925	10,200	60
100% of PIA for widows and widowers	700	3,300	--
Noncontributory credits for military service after 1956	35	130	--
Election to receive larger future benefits by certain beneficiaries eligible for more than 1 actuarially reduced benefit	10	100	--
Children disabled at ages 18-21	10	--	13
Liberalized disability insured status requirement for the blind	25	--	30
Liberalized workmen's compensation offset	7	55	5
Eliminate support requirement for divorced wives and surviving divorced wives	15	--	10
Actuarially reduced benefits to widowers at age 60	5/	--	5/

1/ Present-law beneficiaries whose benefit for the effective month would be increased under the provision.

2/ 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/ Noninsured persons aged 72 and over.

4/ Additional benefit payments represent benefits for months in calendar year 1971. Some 900,000 persons who will receive some benefits for months in 1971 under present law would receive additional benefits under the provision; about 100,000 persons who will receive no benefits for months in 1971 under present law would receive some benefits under the provision

5/ Less than $500,000 in additional payments; less than 500 newly eligible widowers.

Note.--The above figures are not additive because the time periods are not uniform and because a person may be affected by more than one provision.

Office of the Actuary--Baltimore
May 11, 1970

I have a telegram from the California Association of Nursing Homes, which says:

WASHINGTON, D.C., *May 15, 1970.*

Hon. H. ALLEN SMITH,
House of Representatives,
Washington, D.C.:

(The bill grants increases to social security beneficiaries and at the same time limits welfare patients (large percentage of which are senior citizens) to ninety days nursing home care after which Federal percentage of matching funds is reduced thirty-three and one-third percent and hospital and mental hospital benefits similarly reduced after sixty days.)

This will cost our State several million dollars in matching funds and may result in our State plan being out of compliance with the Department of Health, Education, and Welfare. Although House Ways and Means held two sets of hearings on the titles 18 and 19 amendments, these provisions were never discussed because they were submitted by HEW long after the hearings closed. We believe in view of all this H.R. 17550 should not have gag rule—should have eight hours of debate with certain floor amendments allowed.

CALIFORNIA ASSOCIATION OF NURSING HOMES, SANITARIUMS, REST HOMES AND HOMES FOR THE AGED.
SACRAMENTO, CALIF.

I also have a telegram from an individual which says:

BURBANK, CALIF.

Hon. H. ALLEN SMITH,
House of Representatives,
Washington, D.C.:

H.R. 17550 due Wednesday crime against old, sick, needy vote no. Community watching your stand.

KATHERINE ARTU.

Governor Reagan said:

WASHINGTON, D.C., *May 19, 1970.*

Hon. H. ALLEN SMITH,
Rayburn Building,
Washington, D.C.:

We understand that the Social Security amendments (H.R. 17550) will be considered by the House this week, if a rule is granted. The California Dept. of Health Care Services estimates that, in its present form the bill contains the provisions of H.R. 16654 (formerly H.R. 16264) which would increase State costs in fiscal 1970–71 by $20.4 million.

We understand Congress desire to reduce expenditures in the title XIX (medicaid) program. As you may know, California, has taken action this year to contain the ever increasing financial pressures in the medical program. We support continued efforts to contain medical care costs at the national level. We are concerned, however, that the change in Federal participation is not a true cost reduction measure. While it does no doubt reduce Federal expenditures, it does so in a way that shifts the fiscal burden to the States. Furthermore, the 235 million saved is earmarked by Bureau of Budget to help defray fiscal 1971 start up costs of Welfare Reform Act which is still a long way from law. We request that you withhold support of this portion of H.R. 17550.

RONALD REAGAN,
Governor, State of California.

Based upon those, I talked to a number of people yesterday, and this is the information I wanted to bring to the attention of the chairman of the Ways and Means Committee so that he can appropriately clear the record regarding it.

The individuals I talked to yesterday stated:

The proposed amendment to title XIX would be—

First, an increase in the Federal matching percentage by 25 percent for outpatient hospital services, clinic services and home health services;

Second, a decrease in the Federal percentage by one-third after the first 60 days of care—in a fiscal year—in a general or TB hospital;

Third, a reduction in the Federal percentage by one-third after the first 90 days of care in a skilled nursing home;

Fourth, a decrease in Federal matching by one-third after 90 days of care in a mental hospital and provision for no Federal matching after an additional 275 days of such care during an individual's lifetime; and

Fifth, authority for the Secretary to compute a reasonable cost differential for reimbursement purposes between skilled nursing homes and intermediate care facilities.

My conclusion, from what they stated was that the States must then take action to—

First. Absorb the fiscal impact with State and local funds, or

Second. Reduce overall medicaid benefits, or

Third. Reduce skilled nursing home benefits regardless of patient need, or

Fourth. Classify patients as "intermediate care" or "custodial." Many States do not have an intermediate care program. Some States with an intermediate care program have already classified nursing homes and patients as intermediate care on a wholesale basis without regard to required standards or patient needs. The Feredal financial assistance in intermediate care is limited to grant-in-aid recipients. Medical-assistance-only patients in the medicaid program would not be eligible for Federal assistance in intermediate care facilities.

Mr. Speaker, I have attempted to check on these statements, and I have come to some personal conclusions.

It looks like the language they are questioning is found in the bill on page 83 beginning on line 21, and continuing through line 16 on page 87. In the committee report a discussion of this language is found beginning at (e) at the bottom of page 38 and continuing on page 39.

What the bill does is to attempt to encourage the several States to more efficiently and less expensively use the Medicare and medicaid programs. To do this the bill provides for an increase in Federal matching funds by 25 percent for outpatient hospital services, clinical health services and home health services. At the same time, the bill decreases the Federal matching share payments by one-third after a patient's first 60 days in a general or TB hospital.

Also reduced by one-third is the Federal matching share after the first 90 days of patient care in a skilled nursing home or a mental hospital.

The reductions in Federal matching funds for institutional care, coupled with the increase in Federal matching funds for out-of-hospital patient care, reflects the bill's intention to cut costs of these programs.

The Ways and Means Committee has also received information concerning the average length of stay and similar statistics indicating that their cutoff is more than reasonable.

The nursing homes, however, state that they are in a box. Their position is that a number of patients need more care than an arbitrary 90-day period, that most nursing homes must operate at between 80 and 85 percent continuous bed capacity in order to make it economically. They fear that when patients are cut off from full Federal assistance after 90 days that new patients will not be available to fill the beds at the higher Federal matching payment level for a new 90-day period.

With the generally tight budget straits that most States find themselves in at the present time, it would seem to me rather unlikely that the States will try to pick up the slack caused by the reduction in the Federal percentage. As Governor Reagan pointed out, it could cost California $20.4 million the first year. Therefore, it does seem likely the States will cut back to the Federal level, thus reenforcing the fears of the nursing home people with respect to their economic situation.

So there is a dilemma here. Any cutoff will be arbitrary. Some indigent patients with no means of support and a disease requiring skilled nursing home care over a period exceeding 90 days probably are going to have some problems. Either the patient will have to pay $30 a day out of his own pocket, or, if he is unable to do it, probably the nursing home will have to pay or absorb it. Obviously patients in that condition will not be turned into the street.

Without being critical, I imagine there are some patients in these skilled nursing homes today who could well be moved out before the 90 days but they are not moved out in order to keep the beds full and to keep the Federal funds coming in.

However, I do suggest that some language might be considered to provide a waiver of the 90-day rule. It could provide for a medical review of any case where the doctor in charge believes that additional skilled care is required.

It seems that some cutoff date, reasonably arrived at, should be instituted in order that the Federal Government can assure some control over the expenditures of the Federal matching fund program.

While the nursing home people can make a case for possible future impairment of income due to the 90-day cutoff in the bill, I raise a question as to whether or not the constant clamor of patients to get into hospitals and the resulting overflow will not continue to provide for the skilled nursing home industry a continous flow of patients who are well enough to leave a hospital but still will require regular doctor and nursing care.

Obviously, no legislation can be perfect. There are some bad parts in this bill, but there are a number of very, very good provisions.

Mr. Speaker, if either the distinguished chairman of the committee or the ranking minority member wish to make any comments in connection with this, I will be more than pleased to yield to them. If not, I reserve the balance of my time.

Mr. BOLLING. Mr. Speaker, I yield 5 minutes to the gentleman from Texas (Mr. PICKLE).

(Mr. PICKLE asked and was given permission to revise and extend his remarks.)

Mr. PICKLE. Mr. Speaker, I have some strong reservations about portions of this particular bill, H.R. 17550. I want to ask some questions that I think should be answered before we proceed with the rule. I have just now been able to reach the floor and I have not therefore heard all of the discussion of the two speakers who preceded me. I hope I am not repeating in some of these questions which concern me, but I think they ought to be discussed by this body.

I have received considerable correspondence and many telegrams from the skilled nursing homes in my district. I am sure many of my colleagues have received a similar number of protests or expressions of concern. These nursing homes and my Texas State Department of Welfare are concerned about section 225 of this bill, which deals with the establishment of incentives for States to emphasize outcare under the medicaid program. This provision, among other things, provides for the cutback of one-third of the Government's share of matching funds for every patient who stays in a skilled nursing home after 90 days. In Texas the Federal Government's share is two-thirds of the cost and the State's share is one-third. In some States the Federal Government's share is even greater. I believe it is in the State of Arkansas.

My concern is with regard to these patients who are still ill and require care after 90 days. Where are they going to go when the money is cut off? The Texas State Department of Welfare is already having severe trouble meeting its increased financial requirements. They are not sure that they can make up this loss of one-third of the Federal funds. So if the States cannot make up for the lost funds, then where are the sick and the elderly poor going to be cared for after 90 days?

Now, I suppose and I understand that it is intended that some of the patients can be placed in intermediate care centers, but I do not see any assurance here that there are near enough of these intermediate care facilities to handle all of these people who are going to be turned out of these skilled nursing homes after 90 days.

Also, where is the State going to get the money to care for the person whose health condition is so poor that he requires nursing care for a period longer than 90 days?

I certainly do not see why or how 90 days was picked as the cutoff point. It sounds as though that is an arbitrary number of days to me. How can we say everyone ought to be well enough to leave a skilled nursing home after 90 days?

The stated purpose of this bill is to encourage the States to utilize less expensive care than the skilled nursing home, such as the intermediate care centers. I want to know where is the money going to come from to pay for this increased use of these health care centers, these intermediate care centers.

Does it say in this bill that the Federal Government is going to increase the amount of matching funds that it is now putting into intermediate care centers, how much those intermediate care centers are going to cost the State, and where are they going to get the funds even if the Federal Government increases its share to the intermediate facilities? I am still concerned about where the States are going to get the funds with which to obtain the skilled nursing care for a period of more than 90 days.

Mr. KAZEN. Mr. Speaker, will the gentleman yield?

Mr. PICKLE. I yield to the gentleman from Texas.

Mr. KAZEN. The gentleman it seems to me is confusing two issues. The intermediate care centers are not the same thing as your skilled nursing institutions. You cannot substitute one for the other. In rural areas you do not even have enough nurses to staff the hospitals, and a lot of our hospitals are losing their affiliation with the medicare program as a result thereof. Where in the world would these people go if this skilled nursing service is denied them?

The SPEAKER. The time of the gentleman from Texas has expired.

Mr. PICKLE. Mr. Speaker, I wonder if the gentleman from Missouri would yield to me 5 additional minutes?

Mr. BOLLING. The gentleman desires 5 additional minutes?

Mr. PICKLE. Yes.

Mr. BOLLING. I would be delighted to yield the gentleman 5 additional minutes.

Mr. KAZEN. Mr. Speaker, if the gentleman would yield further, I would remind the gentleman that there is no substitute for the skilled nursing program. Certainly the majority of the people that are in the skilled nursing facilities require more than the 90 days' care. In Texas alone I was advised this morning that this program is going to cost the State $33 million to begin with and they do not know where they are going to get it. Mr. Speaker, I commend the gentleman from Texas for his remarks and wish to associate myself with his position.

Mr. PICKLE. If I may respond to the gentleman, Mr. KAZEN, I am not confused; at least, I do not think I am confused about the difference between the skilled nursing homes and intermediate care centers. I was advised yesterday that within the next year and a half, the next 18 months, it will cost Texas nearer the figure of $60 million but I do not have the comparative figures for the various other States.

Mr. FUQUA. Mr. Speaker, will the gentleman yield?

Mr. PICKLE. I yield to the gentleman from Florida.

Mr. FUQUA. I want to thank the gentleman for bringing this to the attention of the House because this is a very important matter and I want to associate myself with the remarks that the gentleman has made.

I want to support this bill. However, this is a very unfair provision. It will work a hardship on our States, especially in view of the fact that there has been no advance notice and many of the State legislatures are not in session. However, they are going to have to come up with this money. I see no way possible whereby they can make up the deficit they will be required to make if this particular section is enacted.

I would hope we could amend the rule in order to debate this particular issue and not have to depend entirely upon a motion to recommit.

Mr. MILLS. Mr. Speaker, will the gentleman yield to me at this point?

Mr. PICKLE. I shall yield to the distinguished gentleman from Arkansas to make a statement but before I yield to the gentleman I want to ask, What are we going to do with the nursing home industry, when we suddenly say to them, "We are not going to pay for any of this care after 90 days." This is a little harsh and constitutes a sudden requirement which they have got to meet. I am sure that there is some truth to the statement that some of the skilled nursing homes have either abused or have kept some of the patients in the home longer than, say, the 90 days that you have arbitrarily set in this bill. Perhaps, they have kept them there longer than necessary, I know in some cases up to 800 days. But to say in this bill, without a chance to amend it in order to get at the problem involved in carrying out the intent of the provision and that we have got to take it all, does violence to the skilled nursing home problem. I am concerned that if this rule is adopted we will have no chance to amend it or to work on it. We are not dealing with the tax aspect. We are talking about the skilled nursing care problem.

Mr. STUBBLEFIELD. Mr. Speaker, will the gentleman yield?

Mr. PICKLE. I yield to the gentleman from Kentucky.

Mr. STUBBLEFIELD. Mr. Speaker, I thank the gentleman from Texas for yielding, and I want to associate myself with the remarks being made by the gentleman from Texas. I too am deeply concerned about this bill, because the Kentucky State Legislature does not meet again for 2 years, and I do not know where in the world they are going to get the money to handle this situation.

Mr. PICKLE. Mr. Speaker, I would say to the gentleman from Kentucky that I think the problem that his State is faced with is the same one all the States are facing, and they are certainly becoming alarmed about this situation.

Mr. MILLS. Mr. Speaker, will the gentleman yield?

Mr. PICKLE. I yield to the gentleman from Arkansas.

Mr. MILLS. Mr. Speaker, I thank the gentleman for yielding, and I am not going to accuse the gentleman's State of being in the same category as some of the other States in the administration of this program, but if the gentleman is telling the House that this means a $30 million increase in the cost to the State then it simply means that the gentleman's State is not going to correct what we have found to be a real problem in connection with the Federal costs in these nursing homes. There is undoubtedly more overutilization in the skilled nursing homes than there is any-

where else when we hear about this problem because in many instances they keep people in these skilled nursing homes for long periods of time when the facts are, in a great majority of the cases, that the patient or the individual would be just as well off in the intermediate care-type nursing home, which is the type nursing home in the gentleman's State and my State that is in the big majority.

These skilled nursing homes are the skilled nursing homes that require a nurse around the clock. The patient who is there is supposed to have a doctor, maybe not every day, but on certain occasions. If they do not need that degree of care, then why continue to pay for that type of care when the other care will do them just as much good?

The SPEAKER. The time of the gentleman has again expired.

Mr. PICKLE. Mr. Speaker, will the gentleman from Missouri yield me 2 additional minutes?

Mr. BOLLING. Mr. Speaker, I yield 2 additional minutes to the gentleman from Texas.

Mr. MILLS. If the gentleman will yield further, these are the facts that we have found in our investigations.

Mr. PICKLE. I thank the gentleman for the additional time, because I want to respond to the gentleman from Arkansas on this matter.

I can report to the gentleman that my State has reported to me it will cost them in our State a very large sum of money, whether $30 million or $60 million, I am not sure, and it does concern them.

Mr. MILLS. If the gentleman will yield further, it could not cost that much money because, in the first place, there is not that much money involved in it.

Mr. PICKLE. I am more apt to believe that my State knows as much what they are talking about as the gentleman does.

Mr. MILLS. They do not in this instance.

Mr. PICKLE. The second thing is this: I have said that there may be some abuses in these skiled nursing homes——

Mr. MILLS. A whole lot of it.

Mr. PICKLE. I have some familiarity with the problem. I too sometimes wonder if they should keep them that number of days, and if it is not too long. But this bill is going to arbitrarily select a date of 90 days, and then turn them out. Well, that creates a big problem. I have no assurance that in my State there are enough of these intermediate care centers, and of those that we have they are already overloaded. All you are going to do is put more money into this particular sector. You do not really cure the problem. You do not give us any chance to work out this problem when you adopt this rule that is a closed rule.

Mr, MILLS. If the gentleman will yield further; if the gentleman's State does not change any of its present practices with respect to this program there would be an additional cost on your State of around $3 million. But the whole purpose of it is to avoid this cost to the Federal Government and to the State governments through elimination of this abusive overutilization, and I am sure the gentleman would want that done for his taxpayers.

Mr. PICKLE. Mr. Speaker, our State is willing to cooperate in trying to find a better answer to the nursing problems, but for this particular Committee on Ways and Means to come out and tell us you are going to make this a 90-day cutoff period because of these alleged abuses, and not give them a chance to work out some other solution, is an unfair position to put the States in.

Mr. MILLS. It is the same kind of limitation we have with respect to medicare and have had since its inception.

Mr. PICKLE. I hope, Mr. Speaker, that this rule may not be adopted so that we will have a chance to send it back to committee, and have a chance to work on this particular section on the nursing program.

The SPEAKER. The time of the gentleman has again expired.

Mr. BOLLING. Mr. Speaker, I move the previous question on the resolution.

The SPEAKER. The question is on ordering the previous question.

The question was taken; and the Speaker announced that the ayes appeared to have it.

Mr. PICKLE. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER. Evidently a quorum is not present.

The Doorkeeper will close the doors, the Sergeant-at-Arms will notify absent Members, and the Clerk will call the roll.

The question was taken; and there were—yeas 201, nays 181, not voting 47, as follows:

[Roll No. 132]

YEAS—201

Abbitt	Cunningham	Hull
Adair	Daniel, Va.	Hunt
Addabbo	Daniels, N.J.	Hutchinson
Albert	Davis, Wis.	Ichord
Alexander	Delaney	Johnson, Calif.
Anderson, Ill.	Dellenback	Johnson, Pa.
Annunzio	Denney	Jonas
Arends	Dent	Jones, Tenn.
Baring	Devine	Kee
Barrett	Dingell	Keith
Beall, Md.	Dulski	Landrum
Berry	Dwyer	Langen
Betts	Edmondson	Latta
Biaggi	Edwards, Ala.	Lukens
Biester	Ellberg	McClory
Blackburn	Erlenborn	McCloskey
Blanton	Eshleman	McCulloch
Boggs	Evins, Tenn.	McDade
Boland	Fallon	McDonald, Mich.
Bolling	Fascell	Madden
Bow	Feighan	Mailliard
Brasco	Findley	Marsh
Bray	Fish	Martin
Brown, Ohio	Flood	Mathias
Broyhill, N.C.	Flowers	May
Broyhill, Va.	Ford, Gerald R.	Mayne
Buchanan	Frelinghuysen	Meskill
Burke, Fla.	Friedel	Michel
Burke, Mass.	Fulton, Tenn.	Miller, Ohio
Burleson, Tex.	Garmatz	Mills
Burlison, Mo.	Gibbons	Minshall
Burton, Utah	Gilbert	Mize
Button	Goodling	Mizell
Byrnes, Wis.	Gray	Mollohan
Carey	Green, Pa.	Moorhead
Cederberg	Griffiths	Morgan
Celler	Gubser	Morton
Chamberlain	Hagan	Mosher
Chappell	Hall	Murphy, Ill.
Clancy	Halpern	Murphy, N.Y.
Clark	Hamilton	Myers
Clausen, Don H.	Hammer-schmidt	Nedzi
Collier	Hanley	Nelsen
Conable	Hansen, Idaho	Nix
Corbett	Hansen, Wash.	Olsen
Corman	Harvey	O'Neal, Ga
Coughlin	Hastings	Pepper
Cowger	Hogan	Perkins
Cramer	Holifield	Pettis
Crane	Hosmer	Poff
Price, Ill.	Schneebeli	Vanik
Pryor, Ark.	Schwengel	Vigorito
Pucinski	Shipley	Watkins
Quie	Sisk	Watts
Railsback	Smith, N.Y.	Whalen
Rees	Snyder	Widnall
Reid, Ill.	Springer	Williams
Rhodes	Staggers	Wilson, Bob
Rivers	Stanton	Wilson, Charles H.
Robison	Steed	Wyatt
Rodino	Steiger, Ariz.	Wylie
Rooney, N.Y.	Talcott	Wyman
Rostenkowski	Teague, Calif.	Zablocki
Ruppe	Thompson, Ga.	Zion
Ruth	Thomson, Wis.	Zwach
Sandman	Udall	
Satterfield	Ullman	
Scherle	Vander Jagt	

NAYS—181

Abernethy	Haley	Poage
Adams	Hanna	Podell
Anderson, Calif.	Harrington	Powell
Andrews, Ala.	Harsha	Preyer, N.C.
Andrews, N. Dak.	Hathaway	Price, Tex.
Ashbrook	Hawkins	Purcell
Bennett	Hébert	Quillen
Bevill	Hechler, W. Va.	Randall
Blatnik	Heckler, Mass.	Rarick
Brademas	Helstoski	Reid, N.Y.
Brinkley	Henderson	Reuss
Brock	Hicks	Riegle
Brooks	Horton	Roe
Broomfield	Howard	Rogers, Fla.
Brotzman	Hungate	Rooney, Pa.
Burton, Calif.	Jarman	Rosenthal
Cabell	Jones, N.C.	Roth
Caffery	Karth	Roybal
Camp	Kastenmeier	Ryan
Carter	Kazen	St Germain
Casey	King	Schadeberg
Clawson, Del	Koch	Scheuer
Cleveland	Kuykendall	Scott
Collins	Kyros	Sebelius
Conte	Lennon	Shriver
Conyers	Lloyd	Sikes
Culver	Long, La.	Skubitz
Daddario	Long, Md.	Slack
de la Garza	Lowenstein	Smith, Calif.
Dennis	Lujan	Smith, Iowa
Derwinski	McClure	Stafford
Dickinson	McEwen	Steiger, Wis.
Diggs	McFall	Stephens
Donohue	McKneally	Stratton
Dorn	McMillan	Stubblefield
Dowdy	Macdonald, Mass.	Stuckey
Downing	Mahon	Sullivan
Duncan	Mann	Taft
Eckhardt	Meeds	Taylor
Edwards, La.	Melcher	Teague, Tex.
Esch	Mikva	Thompson, N.J.
Evans, Colo.	Minish	Van Deerlin
Farbstein	Mink	Waggonner
Fisher	Monagan	Waldie
Flynt	Montgomery	Wampler
Foreman	Morse	Watson
Fountain	Moss	Weicker
Fraser	Natcher	Whalley
Frey	Nichols	White
Fulton, Pa.	Obey	Whitehurst
Fuqua	O'Hara	Whitten
Galifianakis	O'Konski	Wiggins
Gaydos	O'Neill, Mass.	Winn
Gettys	Passman	Wold
Giaimo	Patman	Wolff
Gonzalez	Patten	Wright
Griffin	Pelly	Wydler
Gross	Philbin	Yates
Grover	Pickle	Yatron
Gude	Pike	Young
	Pirnie	

NOT VOTING—47

Anderson, Tenn.	Dawson	McCarthy
Ashley	Edwards, Calif.	MacGregor
Aspinall	Foley	Matsunaga
Ayres	Ford, William D.	Miller, Calif.
Belcher	Gallagher	Ottinger
Bell, Calif.	Goldwater	Pollock
Bingham	Green, Oreg.	Reifel
Brown, Calif.	Hays	Roberts
Brown, Mich.	Jacobs	Rogers, Colo.
Bush	Jones, Ala.	Roudebush
Byrne, Pa.	Kirwan	Saylor
Chisholm	Kleppe	Stokes
Clay	Kluczynski	Symington
Cohelan	Kyl	Tiernan
Colmer	Landgrebe	Tunney
Davis, Ga.	Leggett	

So the previous question was ordered.

The Clerk announced the following pairs:

On this vote:

Mr. Hays for, with Mr. Edwards of California against.
Mr. Colmer for, with Mr. Brown of California against.
Mr. Kluczynski for, with Mr. Roberts against.
Mr. Aspinall for, with Mr. Stokes against.
Mr. Rogers of Colorado for, with Mr. Bingham against.
Mr. Matsunaga for, with Mrs. Chisholm against.
Mr. Byrne of Pennsylvania for, with Mr. Clay against.
Mr. Miller of California for, with Mr. Ottinger against.
Mr. Landgrebe for, with Mr. McCarthy against.
Mr. Kyl for, with Mr. Leggett against.
Mr. Roudebush for, with Mr. Foley against.
Mr. Kirwan for, with Mr. Symington against.
Mr. Reifel for, with Mr. Goldwater against.

Until further notice:

Mrs. Green of Oregon with Mr. Ayres.
Mr. Jones of Alabama with Mr. MacGregor.
Mr. Tunney with Mr. Pollock.
Mr. Davis of Georgia with Mr. Bush.
Mr. Ashley with Mr. Saylor.
Mr. Tiernan with Mr. Belcher.
Mr. William D. Ford with Mr. Brown of Michigan.
Mr. Cohelan with Mr. Bell of California.
Mr. Jacobs with Mr. Dawson.
Mr. Anderson of Tennessee with Mr. Kleppe.

Messrs. FISHER, MAHON, HECHLER of West Virginia, ECKHARDT, FRASER, MONAGAN, WHALLEY, and HARRINGTON changed their votes from "yea" to "nay."

Mr. TEAGUE of California and Mr. BIAGGI changed their votes from "nay" to "yea."

The result of the vote was announced as above recorded.

The doors were opened.

PROVIDING FOR CONSIDERATION OF H.R. 17550, SOCIAL SECURITY AMENDMENTS OF 1970

The SPEAKER. The question is on the resolution.

The question was taken; and the Speaker announced that the ayes appeared to have it.

Mr. LONG of Louisiana. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER. Evidently a quorum is not present.

PARLIAMENTARY INQUIRY

Mr. BURTON of California. Mr. Speaker, a parliamentary inquiry.

The SPEAKER. The gentleman will state the parliamentary inquiry.

Mr. BURTON of California. Mr. Speaker, as I understand the situation, if the rule is rejected, then that would leave us an effective opportunity to restore the current Federal matching to the States for certain nursing home care after 90 days; is that correct, Mr. Speaker?

The SPEAKER. The Chair understands the gentleman's question, but the Chair must state that that is not a parliamentary inquiry.

PARLIAMENTARY INQUIRY

Mr. BOLLING. Mr. Speaker, a parliamentary inquiry.

The SPEAKER. The gentleman will state his parliamentary inquiry.

Mr. BOLLING. As the manager of the rule, would I be correct in stating that the parliamentary situation would be that if this rule were defeated, the bill made in order by the rule, namely, the increase in social security, could not come up?

The SPEAKER. The Chair will state that that is a matter of procedure and a question for ths gentleman from Arkansas.

Mr. BOLLING. Mr. Speaker, a further parliamentary inquiry.

The SPEAKER. The gentleman will state it.

Mr. BOLLING. If the rule making in order the bill which is provided for by the rule were defeated, the bill would not be in order?

The SPEAKER. The Chair will state, without passing upon the question at this point as to whether or not this would be a privileged bill, that if the rule should be rejected the bill would not come up at this time.

Mr. BYRNES of Wisconsin. Mr. Speaker, will you permit me to comment on the fact that the report on this bill did not comply with the Ramseyer rule, so an objection could be made to bringing up the legislation unless there is a rule waiving that point of order.

Mr. MILLS. That is exactly the point of the gentleman from Missouri.

The SPEAKER. The Chair has ruled that a quorum evidently is not present.

The Doorkeeper will close the doors, the Sergeant at Arms will notify absent Members, and the Clerk will call the roll.

The question was taken; and there were—yeas 297, nays 83, not voting 49, as follows:

[Roll No. 133]

YEAS—297

Abbitt	Bray	Corbett
Adair	Brown, Ohio	Corman
Addabbo	Broyhill, N.C.	Coughlin
Albert	Broyhill, Va.	Cowger
Alexander	Buchanan	Cramer
Anderson, Ill.	Burke, Fla.	Crane
Andrews, Ala.	Burke, Mass.	Culver
Andrews, N. Dak.	Burleson, Tex.	Cunningham
Annunzio	Burlison, Mo.	Daddario
Arends	Burton, Utah	Daniel, Va.
Barrett	Button	Daniels, N.J.
Beall, Md.	Byrnes, Wis.	Davis, Wis.
Bennett	Camp	Delaney
Berry	Carey	Dellenback
Betts	Carter	Denney
Bevill	Casey	Dent
Biaggi	Cederberg	Derwinski
Blester	Celler	Devine
Blackburn	Chamberlain	Diggs
Blanton	Chappell	Dingell
Boggs	Clancy	Donohue
Boland	Clausen, Don H.	Dorn
Bolling	Collier	Downing
Bow	Conable	Dulski
Brasco	Conyers	Duncan
Eckhardt	Long, Md.	Roe
Edmondson	Lujan	Rogers, Fla.
Edwards, Ala.	Lukens	Rooney, N.Y.
Eilberg	McClory	Rooney, Pa.
Erlenborn	McCloskey	Rosenthal
Esch	McClure	Rostenkowski
Eshleman	McCulloch	Roth
Evans, Colo.	McDade	Ruppe
Evins, Tenn.	McDonald, Mich.	Ruth
Fallon	McEwen	Ryan
Farbstein	McFall	St Germain
Fascell	Macdonald, Mass.	Sandman
Feighan	Madden	Satterfield
Findley	Mailliard	Schadeberg
Fish	Marsh	Scherle
Flood	Martin	Scheuer
Flowers	Mathias	Schneebeli
Ford, Gerald R.	May	Schwengel
Ford, William D.	Mayne	Scott
Fountain	Meeds	Sebelius
Frelinghuysen	Meskill	Shipley
Friedel	Miller, Ohio	Shriver
Fulton, Pa.	Mills	Sikes
Fulton, Tenn.	Minish	Sisk
Galifianakis	Mink	Skubitz
Gallagher	Minshall	Slack
Garmatz	Mollohan	Smith, Calif.
Gaydos	Monagan	Smith, Iowa
Giaimo	Moorhead	Smith, N.Y.
Gibbons	Morgan	Snyder
Gilbert	Morton	Springer
Goodling	Mosher	Stafford
Gray	Moss	Staggers
Green, Oreg.	Murphy, Ill.	Stanton
Green, Pa.	Murphy, N.Y.	Steed
Griffiths	Myers	Steiger, Ariz.
Grover	Natcher	Steiger, Wis.
Gubser	Nedzi	Stratton
Gude	Nelsen	Sullivan
Halpern	Nix	Taft
Hamilton	O'Hara	Talcott
Hammer-schmidt	O'Konski	Teague, Calif.
Hanley	Olsen	Thompson, Ga.
Hanna	O'Neal, Ga.	Thomson, Wis.
Hansen, Idaho	O'Neill, Mass.	Udall
Harrington	Ottinger	Ullman
Harsha	Patten	Van Deerlin
Harvey	Pelly	Vander Jagt
Hastings	Pepper	Vanik
Hathaway	Perkins	Vigorito
Hébert	Pettis	Wampler
Hicks	Philbin	Watkins
Hogan	Pike	Watts
Holifield	Pirnie	Weicker
Hosmer	Podell	Whalen
Howard	Poff	Whalley
Hull	Powell	Whitehurst
Hunt	Preyer, N.C.	Whitten
Ichord	Price, Ill.	Widnall
Jarman	Price, Tex.	Williams
Johnson, Calif.	Pryor, Ark.	Wilson, Bob
Johnson, Pa.	Pucinski	Wilson, Charles H.
Jonas	Quie	Winn
Jones, Tenn.	Quillen	Wolff
Karth	Railsback	Wyatt
Kee	Rees	Wydler
Keith	Reid, Ill.	Wylie
King	Reid, N.Y.	Wyman
Koch	Reuss	Yates
Kuykendall	Rhodes	Yatron
Kyros	Riegle	Zablocki
Landrum	Rivers	Zion
Langen	Robison	Zwach
Latta	Rodino	

NAYS—83

Abernethy	Fraser	Mann
Adams	Frey	Melcher
Anderson, Calif.	Fuqua	Michel
Ashbrook	Gettys	Mikva
Baring	Gonzalez	Montgomery
Brademas	Griffin	Morse
Brinkley	Gross	Obey
Brock	Hagan	Passman
Brooks	Haley	Patman
Broomfield	Hall	Pickle
Brotzman	Hawkins	Poage
Burton, Calif.	Hechler, W. Va.	Purcell
Cabell	Heckler, Mass.	Randall
Caffery	Helstoski	Rarick
Chisholm	Henderson	Roybal
Clawson, Del	Horton	Stephens
Cleveland	Hungate	Stuckey
Collins	Hutchinson	Taylor
Conte	Jones, N.C.	Teague, Tex.
de la Garza	Kastenmeier	Thompson, N.J.
Dennis	Kazen	Waggonner
Dickinson	Lennon	Waldie
Edwards, La.	Lloyd	Watson
Fisher	Long, La.	White
Flynt	Lowenstein	Wiggins
Foley	McKneally	Wold
Foreman	McMillan	Wright
	Mahon	Young

NOT VOTING—49

Anderson, Tenn.	Davis, Ga.	Matsunaga
Ashley	Dawson	Miller, Calif.
Aspinall	Dowdy	Mize
Ayres	Edwards, Calif.	Mizell
Belcher	Goldwater	Nichols
Bell, Calif.	Hansen, Wash.	Pollock
Bingham	Hays	Reifel
Blatnik	Jacobs	Roberts
Brown, Calif.	Jones, Ala.	Rogers, Colo.
Brown, Mich.	Kirwan	Roudebush
Bush	Kleppe	Saylor
Byrne, Pa.	Kluczynski	Stokes
Clark	Kyl	Stubblefield
Clay	Landgrebe	Symington
Cohelan	Leggett	Tiernan
Colmer	McCarthy	Tunney
	MacGregor	

So the resolution was agreed to.

The Clerk announced the following pairs:

Mr. Hays with Mr. Ayres.
Mr. Davis of Georgia with Mr. Belcher.
Mr. Nichols with Mr. Kleppe.
Mr. Matsunaga with Mr. Pollock.
Mr. Miller of California with Mr. Bell of California.
Mr. Byrne of Pennsylvania with Mr. Reifel.
Mr. Kluczynski with Mr. Brown of Michigan.
Mr. Aspinall with Mr. Kyl.
Mr. Symington with Mr. Mize.
Mr. Roberts with Mr. Bush.
Mr. Rogers of Colorado with Mr. Landgrebe.
Mr. Stubblefield with Mr. MacGregor.
Mr. Edwards of California with Mr. Clay.
Mr. Colmer with Mr. Roudebush.
Mr. Blatnik with Mr. Saylor.
Mr. Jones of Alabama with Mr. Mizell.
Mr. Anderson of Tennessee with Mrs. Hansen of Washington.
Mr. Tiernan with Mr. McCarthy.
Mr. Tunney with Mr. Goldwater.
Mr. Clark with Mr. Bingham.
Mr. Stokes with Mr. Cohelan.
Mr. Leggett with Mr. Ashley.
Mr. Jacobs with Mr. Dowdy.
Mr. Brown of California with Mr. Kirwan.

Mr. CONYERS changed his vote from "nay" to "yea."

Messrs. HAGAN and DICKINSON changed their votes from "yea" to "nay."

The result of the vote was announced as above recorded.

The doors were opened.

A motion to reconsider was laid on the table.

SOCIAL SECURITY AMENDMENTS OF 1970

Mr. MILLS. Mr. Speaker, I move that the House resolve itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 17550) to amend the Social Security Act to provide increases in benefits, to improve computation methods, and to raise the earnings base under the old-age, survivors, and disability insurance system, to make improvements in the medicare, medicaid, and maternal and child health programs with emphasis upon improvements in the operating effectiveness of such programs, and for other purposes.

The SPEAKER pro tempore (Mr. PRICE of Illinois). The question is on the motion offered by the gentleman from Arkansas.

The motion was agreed to.

IN THE COMMITTEE OF THE WHOLE

Accordingly the House resolved itself into the Committee of the Whole House on the State of the Union for the consideration of the bill H.R. 17550, with Mr. DINGELL in the chair.

The Clerk read the title of the bill.

By unanimous consent, the first reading of the bill was dispensed with.

The CHAIRMAN. Under the rule, the gentleman from Arkansas (Mr. MILLS) will be recognized for 2 hours, and the gentleman from Wisconsin (Mr. BYRNES) will be recognized for 2 hours.

The Chair recognizes the gentleman from Arkansas.

Mr. MILLS. Mr. Chairman, I yield myself 15 minutes.

Mr. Chairman, the general subject of social security has been the first order of business before the Ways and Means Committee for the past 7 months. On October 15 last the committee began its public hearings on all aspects of the Social Security Act including the old age, survivors, and disability insurance programs, the public assistance programs, and the medicare and medicaid programs. This bill, which was unanimously reported, is the third separate bill relating to the social security program recommended for action by the committee as a part of its recent deliberations. It completes, as far as I know, the committee's plans for action in the field of social security for this Congress.

Mr. Chairman, the committee spent many, many hours in executive session. We called into executive session many people who were in a position to be helpful to us with respect to the matters we had under consideration in the hearings and which we were then considering in executive session. At no time did we fail to consider any of the suggestions that were made to us either in the hearings or in the executive sessions of the committee.

Let me very briefly go through some of the provision of the bill and dwell a little more at length on one or two of the provisions that seem to have caused some degree of concern on the part of some of the Members today.

Social security payments to the 26.2 million beneficiaries on the rolls and others who come on the rolls in the future would be increased by 5 percent, beginning with payments for the month of January 1971. Of course, this payment generally arrives on the third day of the month, so it would be received around the 3d of February 1971. The benefit increase would mean additional payments of about $1.7 billion in the first year. Bear in mind that the amount rises as more and more people retire and become beneficiaries in the following years.

In addition, Mr. Chairman, because of great interest in the matter—not because of any personal feeling on my part that it is a good thing, frankly, but because there is a great deal of interest—the committee has again seen fit to raise the present level of $1,680 per year to $2,000 per year that one can earn in employment and still not lose any of his social security payments. It is estimated that this will benefit about 900,000 present beneficiaries and will make eligible about 100,000 more persons, and this in the first year alone will cost around $475 million.

A provision which was recommended by the President is included in the bill, increasing the widow's benefit taken at age 65 or later from 82.5 percent of the primary benefit—that is the retirement benefit which would have been paid to her husband at age 65—to 100 percent. That, Mr. Chairman, will provide an immediate increase to 3.3 million widows and widowers; it will cost $700 million in additional benefits for the first 12 months.

Another provision recommended by the President included in the bill would provide an age 62 computation point for men. That provision would apply the same rule to men that presently is in law with respect to the computation of benefits for women. The Congresswoman from Michigan (Mrs. GRIFFITHS) and others told us we were decidedly discriminatory in not making the provision in present law apply to men as well as to women. The gentlelady deserves a great deal of credit for convincing the committee that this provision was sound and should be adopted.

What it means frankly, let me take a moment, is that if it would result in a higher benefit the person who retires at 65 could include the 3 years of earnings between 62 and 65 in place of 3 previous years of earning some time back when the person was not paying taxes on as much earnings as he may have done just before retirement.

So what this provision does is grant men an additional 3-year dropout in addition to the 5 years which are presently in law in determining what the average income of that person is for benefit computation purposes. This will help immediately 10.2 million people who are on the rolls on the effective date, which in this instance would also be January 1, 1971.

In addition, it makes eligible 60,000 additional people who would not otherwise be eligible under existing law. Some of these are dependents or survivors of workers as well as the workers themselves.

Under present law, if a woman applies for a retirement benefit prior to age 65, which she can do on a reduced basis, she can get that benefit on the basis of her own work record. Then at age 65, if she applies for a benefit based upon her spouse's record, the law now requires that amount of the spouse's benefit be reduced because of the period—up to 3 years—that she has been drawing benefits on her own.

The gentleman from Wisconsin (Mr. BYRNES) called this situation to the attention of the committee, and pointed out that there are some 100,000 beneficiaries who would be immediately affected by the provision, and that it was simple equity to do what we are doing here. It does not cost as much as many of the other changes. In this instance it is about $10 million in the first year.

We have eliminated the test we have in the present law in regard to the support requirements for divorced women—this I will not go into at the moment.

The insured status requirement for disability insurance for individuals who are blind has been amended and liberalized, and I will describe this item in detail later.

Disability benefits under present law are affected by the receipt of workmen's compensation when a person gets workmen's compensation and also disability benefits. Both of these benefits are paid for, in one instance altogether by his employer and in the other by the worker and his employer. He cannot get combined payments under both programs of more than 80 percent of the average current earnings he had just before becoming disabled. We have changed that in the bill to 100 percent. We say he can get up to 100 percent of his average earnings—adjusted to take account of rising wage levels—for the 5 years prior to the time he became disabled. That, too, is helpful to many people on disability.

Additional wage credits for the members of the uniformed services are provided in the bill. We are providing them for the benefit of those who have been in the service from 1957, when military service first came under social security, through 1967. Present law provides for such credit for such service after 1967. There are approximately 130,000 beneficiaries who will be immediately affected, and there is a cost of some $35 million in the first 12 months.

There are other amendments I will not take time to mention now but will explain later in some detail. I want now to get into the medicare and medicaid contained in the bill.

These two programs have caused me considerable worry. I know that is true of other members of the committee and of other Members of the Congress, frankly. It has been utterly impossible for us to make any degree of accurate prediction with respect to the cost of medicare on the one hand. On the other hand, we are hopelessly involved in medicaid with no way in the world of making any determination whatsoever as to what the cost is going to be. The States determine those costs.

Here is an open-ended proposition. We tell the States to set the standards, to decide who is eligible for this, and that we will match them, with no State getting less than 50 percent of the total cost from the Federal Government and some States even up to 83 percent of the total cost from the Federal Government. That is the medicaid part.

We have made a series of changes both in medicare and in medicaid in trying to reduce what we see as forthcoming large increases in costs from year to year in both of these programs.

In the case of medicare it is difficult to make any prediction as to what the effect of the combined amendments will be, but we are told by those who are in a position to know, that we can say that we have obtained a tighter hold on this program. As a result of the many amendments and improvements we have made, in bringing about greater effectiveness and efficiency in operation, the costs in the future will not be as great in the case of medicare as they would be without this series of amendments.

One thing we have done in the nature of liberalizing the program, which many of us thought was fair and just, is to allow a person to buy his way into medicare. That is plan A of medicare. All people over 65 years of age who want to, whether they are under social security or not, can buy their way into plan B, which is the program that pays for the doctor bills primarily. Except for those who came under the transitionally insured provision, however, plan A has been exclusively available to those people who were eligible for benefits under railroad retirement or social security, where they have paid a tax at some time or other during their working years. However, there are many people—retired schoolteachers, for instance—in various States, where social security has never been extended to them, who would be given the opportunity now for the first time to pay their way into plan A. The cost initially is $27 a month to them. That premium will rise as the costs of hospitalization, which is largely the element within plan A, may go up. We thought this was a good change.

We also provided on a limited basis, by amendments to plans A and B, for people to have the option, if they want to, of getting their care under what is known as a health maintenance organization, such as the Kaiser plan, and such as the plan in New York City, and such as the plan in the city of Detroit. We have not designated this as plan C. We did not think it was necessary and there was some opposition to doing it that way. But we have made it available. We are saying, though, that anyone who does opt to take this arrangement, which involves, of course, hospitalization care and the other benefits under medicare, getting away from the hospital oriented aspects of plans A and B—we will not pay to the health maintenance organizations more than 95 percent of the cost of the medicare benefits that would have been paid under plans A and B outside the health maintenance organizations. Very frankly, I cannot tell you how they are going to make that determination, but I am assured by those who administer the program that it will be possible for them to make an actuarial determination as to what the costs would have been.

Mr. BYRNES of Wisconsin. Will the gentleman yield?

Mr. MILLS. Yes; I am glad to yield to the gentleman. I wish he would help me out if I do not elaborate on something.

Mr. BYRNES of Wisconsin. I think I would only say in addition that it is the beneficiary, the individual involved in getting the 5 percent. It is the provider of the service which would have to do it for 5 percent less than the cost for other providers.

Mr. MILLS. I did not make that clear, and I appreciate my friend saying that. I was talking about providers—the health maintenance organizations—getting 95 percent and having to agree that they would get no more than 95 percent in order to serve these people.

We have asked for some experiments to be carried on. We have asked the Department of Health, Education, and Welfare to undertake to find out just what would be the effect on costs on prepricing, or prospective reimbursement, of hospital costs. Today the medicare people in a given area may be paying $50 a day, let us say, for the cost of care for this particular medicare patient.

They could get a commitment for a year from the hospital that says: "We will take care of all of the medicare patients at a rate of $45 per day provided the program pay us that amount even if we do it, actually, by lowering our cost to $40 per day."

That is what we are asking them to experiment with, and we think there can be a material savings, because under the present program of paying the full retroactive cost to hospitals, there is no incentive whatsoever for the hospital to bring about any reductions, to bring about better management and procedures with respect to the care of these patients.

The CHAIRMAN. The time of the gentleman from Arkansas has expired.

Mr. MILLS. Mr. Chairman, I yield myself 10 additional minutes.

The CHAIRMAN. The gentleman from Arkansas is recognized for 10 additional minutes.

Mr. MILLS. Mr. Chairman, there are other types of experiments that we want them to carry out.

Now, there is one provision in the bill that I am sure some of my friends may be somewhat concerned about, but I have not heard any opposition to it since we reported the bill. We had representatives of the AMA and the doctors with us in executive session. Under the committee bill the medicare program for reimbursing physicians' charges would be limited by providing:

First, for fiscal year 1971 medical charge levels—that is, the doctors' charges—recognized as prevailing today would be increased beyond the 75th percentile of actual charges in a locality during the previous elapsed calendar year;

Second, for fiscal year 1972 and thereafter the prevailing charge levels recognized for a locality may be increased in the aggregate only to the extent justified by indices reflecting changes in cost of the practice of physicians and earnings levels generally; and

Third, for medical supplies, equipment and such, that in the judgment of the Secretary generally do not vary significantly in quality from one supplier to another, charges allowed may not exceed the lowest levels at which such supplies, equipment, and services are widely available in a locale.

I think I must explain really what we mean by the term "75th percentile" for fear that there may be some who may get the wrong impression of what we are talking about. The doctors of a given community or area that is used constitutes 100 percentile. What we are saying is that we will not under any fee provision I mentioned pay what doctors charge in the highest 25 percentile. We will pay the fees that are charged by the doctors under the 75th percentile. That is what it means, and they have fixed their fees, of course.

The Department has paid fees in the past on the basis of them being prevailing charges, but there are different charges in the medical profession even within a city for the same services, and we can well understand that because doctors are like all the rest of us. Some of them think they are better than others in their profession. So, they charge a little higher fee. In other words, one doctor may want $1,500 for a particular operation but 75 percent of the doctors within that community charge $1,200 or less for the same operation. Therefore, what we are talking about and telling to this doctor who has been charging $1,500 in the past, we are not going to base our payment on more than 75 percent of what the doctors generally have been receiving—$1,200 in this case.

Mr. Chairman, we have a provision on the payment of services for teaching physicians. This has caused quite a bit of a problem in the past. There will be a committee amendment offered to see to it that the language of the bill actually does what the committee intended to do when it adopted the provision, because there seems to be some confusion as to whether it does. But they will be paid. They will be paid not on the basis of a fee for services, they will be paid for services on the basis of reasonable costs when other patients in the hospital, or that part of the hospital, who have the ability to pay actually do pay charges.

We are also providing the authority to the Secretary to terminate the payments to suppliers of services who are now and will in the future be abusing the medicare program.

We made a number of other amendments, but I will discuss them later in more detail—amendments having to do with physical therapy, things of that sort, which we have changed slightly.

Let me get to the point that seems to have disturbed some of my colleagues who voted to open up the rule and perhaps who even voted against the rule, other than for their personal view as to a matter of principle of opposing a closed rule.

The Federal medicare matching for State outpatient services will be increased, and the Federal matching with respect to long-term institutional care will be decreased. Certain other limitations would be improved.

It will cost us more additional Federal dollars to match moneys with the States, and it will cost the States some money for certain outpatient services, but if you supply them with the outpatient service in time you may well avoid the more expensive service of paying for their care in a hospital for an extended period of time, and then in a skilled nursing home even beyond that.

So on the whole the cost of the program, if it works as we think it should work, over a period of time could even be less with this new provision than it would be under existing law. But it is equally true to a degree, I have always found here in the Congress, that there are serious questions raised whenever you try to regulate something that is presently unregulated. Some people in the States may be more interested in collecting Federal dollars than in finding the most appropriate level of care for medicaid patients.

Let me tell you about the skilled nursing homes—and I have got many friends who run fine nursing homes, and I am not quarreling with them. I am quarreling with those who are not my friends, those who have abused this program and who have taken advantage of the program—a program with a total cost of almost $700 million this year in Federal funds alone—through overutilization of skilled nursing home facilities.

I want all of these people who are entitled to such a service to have that service, but if a person is in medical need we say under the medicare part we will not pay one penny for the support of that person beyond 100 days of extended care for somebody under medicare. We are saying now to the States that we will match you on the basis of our existing medicaid formula, which today in Texas is two-thirds of the total cost, and in Arkansas it runs close to 80 percent of the total cost, we will match you up to 90 days, but if you have not got that patient sufficiently improved, as we think you should, to move that patient out into an intermediate care facility or into the patient's home for further convalescence and recuperation, then we are going to cut that 66⅔ percent, or that 80 percent, by one-third. We are going to hold back one-third of it.

What we are trying to do is to impel these States to bring into existence a better degree of operational control, to see to it that there are not the types of overutilization in the future under these arrangements that presently exist in so many of these skilled nursing homes.

Now, out of that $700 million how much do you think we can save for the Federal Government and the States? We think we can save a $100 million when this is in full operation and not inconvenience anybody who otherwise would be entitled to this. But of course these nursing homes are going to scream; they have not down in my State, and they did not do it when we had them in executive session of the committee, but they are going to tell you their side of the story.

I would hope in the future when you do get complaints about what we are doing in this program that before you make up your mind just on the basis of a one-sided report on the proposition that you give some of us on the committee an opportunity to discuss with you what the other side may be.

I will tell you one thing; do not misunderstand the situation. This nursing home business has evidently become a very profitable business. Why is it that people who operate the Holiday Inn, for instance, are going into a nationwide program of Holiday Inn-type nursing homes? Now I know those people. They are smart. They are as good businessmen as we have anywhere in the United States. They do not go into something that is not a profitable venture. What we are saying in this provision is to take these people out of the skilled nursing homes when they have reached the point, whether it be after 90 days or 30 days or 60 days, of not needing this type of skilled help, and put them in an intermediate or domiciliary type of nursing home that is for those who are that far along in their treatment. We are doing this in the hope that it will cost the program a lot less to care for these people.

You get a lot less money from your State welfare department when you put them there. Is it not clear why there would be resistance to reducing payments to a nursing home for a year's care or a convalescent patient?

It is utterly impossible for me to believe that medical science has not gotten to the point where most of these people will not be so improved at the end of 90 days that they can get what it takes to care for their needs in a less expensive type of nursing home.

So I would suggest to you that what we have done in this instance is not to force the cost on the States.

All we want the States to do is to take advantage of the support that we are giving to them to see to it that these nursing homes are not overused, just as we have taken away some things with respect to hospitals under medicare.

Mr. BYRNES of Wisconsin. Mr. Chairman, will the gentleman yield?

Mr. MILLS. I yield to the gentleman.

Mr. BYRNES of Wisconsin. I think the gentleman might point out that so far as medicare is concerned, we have a cutoff, completely—with no payment at all at 100 days.

Mr. MILLS. Yes, 100 days.

Mr. BYRNES of Wisconsin. Also, these people, it should be recognized, if their situation is such, have, prior to going into extended-care facilities, 60 days in a hospital or at least they have the potential of being there for that period of time. So it is not as though we are just saying we are going to give only 90 days of service to these people because if the situation requires it, they also had hospitalization preceding that.

Mr. MILLS. It is 60 days that are available, plus 90 days, and the Federal Government is a participant in that period of time. In most instances it pays most of the cost of that in most of the States.

All we are saying is, let us wake up, States, before you go bankrupt and before you bankrupt us through this overutilization. Let that not be the cause of either one of us going broke.

Mr. Chairman, I would now like to give a more detailed description of the major provisions of the bill.

AMENDMENTS TO THE OLD-AGE, SURVIVORS AND DISABILITY INSURANCE PROGRAM

BENEFIT INCREASE

The bill provides for a 5-percent across-the-board increase in benefits, to be effective with the benefits payable next January. In recommending this increase, the committee was not making any forecast of future economic changes. On the other hand, it was not unmindful of the continued rise in the cost of living—1.1 percent from January to March—that continues to erode the purchasing power of social security benefits.

In the committee we gave careful consideration to the President's proposal for automatic cost-of-living increases in benefits, but the majority of the committee, after reviewing all of the evidence presented, rejected the proposal.

Your committee has over the years taken action to maintain social security benefits at realistic and adequate levels. From time to time, these benefits have been increased to take account of changes in the national economy, including not only changes in living costs but also changes in living standards and changes in wage levels. It is clear that economic changes this year will necessitate a 5-percent benefit increase by the beginning of next year if we are to maintain the real value of the present social security benefits.

Monthly benefits for workers who retire at age 65 in 1971 now range from $64 to $193.70; under the bill they would range from $64 to $203.40. Benefits for a couple in January 1971 would average $199 under present law; under the bill the benefits would be increased to $218. For a widowed mother with two children, the average benefit for January 1971 under present law would be $298; under the bill, it would be $314.

Some 25.6 million beneficiaries on the rolls in January 1971 would have their benefits increased; and, of course, all those coming on the rolls thereafter will also get the advantage of the increase. An estimated $1.7 billion in additional benefits would be paid in the first 12 months as a result of the 5-percent benefit increase.

INCREASE IN SPECIAL AGE 72 PAYMENTS

The bill would also increase by 5 percent the special payments that are made under present law to certain people who reach age 72 before 1972 and who are not insured for regular cash benefits under the social security system. These payments would be increased from $46 to $48.30 for an individual and from $69 to $72.50 for a couple. About 6,000 people who do not now get these special payments—generally because they are not eligible for higher payments under some other Government system—would qualify for some payments and about 620,000 who now get the special payments would get higher payments. An estimated $17 million in additional payments would be paid out in the first 12 months; about $15 million of this amount—payments to people who had very little or no coverage under the system—would be paid from general revenues.

LIBERALIZATION OF THE RETIREMENT TEST

Your committee's bill would liberalize the retirement test by increasing from $1,680 to $2,000 the amount a beneficiary under age 72 can earn in a year and still be paid full social security benefits for the year. If a beneficiary's annual earnings exceed the $2,000 annual exempt amount, $1 in benefits is withheld for each $2 up to the next $1,200 of earnings—that is, earnings between $2,000 and $3,200 under the bill, rather than between $1,680 and $2,880 as in present law—and for each $1 above that amount. Under the bill, the amount of earnings a beneficiary can have in any month and still get benefits for that month—regardless of the amount of his annual earnings—would continue to be one-twelfth of the annual exempt amount. Thus it would be increased from $140 to $166.66.

The bill would also improve the operation of the retirement test as it applies in the year in which a worker reaches age 72. Only earnings for months before age 72 would be counted in determining whether earnings in that year exceed $2,000.

Under these provisions, effective for taxable years ending after 1970, about 900,000 beneficiaries would receive additional benefits and about 100,000 people who receive no benefits under present law would receive some benefits. The first year's cost would be about $475 million.

The retirement test liberalization in the bill, I know, does not go as far as some people would like. There are those who would eliminate the test entirely and make old-age social security benefits an annuity rather than benefits to replace earnings that are lost by reason of retirement. To eliminate the retirement test entirely, however, would cost over six-tenths of 1 percent of taxable payroll—more than $2.5 billion a year—and the additional expenditure would help only a small percentage of the beneficiaries—those who for the most part are already better off than most beneficiaries by reason of the fact that they can continue to work.

INCREASE IN BENEFITS FOR AGED WIDOWS

The bill would increase benefits for a widow—or widower—who begins to get benefits at age 65 and over from 8½ percent to 100 percent of the amount her deceased husband would have received if his benefits had started at or after age 65. For widows and widowers who take their benefits between ages 62 and 65 the benefits would be reduced, similar to the way in which a worker's benefit is reduced under present law if he applies for benefits before age 65. Thus a widow would be assured of getting the same benefit amount as her husband would have gotten at the same age if he had lived. The increase would apply to beneficiaries now on the rolls and to those who come on in the future, and would, in conjunction with the 5-percent general benefit increase, provide an estimated increase of $21 in the average benefit paid to aged widows, an increase of almost 21 percent over the average widow's benefit of $102 a month paid under present law. Some 3.3 million widows and widowers on the rolls at the end of January 1971 would receive higher benefits under this provision, and $700 million in additional benefit payments would be made in the first 12 months.

AGE 62 COMPUTATION POINT FOR MEN

Under present law the number of years used in figuring a man's average earnings on which his retirement benefit is based, and the number of years of work under the social security program a man must have to become insured for retirement benefits, are different than they are for a woman. For a man all years up to age 65 must be taken into account for both of these purposes, while for a woman, only years up to age 62 are included. As a result, when a man and a woman of the same age have exactly the same earnings and retire at the same age, the man's retirement benefit will be lower. This occurs because 3 more years of low earnings—as, for example, years when the limit on earnings taxed and counted for benefits was lower than it is now—must be counted in determining a man's benefit amount. Also, under present law, when a man and woman of the same age are credited with the same amount of earnings in the same years, the woman may meet the insured status requirement while the man may not. Your committee's bill would shorten by three the number of years over which a man's average monthly earnings are figured in retirement cases, and make the ending point for determining eligibility for retirement benefits the year in which a man reaches age 62, the same as the ending point for women under present law. About 10.2 million people—male workers, and their dependents, and survivors—now getting benefits would have their benefits increased by this change. In addition, about 60,000 people who are not now eligible for benefits would become eligible because of the change in the insured status provision. An estimated $925 million in additional benefits would be paid out in the first 12 months.

ACTUARIAL REDUCTION IN BENEFITS

Under present law a married person who has worked and is eligible for a benefit as a retired worker and one as a wife or husband cannot apply for just one of the benefits; when he applies for one he is deemed to have applied for both. As a result, a person who claims benefits before age 65 has both benefits actuarially reduced. He cannot take one before age 65, wait until age 65 to claim the other, and get the second one in an unreduced amount, even though it might be advantageous for him to do so. Also, under present law, a wife—or husband—who has worked and become eligible for an old-age insurance benefit based on her own earnings, who takes that benefit before age 65, and who later becomes eligible for a wife's benefit when her husband applies for his retirement benefit can get less in benefits than would a wife who never worked or contributed to the program.

Under the bill, a person who is under age 65 and eligible for benefits as a retired worker and also as a spouse could choose to apply for one or the other of the benefits right away and wait until age 65 to claim the other, and the reduction that is made in the benefit taken early would not affect the amount of the benefit taken later.

Approximately 100,000 beneficiaries on the rolls would be immediately affected by this provision, which will result in additional benefit payments estimated at $10 million during the first 12 months.

DEPENDENT WIDOWERS' BENEFITS AT AGE 60

Under present law an aged widow can become entitled to benefits at age 60, but an aged dependent widower cannot become entitled to benefits until age 62. This situation results from a provision in the 1965 amendments which lowered the age of eligibility for widows from 62 to 60, but did not change the age of eligibility for dependent widowers.

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

CHILDHOOD DISABILITY BENEFITS FOR CHILDREN DISABLED BEFORE AGE 22

Childhood disability benefits would be payable to a disabled dependent adult son or daughter whose disability began after age 18 and before age 22. Under present law, a person must have become disabled before age 18 to qualify for childhood disability benefits on his parent's social security account.

About 13,000 people—disabled children and their mothers—would immediately become eligible for benefits. About $10 million in additional benefits would be paid out during the first 12 months.

DISABILITY INSURED STATUS FOR THE BLIND

The bill would modify the disability insured-status requirements for the blind. To qualify for disability benefits, a blind person would have to be fully insured only—that is, he would need only as many quarters of coverage as the number of calendar years elapsing after 1950—or the year he reached age 21, if later—up to the year of disability. For example, a 32-year-old person who becomes blind this year would be insured if he has 10 quarters of social security coverage, regardless of when his coverage

was acquired. He would no longer have to meet a requirement of substantial recent covered work—generally 20 quarters of coverage in the period of 40 calendar quarters preceding disability.

About 30,000 people—blind workers and their dependents—would become immediately eligible for monthly benefits, and about $25 million in additional benefits would be paid out during the first 12 months.

DISABILITY BENEFITS AFFECTED BY RECEIPT OF WORKMEN'S COMPENSATION

The bill would modify the provisions under which social security disability benefits are reduced in certain cases where workmen's compensation is also payable. Under present law, the combined social security and workmen's compensation payments for a disabled worker and his family cannot exceed 80 percent of the worker's average earnings before he became disabled. Under the bill, the disabled worker and his family would be able to receive combined benefits equaling 100 percent of his average earnings.

WAGE CREDITS FOR MEMBERS OF THE UNIFORMED SERVICES

The bill would improve social security protection for some servicemen and veterans. Present law provides for a social security wage credit of $100 a month, in addition to credit for basic pay, for military service performed after 1967. Under the bill, the additional $100-a-month wage credits would also be provided for service during the period from 1957—when military service was covered under social security—through 1967. Approximately 130,000 beneficiaries would be immediately eligible for higher benefits because of the additional credit, and $35 million in additional benefits would be paid out in the first 12 months.

OTHER OASDI AMENDMENTS

I have described the major changes the bill would make in the cash benefits part of the social security program. In addition, the bill contains a number of miscellaneous technical changes that I will not go into in detail. They are fully explained in the committee report.

MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH

The Committee on Ways and Means conducted a thorough review of the operations of the medicare and medicaid programs. In the course of this review, the committee became convinced that there are serious deficiencies in the operation and administration of these programs that need correction. The Department of Health, Education, and Welfare assured the committee that it will continue its present strong efforts to improve the operating effectiveness of these programs. This bill will make a number of modifications which, taken together, show promise of significantly advancing the goal of making these programs more economical and more effective in carrying out their original purposes. These amendments will, we believe, not only help to control the constantly rising costs of the medicare program, but also provide important new tools to the Government, as well as the carriers and intermediaries who help administer this program, to carry out their administrative functions more effectively.

COVERAGE AND BENEFIT CHANGES UNDER MEDICARE

We gave extensive consideration to the problems of several groups of persons who are either denied medicare coverage presently, or who do not receive full benefit from the medicare program. We are recommending certain changes to remedy these existing inadequacies.

FEDERAL EMPLOYEE HEALTH PROGRAM AND MEDICARE

First, the bill would require that, effective with January 1, 1972, no payment would be made under medicare for the same services covered under a Federal employees health benefits plan, unless in the meantime the Secretary of Health, Education, and Welfare certifies that the Federal employees health benefits program has been modified to make available coverage supplementary to medicare benefits and that Federal employees and retirees, age 65 and over, will continue to have the benefit of a Government contribution toward health insurance premiums.

It is our hope and intent that the Secretary will be able to make this certification before January 1972. The intent is to bring about a better coordinated relationship between the Federal employees health benefits program and medicare and to assure that Federal employees and retirees, age 65 and over, will eventually have the full value of the protection offered under medicare and the Federal employees program. At present, a Federal employee who is covered under an 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 both programs.

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

MEDICARE FOR THE UNINSURED

Another group to which we gave special attention is that group of individuals reaching age 65 who are not eligible for part A benefits. Under the bill, people reaching age 65 who are ineligible for hospital insurance benefits under medicare would be able to enroll, on a voluntary basis, for hospital insurance coverage under the same conditions under which people can enroll under the supplementary medical part of medicare. Enrollment for supplementary medical insurance is also required. Those who enroll would pay the full cost of the protection—$27 a month at the beginning of the program, rising as hospital costs rise. States and other organizations, through agreements with the Secretary would be permitted to purchase such protection on a group basis for their retired—or active—employees age 65 or over, including groups of teachers who have never been covered under the program.

Present law provides hospital insurance protection under a "special transitional provision" for people—with the exclusion of certain groups—who are not qualified for cash benefits under the social security or railroad retirement program and who attained age 65 before 1968. But some older people who reach age 65 after 1967 cannot qualify under the transitional provision, and the provision itself 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.

It has become very difficult for many in the uninsured group 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 for limited periods of hospitalization. Few private health insurance companies offer their regular hospital expense plans to the aged and very little is comparable in protection to that afforded under the medicare program.

STUDY OF MEDICARE FOR THE DISABLED

We also gave extensive consideration to a proposal to extend hospital insurance protection under title XVIII to disabled workers entitled to monthly cash disability benefits under the social security and railroad retirement programs. Extending hospital insurance protection to these beneficiaries would be most desirable. It is clear that a severely disabled social security beneficiary is as much or more in need of medicare protection as the able-bodied man who has reached age 65 and is still working. However, we have regretfully concluded that such an extension is not advisable at the present time primarily because of the cost involved.

The committee has requested the Advisory Council on Social Security that is currently in existence to include in its report to the Congress the results of its study of the current need of the disabled for health insurance protection, the costs involved in providing this protection, and the ways of financing this protection.

HEALTH MAINTENANCE ORGANIZATION OPTION

Under the bill, individuals eligible for both part A and part B medicare coverage would be able to choose to have their care provided by a health maintenance organization—a prepaid group health or other capitation plan.—The Government would pay for such coverage on a capitation basis not to exceed 95 percent of the cost of medicare benefits had the beneficiaries not been enrolled with the health maintenance organization.

Under present law, organizations providing comprehensive health services on a per capita prepayment basis cannot be

reimbursed through a single capitation payment for services covered under both parts of the medicare program. Instead, medicare reimbursement to group practice prepayment plans must be related to the costs to the organization of providing specific services to beneficiaries. However, under the committee bill, the financial incentives to control the utilization and cost of services that such organizations have in their regular business would be made applicable as well to their relationship with medicare.

IMPROVEMENTS IN OPERATING EFFECTIVENESS OF MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS

LIMITATION ON CAPITAL COST REIMBURSEMENT

Under the bill, reimbursement amounts to providers of health services under the medicare, medicaid, and maternal and child health programs for capital costs, such as depreciation and interest, would not be made with respect to capital expenditures which are inconsistent with State or local health facility plans. While a signifiacnt amount of Federal money is currently being expended in the interest of furthering health facility planning at the State and local levels, Federal funds are being expended 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. We 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, it was decided necessary to assure that medicare, medicaid, and the maternal and child health programs reimburse providers in a manner that is consistent with State and local health facility planning efforts, in order to avoid paying the higher costs which will result from the duplication or irrational growth of health care facilities.

PROSPECTIVE REIMBURSEMENT AND RELATED EXPERIMENTS

We considered carefully the possibility of providing for reimbursement under the medicare program on a prospective basis. There is reason to believe that payment determined on a prospective basis—rather than the present retroactive basis—offers the promise of encouraging institutional policymakers and managers to manage health institutions more effectively in order to achieve greater financial reward as well as a lower total cost to the programs involved. On the other hand, we were aware in our consideration of such a fundamental change in the present reimbursement method, that possible disadvantages as well as possible advantages must be taken into account. After exploration of the various problems that might arise, we concluded that in view of the far-ranging implications of such a change in reimbursement methods, it would be best at this time to provide for a period of experimentation under titles XVIII, XIX, and V with various alternative forms of prospective reimbursement designed to determine which would be the most effective methods. The Secretary would be required to submit to the Congress no later than July 1, 1972, a full report detailing the results of the experiments and demonstration projects and reporting on the experience of other programs with respect to prospective reimbursement. The report is to include detailed recommendations with respect to the specific methods which could be used in the full implementation of prospective reimbursement.

Although recognizing the promise and potential offered by prospective reimbursement, we also wanted to continue experimentation with other forms of reimbursement. The bill, therefore, includes authorization 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 experimental 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 offer the promise of program savings without any loss in the quality of care. The bill also authorizes experimentation with the use of areawide or communitywide utilization review and medical review mechanisms to determine whether they would bring about more effective controls over excessive utilization of services.

LIMITATIONS ON REASONABLE COSTS

The bill would authorize the Secretary of Health, Education, and Welfare to establish and promulgate limits on provider costs to be recognized as reasonable under medicare based on comparison of the cost of covered services by various classes of providers in the same geographical area. Hospitals and extended care facilities could charge beneficiaries for the costs of services in excess of those that are necessary to the efficient delivery of needed health services—except in the case of an admission by a physician who has a financial interest in the facility. 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. Costs can vary from one institution to another as a result of several factors. However, where excessively high costs are a result of gross inefficiency, the provision of amenities in plush surroundings, or of other factors unrelated to the cost of the efficient delivery of needed health services, payment of the excess cost would be avoided.

LIMITATION ON RECOGNITION OF PHYSICIAN FEE INCREASES

Members are no doubt concerned about the steady increase in costs of the supplementary medical insurance part of the medicare program, with the consequent rise in the monthly premium paid by the aged. While administrative steps have been taken to hold down this rise, they have certain inequities and other disadvantages. It is apparent that more positive action by the Congress is necessary.

The bill moves 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 the economic data indicate would be fair to all concerned. Accordingly, under the bill, charges determined to be reasonable under the present criteria in the medicare, medicaid, and material and child health law would be limited by providing: First, that for fiscal year 1971 and thereafter medical charge levels recognized as prevailing may not be increased beyond the 75th percentile of actual charges in a locality during the previous elapsed calendar year; second, that for fiscal year 1972 and thereafter the prevailing charge levels recognized for a locality may be increased, in the aggregate, only to the extent justified by indexes reflecting changes in costs of practice of physicians and in earnings levels; and third, that for medical supplies, equipment, and services—other than physicians' services—that, in the judgment of the Secretary, generally do not vary significantly in quality from one supplier to another, charges allowed as reasonable may not exceed the lowest levels at which such supplies, equipment and services—including laboratory services—are widely available in a locality.

TEACHING PHYSICIANS

The committee considered at length the matter of payment for services of teaching physicians under medicare and concluded that some changes in the situations under which such payments should be made, and how they should be made, is needed. We concluded that the present procedure of making payment to physicians on a fee-for-service basis in settings where patients are normally expected to pay such fees is entirely proper. On the other hand, it seemed clear that 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. Under the bill, therefore, medicare would pay for the services of teaching physicians on the basis of reasonable costs, rather than fee-for-service charges, unless other patients who have insurance or are able to pay are also charged for such services and the medicare deductibles and coinsurance amounts are regularly collected from those who can afford to pay them. Medicare payment would also be authorized for services provided to hospitals by staff of certain medical schools.

TERMINATING PAYMENTS TO THOSE WHO ABUSE THE PROGRAM

It has become clear that some few providers and suppliers of health services have abused the medicare and medicaid programs. Although the number of such persons has been relatively small, their actions reflect badly on the vast majority of conscientious men and women in the

health care field. Moreover, their actions lead some people to question the soundness of the very programs which are victimized by this abuse. But most important of all, the beneficiaries of these programs are needlessly hurt by these few—not only in terms of the higher costs they must pay, but in some instances, the danger to their health sometimes posed by these abuses.

The bill would, therefore, authorize the Secretary of Health, Education, and Welfare to terminate payment for services rendered by a supplier of health and medical services found to be guilty of program abuses. 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. Program review teams would be established to furnish the Secretary professional peer review in carrying out this authority. The Secretary would make the names of such persons or organizations public so that beneficiaries would be informed about which suppliers of health services cannot participate in these programs. We do not expect that any large number of suppliers of health services will be suspended from these programs because of abuse. However, the pressure of the authority and the exercise of the authority in even a relatively few cases can be expected to provide a substantial deterrent.

REASONABLE COSTS NOT TO EXCEED CHARGES

We believe 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. The bill would provide, therefore, that payments for institutional services under the medicare, medicaid, and maternal and child health programs could not be higher than the charges regularly made for those services.

INSTITUTIONAL PLANNING UNDER MEDICARE

Under present medicare law, there is no requirement for providers of services to develop their own fiscal plans such as operating and capital budgets. However, we are 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 bill would require health institutions under the medicare program to have a written plan reflecting an operating budget and a capital expenditures budget.

GUARANTEE OF PAYMENT OF EXTENDED CARE BENEFITS

Posthospital extended care benefits and posthospital home health benefits were intended as alternatives to continued inpatient hospital care and are limited to medicare beneficiaries who, while no longer in need of hospital care, still require skilled nursing care or, in the case of home health benefits, physical or speech therapy.

Under current law, a determination of whether a patient requires the level of care that is necessary to qualify for extended care facility or home health benefits cannot generally be made until some time after the services have been furnished. I imagine that nearly all members are aware that in many cases such benefits are being denied retroactively, with the harsh result that the patient is unexpectedly faced with a large bill, or the facility or agency has a patient who may not be able to pay his bill. Many Members have no doubt received letters from both nursing home administrators and beneficiaries graphically outlining the problems this situation creates for them. 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. To provide a solution to this problem, the bill would authorize the Secretary of Health, Education, and Welfare to establish specific periods of time—by medical condition—after hospitalization during which a patient would be presumed, for payment purposes, to require extended care level of services in an extended care facility. A similar provision would apply to posthospital home health services.

PROHIBITION AGAINST REASSIGNMENT

We also studied the problems which have arisen due to reassignment by physicians or others who provide services under the medicare and medicaid programs of their right to receive payment. Experience with this practice shows that such reassignments have often 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, both in the medicare and mediaid programs. Fraudulent operations of collection agencies have been identified in medicaid; and substantial overpayments—in at least one case exceeding a million dollars—have been found in the medicare program. The bill would overcome these difficulties by prohibiting payment under medicare—part B—and medicaid to anyone other than a patient, his physician, or other person providing the service, unless the physician—or, in the case of medicaid, another type of practitioner—is required as a condition of his employment to turn over his fees to his employer or unless there is a contractual arrangement between the physician and the facility in which the services were provided under which the facility bills for all such services.

NOTICE OF UNNECESSARY ADMISSION

The bill provides for stopping payment under medicare where a utilization review committee of the institution finds admission was not necessary. 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 portion of admissions. When the utilization review committee reviews a long-stay case and determines that further stay in the institution is not medically necessary, the committee notifies the physician, the patient, and the institution of its finding and medicare payment is discontinued after the third day.

The bill would require a similar notification, and a similar payment cutoff 3 days after notification to be made where the utilization review committee finds a case in its review of admissions where hospitalization or extended care is not necessary.

PHYSICAL THERAPY

Under present law, physical therapy is covered as an inpatient hospital service, an inpatient extended care service, a home health service, and a service incident to physicians' services. Physical therapy is also covered when furnished under prescribed conditions by a participating hospital, extended care facility, home health agency, clinic, rehabilitation agency, or public health agency to its outpatients. The physical therapist may be either an employee of the participating facility or he may be self-employed and furnish his services under arrangements with and under the supervision of the facility.

The limitations imposed under present law on the coverage of physical therapy have been a source of some difficulty. For example, it has been difficult to explain why physical therapy services cannot generally be furnished in the therapist's office, especially in cases where the latter is more accessible than the facility to which the beneficiary must travel to obtain the service.

The bill would make three changes in the handling of physical therapy services under medicare. First, it would provide that beneficiaries would be covered under medicare's supplementary medical insurance program for up to $100 per calendar year of physical therapy services furnished by a licensed physical therapist in his office or the patient's home under a physician's plan of treatment. Second, hospitals and extended care facilities could continue to provide covered physical therapy services to inpatients who have exhausted their days of hospital insurance coverage or are otherwise ineligible for that coverage. Third, where physical therapy is furnished under contractual arrangement with any provider of services, medicare reimbursement to the institution will in all cases be based on a reasonable salary payment for the services.

INCENTIVES FOR STATES TO EMPHASIZE OUTPATIENT SERVICES

Under present law a uniform Federal matching percentage is applied to all forms of health services covered under the State medicaid plan. In order to encourage more efficient use of health services, the bill would create incentives for the States to encourage outpatient services and disincentives for long stays in institutional settings. The bill would provide for: First, an increase in the Federal matching percentage by 25 percent for outpatient hospital services, clinic services and home health services; second, a decrease in the Federal percentage by one-third after the first 60 days of care—in a fiscal year—in a general or TB hospital; third, a reduction in the Federal percentage by one-third after the first 90 days of care in each fiscal year in a skilled nursing home; and fourth, a decrease in Federal matching by one-third after 90 days of care in a mental hospital and provision for no Federal matching after an additional 275 days of such care during an individual's lifetime.

Also, under the bill the Secretary would be granted authority to compute for reimbursement purposes a reasonable cost differential between the cost of skilled nursing home services and the cost of intermediate care facilities in order to assure that supporting care in these alternate institutions results in decreased costs.

ELIMINATION OF REQUIREMENT FOR BROADENED MEDICAID PROGRAMS

Under the present medicaid law, each State is required to 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." In accordance with the committee's recommendation last year, the Congress suspended the operation of this provision for 2 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 bill would remove this entire provision from the act. There is evidence that this requirement has been used to require states to have larger programs than they really wished to. When the operations of the State medicaid programs have been substantially improved and there is assurance that program extensions will not merely result in more medical cost inflation, the question of required expansion of the program could then be reconsidered.

HOSPITAL REIMBURSEMENT UNDER MEDICAID

Under present regulations of the Secretary, States are required to reimburse hospitals for inpatient care under medicaid on the basis of the reasonable cost formula established under medicare. Many States have pointed out the serious problems which have arisen under this requirement. They pointed out that use of the medicare formula for medicaid reimbursement can result in their paying more than the actual cost of providing inpatient care to those eligible for medicaid. The bill retains the intent of the original provision—to avoid having hospitals or their private patients subsidize inpatient care for the poor—by providing for payment of actual and direct costs of inpatient care for medicaid eligibles. States would be permitted to pay hospitals on the basis of a State's own method of determining reasonable cost, provided there is assurance that the medicaid program would pay the actual cost of hospitalization of medicaid recipients.

HELP FOR STATES TO SET UP MODERN MEDICAID CLAIMS HANDLING PROCEDURES

Under the present law, Federal medicaid matching is set at 50 percent for administrative costs and States are required to use methods of administration deemed necessary by the Secretary for efficient operation of the program. Despite the inducement of 50 percent matching and the requirement for efficiency, 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. The bill would meet this problem by providing that Federal matching at the 90-percent rate would be available under medicaid for the States to set up mechanized claims processing and information retrieval systems. Federal matching for the continuing operation of such systems would be at the 75-percent rate. It is expected that this financial support and technical support from Federal Government will aid the States in realizing efficient and effective administration of the program, and in reducing program costs. I expect the Department of Health, Education, and Welfare to provide substantial technical support to the States in carrying out this provision.

UTILIZATION REVIEW COMMITTEES UNDER MEDICAID

Under the present medicare law, each hospital and extended-care facility is required to have a utilization review committee to review all long-stay cases as well as review, on a sample or other basis, admissions, durations of stay, and professional services. The reasons for requiring hospitals and extended-care facilities to have utilization review committees for medicare cases apply with equal force to review of medicaid cases, but there is now no such requirement in the medicaid law. The bill would require these institutions participating in the medicaid law. The bill would require these institutions participating in the medicaid or maternal and child health programs to have cases reviewed by the same utilization review committee already reviewing medicare cases. A utilization review committee which meets the standards established under medicare would be required in hospitals and skilled nursing homes not participating in medicare.

COST-SHARING UNDER MEDICAID

Under present law, a State cannot impose deductibles or other cost-sharing devices on cash public assistance recipients. In addition, while deductibles or copayments can be imposed with respect to the medically indigent, they must be "reasonably related to the recipient's income and resources." The bill would provide that States be permitted to impose a flat cost-sharing provision with respect to people eligible under medicaid programs but not eligible for cash public assistance payments. This change would allow States to explore the cost advantages that might result from the direct savings and possible decrease in utilization that cost-sharing devices of a specified amount for all the medically indigent might create. Even a small charge gives the recipient a sense of participation and might reduce excessive use of services.

ROLE OF STATE HEALTH AGENCY IN MEDICAID

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 the medicaid and maternal and child health programs. This duplication of effort in the establishment and maintenance of health standards is unnecessary and inefficient. The bill would require the State to have the same agency perform these functions for the medicare, medicaid, and the maternal and child health programs.

MISCELLANEOUS AND TECHNICAL AMENDMENTS

The bill contains several miscellaneous provisions designed primarily to assist individuals who have been disadvantaged under the program. For example, the bill would remove from the law the requirement that an aged person must enroll for the part B medical insurance within 3 years after he became eligible to enroll. We found that this provision was no longer necessary to avoid selection against the program.

FINANCING PROVISIONS

At the present time, the social security cash benefits program is in close actuarial balance, while the hospital insurance program has an actuarial deficiency; that is, it is expected that over the long-range future the income to the hospital insurance program will be considerably less than the cost of the program. To meet the cost of the cash benefits program as it would be expanded by the bill and to bring the hospital insurance program into actuarial balance, the contribution rates for the programs would be adjusted and the contribution and benefit base—the maximum amount of annual earnings subject to contributions and used in computing benefits—would be increased.

(a) Increase in the contribution and benefit base: The bill provides for an increase in the ceiling on taxable and creditable earnings to $9,000, effective for 1971. This increase would take account of the increases in earnings levels that have occurred since 1968 when the $7,800 ceiling on earnings went into effect and would cover the total earnings of an estimated 79 percent of all workers—the same percentage as the $7,800 base covered when it went into effect.

People earning amounts between $7,800 and $9,000 a year will pay taxes on an additional $1,200 of earnings. In return, of course, they will get credit for more earnings and will thus get higher benefits. The higher creditable earnings resulting from the increase in the ceiling on earnings will make possible benefits that are more reasonably related to the actual earnings of workers at the higher earnings levels. If the base were to remain unchanged, more and more workers would have earnings above the creditable amount and these workers would have benefit protection related to a smaller and smaller part of their full earnings.

The proposed increased in the contribution and benefit base would not only provide higher future benefits for people at higher earnings levels, but would also help to finance the changes made by the bill. This comes about because an increase in the base results in a reduction in the overall cost of the social security program as a percent of taxable payroll and the benefits provided are a higher percentage of earnings at the lower levels than at the higher levels while the contribution rate is a flat percentage of earnings. When the base is increased, higher benefits are provided on the basis of the higher earnings that are taxed and credited, but the cost of providing

these higher benefits is less than the additional income from the employer and employee contributions on earnings above the former maximum and up to the new maximum amount.

(b) Changes in the contribution rates: Under the schedule of contribution rates for cash benefits contained in the bill, the contribution rates for employers and employees scheduled for 1971–72 would be held to the present level of 4.2 percent each, instead of being allowed to go up to 4.6 percent each as under present law. The rates scheduled for 1973–74 would be 4.2 percent each instead of 5 percent each as under present law. After 1979, the contribution rate would be 5.5 percent each, instead of 5 percent each as under present law.

For the self-employed, the rate scheduled for 1971–72 for the cash benefits part of the program would be 6.3 percent, instead of 6.9 percent as under present law. The rate scheduled for 1973–74 would be 6.3 percent instead of 7 percent. This rate would remain in effect until 1975, at which time the increase to 7.0 percent scheduled under present law would go into effect.

The bill also provides for increases in the contribution rate schedule for the hospital insurance program. The contribution rate scheduled for 1971–72 would be increased from 0.6 percent each for employees, employers, and the self-employed to 1 percent each, instead of being gradually increased from the present rate of 0.6 percent to 0.9 percent in 1987 and after, as under present law. The rate would be kept at 1 percent thereafter.

I include the full schedule of contribution rates under present law and under the bill, for both cash benefits and medicare, in the RECORD at this point:

PRESENT AND PROPOSED SOCIAL SECURITY CONTRIBUTION RATES

[In percentages]

Period	Cash benefits		Medicare		Total	
	Present law	Committee bill	Present law	Committee bill	Present law	Committee bill
EMPLOYER AND EMPLOYEE, EACH						
1971–72	4.6	4.2	0.6	1	5.2	5.2
1973–74	5.0	4.2	.65	1	5.65	5.2
1975	5.0	5.0	.65	1	5.65	6.0
1976–79	5.0	5.0	.7	1	5.7	6.0
1980–86	5.0	5.5	.8	1	5.8	6.5
1987 [1]	5.0	5.5	.9	1	5.9	6.5
SELF-EMPLOYED						
1971–72	6.9	6.3	.6	1	7.5	7.3
1973–74	7.0	6.3	.65	1	7.65	7.3
1975	7.0	7.0	.65	1	7.65	8.0
1976–79	7.0	7.0	.7	1	7.7	8.0
1980–86	7.0	7.0	.8	1	7.8	8.0
1987 [1]	7.0	7.0	.9	1	7.9	8.0

[1] And after.

Mr. Chairman, your committee believes that the bill we are submitting for your consideration is a good bill, a reasonable bill, and one that the Members of the House will accept as being needed in order to keep the social security program up to date and responsive to the needs of today. I urge its prompt passage.

Mr. DANIELS of New Jersey. Mr. Chairman, will the gentleman yield?

Mr. MILLS. I yield to the gentleman.

Mr. DANIELS of New Jersey. Mr. Chairman, I rise to compliment the distinguished chairman of the Committee on Ways and Means for his very fine and outstanding statement.

As you know, I served as chairman of the subcommittee on retirement insurance and health benefits. There is a section in the bill, section 201, dealing with payments under the medicare program of individuals covered by the Federal employee's health insurance programs which causes me some concern.

The language appears to me to be rather ambiguous and also it appears that perhaps the Committee on Ways and Means has entered into an area of legislation which is properly within the jurisdiction of the Committee on Post Office and Civil Service of the House.

So I have asked my staff to prepare some questions to clarify the meaning of that section.

I would appreciate it if the distinguished gentleman from Arkansas, would further explain the provisions of the bill which affect the Federal employee's health benefits program. Can the gentleman tell me whether or not my understanding is correct, that when an individual is covered by medicare and also by other insurance including group insurance by an employer, medicare pays its benefits without regard to the other insurance?

Mr. MILLS. What happens now is that medicare picks up the initial cost for services rendered that are payable under medicare, whether or not a person may be entitled also to get payment under a Federal employee health program. Actually, the same thing is true with respect to insurance companies and others.

What we are trying to do here is to call the attention of the Civil Service Commission and the people downtown to the fact that we think that there should be some integration of these two programs. An individual should not be eligible for the same benefits under two or three programs and have to pay for all of them but not get the full benefit of all of them. In each instance the employee has to pay something, of course. He is paying twice. What we want to do is to have it worked out on some basis to the point at which medicare will take the initial cost, and then let the health employees program provide whatever additional benefit the Civil Service Commission and the Congress, working with your committee and the comparable committee in the Senate, would decide would be appropriate.

But the way it is today, they are paying for two programs, and actually one program is paying the cost of their medical services. We are not invading your jurisdiction. We have a perfect right to say what we do here in that we say:

(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, 1972, 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 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 upon or after attaining age 65, in addition to the health benefits plans available before he attains such age, one or more health benefits plans which offer protection supplementing the combined protection provided under parts A and B of this title and one or more health benefits plans which offer protection supplementing the protection provided under part B of this title alone—

And so on. We have no jurisdiction in this area, and that was recognized by the author of this suggestion, Mr. BROYHILL, who incidentally used to be on your committee. It would be his thought and my thought completely that we are not binding anybody here to do anything outside of the executive branch. We are trying, however, to put some degree of incentive and inducement in other areas downtown, other than the Department of Health, Education, and Welfare, to bring about some degree of integration and avoid in the future this duplicate payment by these people.

Any improvement of any program would clearly have to initiate in the gentleman's committee.

Mr. DANIELS of New Jersey. Unless the Secretary of the Health, Education, and Welfare determines and certifies that the plan is modified to provide a complimentary or supplementary level of benefits, then——

Mr. MILLS. Medicare is not responsible.

Mr. DANIELS of New Jersey. The employee is enrolled in that.

Mr. MILLS. The employee is enrolled in that program and he has been paying for it.

Mr. DANIELS of New Jersey. Then I refer the gentleman to page 116 of the committee report, where you go on to state, as I interpret it, that the Government will be obliged to pay 50 percent of the high-option benefits premium. I am wondering——

Mr. MILLS. Very frankly, I would have preferred that that provision not be worded quite that way because it can be interpreted by some as a directive by our committee to your committee with a specified position. Frankly, I do not think Congress has any right legally or under the Constitution to tell one department of the Government anything more than to report back to us with a solution. I do not think we can tell that department, frankly, that you have got to do it in this particular way.

Mr. DANIELS of New Jersey. I thank the gentleman for his explanation.

Mr. MILLS. I do not think it would be binding on them anyway.

Mr. HUNGATE. Mr. Chairman, will the gentleman yield?

Mr. MILLS. I yield to the gentleman from Missouri.

Mr. HUNGATE. Mr. Chairman, I refer the chairman to section 263 of the bill, page 136.

A great many of my constituents have expressed interest in the subject of section 263 regarding chiropractic coverage and services. I commend the com-

mittee for its study on this and I wonder if the chairman can give us the committee's views.

Mr. MILLS. The committee made as diligent an effort in this area as it is possible to make in any area, trying to work this out. There are some questions involved and there is still some argument between those who practice this service and the department downtown as to what the costs would be

This is not a one-sided matter. There are some people violently opposed to chiropractic services being included and being described in a manner which will make the practitioners physicians under the program.

We have over 19 million people who are eligible to participate in plan B. I understand those 65 years of age and older who actually from time to time make use of chiropractic services number between 1 and 2 million. So the only thing we could work out is that we would be charging everybody—those who do not use such services and those who do use such services. And we tried to think of doing it on the basis of leaving it up to an individual and letting the individual who did take the option pay more, but it is my recollection that the costs of that would have been much higher because the costs would have been paid by the 1 or 2 million and not spread over the 19 million. We have asked the Department to report back to us just how this coverage can be properly included under the medicare program—not whether it should be, but we have asked them to tell us how it can be done.

Mr. HUNGATE. Mr. Chairman, I thank the gentleman from Arkansas.

Mr. PETTIS. Mr. Chairman, will the gentleman yield?

Mr. MILLS. I yield to the gentleman from California.

Mr. PETTIS. Mr. Chairman, I rise to ask a question for clarification.

Section 227 of the bill adds a new section 1862(d) providing that the Secretary of Health, Education, and Welfare will establish, in each State, "one or more program review teams" after consulting with "local professional societies, carriers, intermediaries, and consumer representatives." When a provider furnishes unneeded services or supplies, and so forth, the Secretary, with the concurrence of the physicians or other professional health personnel of the review team, will be allowed to refuse payment and, in some cases, to terminate agreements with the offending provider. Was it not the intention of the committee that true peer review take place, and is that not what was intended by the phrase, "concurrence of the physicians or other professional health personnel of the review team"? For example, does this not mean that when a physician provider is charged with abuse, his conduct would be judged only by the physician members of the review team.

Mr. MILLS. It will have to be by his peers. It has to be a doctor who is a peer of a doctor. The peer of a lawyer is a lawyer. This does not mean you have a team of lawyers going in and trying to evaluate the professional ethics and background of a physician. There is no question but what that is the intent of the bill. I think really the bill itself is clear, but I appreciate the gentleman's raising the point, so there can be no doubt as to what the intent of the language of the bill is.

Mr. DENNEY. Mr. Chairman, will the gentleman yield?

Mr. MILLS. I yield to the gentleman from Nebraska.

Mr. DENNEY. Mr. Chairman, I have just one question for clarification. I heard the gentleman's statement about raising the widows up to 100 percent of entitlement if they apply after age 65. Let us take the situation of a husband who is 80 and whose wife is 74, and the husband dies, and they have been drawing social security. Is the widow still limited to 82.5 percent?

Mr. MILLS. No; this applies to those now on the rolls and in the future who become widows at 65.

Mr. DENNEY. Even though she is drawing the widow's entitlement?

Mr. MILLS. She gets 100 percent after January 1, 1971.

Mr. GUBSER. Mr. Chairman, will the gentleman yield?

Mr. MILLS. I yield to the gentleman from California.

Mr. GUBSER. Mr. Chairman, I know the gentleman is familiar with the rather unusual problem which exists in teaching hospitals such as Stanford University. It is my understanding that language in the bill would correct the situation so they can live with it.

Mr. MILLS. We thought so, but we have a committee amendment to make certain that amendment does exactly what we intend it to do, and that amendment will probably take care of it.

Mr. RHODES. Mr. Chairman, will the gentleman yield?

Mr. MILLS. I yield to the gentleman from Arizona.

Mr. RHODES. I thank my good friend from Arkansas for yielding.

As the gentleman from Arkansas (Mr. MILLS) is aware, I have been most interested in the concept of ambulatory surgical centers as a means of reducing medical costs while improving the quality of medical care now being delivered to this type of patient. I have also been privileged to direct the attention of the committee to a presently operating come-and-go surgical center in Phoenix, Ariz., known as Surgicenter. Surgicenter has been approved by almost every major commercial insurance carrier in the Phoenix area.

At present, as the gentleman is aware, some of the services provided by the Surgicenter are not included within the supplemental medical insurance program.

It is my understanding, however, that under the legislation reported by the committee, services rendered by an institution such as Surgicenter could be covered on an experimental basis. I would like to ask the gentleman whether, in his opinion, this could be done under the proposed legislation.

Mr. MILLS. Let me say to my friend from Arizona, under section 222, the section to which the gentleman referred, the Secretary would be permitted to conduct—the gentleman understands, he is not required—a demonstration project with a facility such as Surgicenter, Inc., and pay it for the noncovered medicare services the institution furnishes on an experimental basis.

I recall the gentleman's testimony concerning this very fine facility in Phoenix, and I trust the Secretary, who is a very fine individual, a very discerning individual, as the gentleman is well aware, will give every consideration to its inclusion under the applicable provisions of this legislation.

Mr. RHODES. I thank the gentleman.

Mr. CONABLE. Mr. Chairman, will the gentleman yield?

Mr. MILLS. I am glad to yield to my friend from New York, a member of the committee.

Mr. CONABLE. I should like to compliment my distinguished chairman on his statement. There is some concern in my State, I find, about something the committee did relative to Federal reimbursement under the medicaid formula under title XIX. As I recall, this provision increases the Federal share of reimbursement for treatment in outpatient clinics in hospitals.

Mr. MILLS. That is true.

Mr. CONABLE. While decreasing the Federal share paid for long-term patients under medicaid.

Mr. MILLS. In skilled nursing homes.

Mr. CONABLE. In skilled nursing homes. There is some feeling this might run the cost of medicaid up. I wonder if I could have the view of the distinguished chairman on that?

Mr. MILLS. The whole purpose, as I said earlier, is to bring about a reduction in the total cost of medicaid, by requiring the State agency which administers the program to use greater care with respect to the type of medical facility that is being used in the care of the particular patient who is eligible for medicaid under that State law.

We feel—and we have a lot of evidence to justify it—there is an extreme amount of overutilization of skilled nursing homes. In other words, the people could get along just as well in the intermediate-care or domiciliary-type nursing homes. They do not need the more expensive type of care provided in the skilled nursing homes.

Mr. CONABLE. I thank the gentleman.

Mr. MILLS. The States can correct this without any additional cost to them, in our opinion. It does not mean that anybody is going to be thrown out. If it is decided that the patient has to stay, if that is the opinion of the doctor and the opinion of whatever review committee they may have, all we say is that we are not going to pay indefinitely the 66⅔ percent of the cost of such care in Texas or the 80 percent of the cost in Arkansas, that we will reduce that by one-third. If they want to keep them there, that is their business.

Mr. PICKLE. Mr. Chairman, will the gntleman yield?

Mr. MILLS. I yield to my friend from Texas.

Mr. PICKLE. I thank the gentleman for yielding.

What assurance do we have in this bill that the intermediate care centers will be given extra help in the furtherance of this program, if these people are assigned to them? Or what assurance do they have that their program will not be discontinued or cut off?

Mr. MILLS. There is no assurance of that.

Mr. PICKLE. Or what assurance do they have that the States can give them this?

Mr. MILLS. There is nothing in this bill on that. Whatever duration the State sets for a person to reside or stay in a domiciliary or nursing home we will match it under present law. In your State we said two-thirds of the cost would be Federal, and it will continue to be, with no cutoff date whatsoever for intermediate care. The only cutoff is with respect to that type of expensive nursing home care where we will say that if you cannot get your patient well in 90 days, where the patient can either go home or to an intermediate care facility, then we will have to cut back on the amount, because we are not going to continue to have this thing jump up by millions of dollars a year for every year in the future. That is the whole purpose of it. These are Federal dollars we are spending.

Mr. PICKLE. Yes. Will the gentleman yield further?

Mr. MILLS. Yes.

Mr. PICKLE. Under the bill as you have it before us, there is approximately $99 million to $100 million that will be saved or cut from the Federal expenditure in the future.

Mr. MILLS. It will not have to be picked up by the States at all.

Mr. PICKLE. Who picks up that $99 million, then?

Mr. MILLS. Nobody.

Mr. PICKLE. Or even a reasonable portion of it?

Mr. MILLS. If my friend from Texas will listen to me for 1 minute, we have unlimited evidence that the skilled nursing homes are being overutilized. The gentleman knows the meaning of the term "overutilization." It means that people are staying there or days, weeks, and months beyond the time required for them to stay there in order to recover from whatever ailment they have.

We cannot go on paying that kind of cost. It is what we tried to stop in hospitalization and have stopped in extended care facilities under the medicare program, where we have better control of it, and we will not let these States who have an overutilization problem spend us into Federal debt. The committee will not, at least.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield myself 15 minutes.

Mr. Chairman, in view of the very able and thorough explanation of this legislation by the chairman of the committee, I believe that my remarks can be quite brief. I do want to rise, however, in support of this legislation.

This bill includes many structural changes in the cash benefit program and the medicare, medicaid, and maternal and child health programs that, in my judgment, are much needed and certainly produce a more equitable system. Some of these changes remove clear inequities. Others, particularly in the medical programs, provide for experiments and pilot projects within general guidelines that it is hoped will lay the foundation for resolving some of our most difficult problems.

Let me emphasize, though, at this point some of the more salient and important changes in our present systems that are made by this legislation.

First, let me refer to the old age, survivors, and disability insurance program that we normally refer to as the cash benefit side of the system, as against the health and medical programs, which provide service benefits.

Mr. Chairman, a change which I know will be welcomed by most Members of the House and by many of our people is the increase in the annual amount that a person aged 65 or older can earn and still be eligible for full retirement benefits under the old age and survivors insurance system. That amount is increased to $2,000, from its present level of $1,680.

It should be noted at this point that Congress has failed through the years to keep the retirement test realistic in terms of changes in the real value of our money.

The cost of living has gone up from time to time, as we all know. Eventually, we have made corrections as far as cash benefits are concerned. We have sometimes delayed, but we have always done it.

In the case of the retirement test, however, we have neglected to keep its formula consistent with changes in the cost of living. I think the increase we provide here is definitely a step in the right direction.

Another major change, which I think is most needed, would liberalize benefits to widows and widowers. We must recognize that a retired man and wife can receive a benefit equal to 150 percent of an individual's benefit. In other words, if a retired male 65 or older is entitled to $100, he and his wife can receive $150 in benefits. But, let us assume that the husband dies. The living costs of the widow are not reduced to $82.50, automatically, even though they may decline to some extent because there is now only one person in this household. But $82.50 is all the widow would be entitled to receive under present law. And it seems to me this reduction to 82½ percent of the primary benefit has always been too much as far as the widow is concerned.

So under this bill the widow would be entitled to the same benefit that the husband would have had as a primary beneficiary. In other words, the widow's benefit would become 100 percent of her husband's primary benefit, rather than 82.5 percent as under present law.

Mr. Chairman, I think this is a most necessary recognition of a problem affecting many older people. It would mean that some 3.3 million widows and widowers would receive increased benefits.

Another proposed change would permit computation of benefits for men by including years only up to age 62. Women already can compute benefits by this method, so this is simply a matter of producing equity for men.

Another proposed change, which the chairman mentioned, is one of particular concern to me. It came to my attention that a married woman who had worked much of her life, took an actuarially reduced benefit at age 62, based upon her own earnings record. Then, when she became eligible at age 65 to receive a wife's benefit, she was held to the same reduction of her wife's benefit at age 65 that she received when she claimed a benefit on her own account at age 62. In such a case, a wife who had worked for years could be receiving a much smaller benefit than a wife who had never worked in her life.

This bill would correct that inequity, and no longer penalize a woman worker because she takes a reduced benefit before age 65 on her own account.

Mr. MILLS. Mr. Chairman, will the gentleman yield at that point?

Mr. BYRNES of Wisconsin. I yield to the gentleman from Arkansas.

Mr. MILLS. Mr. Chairman, one point I think everyone should understand in connection with what the gentleman from Wisconsin is talking about, is that this lady was taxed during her working years on her work record; is that not correct?

Mr. BYRNES of Wisconsin. That is right.

Mr. MILLS. It was on her own work record that she claimed benefits at age 62. Her husband was taxed on his work record during his working years, and she claimed benefits as a wife on his work record when she reached 65. Also I believe the record ought to show that the gentlewoman from Michigan (Mrs. GRIFFITHS) has been interested in this matter for some time.

Mr. BYRNES of Wisconsin. That is one of the areas which she and I have been working together on—the equalization of disparities in benefits between men and women, and between working women, and other women.

Mr. MILLS. But until we can do what the gentlewoman has recommended, this provision at least corrects the inequity that arises in this particular case.

Mr. BYRNES of Wisconsin. I am not suggesting—and the gentlewoman from Michigan and the gentleman from Arkansas woul not agree, I am sure—that we have in this bill removed all the inequities that we would have liked to remove. There were items on which I think most committee members wanted to act. There was, for instance, the matter of covering the disabled under medicare. This was one of many suggested changes which we knew had great merit, but which we could not include in the bill. Managing this system involves much more than simply providing benefits. We also have to be concerned with how we are going to pay for any benefits that we do provide, and how we are going to keep the system in balance.

Let me suggest that this sort of problem involves basic questions which should be of concern not only to our committee, but to every Member of this House. And I am talking primarily about maintaining the integrity of this system.

Let us remember that some 25 million people are receiving cash benefits under this system and are dependent upon it in varying degrees. Some 72 million more are contributing to social security, and, therefore, have a vital interest in it.

One of the worst things this Congress, or any Congress, could do would be to take action which would jeopardize the capacity of the system to meet future commitments to those people who today are paying taxes. And this could be jeopardized if the burden of taxes rose beyond a tolerable level.

So as we look at proposals to liberalize benfits or to make any changes that cost money, we have to balance these against the burden they would impose on taxpayers. I suggest that we are reaching the point where that burden is tremendously high, and from now on we are going to have to be extremely cautious.

Mr. MILLS. Mr. Chairman, will the gentleman yield?

Mr. BYRNES of Wisconsin. I yield to the gentleman.

Mr. MILLS. I appreciate so much the gentleman from Wisconsin bringing up this matter. I have tried to impress upon the people who are presently receiving these benefits this very fact, that as this tax goes up it becomes an ever-increasing burden. And this tax, being imposed on wages without allowing deductions or a personal exemption, is different from the income tax.

For instance, I think the membership should know that the 1st of January 1971, if a man is making $9,000 or more he will be paying $468 in that year in social security tax.

Mr. BYRNES of Wisconsin. And I would add that it must be recognized that not only are we increasing the taxable base from $7,800 to $9,000 in this bill, but we also are increasing the rate, eventually, by 1.2 percent, which is an additional burden. We are approaching a point, in fact, under the bill, where a family of four with $7,000 annual income will be paying more in social security taxes than in income tax.

And this does not take into account the situation of the self-employed, whose tax is even higher.

In another dimension, we also have to recognize that the tax on the employer constitutes money which otherwise might go for an increase in take-home pay or other benefits to the worker. So the worker is, in large measure, paying not only his own tax but the employer's tax as well.

Mr. GROSS. Mr. Chairman, will the gentleman yield?

Mr. BYRNES of Wisconsin. I yield to the gentleman.

Mr. GROSS. Mr. Chairman, the gentleman from Wisconsin is making an important statement and it seems to me there ought to be more than 13 Members on the floor of the House. Therefore, Mr. Chairman, I make the point of order that a quorum is not present.

The CHAIRMAN. The gentleman from Iowa makes the point of order that a quorum is not present. Evidently a quorum is not present. The Clerk will call the roll.

The Clerk called the roll, and the following Members failed to answer to their names:

[Roll No. 134]

Adams	Eckhardt	Pirnie
Addabbo	Edwards, Calif.	Pollock
Albert	Ellberg	Powell
Alexander	Evins, Tenn.	Rarick
Anderson, Tenn.	Findley	Reid, N.Y.
	Foreman	Reifel
Ayres	Galifianakis	Riegle
Baring	Goldwater	Rivers
Belcher	Gray	Roberts
Bell, Calif.	Hansen, Wash.	Robison
Bingham	Harsha	Rogers, Colo.
Blatnik	Hays	Rogers, Fla.
Brown, Calif.	Hébert	Rosenthal
Brown, Mich.	Horton	Roudebush
Buchanan	Jacobs	Scheuer
Burton, Utah	Kirwan	Sikes
Bush	Kleppe	Smith, Calif.
Byrne, Pa.	Kluczynski	Springer
Celler	Kyl	Stafford
Chamberlain	Landgrebe	Stokes
Chappell	Leggett	Stratton
Clark	McCarthy	Symington
Clay	MacGregor	Tiernan
Cohelan	Matsunaga	Tunney
Colmer	Mikva	Watson
Corbett	Miller, Calif.	Wilson, Charles H.
Davis, Ga.	Murphy, N.Y.	
Dawson	Nichols	Young
Dellenback	Ottinger	
Diggs	Patman	

Accordingly the Committee rose; and the Speaker pro tempore (Mr. PRICE of Illinois) having assumed the Chair, Mr. DINGELL, Chairman of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill H.R. 17550, and finding itself without a quorum, he had directed the roll to be called, when 342 Members responded to their names, a quorum, and he submitted herewith the names of the absentees to be spread upon the Journal.

The Committee resumed its sitting.

The CHAIRMAN. The Chair recognizes the gentleman from Wisconsin (Mr. BYRNES).

Mr. BYRNES of Wisconsin. Mr. Chairman, the burden of taxes that today's workers and tomorrow's workers will pay can be determined by looking at page 11 of the committee report which sets out the schedule of those rates for the old age, survivors, and disability insurance program and the health insurance program.

The rates on page 11 are those the employee must pay himself and therefore state only one-half of the actual total rate. In order to get the total rate, we must double the rate shown on page 11 for employees since an equal amount is also paid by the employer on behalf of the employee. The rate on the self-employed, which is generally about 50 percent higher than the individual employee rate, is also shown in this chart.

The chart shows that the real rate we are imposing by this bill on tomorrow's workers will reach 13 percent in 1980. And this assumes that no further increases are to be enacted in the future.

Let it also be remembered that this is a gross tax on wages or self-employment income. The tax is imposed on the first dollar a person earns. There is no deduction allowed. A personal exemption is not provided. Medical expenses, work-related expenses, casualty losses, and other items that are allowed in our income tax law are not allowed in the application of this tax. The student who works this summer and earns a very small amount will pay no income taxes, but he will pay a social security tax.

Amending the Social Security Act is not a one-sided proposition. We have to look at the benefits, as we have in this bill, to be sure that we provide equity to social security beneficiaries, but we cannot simply focus on the benefit side of the ledger. We must also look at the burden we are placing on the workers to pay for those benefits.

Quite frankly, I am afraid that too many Members of this House—and I am sure the situation is also true of the other body—have a tendency to look only at the benefits side of the picture. That is apparent if we look at the bills that have been introduced by various Members of the Congress. Nearly 1,000 bills have been induced to improve the social security program. While nearly all of these bills impose substantial costs, very few of them provide for the corresponding increase in the tax burden that would be necessary. Mr. Chairman, we must recognize that amendments to the program are a two-edged sword.

Let me briefly talk about the amendments to the medical programs—medicare, medicaid, and maternal and child health—included in this bill. This bill does not meet all of the problems that we face in these difficult programs. We have a long way to go before we can be content with our medicare and medicaid programs.

These programs do need remodeling. In this bill we did not remodel either. We have faced up to some of the individual problems that have developed and recommended specific solutions that we feel are sound.

Particularly in the medicaid program—which is now a $5 billion program and still growing—much more needs to be done, I am inclined to think we should look at the potential of converting medicaid, to the extent feasible, into a program of a subsidized insurance and impose a premium liability on the basis of the individual's capacity to pay rather than retaining the present welfare program.

But that is something for the future. In the present bill we have done the best we can do with the information available and the suggestions that were presented to the committee. Looking at the improvements as a whole, we have to say we have every expectation they will lead to improvement.

But now, Mr. Chairman, let me focus on an aspect of the bill that disappoints me a great deal. That is the refusal of the committee—and I dislike to say this, but it is a fact—on a partisan basis, to do what both major party platforms in the last election recommended: Provide for automatic increase in social security benefits commensurate with increase in the cost of living.

For my friends on the other side, in case they have not read their 1968 Democrat platform recently, let me quote from it:

OLDER CITIZENS

A lifetime of work and effort deserves a secure and satisfying retirement. Benefits especially minimum benefits, under Old Age,

Survivors, and Disability Insurance should be raised to overcome present inadequacies and thereafter should be adjusted automatically to reflect the increases in living costs.

When the President of the United States sent his message on social security to the Congress, he recommended an "escalation provision" for social security recipients. He stated:

I propose that the Congress make certain once and for all that the retired, the disabled, and the dependent never again bear the brunt of inflation. The way to prevent future unfairness is to attach the benefit schedule to the cost of living.

Describing the recommendation he made, the President went on to say:

Benefits will be adjusted automatically to reflect increases in the cost of living. The uncertainty of adjustment under present laws and the delay often encountered when the needs are already apparent is unnecessarily harsh to those who must depend on Social Security benefits to live.

Benefits that automatically increase with rising living costs can be funded without increasing Social Security tax rates so long as the amount of earnings subject to tax reflects the rising level of wages. Therefore, I propose that the wage base be automatically adjusted so that it corresponds to increases in earnings levels.

These automatic adjustments are interrelated and should be enacted as a package. Taken together they will depoliticize, to a certain extent, the Social Security system and give a greater stability to what has become a cornerstone of our society's social insurance system.

Mr. Chairman, we will propose as a motion to recommit with instructions to report it back with an amendment providing automatic cost of living adjustments to take effect not in substitution of anything that has been done in this bill, but to assure that in the future these benefits we have provided will keep pace with changes in living costs.

Our motion will insure that the earnings test, the amount people can earn without suffering diminution of benefits, will also keep pace with increases in real earnings.

In order to insure the financial integrity of the system as the President emphasized, the wage base will automatically be adjusted every 2 years as the earnings of covered workers increase. This will maintain the existing relationship between the wage base and the wages of covered workers.

Under the provision for automatic benefit increases, we will compare in the third quarter of each year the change in the cost of living as against that in the third quarter of the previous year. Whenever the cost of living has increased by 3 percent or more there will be a comparable increase in social security benefits beginning the following year.

The wage base computation will only be made every other year—in each even-numbered year beginning in 1972. This will avoid constant change in the wage base subject to tax with the readjustments of payrolls that would be necessary. The average wages paid covered workers in the first calendar quarter of the computation year will be compared with those paid covered workers in the first quarter of 1971. The taxable wage base will be adjusted, effective the following January 1, by a corresponding amount. A corresponding increase will also be provided in the earnings limitation, again effective the following January 1 for all calendar year taxpayers.

I hope the House will act on this issue on a bipartisan basis, as was expressed in both political platforms in 1968, in order to provide the simple justice that social security beneficiaries—both present and future—deserve and have been promised.

Let me make it clear that this does not assume that the administration and the Congress will not have to consider the appropriations of benefit levels sometime in the future. I believe it will be essential to do so, as we have in the past. From time to time, we should look at the changes in the standard of living and the general economic conditions under which all our people live in considering the benefit level. There should be adjustments when these criteria require them, and Congress can specifically deal with this issue periodically.

This amendment does not foreclose Congress from acting, but simply says that in the event Congress does not act, increases will be automatic. This will give the older people, dependent upon social security as their base of protection, an assurance that there will not be a long delay in compensating them for any inflation that occurs. There have been serious delays Mr. Chairman, the most conspicuous being between 1940 and 1951, and between 1959 and 1965 when no increases were granted. Some people retire and die before needed increases are enacted. Even those who collect increases have lost something in the interim.

I am not criticizing the committee for not having kept benefits current with the cost of living, but we can criticize the delay that has often occurred. This delay often has been much longer than would have occurred if we had provided automatic increases.

I know the argument will be made that we are delegating some authority to the executive branch. We are not delegating authority. We are saying in the statute that when specific well-defined events occur, certain equally specific and well-delivered results will ensue. We are not granting discretion to someone in the executive branch, or providing them with any options. We require specific action in the event of specific circumstances.

We also leave open to ourselves the opportunity—and I hope we will act on it, to make additional adjustments above the cost-of-living increases that may be necessary to maintain the standard of living of older people.

Mr. Chairman, I hope that this bill is adopted. I think it is good legislation. But I think we can make it much better and keep our promise, both as Republicans and Democrats, to the American people by adopting the motion to recommit.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield such time as he may require to the gentleman from Virginia (Mr. BROYHILL).

(Mr. BROYHILL of Virginia asked and was given permission to revise and extend his remarks.)

Mr. BROYHILL of Virginia. Mr. Chairman, I rise in support of this legislation.

Mr. Chairman, H.R. 17550 contains some badly needed changes in the social security, medicare, and medicaid programs.

On balance, it is a sound bill, providing greater equity than existing law for both the beneficiaries of these programs and for the taxpayers who support the programs.

But this is not to say the measure is fiawless. Along with a number of my colleagues, I am concerned about one of its provisions, a major omission from it, and one of its implications.

The provision of concern is the 5-percent increase in cash benefits. Although I am wholeheartedly in favor of increasing social security payments so that beneficiaries do not have to lower their standards of living in infiationary times, I also am concerned about the burdens imposed on taxpayers every time benefits are increased. Together with the 15-percent rise we approved late last year, this newly proposed advance would bring the total benefit increase within 1 year's time to 21 precent, which is far above the advance in living costs due to infiation in this period.

The omitted item of concern is the administration's proposal to tie social security benefits in the future to increases in the cost of living. It is truly unfortunate that this was kept out of the bill by a straight, party line vote, especially in view of the fact that such a provision has been endorsed by both political parties.

The provision, among other things, would assure beneficiaries that they would no longer have to bear the brunt of soaring infiation. Our civil service retirees have had this assurance for 8 years, and our military retirees have had it for 12 years, so why should our social security beneficiaries not have this assurance now?

Tying benefit increases to a reliable statistical gage—actual increases in earnings of workers in covered employment—would be far more realistic and economically practical than leaving them dependent upon executive discretion or congressional inclination.

I might emphasize the point, which already has been made, that this provision would not turn over a congressional prerogative to the executive branch. The Congress still would be free to make whatever adjustments in social security it deemed desirable or necessary. Due attention could be paid, for example, to changes in standards, as well as basic costs of living.

My third cause for concern has to do with the actuarial imbalance the bill would bring about.

It is, of course, not the imbalance itself that bothers me. But the Committee on Ways and Means has, in the past, adhered strictly to rather narrow criteria on imbalances in social security funds. And I am lending support to this bill on the assumption, and trust, that the anticipated imbalance—however slight and short lived—does not represent a departure from longstanding form, and will not be used to provide a precedent for a policy shift in the future.

As I said at the outset, the bill is a good one, on balance. I have discussed my three points of concern not so much to sound an alarm as to raise a note of caution.

The measure's imperfections are not only far outweighted by its merits, but are insufficient to form a solid base of opposition. They do not represent damage to the social security system, but they do represent steps which should be taken with great care, to avoid some serious stumbling in the future.

Most of the proposed changes in the social security system embodied in H.R. 17550 are not only sorely needed but long overdue.

I have felt for some time that the retirement test needed to be liberalized. Certainly a limit of $1,680 on the amount a beneficiary could earn annually without having his benefits decreased is not realistic. This exemption should be higher, and $2,000 is clearly not too high.

Other needed changes are proposed in benefits for widows and widowers, about 3.3 million of whom would be eligible for additional, and more equitable, payments starting in January of 1971.

For example, a lady who applies for widow's benefits at age 62 or older is entitled now to receive only 82½ percent of the amount her husband would have been eligible to receive. Under the bill, she could receive 100 percent of the husband's benefits.

Still another praiseworthy provision would liberalize the law allowing a social security wage credit of up to $100 a month—in addition to credit for basic pay—for military service performed after 1967. H.R. 17550 would provide those additional wage credits for military service starting in 1957, the year when military service became covered under social security.

As laudable and desirable as such changes would be, however, perhaps the most welcomed improvements proposed in the bill would be in the medicare, medicaid and maternal and child health programs.

Taken as a whole, these proposals would make the programs much more effective than they are today. Costs would be held down without sacrificing the health needs of the beneficiaries. And considering the financial condition of the medicare program, these are the sort of changes which simply must be made.

Although this entire section of the bill is commendable, I am especially pleased with one particular provision which is designed to bring about coverage, supplementary to medicare, in Federal employee health benefit plans.

This provision specifically would require that, effective January 1, 1971, no payment would be made under medicare for services which also were covered under a Federal employee health benefit plan, unless in the meantime the entire Federal employees health benefit program had been modified to include coverage supplemental to medicare, and provisions assuring that Federal employees and retirees age 65 or older would continue to have the benefit of Government contributions toward their health insurance premiums.

Under present law, the Federal employee health benefit plans provide coverage which duplicates that of medicare. But they do not make payments for services which are duplicated. Participants in both programs can collect only through medicare.

A Federal employee may have contributed all along to one of these Government plans and to medicare, too, yet would be able to benefit under medicare only.

Most private employers have furnished their employees with supplementary health care coverage. The Government has not done so, with the resultant inequities to Federal employees and retirees.

This provision of H.R. 17550 should force the Government's hand, and bring an end to an unfair practice.

Because of that provision, and because of the many others which make H.R. 17550 a bill of great value overall, I commend it to the House, Mr. Chairman, and urge its approval.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield such time as he may require to the gentleman from Michigan (Mr. CHAMBERLAIN).

(Mr. CHAMBERLAIN asked and was given permission to revise and extend his remarks.)

Mr. CHAMBERLAIN. Mr. Chairman, I rise in support of H.R. 17550, the Social Security Amendments of 1970.

This is not to say that I am completely satisfied with this bill in all respects. I am not. This legislation does not include all the reforms that the President requested nor some additional changes which I believe should be made.

Nonetheless, H.R. 17550 makes definite and much needed progress in a number of areas which should serve to provide greater equity in our social security program.

Particularly encouraging is the committee's approval of the administration's proposals to improve benefits for widows and increase the amount that an individual may earn without losing benefits. While I personally had hoped that the retirement test could have been further liberalized and sponsored legislation to raise the annual limit to $2,400, I believe that the recommended increase from $1,680 to $2,000 a year will be of considerable help to those who have to work to supplement their retirement incomes.

I was very disappointed, however, that the committee rejected the proposal to provide automatic cost-of-living increases in benefits which I have joined in urging for some time and which was requested by the President. I feel it is regrettable that this decision was made by a strict party line division which is particularly surprising when you consider that such a provision was recommended in the platform of the Democratic Party in 1968 as well as in the platform of the Republican Party. This reform would have assured that the level of benefits would not lag behind the rest of the economy during periods of inflation and would have helped to remove social security adjustments from the political arena into which they have too often been cast. I commend to the attention of my colleagues the supplemental views contained in the report accompanying this bill which discussed this and other shortcomings of the bill as finally approved by the committee.

In addition, I support the purposes of the provisions of the bill designed to improve the effectiveness and hold down the cost of medicare and medicaid and maternal and child health programs. Because of the complexity of these programs we will have to watch carefully how these reforms are implemented in practice. It is apparent from the difficulties that have been experienced to date that the changes recommended by the committee deserved to be tested.

Another area which I very much regret the committee has passed over this time is the proposal to eliminate the requirement that those who continue to work past the age of 65 must nevertheless continue to pay social security taxes. There are hundreds of thousands of people over 65 who because they continue to work cannot under the present law receive any social security benefits, while many others have their benefits reduced. This built-in antiwork discrimination is compounded by the fact that these same people must continue to pay social security taxes, even though they will probably draw benefits for fewer years than those who fully retire at age 65. This is clearly unfair and should be corrected.

These are, of course, not all the reservations which I have about the legislation before us today. Nonetheless, I am satisfied the bill is the best that can be obtained at this time and urge its adoption.

Mr. DEL CLAWSON. Mr. Chairman, will the gentleman yield?

Mr. BYRNES of Wisconsin. I yield to the gentleman.

(Mr. DEL CLAWSON asked and was given permission to revise and extend his remarks.)

Mr. DEL CLAWSON. Mr. Chairman, I thank the gentleman for yielding.

Mr. DEL CLAWSON. Mr. Chairman, although official business in my congressional district requires that I leave before the final vote is taken on the bill before the House of Representatives today, I would like to state that had I been present my vote would have been for H.R. 17550, the Social Security Amendments of 1970.

Mr. WINN. Mr. Chairman, will the gentleman yield?

Mr. BYRNES of Wisconsin. I yield to the gentleman from Kansas.

(Mr. WINN asked and was given permission to revise and extend his remarks.)

Mr. WINN. Mr. Chairman, I support H.R. 17550. I wish to commend my colleagues on the Ways and Means Committee for correcting a number of long-standing inequities in the social security system by this bill, H.R. 17550. I point specifically to that provision which liberalizes disability insurance benefits for blind persons and to that which raises the earnings level from $1,680 to $2,000 a year. Both revisions follow closely legislation which I have introduced in both the 90th and 91st Congresses and which is very long overdue.

However, I feel it is most unfortunate that this bill is being debated here in the House under a closed rule because it does contain one provision which relates to the medicaid program and will have a serious and adverse affect on many incapacitated elder citizens who must

spend lengthy periods of time in some kind of skilled nursing home. We, in Kansas, have an unusually high ratio of senior citizens and many are benefiting from the medicaid program. It is estimated that this bill could withdraw at least $5 million which would have to be made up by State revenues, and it is unlikely the State can take up this additional burden. I fear that enactment of this provision in H.R. 17550 will mean disaster for Kansas welfare program for the aged will result in the closing of many skilled nursing homes, already in desperate short supply.

Mr. MYERS. Mr. Chairman, will the gentleman yield?

Mr. BYRNES of Wisconsin. I yield to the gentleman from Indiana.

(Mr. MYERS asked and was given permission to revise and extend his remarks.)

Mr. MYERS. Mr. Chairman, I wholeheartedly support the provisions in the Amendments to the Social Security Act which would increase payments to the 26.2 million beneficiaries by 5 percent, increase the income limitation to $2,000, and increase survivor's benefits to 100 percent of the primary insurance amount.

I have some doubts about certain other provisions in this measure dealing with medicare and medicaid, but because of the closed rule under which we are considering this legislation it cannot be amended.

It is that which has been omitted from this measure that concerns me most. There is no doubt of the need for the increase in payments for those living on these benefits so long as we are experiencing the inflationary spiral we are in today. However, Congress will once again ignore its responsibility to these people if we fail to make certain that such increases are not used as a political football which is passed only in election years.

For that reason, I shall support the motion to recommit this legislation with instructions to the committee to amend it to include the automatic cost-of-living provision many of us have been working for over the last several years.

There are those who will argue here today that we should not do this because Congress will lose control over social security increases. To me that is an admission that Congress has used the social security issue as a political football. My provision for granting automatic increases based on the cost of living and not whether it is an election year would make the Social Security Administration responsive to the needs of the people.

While a stable dollar is the major long range need to protect older Americans and others who must depend on relatively fixed incomes, I feel this immediate action is required to provide help to these persons against the ravages of inflation. Adoption of our porposal to provide automatic increases in social security benefits equal to rises in living costs would be a major step in that direction.

As introduced and supported by scores of minority Members in the House, such an amendment to social security would provide that whenever the consumer price index goes up by a specified percentage, then old-age, survivors, and disability insurance benefits would be increased in an equal percentage.

The most important argument for automatic cost-of-living increases in social security benefits, of course, is the help it would give to older people.

Most older Americans are relatively defenseless against higher living costs produced by the inflationary spiral. Help should be available to the retiree as soon as he or she is hit by the dollar-value loss. He should not have to wait 1, 2, 3, to 5 years for such relief through general amendments to the Social Security Act. This is especially so when such increases often fail to compensate fully for changes in living costs anyway.

It is regrettable, but true, that many of the elderly simply cannot wait. Some are of most advanced age and may not even live to get the benefit of increase "promises." A high percentage of these extremely old people are ones with the lowest resources.

I believe that compassion, equity, and commonsense demand that we stop making older people wait until some future Congress chooses to compensate them for social security benefit losses created by inflation.

Convinced as I am of the urgent need for this reform in the social security system, I have introduced legislation in support of the cost-of-living provision and will continue to do so with the hope the majorities in Congress will cease its opposition and join us in providing for an automatic offset against the hardships of inflation and its resulting rise in prices which plague our senior citizens.

Mr. MILLS. Mr. Chairman, I yield such time as he may require to the gentleman from Louisiana (Mr. BOGGS).

(Mr. BOGGS asked and was given permission to revise and extend his remarks.)

Mr. BOGGS. Mr. Chairman, the committee has done an outstanding job in reporting this bill. It is vitally important to the millions of Americans who receive social security benefits.

Mr. Chairman, I want to express my support of the provisions of H.R. 17550, even though in many ways the bill does not go as far as I had hoped that it would.

The 5-percent benefit increase coupled with the 15-percent increase voted last December will greatly improve the ability of the beneficiaries to get along. Under the bill monthly benefits for a retired worker on the rolls who retired at age 65 or later would range from $67.20 to $231.90. Under existing law, the benefit range for those now receiving old-age benefits is $64 to $220.80. I would like to have raised the minimum benefit to at least $80, because, as we all know, those at the lower end of the benefit scale are generally in the greatest need, and I hope that in the near future we will be able to raise the new minimum of $67.20 substantially.

Under the bill, benefits to widows and widowers if taken at age 65 or later would be increased to 100 percent of the worker's primary insurance amount. Under present law, the widow or widower receives a benefit equal to 82½ percent of the worker's primary insurance amount whether the benefit is applied for at age 62 or later. Your committee's action corrects this long standing weakness in the social security program. For a widow or widower making application for benefits before age 65 the benefit would range from 82.9 percent at age 62 to 100 percent at age 65.

In addition, the bill would increase the amount that a person may earn without having his benefits withheld. Under existing law if he earns more than $1,680 a year he loses some or all of his benefits; between $1,680 and $2,880, $1 in benefits is withheld for each $2 of earnings and above $2,880, $1 in benefits is withheld for each $1 of earnings. Under the bill he would be able to earn $2,000 a year without losing any benefits and the $1 for each $2 band would be extended to $3,200 of earnings. These changes will make it possible for those among the beneficiaries who are able to work to supplement their social security benefits with fairly substantial earnings.

One improvement that I am particularly pleased to see in the bill is the change in the method of figuring benefits for male workers. Under present law benefits are figured differently for men and women and the result is a lower benefit for a male worker than for a woman worker with the same earnings. Under this bill, benefits for both men and women would be averaged over a number of years figured up to the year the worker attained age 62, as is presently the case for women workers. This provision means that a man and woman of the same age working side by side in a factory and earning the same amount of money would receive the same retirement benefit.

Two other changes in the program incorporated in this bill are due in large part to the efforts of our distinguished colleague from Michigan, the Honorable MARTHA GRIFFITHS. Under present law a divorced wife or surviving divorced wife can receive benefits on her former husband's account if they had been married for at least 20 years, if, at the time, she applies for benefits she was receiving support from her former husband or there was a court order for her support. Many women at the time of the divorce take a property settlement in lieu of alimony or for other reasons refuse to accept any support. Also, in some few States it is not possible under the law for a woman to get alimony. Under the bill, the support requirement would be removed and benefits would be payable solely on the basis of a marriage which lasted at least 20 years. Also, under the bill, widowers would be eligible to receive benefits at age 60, the same as that for a widow. Widow's benefits at age 60 have been payable since 1965 and now the same protection will be afforded dependent widowers.

So far as medicare is concerned I am glad to report that the bill would make some much-needed improvements in the health insurance program. But I am disappointed that there is no provision for medicare for the disabled. The 1967 Social Security Amendments required the Secretary of Health, Education, and Welfare to establish an advisory council to study the problems of health insurance for the disabled. In January 1969 the

council recommended extension of health insurance coverage to disabled beneficiaries. I would have liked for this bill to have included a provision to carry out this recommendation. Nevertheless, the provisions that are included in the bill are good ones and I hope that all of you will join me in supporting them.

Mr. MILLS. Mr. Chairman, I yield such time as he may require to the gentlemen from Ohio (Mr. VANIK).

(Mr. VANIK asked and was given permission to revise and extend his remarks.)

Mr. VANIK. Mr. Chairman, I am pleased to support H.R. 17550, which was reported out of the Ways and Means Committee on which I am privileged to serve. This proposal does not either completely or satisfactorily update the social security program, but it is a step in the right direction.

This bill increases by 5 percent the social security payments to the 26.2 million beneficiaries on the rolls at the end of January 1971, and to those who come on the rolls after that date. The benefit increase would be effective for the month of January 1971, payable in February, and would mean additional benefit payments of $1.7 billion in the first year.

The bill would increase the amount a beneficiary under age 72 may earn in a year and still be paid full social security benefits for the year, from the present level of $1,680 to $2,000. Then, as in present law, for the next $1,200 of earnings there would be a reduction of $1 in a recipient's social security benefits for each $2 of earnings. A reduction of $1 would be made for each $1 of annual earnings above $3,200. This change would involve a cost to the Social Security Fund of almost one-half billion annually.

Another provision would provide $700 million annually in additional benefits to 3.3 million widows and widowers on the rolls at the end of January 1971 by providing that a widow or widower would be entitled to a benefit equal to 100 percent of the primary insurance amount, if first applied for at age 65 or later. Benefits applied for between age 62 and 65 would be proportionately increased over the present 82½ percent rate according to the age of the applicant at the time of application. In addition, widowers under age 62 would be granted the same privilege of applying for benefits on an actuarially reduced basis as now applies to widows.

The further changes under this bill eliminate the differences which favor women over men by providing that male retirees can compute their average earnings to age 62 instead of age 65.

In the medicare provisions, this proposal seeks to make the medicare, medicaid and maternal and child health programs more efficient.

As I stated in my separate views on this bill, I am distressed with the decision to reduce the old-age and disability insurance fund by $30.2 billion in the next 4 years with a compounded loss including interest totaling $54.9 billion by January 1, 1980.

The reduction of the old-age and disability tax rate was achieved by deferring the scheduled increase in the employer-employee combined contribution rate to 10 percent until January 1, 1975. Present law would have increased the combined 8.4-percent rate to 9.2 percent on January 1, 1971, and to 10 percent on January 1, 1973.

I cannot agree with the social security authorities who deplore the healthy growth of the social security fund. Those who criticize and question the soundness of this program are given comfort by our legislative action which diverts almost $62.6 billion from the fund over the next 40 years.

Under regular insurance actuarial standards, the social security trust fund is far below accepted reserve requirements. The tax stretchout further reduces the strength of the trust fund at a time of uncertainties beyond projection or prophecy.

Our action in reducing the tax rate on the old age, survivors', and disability insurance fund is an inflationary action which comes simultaneously with income tax reductions. It would seem provident to place some of the tax reduction into the retirement reserve.

Furthermore, the trust funds are becoming more substantial investors in the Federal debt. The time is not far distant when 40 percent of the Federal debt will be held by trust fund accounts. The trust fund contributions constitute the only investment in the Federal debt of millions of American taxpayers. Incredible as it may seem, the substantial investment of the trust funds in the Federal debt have served to keep the Federal interest rate and the public interest rate from reaching even greater heights.

Those who oppose the increased reserves in the social security trust fund are also those who oppose increased benefits. They are willing to shortchange the trust funds in order to reduce pressures for increased benefits and services needed by retired Americans. The worker-contributor will save a few pennies but the corporations of America will have a windfall of $15 billion in 4 years at the expense of a stronger social security fund and a better program.

It is my hope that the next Congress will review this decision and take appropriate action, if necessary, to strengthen the social security fund.

Mr. MILLS. Mr. Chairman, I yield such time as he may require to the gentleman from New York (Mr. GILBERT).

(Mr. GILBERT asked and was given permission to revise and extend his remarks.)

Mr. GILBERT. Mr. Chairman, I wish to congratulate and compliment the chairman of the Committee on Ways and Means and the members of the comimttee who worked so hard and diligently on this bill.

Mr. Chairman, I rise in full support of this bill to increase social security benefits by 5 percent.

This bill is the logical extension of the bill passed by Congress last year in which a 15-percent increase in social security benefits was authorized for more than 26 million Americans who today receive social security benefits.

I am also pleased that the committee has seen fit to take steps that will allow these senior citizens to live in relative comfort and security during this particularly crushing inflationary period the country is now undergoing.

The fight to increase the social security check has been a long, hard, often lonely battle for those of us who are concerned about the plight of our senior citizens. I laud the committee, and particularly our chairman, WILBUR MILLS, for responding so well to this worthwhile cause.

This bill, combined with last year's 15-percent increase, is in accord with my bill, provides a 20-percent benefit increase at the beginning and provides increases up to a total of 50 percent over several years. This is a first step toward the ultimate attainment of the 50-percent increase in benefits which will finally bring our golden age citizens up to a decent minimum living standard.

I will not go into detail on the bill since it has already been widely discussed, but the increases allowed in this bill raising the present level from $1,680 a year to $2,000 a year are certainly a step in the right direction.

For every $2 of earnings up to $3,200, a recipient's benefits would be reduced only by $1. This means that a social security recipient not only has a higher level under our bill, but is allowed incentive earnings.

An important provision of the new bill, as far as I am concerned, is the increased benefits for widows up to age 65. Up until now, they have only been receiving 80 percent of benefits. Under the new bill, as I had earlier proposed to the committee, benefits will now be 100 percent. There are presently more than 3 million widows and widowers on social security rolls. The increased benefits will dramatically increase their standard of living under social security.

As always, my committee has reported out a complex and tightly written bill which is primarily designed to assist those people who have worked hard all their lives and deserve to live out their retirement years in dignity and decency. We have discovered in our investigations in recent years that some social security recipients have had to go on welfare to survive. I cannot think of any worse condemnation of the social security system than that. Last year's 15-percent increase was an attempt to correct those inequities.

This year's bill is the second phase, and I am confident that as the years go on, my committee—and the House—will continue to move forward along the same liberal lines.

In these years of inflation and declining quality of services, we cannot desert those millions of people who have dedicated their lives to this Nation's improvement. This country was built by the working man and he is the bulwark of our free, democratic process today, and we must insure that when the working man or woman retire, we are not relegating him to second-class status. I am very pleased with this year's bill, and I would hope that it will receive the enthusiastic endorsement of all the Members of the House.

Mr. MILLS. Mr. Chairman, I yield

such time as he may require to the gentleman from Florida (Mr. PEPPER).

(Mr. PEPPER asked and was given permission to revise and extend his remarks.)

[Mr. PEPPER addressed the Committee. His remarks will appear hereafter in the Extension of Remarks.]

Mr. MILLS. Mr. Chairman, I yield such time as he may consume to the gentleman from Kentucky (Mr. STUBBLEFIELD).

(Mr. STUBBLEFIELD asked and was given permission to revise and extend his remarks.)

Mr. STUBBLEFIELD. Mr. Chairman, since the bill to amend the Social Security Act has been brought to the House floor under a closed rule, making it impossible to offer amendments from the floor and making it necessary to vote either for or against the measure in its entirety, I feel that I must vote for the bill. This is not to say, however, that I favor all of its provisions. I am definitely opposed to the nursing home provision and I expect to do all within my power to encourage the conferees to delegate this section from the bill. I feel that it would work a great injustice on all our elderly citizens.

Mr. MILLS. Mr. Chairman, I yield such time as he may consume to the gentleman from Missouri (Mr. BURLISON).

(Mr. BURLISON of Missouri asked and was given permission to revise and extend his remarks.)

Mr. BURLISON of Missouri. Mr. Chairman, today should mark a great milestone in the lives of our senior Americans. The bill we are now considering will add a 5-percent, across-the-board increase for social security recipients. This, added to the 15-percent increase which we approved a few months ago means that many of our people have received a substantial improvement in living standards in a short period of time. The Congress is to be commended for this action.

But this is not all we are doing by our action today. We are, first, raising the retirement exemption from the present $1,680 to $2,000, with a 50-percent reduction in benefits between $2,000 and $3,200.

Second. Benefits equal to 100 percent of primary insurance for widows and widowers over 65, with proportional increases over the 82.5 percent current rate for those between 62 and 65. In addition, widowers under 62 would be granted the same privilege accorded widows applying for actuarially reduced benefits.

Third. Reduction of the computation point for benefits for men from 65 to 62 and elimination of the actuarial reduction in spouse's benefits when such benefits are applied for in addition to retirement benefits.

Fourth. Permitting individuals receiving disability insurance, workmen's compensation, and social security to receive 100 percent instead of 80 percent of average earnings.

Fifth. Extension of the $100 monthly military service credit back to 1957 instead of 1967 in current law.

Sixth. Raising the age for child's benefits for persons disabled prior to age 18 to age 22.

Mr. Chairman, this is monumental legislation. Hopefully, we will overwhelmingly pass this bill today as an added incentive to the Senate and the President to promptly get our legislation into effect.

Mr. ROSTENKOWSKI. Mr. Chairman, I rise in support of this bill.

Mr. Chairman, the bill not only improves benefits but also makes significant improvements in several provisions of the social security law—provisions relating to our old, our blind, our widows and widorers and to those adults who have been disabled since childhood. These provisions will benefit the approximately 26 million recipients presently on the rolls by increasing payments by nearly $4 billion during the first year after enactment. In the State of Illinois alone there are around one and a third million social security beneficiaries whose benefits would be increased under the bill by about $230,000,000 during the first year.

Of course, there are still problems to be solved and situations to be improved in the social security system, but I believe this bill has brought us further along on the way to take care of those of our people who can no longer take care of themselves.

The 5-percent, across-the-board increase in social security benefits is an indication of our concern not to let the income of our social security beneficiaries lag behind the steady upward movement of prices and wages.

I am happy to point out that the committee has increased the amount of earnings a social security beneficiary may have and still get full benefits. At present that amount is only $1,680 a year. The increase to $2,000 is not dramatic—it should be more—but it does represent the approximate increase in earnings levels since 1968 when the $1,680 figure was set. To that extent the committee has recognized that these beneficiaries who desire to and are able to work ought to be encouraged. I think, therefore, we have moved forward.

The bill corrects a situation relating to the benefits to our aged widows and dependent widowers. It recognizes that a widow's needs are the same as those of the retired worker, and provides that an aged widow's benefits would be the same amount as for the retired worker.

The bill will at long last remove an inequality in the law under which retirement benefits for men were computed on a less favorable basis than for women. I applaud this improvement. I hope that sometime soon we will also find a practical and equitable way to base a husband's and wife's retirement benefits on their combined earnings under social security.

Mr. Chairman, I am also pleased to support the provision in the bill which will extend disability benefits to those young people who become totally disabled after reaching age 18 but before age 22, where the parent is retired and getting benefits or has died. Patterns of living, and our education and training requirements have changed to the extent that many young people do not have any regular earnings and are dependent on their parents for support until they are in their early 1920's. The law had been brought up to date in one respect by providing child's benefits to students until age 22. This provision is a logical and commendable extension of this recognition.

Mr. Chairman, I have long been aware of the particular handicap that besets our blind disabled and I am pleased to report that under this bill the eligibility requirements for social security benefits are somewhat eased for the blind.

Mr. Chairman, we all know Mark Twain's witticism that everybody talks about the weather but nobody does anything about it. Similarly, there has been a lot of concern but not much action so far about the spiraling medical costs. I am particularly pleased to support the provisions of this bill that show energetic and resourceful efforts to control these costs and I earnestly hope that they will be as successful as the members of the Committee expect them to be.

Mr. Chairman, I am humbly proud to have had a part in developing this bill and I want, in particular, express my admiration for the untiring and competent leadership of the chairman of the Ways and Means Committee, our honorable colleague, WILBUR MILLS, in keeping this bill on the narrow path between the desirable and the possible. I entreat my colleagues in this distinguished body to join me in its support.

Mrs. GRIFFITHS. Mr. Chairman, as a member of the Committee on Ways and Means I wish to say that I strongly support all of the provisions in the bill reported by our committee. The bill would make many improvements in the social security program, a program that is vitally important to millions of Americans.

I was especially happy to see included in the bill two of the provisions that first I and then others among my fellow Congressmen have been recommending for so, long—provisions that would insure that men and women in the same situation would be treated equally under the program.

The age 62 computation point for men provided by the bill will provide equal treatment for men and women in determining benefit eligibility and computing benefit amounts under the program. Both will be figured up to age 62 now, instead of up to age 62 for women and up to age 65 for men, as is the case under present law. As a result, a man and a woman of the same age and with the same earnings will get the same benefits. No longer will the man get less, as he does under present law.

Another area in which equal treatment of men and women is provided by the bill is that of the age of eligibility for widow's and widower's benefits. Under present law the age of eligibility for widows is 60 while widowers must wait until they are 62 to get their benefits. The bill would lower the age for widowers from 62 to 60, making it the same as it now is for widows.

This provision would correct an unequality in the treatment of men and women that has existed since 1965 when the age of eligibility for widows was lowered from age 62 to 60 but the age of eligibility for dependent widowers remained 62. There is no valid reason for this difference in treatment of men and women and it should be corrected.

Another provision I am particularly

happy to see included in the bill is the one that would eliminate the support requirements for divorced wives and widows. Under present law benefits are payable to aged divorced women and to divorced mothers with minor children only if they meet rigid support requirements. When I offered the amendment originally, I never expected it to work in this way. I am happy now to correct it. A divorced woman is required to show that, first, she was receiving at least one-half of her support from her former husband; or second, she was receiving substantial contributions from her former husband pursuant to a written agreement; or third, there was a court order in effect providing for substantial contributions to her support by her former husband.

The intent of the Congress is providing benefits for divorced women was to protect divorced women with young children and women whose marriages were dissolved after they have reached an age where they might not be able to go out and earn retirement protection for themselves. The need for social security protection is particularly acute for women who have spent their lives as homemakers and who have never worked outside the home. Removal of the support requirements will permit these women to qualify for benefits.

These provisions are unquestionably a substantial move in the direction of equal treatment of men and women under the program and, as I have said, I strongly support them. I must say though, that I was most disappointed that the bill does not include other provisions that are needed in order to give equal treatment to women and men. We need to eliminate the support requirements for husband's and widower's benefits since there are no support requirements for wife's and widow's benefits and we ought to provide father's benefits under the same conditions as we provide mother's benefits.

And I was more than disappointed that our committee did not see fit to include my proposal to permit a working couple to combine their earnings and have their social security benefits figured as though all of their earnings were the earnings of one of them. Under present law an aged couple can get less in total monthly benefits if both the man and wife worked than a couple getting benefits based on the same total earnings where only the husband worked. For example, when only the husband works and earns $7,800 a year, benefits to the couple at age 65 would be $376.10—250.70 to the husband and $125.40 to the wife; if the husband and wife each had earnings of $3,900—combined earnings of $7,800—their benefits would be $309—$154.50 each.

The committee did request the Advisory Council on Social Security that is currently reviewing all aspects of the social security program to study this issue and to include in its report specific recommendations on how the benefits paid to a married couple may be equitably based on their combined earnings. I shall be particularly interested in seeing that report.

While the bill does not include everything I would have liked it to include, and while I am sure that other Members have special interests that were not taken care of in the bill, it is, nevertheless, a good bill and one that I believe every Member of the House can accept with enthusiasm.

Mr. BURKE of Massachusetts. Mr. Chairman, I support the bill which the distinguished chairman and ranking minority member on the Committee on Ways and Means have introduced. Last year, when the committee provided for a 15-percent increase in benefits, I expressed my support for that increase, though I thought then that increase was insufficient. The 5-percent increase in the present bill will partially compensate for the inadequacy of the increase that was enacted last year. Nevertheless, the total increases passed last year and under consideration in this bill do not provide adequate purchasing power for the approximately 25 million social security beneficiaries—our aged, our widows, our orphans, and our disabled. These people generally have very little income other than the benefits they get under our Nation's social security program.

The bill also increases from $1,680 to $2,000 the amount of earnings a beneficiary may have in a year and still draw his full benefits. This is a step forward, though in today's economy I believe an amount higher than $2,000 would be preferable. For the large number of beneficiaries whose benefits supplemented by modest earnings constitute their source of income, the increase to $2,000 will be an important help in maintaining their purchasing power. For many beneficiaries who can earn $2,000 or somewhat more this increase will result in $320 more in total income for a year.

I am especially glad that the committee adopted a number of improvements in the disability insurance program. One much needed change which I have supported would permit payment of benefits to a child on his parent's record if he was disabled before age 22, rather than before age 18 as at present. This change will fill a much needed gap in the protection to young people who become disabled after leaving high school but before they have had the opportunity to work long enough in covered employment to build their protection on the basis of their own work. It is a vital and valuable improvement.

Another very important improvement in the disability provisions would permit a blind person to qualify for disability benefits even though he does not have 20 quarters of coverage during the 10 years up to and including the year in which he claims the benefits. I am sure we all realize the problems many blind people have in working sufficiently to be able to qualify for benefits.

One of the most unfortunate results of the present medicare program is the effect it has on the protection offered to employees of State and local governments who, because of a satisfactory retirement system of their own, do not have coverage under social security, and thus they do not have medicare protection. Yet for most of these, Blue Cross and other programs have adapted their protection to supplement the protection offered by medicare. Thus for many public servants, either the protection available to cover hospital and medical costs has gone down or their costs have risen beyond reason. It is with great satisfaction that I tell you that this bill makes medicare protection available to all uninsured workers at a cost of $27 a month for the hospital insurance coverage, and that the States and other organizations may, by agreement with the Secretary, purchase this coverage on a group basis for their retired employees age 65 or over.

I cannot stress too strongly the value of these and the many other improvements which this bill makes in the social security program. I urge all of you to vote for the bill, on which the committee has spent many hours of concerned study.

Mr. FULTON of Tennessee. Mr. Chairman, today we take an important step forward in passage of this legislation to helping an important and deserving segment of our society keep pace with the rising cost of inflation.

Passage of the Social Security Amendments of 1970 by the House of Representatives today will provide this protectection to the millions of retired Americans who depend on their social security monthly benefits for their livelihood.

Since February of 1968, when benefits were increased by the 90th Congress the cost of living has risen almost 13 percent. In December of last year the Congress increased bnefits an additional 15 percent but this hardly keeps pace with inflation when one considers the preceding months for which they were not compensated.

This new legislation will add another 5 percent increase in benfits in January 1971. This will hardly match the expected 6 percent cost-of-living increase that is threatened to occur during calendar 1970.

Mr. Chairman, there is tragic irony in this increase in social security benefits. Since my election to the House Ways and Means Committee in 1965 that committee has reported and the Congress has approved social security benefit increase totaling more than 37 percent. Yet it is reported that the buying power today of the weekly after-tax earnings of the average nonsupervisory worker in private employment, about 48 million workers, is less than last year and below what it was in 1965.

Thus, while social security benefits have risen some 37 percent in the last 5 years the social security benefit dollar provides little more if any in purchasing power than it did half a decade ago.

It had been my hope that the committee would have found it possible to bring to the floor a bill with a 10-percent benefit increase effective July 1 of this year.

Regrettably we were not in a position to do so because existing and expected moneys in the trust fund simply will not permit an increase of this size at such an early date.

It is also unfortunate because this Nation is now in its 16th month of economic decline, a decline which gives no reassuring evidence of bottoming out.

The stock market has reached new lows. Industrial output in the Nation has slumped to less than 80 percent of capacity. Unemployment stands at almost 5 percent of the work force with over 1 million Americans joining the ranks of the jobless since December of last year.

And who is it that suffers the most? It is the man on the fixed income, the wage earner, the small businessman.

It is time this administration admitted candidly to itself that its anti-inflation policy of high interest rates and controlled expenditures simply are not sufficient to thwart the economic dangers facing this country. The Congress in December of last year gave the administration certain selective tools it could use to help curb inflation. To date these tools have been ignored despite pleas from almost every segment of the economy and warnings, just this week, from within the administration itself.

Finally, Mr. Chairman, the House has passed legislation which I was privileged to cosponsor, increasing railroad retirement benefits by 15 percent retroactive to January 1 of this year. The bill is now languishing in the Senate. In addition I have offered additional legislation to provide for another 5-percent increase in railroad retirement benefits on January 1, 1971, to maintain the traditional benefit equality between the social security and railroad retirement systems.

The need for an increase in railroad retirement benefits is urgent because while social security beneficiaries are enjoying their 15-percent increase today, railroad retirees have had no increase in more than 2 years.

It is my hope that the Senate acts immediately on the railroad retirement legislation already passed by the House and amends the bill to include the provision in my bill which will grant an additional 5-percent increase in January of next year when the new social security benefit increase becomes effective.

Mr. HOGAN. Mr. Chairman, I would like to state my enthusiastic support for the bill before us.

May I first commend the chairman and members of the Ways and Means Committee for their extensive review and analysis of a very complex piece of legislation and its programs.

In the product of their efforts I see the solution to many problems and inequities which have hampered the effectiveness of the social security and medicare-medicaid programs, and I feel the administration of these programs will be vastly improved as a result.

I am particularly pleased to note that certain provisions which I sponsored in my bill H.R. 14239 are contained in the committee's recommendations. Among those are provisions to—

Increase widows' benefits to 100 percent for those persons over 65 years of age;

Authorize a computation age of 62 for men, thereby eliminating an inequity;

Modify the earnings test so that earnings in and after the month a person reaches the age 72 are not counted against his annual income; and

Provide benefits to disabled dependents who become totally disabled after age 18 and prior to age 22.

Although the committee did not go as far as I would have liked in reducing the number of quarters required for the blind to be eligible for disability benefits, the bill before us does provide a relaxation of existing requirements which is an improvement.

Similarly, I would like to have seen the earnings limitation for those over 65 lifted completely. The committee has seen fit to increase the amount of $2,000, which I, of course, approve as it will mean a lot to those who are willing and able to work to supplement their meager annuity, particularly under existing inflationary conditions.

These are just a few of the myriad of situations to which this bill responds. As I understand it, benefits wll accrue to approximately 41 million persons in the amount of $3.9 billion in the first year under the provisions of this bill.

This includes the overall 5-percent increase in benefits effective January 1, 1971, which I wholeheartedly approve. I praise the committee for its farsightedness in acting now to include this increase which I do not doubt will be sorely needed by next January 1.

We in the Congress have a commitment to maintain social security and to upgrade and extend that program and others to meet the needs of our senior Americans. By passing this bill, Congress will be continuing to fulfill that commitment. Therefore, I urge every Member to support this legislation.

Mr. MINISH. Mr. Chairman, the Social Security Act of 1970 contains many constructive amendments which provide needed structural improvements in social security, medicare, medicaid, and maternal and child health programs. However, the more substantive provisions of the legislation fall short of providing adequately for America's senior citizens.

Most of the Ways and Means Committee's decisions are worthwhile and deserving of strong support. For example, the legislation proposes a liberalization of the retirement test, alters the requirements for the blind to qualify for disability payments under social security, reduces the benefit computation point for men to 62, and raises the age for child disability benefits from 18 to 22.

H.R. 17550 also includes a section allowing both widows and widowers 65 or over to receive 100 percent of their spouse's retirement benefit. Under present law, they are restricted to only 82.5 percent of the spouse's benefit.

The 5-percent, across-the-board increase to take effect next January 1 is inadequate at a time when the cost of living is rising annually by approximately 6 percent. Inflation exacts its harshest toll on our elderly citizens, many of whom must struggle to get by on a low, fixed income while prices continue to rise.

A solution to the dilemma of inflation for older persons is contained in legislation I introduced last year. Under my measure an automatic reappraisal of social security benefits would be required every 3 months. Whenever prices in such a period have risen above a certain point, there would be a parallel increase in social security benefits. Such a cost of living mechanism is necessary to prevent the erosion of benefits by rising prices which force the elderly to fall further and further behind in the race with living costs.

Mr. Chairman, H.R. 17550 is being considered under a traditional closed rule barring all amendments. Hopefully the legislation will be improved when it reaches the Senate to provide for a more adequate increase in benefit levels and the institution of a cost-of-living mechanism to tie future benefit increase to the rising cost of living.

Mr. FLOOD. Mr. Chairman, I am grateful for this opportunity to express my strong support for H.R. 17550, a bill that would make several important and much-needed improvements in the social security program.

The improvements that would be made in the social security program under the bill would affect, of course, not only the 25½ million people now getting benefits, but also the 94 million workers who are currently contributing to the program. The most important provision of the bill, since it would affect all present and future beneficiaries, is the provision for an across-the-board benefit increase of 5 percent for all social security beneficiaries on the rolls in January 1971 and for those coming on the rolls thereafter. The 15-percent benefit increase that was enacted just last December brought the beneficiaries up to date with the cost of living. But, of course, the cost of living has continued to rise since that time and shows no signs of any significant slowdown in the very near future.

I am glad to see that the bill calls for an increase in the contribution and benefit base—the maximum amount of annual earnings taxed and counted for benefits under the program. The higher creditable earnings resulting from the increase in the base from $7,800 to $9,000 would make possible an ultimate maximum benefit, on average monthly earnings of $750, of $283. While this increase in the base will of course help to finance the improvements in the program that the bill would provide, the really important thing is that it will help to keep the program up to date in terms of today's earnings levels. As a result, it will be possible to pay benefits that are more reasonably related to the actual earnings of workers at the higher earnings levels.

The bill would also change the retirement test—the provision in the law under which a person under age 72 has some or all of his benefits withheld if he earns over a certain amount—by increasing from $160 to $2,000 the amount a person can earn and still get all of his benefits for the year. I am most pleased to see the change included in the bill.

I am also pleased that the committee has seen fit to increase the amount of an aged widow's benefit under social security. Women getting aged widow's benefits on the average get lower benefits than do most other social security beneficiaries. In addition, surveys of so-

cial security beneficiaries have shown that, on the average, women getting aged widow's benefits have less income from sources other than social security than do most other beneficiaries. Therefore, an increase in benefits for aged widows—and also for widowers—is an improvement in the social security program that we should all go along with. The bill would equalize the treatment under social security of aged widows and widowers by lowering the age of eligibility for aged dependent widower's benefits from 62 to 60 and thereby granting widowers the same privilege of applying for actuarially reduced benefits as now applies to widows. I endorse this change.

I am only sorry that an emergency meeting in my State means that I will not be able to be recorded as voting in favor of this bill.

Mr. BRINKLEY. Mr. Chairman, I wish to call attention to the proposed amendment to title XIX of the Social Security Act relating to medicaid. It is my understanding that there were no public hearings on this part of H.R. 17550 to indicate what effect it would have on the aging.

If Federal medicaid funds for skilled nursing home care are reduced after 90 days of benefits in a year by one-third, we are saying, in effect, that if the aged recipient does not improve in 90 days, then give him less care with less skilled personnel.

I hope the Congress will carefully consider the fate of our elderly citizens in nursing homes should they suddenly have no place to live and no one to care for them. It is most important for us to realize that the present medicaid program is vital to the well-being of millions of indigent Americans.

In Georgia, as well as other States, many patients from State hospitals are admitted to nursing homes, and the only source of support most of them have is the medicaid program. Without medicaid, as it now exists, these senior citizens, who deserve the very best we can give them, would have to return to the State hospitals to a life of meaningless existence. It appears that the first program designed to assist our elderly ill is now being eroded.

Additionally, the nursing home industry would be seriously jeopardized financially throughout the country. Indeed, in the State of Georgia, the State health department has estimated that the nursing homes of Georgia would lose over $7 million in Federal funds, and State funds just are not available to replace them.

It is my further understanding that the proposed amendment is:

First, an increase in the Federal match ing percentage by 25 percent for outpatient hospital services, clinic services and home health services;

Second, a decrease in Federal percentage by one-third after the first 60 days of care—in a fiscal year—in a general or TB hospital;

Third, a reduction in the Federal percentage by one-third after the first 90 days of care in a skilled nursing home;

Fourth, a decrease in Federal matching by one-third after 90 days of care in a mental hospital and provision for no Federal matching after an additional 275 days of such or during an individual's lifetime; and

Fifth, authority for the Secretary of Health, Education, and Welfare to compute a reasonable cost differential for reimbursement purposes between skilled nursing homes and intermediate care facilities.

The administration estimated that the amendment to title XIX would reduce Federal expenditures by $238,000,000. This will make it necessary for the States to:

First. Absorb the fiscal impact with State and local funds, or

Second. Reduce overall medicaid benefits, or

Third. Reduce skilled nursing home benefits regardless of patient need, or

Fourth. Classify patients as "intermediate care" or "custodial." Many States do not have an intermediate care program. Some States with an intermediate care program have already classified nursing homes and patients as intermediate care on a wholesale basis without regard to required standards or patient needs. The Federal financial assistance in intermediate care is limited to grant-in-aid recipients. Medical-assistance-only patients in the medicaid program would not be eligible for Federal assistance in intermediate care facilities.

I believe that the record will show that past efforts to severely curtail utilization of extended care facilities or skilled nursing homes have resulted in increased use of hospital benefits at several times the cost of skilled nursing home care. Similar results may occur under this amendment since the 60-day limit on hospital stays is almost no effective limit.

Mr. SCHADEBERG. Mr. Chairman, I rise in support of this legislation H.R. 17750. It is not perfect. That does not mean I am critical of the members of the Committee on Ways and Means. I think they have done a good job. They had to work with what we have and the needs that needed fulfilling.

Our senior citizens are the No. 1 victims of the inflational spiral that has been afflicting our economy. A large share of the blame for this inflationary spiral must be laid at the doorstep of members of this House who have through the years concocted scheme after scheme to spend the taxpayers' money. Many of the programs in unrestricted escalation caused a deficit spending by the Government of astronomical proportions. Our senior citizens had borne the brunt of reckless spending and the unrestricted proliferation of our Federal bureaucracy.

I congratulate the committee for including into this legislation the raising of the amount of money a social security beneficiary can earn before his benefits are reduced. I have introduced legislation in each new Congress to which I was privileged to represent my people that would permit a raise in earned income before reduction in benefits and it is good to know that the Committee has seen fit to act favorably on this matter at this time.

I am in favor of automatic increases in benefits in keeping with increases in the cost of living due to inflation. It is long past due since the social security beneficiaries are the victims of congressional fiscal actions. Social Security benefits are paid for by the people and as such should not be manipulated for political advantage of members of this House who impose the taxes.

Mr. PATMAN. Mr. Chairman, nursing homes are providing an excellent and needed health service for our older citizens. Never before in history have such large numbers of elderly people had access to skilled long-term care. It seems to me to be highly unfortunate that this House would now, in an effort to achieve the worthy goal of improved preventive treatment and outpatient care, strike a damaging blow to nursing homes by approving an inflexible 90-day limit on extended care after which time Federal medicaid support funds would be reduced.

What of the patients affected by this action? If a State is unable to take up the financial slack when the Federal Government cuts back on assistance after 90 days, are the patients to be thrown out into the streets or deposited in the homes of their children who have neither the facilities nor the training to provide adequate care? While there may be a few who remain in extended care facilities when their health does not require it, the effect of the action being considered today would be to reduce assistance for all medicaid patients regardless of their health condition. This may remove the few who do not really need skilled care, but how many in genuine need will suffer as a result?

Mr. Chairman, there are better ways of going about this, and I hope the House will not approve this disruptive and inflexible requirement which threatens the nursing home industry, the fiscal condition of our States, and the health and well-being of many elderly citizens who require skilled long-term care.

Mr. DENNIS. Mr. Chairman, I vote today for H.R. 17550 which increases social security benefits by 5 percent, raises the amount of earned income which may be retained without sacrifice of benefits from $1,680 to $2,000, provides for a 100-percent widow's benefit if applied for at age 65 or later, liberalizes provisions as to benefits for divorced women, and, along with other amendments, makes several important reforms regarding medicare and medicaid.

I should like, however, to emphasize the concern which I feel, and which needs to be kept in mind by all of us, regarding the expense of these liberalized benefits and the tax burden on our working population which is necessary to support them. The tax base, starting January 1, 1971, will go from $7,800 to $9,000 per year, and the tax rate on each employee goes from 4.8 percent to 5.2 percent in 1971–72, and to 6.5 percent by 1987. This means a combined rate on employer and employee of 13 percent. The rate on the self-employed by 1987 will be 8 percent.

This burden is being imposed less than 5 months after a 15 percent increase, which I also supported, and this 20 percent increase admittedly outstrips the increase in the cost of living.

All of us, myself included, take pleasure in providing a livable retirement

fund for our elderly people who depend on social security, but we can't ignore the ever increasing tax burden on the wage earner and on the income producer in our society.

The future is clouded, but the answer would seem, perhaps, to lie in so conducting our collective affairs that an ever increasing inflation does not constantly rob our elderly citizens, and force correspondingly increased taxes upon our wage earning people.

Mr. WIGGINS. Mr. Chairman, I have serious misgivings concerning that portion of the pending legislation dealing with nursing home services. I would have preferred a different procedure than that under which we are now considering this bill, so that appropriate amendments would be in order. But the rule is closed, and we are confronted with an all or nothing alternative when the legislation considered as a whole plainly contains much good, as well as the questionable nursing home provision.

The Congress must address itself to the problem of skyrocketing medicare and medicaid costs. The Ways and Means Committee has found that one reason for this cost spiral is that elderly patients are routinely placed in expensive skilled nursing home facilities for unlimited periods. Under existing law, the Federal Government pays a share of the cost of this service. The committee has further found that many, but not all, elderly patients do not require the expensive care which must be available in a qualified nursing home. Obviously, it makes fiscal sense to transfer patients to less expensive intermediate care centers as soon as it becomes medically possible to do so. Finally, the committee has found that nearly all patients do not require the intensive and expensive care available to them in a skilled nursing home beyond 90 days.

The response to these findings by the committee is to provide financial incentives to States to remove patients to less expensive facilities as quickly as possible. The recommendations contained in the bill are as follows:

First. The Federal share of financial assistance to patients in skilled nursing homes is reduced by one-third after the first 90 days of a patient's confinement; and.

Second. An increase by 25 percent in the Federal share of financial assistance to facilities providing an alternative to the intensive care available in skilled nursing homes.

Mr. Chairman, I am entirely in agreement with the determination by the committee that medicaid costs for nursing home care must be brought under control. The efforts on the part of the committee to encourage transfers to less expensive facilities merits my support. But the committee has devised a formula which is arbitrary and does not recognize that proper medical care is an individual, personal matter, and cannot be intelligently dispersed based on statistical averages.

Were the House operating under procedures permitting amendments to this bill, I would have preferred language requiring an individual reevaluation of patients so that the full Federal contribution would remain available to individuals truly in need of intensive skilled nursing home facilities beyond the arbitrary limit fixed in the bill. Since such amendments cannot be considered in the House, it is my hope that the Senate will give special consideration to this problem during its deliberations.

Mr. Chairman, much misinformation has been furnished to families with loved ones in skilled nursing home facilities. These institutions will not close. Patients will not be turned out into the streets to die, as some of my mail has suggested.

The first impact will not be felt until January 1, 1971. On that date, the State of California will receive one-third less Federal support for patients remaining longer than 90 days in skilled home facilities. Thereafter, the State may either increase its contributions by the amount of the Federal share lost—estimated at between $15 and $30 million annually—and continue services at the present level, or adopt procedures requiring that patients be provided less expensive intermediate care after 90 days. In the latter event the taxpayers will save substantial sums and the quality of health services need not suffer. A third alternative exists, but it is unthinkable.

It is possible that the State will do nothing and some individual centers, being unable to absorb the lost revenues, will curtail services. This third alternative is not good government nor good business and should not be advertised as the likely consequence of the adoption of this bill.

Mr. ADDABBO. Mr. Chairman, I rise in support of H.R. 17550, the Social Security Act Amendments of 1970. Last October, I introduced legislation designed to bring the Social Security Act up to date through comprehensive amendments providing a substantial increase in benefits for our senior citizens. While this bill does not go as far as I would have liked, it is another important step forward in meeting the realistic needs of our senior citizens.

Last year, the Congress approved a 15-percent general increase in social security benefits, effective January 1, 1970. This was an urgently needed measure in light of inflation and dramatic increases in the cost of living. Those persons living on fixed incomes have been hit hardest by the inflationary period in our economy and the 15-percent increase barely covered the increase in living costs.

INCREASED CASH BENEFITS

H.R. 17550 provides an additional 5-percent increase in benefits under social security effective January 1971—payable in February. This is in addition to the 15-percent increase enacted in December 1969. The amendment will mean additional payments of $1.7 billion to more than 26 million social security beneficiaries during the first year. My bill would have provided a more substantial increase—50 percent over a 2-year period—and I hope that Congress will continue to move toward a more realistic adjustment of cash benefits to meet the basic human needs of beneficiaries of this program.

RETIREMENT INCOME

The restriction on outside earnings under the Social Security Act has been an unreasonable barrier to part time employment for many social security beneficiaries who would otherwise keep occupied and prefer to work. This bill increases the amount a beneficiary may earn and still receive full benefits from $1,680 to $2,000 and provides a reduction in benefits of $1 for every $2 earned above $2,000 but below $3,200 with a $1 reduction for every $1 earned above that amount. This change in the law will benefit some 1 million persons.

WIDOW'S BENEFITS

Another important amendment would entitle a widow, or dependent widower, to receive full benefits at age 65 or 82½ percent of full benefits if applied for at age 62 and a proportionate amount based on the age at which the widow or dependent widower applies for benefits, whether below age 62 or between the ages of 62 and 65. This change will benefit more than 3 million beneficiaries of the program.

AGE 62 COMPUTATION FOR MEN

This amendment provides that benefits for men shall be computed by taking average earnings up to age 62, as is presently the law with respect to benefits for women. This removes the discriminatory provision which based computation of benefits for men on earnings up to age 65.

DISABILITY BENEFITS

There are several major changes with respect to disability benefits. First the amendments would protect blind persons without the requirement that they meet the substantial recent covered work test. In addition, the bill would reduce social security disability benefits where workmen's compensation is paid only where the combined payments exceed 100 percent of average earnings before disability. The present law reduces payments where the amount exceeds 80 percent of average earnings.

Another amendment which I cosponsored provides childhood disability benefits where the disability occurs prior to age 22. This changes the present law which applies only to disabilities beginning prior to age 18. Approximately 13,000 persons will benefit immediately from this amendment.

WAGE BENEFITS FOR SERVICEMEN

Present law authorizes wage credits of up to $100 per month for servicemen based on the number of months in service after 1967. This credit is in addition to benefits computed on basic pay. The amendment would extend this wage credit to servicemen for each month of service between 1957 and 1967 and would increase benefits for approximately 130,000 beneficiaries.

MEDICARE AND MEDICAID AMENDMENTS

The legislation contains reasonable and necessary cost control provisions relating to the medicare and medicaid programs while expanding the benefits of these programs to those over the age of 65 but not previously covered. The ceilings on physician and hospital charges are based upon prevailing charges in each community and are simply designed to keep costs of the programs within nor-

mal bounds. These amendments will, if successful, enable us to expand the scope of health insurance to other parts of our society until such time as national health insurance for all Americans can be enacted.

Mr. Chairman, I would have preferred a broader bill, with higher cash benefits and with an automatic cost of living increase built into the system. I support H.R. 17550 without hesitation however because it is the second important step taken by the 91st Congress toward the goal of realistic benefits for our senior citizens. I urge my colleagues to join me in voting for this bill.

Mr. ROTH. Mr. Chairman, once again Congress has an opportunity to show its concern for the welfare of an important segment of our population—the aged, the widowed, and the orphaned by amending and improving the social security program. The bill before us—H.R. 17550—would make a number of important changes in the social security program. It would do away with a number of injustices which exist in the present program as well as update benefit amounts, the earnings test and the tax base. In addition, it seeks to improve the operation of the medicare program. I would like to congratulate the members of the Committee on Ways and Means who worked so long to bring out this important legislation.

This bill includes all the major legislation proposed by the President last fall except the provisions for automatic increases in benefits geared to rising prices and automatic increases in the tax base geared to rising wage levels. I feel that this is unfortunate for social security benefits must constantly be kept abreast of the cost of living. The effectiveness of these benefits is greatly impaired when they do not become available to the people until 6 months or even a year after the serious need has arisen.

The 5-percent benefit increase which would be provided effective next January, is to me, an attempt to help assure that the rising cost of living does not erode the purchasing power of social security benefits. As a result of this increase the average benefit payable to retired people will rise from an estimated $118 next January to $138 and the average benefit to a retired couple will rise from $199 a month to $218. Altogether, some 25.6 million people will be paid increased benefits starting next January. An estimated $1.7 billion in additional benefits will be paid out in the first 12 months.

About the only way of keeping up with inflation and rising prices that is open to many older people is getting a job. However, the retirement test in the law restricts the amount that a person can earn and continue to receive all of his social security benefits. It is, therefore, quite appropriate that the legislation under consideration increase the amount that an individual can earn from $1,680 a year to $2,000 a year, with a 50-percent reduction in benefits between $2,000 to $3,000. As the result of this change, about $475 million in additional benefits will be paid to about a million people—about 100,000 of whom get no benefits under the present provision—for 1971.

For some time, it has been generally recognized that the benefits paid to widows are generally inadequate. This inadequacy results in large measure from the provision of present law which sets the widow's benefit at 82.5 percent of the retirement benefit which would be paid to her husband at age 65. Wisely, the legislation we are considering provides that benefits payable to a widow who qualifies for benefits at age 65, will be the full amount of the husband's retirement benefit. However, if the widow begins to get her benefit earlier than age 65, it will be reduced just like the other benefits which are payable under present law before age 65. In most cases, the benefits payable will be more than can be paid under present law, but in no case will they be less. This, I think, is a long overdue change. It will result in about 3.3 million widows receiving an additional $700 million in benefits in 1971.

A significant feature of H.R. 17550 is that it makes technical changes in the law to eliminate present provisions which discriminate against some people. One of the more important of these changes deals with the way benefits based on men's earnings are computed. Under the present law, the benefit for a man is based on the number of years up to the time that he is 65 while the benefit for a woman is based on the number of years up to age 62. As a result a man can have a smaller benefit than a woman who is the same age and who had identical earnings. For example, the highest benefit payable under present law for a man who becomes entitled to benefits at age 65 this year is $189.90, while the maximum for a woman is $196.40. The bill would change this so that the benefit for a man would be the same as for a woman.

This change affects not only the retirement benefit paid to a man, but also the benefits paid to his wife while he is alive and to his widow after his death. As a result of the change, about $925 million in additional benefits would be paid out in the first 12 months the provision is in effect. About 10.2 million people who will be entitled to benefits in January 1971 will get higher benefits and about 60,000 people who do not qualify for benefits under present law will become entitled to benefits.

There are a number of other worthwhile changes in the bill which I will not go into at this time, except to say that they make needed minor or technical changes in the law which will result in fairer treatment and higher payments for a number of people. Altogether, the bill would provide more than 26 million people with about $3.6 billion in additional social security benefits next year.

To pay the cost of these benefits and help make the existing medicare program fiscally sound, the bill provides for increasing the social security tax base from $7,800 a year to $9,000 a year, and revises the schedule of social security taxes so that over the next few years a greater portion of the taxes collected will go into the medicare program. Eventually, however, the tax rates for the cash benefits part of the program, as well as for the medicare program, will be increased. As a result, it is hoped the entire social security program, both cash benefits and medicare will be soundly financed.

Mr. DONOHUE. Mr. Chairman, I most earnestly urge and hope that the House will approve overwhelmingly H.R. 17550, the Social Security Amendments of 1970.

Of all the provisions in this complex, far-reaching legislation, Mr. Chairman, by far the primary and most important one is the general 5-percent benefit increase which the bill calls for, effective in January 1971. Coupled with the 15-percent increase voted by Congress, effective in January 1970, this bill will provide, in effect, the 20-percent benefit increase which would have been provided in legislation I proposed some months ago. Infinitely more important than any personal gratification I might feel is the strong prospect that the full 20 percent will soon become a fact. For the 26 million Americans receiving these benefits, struggling to maintain the literal essentials of life, this adjustment is imperative.

It is an established, although unfortunate, fact, that more than one of three Americans over the age of 65 is existing in a state of poverty. Social security's chief actuary estimates that one of every 10 social security recipients has an income low enough to qualify for additional welfare payments.

Current benefits dismally fail in most cases to allow even minimal subsistence standards for our older citizens. It is inconceivable to expect these tens of millions of Americans, all nearly totally dependent on social security payments, to exist on incomes at or near the poverty level. And despite all talk of a cooling economy and an imminent recession, Mr. Chairman, almost every independent economic analyst agrees that consumer prices will rise substantially again this year, probably by about 6 percent. So clearly this bill will do no more than permit these elderly persons to recover next year, most—but not all—of their income eroded away this year by inflation.

Also included in this measure, Mr. Chairman, are a great number of commendable provisions, over which the able ways and means committee no doubt labored for many difficult hours, and for which they are to be commended. Many of these changes, I am happy to say, are ones I have long advocated and supported, such as the increase to $2,000 in the amount of income a beneficiary may earn without a reduction in benefits, and permitting surviving spouses over 65 to receive benefits equal to 100 percent of primary insurance amounts.

A number of other sections of the bill are designed to, and in my judgment

will, strengthen the social security system.

Many of these relate to the two major health programs in the Social Security Act, medicare and medicaid. While the need for these programs cannot be doubted, and their aims are indisputably desirable, evidence is mounting that there are serious deficiencies in their operation and administration which are in need of quick correction. Since the health field's problems are exceedingly complex, this bill proposes a great many relatively small modifications in present procedures. Although none of these individually can be described as sweeping, the changes recommended, taken as a whole, will hopefully allow significant advance toward making medicare and medicaid more economical and more effective in carrying out the goals of the programs.

Various other technical and miscellaneous amendments to the present law are aimed at streamlining the system's operation. As one who has called many times in the past for needed reforms in the social security machinery, I am pleased that many desirable changes are now within our grasp.

Of course, Mr. Chairman, we all realize that further improvements, both in benefit levels and in the system itself, are essential. For example, as costs for food, medical care and all the other basic life needs continue their upward spiral, I hope all Members of Congress will recognize the need for automatic cost-of-living changes in benefits. Many other improvements have been proposed by bills sponsored by me and other legislators.

But let us remember, Mr. Chairman, that we have a primary obligation to try to preserve a decent life standard for these senior Americans whose incomes, for the most part, depend on sympathetic congressional consideration. The measure we are considering proceeds along that path, and I urge its swift and unanimous approval.

Mr. SYMINGTON. Mr. Chairman, due to certain longstanding obligations, which require my presence in St. Louis County, I will not be on the House floor to register my support for the social security bill. If there was any question or doubt concerning the passage of this bill, then I would not allow myself to be absent from the debate on Thursday.

However, there can be no question or objection to the necessity of H.R. 17550, providing for amendments to the Social Security Act. Certainly increased inflation has reduced the real benefits of present social security payments. Therefore the 5-percent increase in payments to the 26.2 million beneficiaries is necessary to compensate for this decline. Increased benefits to widows and widowers are also proper and necessary in order that present legislation be more realistic and thereby effective.

Mr. MIZELL. Mr. Chairman, I rise in support of H.R. 17550, but also concur with the motion to recommit so that changes can be made to include an annual cost of living increase for our social security beneficiaries.

In the past the elderly and others who are confined to the fixed income of social security have suffered year after year from the general increases in the inflationary spiral. Consequently, they have found themselves barely able to maintain a meager income. There is no question that we want to see these people maintain a certain standard of living so that they can retain their pride, their dignity, and their independence in their retirement years.

Three quarters of all of the social security beneficiaries are elderly. According to figures released by the Bureau of Labor Statistics last fall, it takes more than $4,000 a year for a retired couple to maintain a decent standard of living. In this time of fiscal despair, it is impossible for Congress to grant in overall increase to meet that desired level, but to fail to include a cost of living increase clause in this bill, would be risking the chance that the 5 percent overall increase we are passing would be wiped out by inflation in less than a year's time.

Last year's social security bill was reported to the floor almost a year late and we cannot allow the welfare of our elderly citizens to depend on whether or not Congress is going to be expedient in the passage of their bills. The cost of living increase proposal was made last year by the President, but was denied by the Congress. The average annual social security benefit is below the poverty level, and the least we can do for our elder citizens is to assure them of a chance to cope with the yearly increase in the Consumer Price Index. I hope that the Congress will see the wisdom today of making this vital addition to this important legislation.

Mrs. GREEN of Oregon. Mr. Chairman, I do not lightly vote for the recommital of this bill. What impels me to do so is the fact that we are literally always "running to catch up" in the matter of assuring the adequacy of social security benefits paid to those obliged to live on fixed incomes in these times of fierce inflation. The need for some sort of automatic cost-of-living escalation basic to the social security structure seems to me, very evident when we consider the plight of the elderly retired.

It is barely 5 months since we voted increases of 15 percent and already we must acknowledge that another five is quite in order. Who can predict when amendments to the Social Security Act will come before us again—and what is to become of the situation regarding the elderly's attempts to "make do" until that time?

The failure to include an escalator clause is therefore a singularly serious omission and I must, however reluctantly, vote to recommit in the hope that the commitee will see fit to fill in the gap.

GENERAL LEAVE TO EXTEND

Mr. MILLS. Mr. Chairman, in the interest of conserving time, because we do have another bill to consider this afternoon, I ask unanimous consent that all Members may have the privilege of inserting their remarks on the pending legislation at this point in the RECORD.

The CHAIRMAN. Is there objection to the request of the gentleman from Arkansas?

There was no objection.

Mr. BYRNES of Wisconsin. Mr. Chairman, I have no further requests for time.

Mr. MILLS. Mr. Chairman, I had not intended to take any additional time, but I want to yield myself 5 minutes. I want to talk about what I understand is the motion to recommit which will be offered by the gentleman from Wisconsin (Mr. BYRNES).

Mr. GROSS. Mr. Chairman, would the gentleman yield for one question?

Mr. MILLS. I shall be glad to yield to the gentleman from Iowa.

Mr. GROSS. Has the gentleman explained how many amendments there are to the bill?

Mr. MILLS. The committee amendments are technical amendments, except for one which will be explained. There are only three or four of those.

Mr. Chairman, it is my understanding that the gentleman said he would offer as a motion to recommit an amendment that was submitted by the gentleman in the committee providing for increases in benefits, and increases in the wages subject to tax to do two things: First of all, to keep the benefits abreast with increases in the cost of living and to keep the wage base up to date with earnings as they increase; is that correct?

Mr. BYRNES of Wisconsin. Yes; and also retirement—the escalation of the earnings figure and retirement.

Mr. MILLS. Mr. Chairman, this motion seems to have a great deal of attraction when one first thinks about it, as is the usual case I must say when matters are written into either major political party platform. I am sorry that the gentleman referred to the fact that this is in both platforms. I do not think the members of the platform committee gave it enough consideration.

What they are asking the Congress to do is to give up the last restraining, sole possession that it has of all the functions that were given to the Congress in the Constitution and that is, namely, determining what an individual's tax will be.

Do you know what is involved here? We have got to raise the benefits just because the cost of living goes up. Every time you raise benefits you have to raise something else to obtain money in sufficient amounts to pay such benefits. So, how do they propose to do it? By saying they are going to keep the amount of income subject to tax at all times equated with the rise in earnings and salaries and so on.

We are being asked to do something now that I refused to do for the late President Kennedy when he wanted us to give authority to him to raise taxes or lower taxes as he saw fit by not more than 10 percent. President Johnson asked for the same thing. However, I did not hear anyone on either side of the aisle in those days urging that we take the responsibility of controlling the purse strings out of the hands of the Congress and turn it over completely to any administration or agency of Government.

This is not a power to be conferred upon a President or a Cabinet officer. Moreover, this is a power being conferred forever and in perpetuity upon

whomever the man may be that sits as head of the Department of Health, Education, and Welfare.

Mr. Chairman, this is a far-reaching proposition. However, if my information is correct on this point, if you vote for his motion to recommit, as of this time you are voting to fix the amount of income subject to tax not at $9,000 but in about 2 years at $10,200; in a few more years at a still higher figure. Predicated upon the best estimates that are available to me, this means that you are voting to raise the amount of earnings of every covered individual subject to tax to more than $22,000 by 1993.

Now, what is that tax going to be? Because you are going to use all of the base increase that is available in the future to try to keep the benefits geared to what? Just to whatever the cost of living may be. How will Congress ever have any way of increasing benefits that may have to be adjusted upward, regardless of increases in the cost of living, except to increase the tax? When you do this you are not only taking away from the Congress the determination of what the taxable base will be, you are leaving it to an appointed individual downtown, not an elected individual, to say in the future what the tax under social security will be for all of our citizens.

That is more than I have ever been willing to do. I can see good points on the side of my friend, the gentleman from Wisconsin, but I can see these other things, and I hope that my colleagues in the House will fully understand before they pass judgment that they are giving up control of the social security tax; they are giving up control of social security benefits, and Congress will be out of business unless they want to go along with the administration, whatever administration may be in office, and say we are not satisfied with just the increased cost of living for which we have already used all possible increase in the base within the tax, we are out of business because we just cannot raise the tax itself at the same time that they do it downtown.

The CHAIRMAN. The time of the gentleman has expired.

Mr. MILLS. Mr. Chairman, I yield myself 2 additional minutes.

Mr. BYRNES of Wisconsin. Mr. Chairman, will the gentleman yield?

Mr. MILLS. Of course I yield to the gentleman from Wisconsin.

Mr. BYRNES of Wisconsin. Mr. Chairman, of course the gentleman from Arkansas is trying to scare us with what the wage level may be in 1980, but let me call attention to the fact that that is exactly what we have done, is keep the same relationship that this amendment provides between the wages covered, the percentage of wages covered to which the tax is applicable. And you could have scared somebody, I suppose, if you had told them in 1951 that in 1970 the base will be $9,000, but that is exactly what we are at today.

Mr. MILLS. I would not have voted for it in 1950, and in 1950 I would not have given the right to whomever Harry Truman appointed to head that department—if there had been one—to fix this at whatever figure he felt that it should be, and to keep the base set at whatever statistics somebody gave him.

Mr. Chairman, my friend, the gentleman from Wisconsin, and I agree on most things, but we are from the North Pole to the South Pole apart on this.

Mr. BYRNES of Wisconsin. Let us talk about discretion, where is the discretion really that anybody has?

Mr. MILLS. Why should not Congress do this, as it has in the past? In the past Congress has increased the benefits periodically, and the amount of increase in benefits is in excess of the increase in the cost of living for that comparable period of time.

Mr. Chairman, I have had a table prepared which compares what would have happened had the automatic provision been in effect since 1940, since 1950, and since 1954, with what Congress actually voted. I include the table at this point:

Comparison of benefit increases voted by Congress with administration cost-of-living proposal—Cumulative increase to January 1970

[In percent]

Base year 1940:	
Cost-of-living proposal	166.0
Increase voted by Congress	234.9
Base year 1950:	
Cost-of-living proposal	55.4
Increase voted by Congress	89.1
Base year 1954:	
Cost-of-living proposal	37.5
Increase voted by Congress	48.8

I just want to ask the gentleman a political question. This is what it boils down to: Is the Congress going to get any credit for the future adjustments of benefits, or are we going to do what the gentleman from Wisconsin (Mr. BYRNES) suggests: let the Secretary of Health, Education, and Welfare get all of that credit and be accused in the forthcoming election with having voted in 1970 to fix the amount of income subject to tax at better than $22,000.

Now, maybe we will do it in 1993, but let us wait to see if that is what we need to do.

So, Mr. Chairman, I hope the motion to recommit will be defeated.

The CHAIRMAN. Does the gentleman from Wisconsin have further requests for time?

Mr. BYRNES of Wisconsin. No, Mr. Chairman; as much as I would like to add some rebuttal, I did agree with the gentleman from Arkansas that he would have the last opportunity to speak.

Mr. MILLS. Mr. Chairman, we yield back the remainder of our time.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield back the balance of my time.

Mr. MILLS. Mr. Chairman, I yield back the balance of my time.

The CHAIRMAN. Under the rule, the bill is considered as having been read for amendment.

No amendments are in order except amendments to be offered by direction of the Committee on Ways and Means.

Are there any committee amendments?

COMMITTEE AMENDMENTS

Mr. MILLS. Yes, Mr. Chairman, I have three committee amendments which are entirely technical, and two other committee amendments.

(The bill reads in part as follows:)

(Page 84, line 5:)

(1) With respect to the following services furnished under the State plan after January 1, 1971, the Federal medical assistance percentage shall be increased by 25 per centum thereof, except that the Federal medical assistance percentage as so increased may not exceed 95 per centum:

(A) outpatient hospital services and clinic services (other than physical therapy services); and

(B) home health care services (other than physical therapy services); and

(2) with respect to the following services furnished under the State plan after January 1, 1971, the Federal medical assistance percentage shall be decreased as follows:

Mr. MILLS. Mr. Chairman, I offer an amendment.

The Clerk read as follows:

Amendment offered by Mr. MILLS: Page 84, lines 6 and 17, strike out "January 1, 1971" and insert "December 31, 1970".

The amendment was agreed to.

(The bill reads in part as follows:)

(Page 84, line 20:)

(A) after an individual has received inpatient hospital services (including services furnished in an institution for tuberculosis) on sixty 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 any such services furnished thereafter to such individual in the same fiscal year shall be decreased by 33⅓ per centum thereof;

(B) after an individual has recived care as an inpatient in a skilled nursing home on ninety days (whether or not such days are consecutive) during any fiscal year, the Federal medical assistance percentage with respect to any such care furnished thereafter to such individual in the same fiscal year shall be decreased by 33⅓ per centum thereof; and

Mr. MILLS. Mr. Chairman, I offer an amendment.

The Clerk read as follows:

Amendment offered by Mr. MILLS: Page 84, line 23, and page 85, lines 3, 8, and 10, strike out "fiscal" and insert "calendar".

The amendment was agreed to.

(The bill reads in part as follows:)

(Page 87, line 12:)

(2) Section 1121(e) of such Act is amended by adding at the end thereof the following new sentence: "Effective July 1, 1970, the term 'intermediate care facility' shall not include any public institution (or distinct part thereof) for mental diseases or mental defects."

Mr. MILLS. Mr. Chairman, I offer an amendment.

The Clerk read as follows:

Amendment offered by Mr. MILLS: Page 87, line 14, strike out "July 1, 1970" and insert "January 1, 1971".

The amendment was agreed to.

(The bill reads in part as follows:)

(Page 87, line 17:)

PAYMENT FOR SERVICES OF TEACHING PHYSICIANS UNDER MEDICARE PROGRAM

SEC. 226. (a)(1) Section 1833(a)(1) of the Social Security Act is amended by striking

out "and" before "(B)", and by inserting before the semicolon at the end thereof the following: ", and (C) with respect to expenses incurred for services which are furnished to a patient of a hospital by a physician and for which payment may be made under this part, the amounts paid shall be equal to 100 percent of the reasonable cost, to the hospital or other medical service organization incurring such cost, of such services if (i) (I) such services are furnished under circumstances comparable to the circumstances under which similar services are furnished to all persons, or all members of a class of persons, who are patients in such hospital and who are not covered by the insurance program established by this part (and not covered under a State plan approved under title XIX), and (II) none of such persons, or members of such class of persons, are required to pay the reasonable charges for such similar services even when they have private insurance covering such similar services (or are otherwise able to pay reasonable charges for all such similar services as determined in accordance with regulations), or (ii) (I) none of the patients in such hospital who are covered by such program are required to pay any charges for services furnished by physicians, or (II) they are required to pay reasonable charges for such services but payment of the deductible and coinsurance applicable to such services is not generally obtained from them or on their behalf in addition to the portion of such charges payable as insurance benefits under this part".

Mr. MILLS. Mr. Chairman, I offer an amendment.

The Clerk read as follows:

Amendment offered by Mr. MILLS: Page 88, strike out "or (II)" in line 17 and all that follows down through the end of line 21 and insert in lieu thereof the following: "or (II) such patients are required to pay reasonable charges for such services but payment of the deductible and coinsurance applicable to such services is not obtained from or on behalf of some or all of them, in addition to the portion of such charges payable as insurance benefits under this part, even though they have private insurance covering such services (or are otherwise able to pay reasonable charges for all such services as determined in according with regulations)".

Mr. MILLS. Mr. Chairman, this is an amendment which while it is of substance is really a rewriting of the language in the bill so as to carry out the initial intent of the bill, so I would call it a technical amendment.

Mr. Chairman, this more nearly carries out the intention of the committee in this area than does the language in the bill, which we first thought carried out our intention.

The amendment was agreed to.

(The bill reads in part as follows:)

(Page 45, line 14:)

(b) In any case in which the provisions of section 1002(b)(2) of the Social Security Amendments of 1969 apply, the total of monthly benefits as determined under section 203(a) of the Social Security Act shall, for months after 1970, be increased to the amount that would be required in order to assure that the total of such monthly benefits (after the application of section 202(q) of such Act) will not be less than the total of monthly benefits that was applicable (after the application of such sections 203(a) and 202(q)) for the first month for which the provisions of such section 1002(b)(2) applied.

Mr. MILLS. Mr. Chairman, I offer an amendment.

The Clerk read as follows:

Amendment offered by Mr. MILLS: Page 45, after line 24, insert the following new section:

"CERTAIN ADOPTIONS BY DISABILITY AND OLD-AGE INSURANCE BENEFICIARIES

"SEC. 120. (a) Clause (i) of section 202(d)(8)(E) of the Social Security Act is amended—

"(1) by inserting '(I)' after '(i)',

"(2) by adding 'or' after 'child-placement agency,', and

"(3) by adding at the end thereof (after and below clause (i)(I) as designated by paragraph (1) of this subsection) the following:

"'(II) in an adoption which took place after an investigation of the circumstance surrounding the adoption by a court of competent jurisdiction within the United States, or by a person appointed by such a court, if the child was related (by blood, adoption, or steprelationship) to such individual or to such individual's wife or husband as a descendant or as a brother or sister or a descendant of a brother or sister, such individual had furnished one-half of the child's support for at least five years immediately before such individual became entitled to such disability insurance benefits, the child had been living with such individual for at least five years before such individual became entitled to such disability insurance benefits, and the continuous period during which the child was living with such individual began before the child attained age 18,'.

"(b) The amendments made by subsection (a) shall apply with respect to monthly benefits payable under title II of the Social Security Act for months after December 1967 on the basis of an application filed in or after the month in which this Act is enacted; except that such amendments shall not apply with respect to benefits for any month before the month in which this Act is enacted unless such application is filed before the close of the twelfth month after the month in which this Act is enacted."

Redesignate the succeeding sections of the bill accordingly.

And conform the table of contents.

Mr. MILLS. Mr. Chairman, this amendment would have been in the bill except for a misunderstanding on our part of the position of the Department of Health, Education, and Welfare with respect to it and of our own staff.

We had told them only to bring to us those amendments which they were both in agreement on at that particular time. This was not brought in because of a misunderstanding of the position.

It amends that part of the social security laws which says that if a person is adopting a minor, then under certain circumstances if the minor is to receive a social security benefit, the adoption must have taken place under the supervision of a public or private child placement agency.

Now that is existing law that I have just described.

This requirement has worked a hardship in some cases, particularly in certain States, one of which is the State of Texas, where a child placement agency is not normally utilized in certain adoption proceedings.

The proceeding goes forward under an officer of the court, someone appointed by the judge.

This provision would provide with respect to a child adopted by a disability insurance beneficiary, where the requirement that the adoption be supervised by a child placement agency is not met, that benefits would be payable for such child if he was related to the worker or the worker's spouse by blood, step relationship, or adoption and was living with and receiving one-half of his support from the worker for at least 5 years prior to the time the worker became entitled to disability benefits.

Does the gentleman from Wisconsin (Mr. BYRNES), desire to make a statement on the amendment?

Mr. BYRNES of Wisconsin. I agree with what the chairman has said. The only thing I was going to suggest is that maybe some of the gentlemen from Texas who have a particular problem that they would like to meet here may be a little more charitable toward the action of the committee on some other matters.

Mr. MILLS. We would hope so.

The CHAIRMAN. The question is on the amendment offered by the gentleman from Arkansas (Mr. MILLS).

The amendment was agreed to.

The CHAIRMAN. Are there any further committee amendments?

Mr. MILLS. No, Mr. Chairman.

The CHAIRMAN. Under the rule, the Committee rises.

Accordingly, the Committee rose; and the Speaker pro tempore (Mr. ALBERT), having assumed the chair, Mr. DINGELL, Chairman of the Committee of the Whole House on the State of the Union, reported that that Committee having had under consideration the bill (H.R. 17550) to amend the Social Security Act to provide increases in benefits, to improve computation methods, and to raise the earnings base under the old-age, survivors, and disability insurance system, to make improvements in the medicare, medicaid, and maternal and child health programs with emphasis upon improvements in the operating effectiveness of such programs, and for other purposes, pursuant to House Resolution 1022, he reported the bill back to the House with sundry amendments adopted by the Committee of the Whole.

The SPEAKER pro tempore. Under the rule, the previous question is ordered.

Is a separate vote demanded on any amendment? If not, the Chair will put them en gros.

The amendments were agreed to.

The SPEAKER pro tempore. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT OFFERED BY MR. BETTS

Mr. BETTS. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. BETTS. I am in its present form, Mr. Speaker.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. BETTS moves to recommit the bill H.R. 17550 to the Committee on Ways and Means with instructions to report the same back to the House forthwith with the following amendments: Page 10, after line 19, insert the following new section:

AUTOMATIC ADJUSTMENT OF BENEFITS

SEC. 103. (a) Section 215 of the Social Secu-

rity Act is amended by adding at the end thereof the following new subsection:

COST-OF-LIVING INCREASES IN BENEFITS

(i)(1) For purposes of this subsection—

(A) the term "base quarter" means the period of 3 consecutive calendar months ending on September 30, 1971, and the period of 3 consecutive calendar months ending on September 30 of each year thereafter.

(B) the term "cost-of-living computation quarter" means any base quarter in which the monthly average of the Consumer Price Index prepared by the Department of Labor exceeds, by not less than 3 per centum, the monthly average of such index in the later of (i) the 3 calendar-month period ending on September 30, 1971, or (ii) the base quarter which was most recently a cost-of-living computation quarter.

(2)(A) If the Secretary determines that a base quarter in a calendar year is also a cost-of-living computation quarter, he shall, effective for January of the next calendar year, 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 as specified in subparagraph (B) of this paragraph, by an amount derived by multiplying 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 next higher one-tenth of 1 percent if such percentage is an odd multiple of .05 of 1 percent and to the nearest one-tenth of 1 percent in any other case) as the percentage by which the monthly average of the Consumer Price Index for such cost-of-living computation quarter exceeds the monthly average of such Index for the base quarter determined after the application of clauses (i) and (ii) of paragraph (1)(B).

(B) The increase provided by subparagraph (A) with respect to a particular cost-of-living computation quarter shall apply 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, based on the wages and self-employment income of an individual who became entitled to monthly benefits under section 202, 223, 227, or 228 (without regard to section 202(j)(1) or section 223(b)), or who died, in or before December of such calendar year.

(C) 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 December 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 revised previously 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 show the effective date of the primary insurance amounts set forth in column IV of the table immediately prior to its revision.

(ii) The amounts on each line of column I, and the amounts on each line of column III except as otherwise provided by clause (v) of this subparagraph, shall be the same as the amounts appearing in 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 amount of each line of column IV shall be increased from the amount shown in the table immediately prior to its revision by increasing such amount by the percentage specified in subparagraph (A) of paragraph (2), raising each such increased amount, if not a multiple of $0.10, to the next higher multiple of $0.10.

"(v) If the contribution and benefit base (as defined in section 230(b)) 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 shall be extended. The amount in the first additional line in column IV shall be the amount in the last line of such column as determined under clause (iv), plus $1.00, rounding such increased amount (if not a multiple of $1.00) to the next higher multiple of $1.00 where such increased amount is an odd multiple of $0.50 and to the nearest multiple of $1.00 in any other case. The amount on each succeeding line of column IV shall be the amount on the proceding line increased by $1.00, until the amount on the last line of such column is equal to the larger of (I) one-thirtysixth of the contribution and benefit base for the calendar year following the calendar year in which the table of benefits is revised or (II) the last line of such column as determined under clause (iv) plus 20 percent of one-twelfth of the excess of the contribution and benefit base for the calendar year following the calendar year in which the table of benefits is revised over such base for the calendar year in which the table of benefits is revised, rounding such amount (if not a multiple of $1.00) to the next higher multiple of $1.00 where such amount is an odd multiple of $0.50 and to the nearest multiple of $1.00 in any other case. The amount in each additional line of column III shall be determined so that the second figure in the last line of column III is one-twelfth of the contribution and benefits base for the calendar year following the calendar year in which the table of benefits is revised, and the remaining figures in column III shall be determined in consistent mathematical intervals from column IV. The second figure in the last line of column III before the extension of the column shall be increased to a figure mathematically consistent with the figures determined in accordance with the preceding sentence. The amount on each line of column V shall be increased, to the extent necessary, so that each such amount is equal to 40 percent of the second figure in the same line of column III, plus 40 percent of the smaller of (I) such second figure or (II) the larger of $450 or 50 per centum of the largest figure in column III.

(vi) 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 that is not a multiple of $0.10 shall be increased to the next higher multiple of $0.10.

(b) Section 203(a) of such Act (as amended by section 101(b) of this Act) is amended—

(1) by striking out the period at the end of a paragraph (3) and inserting in lieu thereof ", or", and inserting after paragraph (3) the following new paragraph:

(4) when two or more persons are entitled (without the application of section 202(j)(1) and section 223(b)) to monthly benefits under section 202 or 223 for December of the calendar year in which occurs a cost-of-living computation quarter (as defined in section 215(i)(1)) on the basis of the wages and self-employment income of such insured individual, such total of benefits for the month immediately following shall be reduced to not less than the amount equal to the sum of the amounts derived by increasing the benefit amount determined under this title (including this subsection, but without the application of section 222(b), section 202(q), and subsections (b), (c), and (d) of this section) as in effect for such December for each such person by the same percentage as the percentage by which such individual's primary insurance amount (including such amount as previously increased) is increased under section 215(i)(2) for such month immediately following, and raising each such increased amount (if not a multiple of $0.10) to the next higher multiple of $0.10,"; and

(2) by striking out "the table in section 215(a)" in the matter preceding paragraph (1) and inserting in lieu thereof "the table in (or deemed to be in) section 215(a)".

(c)(1) Section 215(a) of such Act is amended by striking out the matter which precedes the table and inserting in lieu thereof the following:

(a) The primary insurance amount of an insured individual shall be 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)(C) or section 230(c), determined as follows:

(1) Subject to the conditions specified in subsections (b), (c), and (d) of this section and except as provided in paragraph (2) of this subsection, such primary insurance amount shall be whichever of the following amounts is the largest:

(i) The amount in column IV on the line on which in column III of such table appears his average monthly wage (as determined under subsection (b));

(ii) The amount in column IV on the line on which in column II of such table appears his primary insurance amount (as determined under subsection (c)); or

(iii) The amount in column IV on the line on which in column I of such table 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 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 (other than a table provided by section 230) 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.

(2) Effective January 1, 1973, section 215(b)(4) of such Act (as amended by section 101(c) of this Act) is amended to read as follows:

(4) The provisions of this subsection shall be applicable only in the case of an individual—

(A) who becomes entitled in or after the effective month of a new table that appears in (or is deemed by subsection (i)(2)(C) or section 230(c) to appear in) subsection (a) to benefits under section 202(a) or section 223; or

(B) who dies in or after such effective month 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) Effective January 1, 1973, section 215(c) of such Act (as amended by section 101(d) of this Act) is amended to read as follows:

Primary Insurance Amount Under Prior Provisions

(c)(1) For the purposes of column II of the 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 effective month of the latest such table.

(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.

(d) Sections 227 and 228 of such Act (as amended by section 102 of this Act) are amended by striking out "$48.30" wherever it appears and inserting in lieu thereof "the larger of $48.30 or the amount most recently established in lieu thereof under section 215(i)", and by striking out "$24.20" wherever it appears and inserting in lieu thereof "the larger of $24.20 or the amount most recently established in lieu thereof under section 215(i)".

Page 29, strike out lines 10 through 20 and insert in lieu thereof the following:

LIBERALIZATION OF EARNINGS TEST

SEC. 107. (a)(1) Paragraphs (1) and (4)(B) of section 203(f) of the Social Security Act are each amended by striking out "$140" and inserting in lieu thereof "$166.66⅔ or the exempt amount as determined under paragraph (8)".

(2) Paragraph (1)(A) of section 203(h) of such Act is amended by striking out "$140" and inserting in lieu thereof "$166.66⅔ or the exempt amount as determined under paragraph (8)".

(3) Paragraph (3) of section 203(f) of such Act is amended to read as follows:

(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 $166.66⅔ or the exempt amount as determined under paragraph (8) multiplied by the number of months in such year. 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."

(b) Section 203(f) of such Act is further amended by adding at the end thereof the following new paragraph:

(8) (A) On or before November 1 of 1972 and of each even-numbered year thereafter, the Secretary shall determine and publish in the Federal Register the exempt amount as defined in subparagraph (B) for each month in any individual's first two taxable years which end with the close of or after the calendar year following the year in which such determination is made.

(B) The exempt amount for each month of a particular taxable year shall be whichever of the following is the larger:

(i) the product of $166.66⅔ and the ratio of (I) the average 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 a determination under subparagraph (A) is made for each such month of such particular taxable year to (II) the average of the taxable wages of all persons for whom wages were reported to the Secretary for the first calendar quarter of 1971, with such product, if not a multiple of $10, being rounded to the next higher multiple of $10 where such product is an odd multiple of $5 and to the nearest multiple of $10 in any other case, or

(ii) the exempt amount for each month in the taxable year preceding such particular taxable year;

except that the provisions in clause (i) shall not apply with respect to any taxable year unless the contribution and earnings base for such year is determined under section 230(b)(1).

(c) The amendments made by this section shall apply with respect to taxable years ending after December 1970.

Page 46, strike out line 1 and all that follows down through page 49, line 17, and insert in lieu thereof the following:

INCREASE OF EARNINGS COUNTED FOR BENEFIT AND TAX PURPOSES

SEC. 121. (a)(1)(A) Section 209(a)(5) of the Social Security Act is amended by inserting "and prior to 1971" after "1967".

(B) Section 209(a) of such Act is further amended by adding at the end thereof the following new paragraphs:

(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 1970 and prior to 1973, is paid to such individual during any 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 the contribution and benefit base (determined under section 230) with respect to employment has been paid to an individual during any calendar year after 1972 with respect to which such contribution and benefit base is effective, is paid to such individual during such calendar year;.

(2)(A) Section 211(b)(E) of such Act is amended by inserting "and beginning prior to 1971" after "1967", and by striking out ": or" and inserting in lieu thereof "; and ".

(B) Section 211(b)(1) of such Act is further amended by adding at the end thereof the following new subparagraphs:

(F) For any taxable year beginning after 1970 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 in any calendar year after 1972, (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

(3)(A) Section 213(a)(2)(ii) of such Act is amended by striking out "after 1967" and inserting in lieu thereof "after 1967 and before 1971, or $9,000 in the case of a calendar year after 1970 and before 1973, or an amount equal to the contribution and benefit base (as determined under section 230) in the case of any calendar year after 1972 with respect to which such contribution and benefit base is effective."

(B) Section 213(a)(2)(iii) of such Act is amended by striking out "after 1967" and inserting in lieu thereof "after 1967 and beginning before 1971, or $9,000 in the case of a taxable year beginning after 1970 and before 1973, or in the case of any taxable year beginning in any calendar year after 1972, an amount equal to the contribution and benefit base (as determined under section 230) which is effective for such calendar year."

(4) Section 215(e)(1) of such Act is amended by striking out "and the excess over $7,800 in the case of any calendar year after 1967" and inserting in lieu thereof "the excess over $7,800 in the case of any calendar year after 1967 and before 1971, the excess over $9,000 in the case of any calendar year after 1970 and before 1973, 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 1972 with respect to which such contribution and benefit base is effective."

(b)(1)(A) Section 1402(b)(1)(E) of the Internal Revenue Code of 1954 (relating to definition of self-employment income) is amended by inserting "and beginning before 1971" after "1967", and by striking out "; or" and inserting in lieu thereof "; and".

(B) Section 1402(b)(1) of such Code is further amended by adding at the end thereof the following new subparagraphs:

(F) for any taxable year beginning after 1970 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 in any calendar year after 1972, (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)(A) Section 3121(a)(1) of such Code (relating to definition of wages) is amended by striking out "$7,800" each place it appears and inserting in lieu thereof "$9,000".

(B) Effective with respect to remuneration paid after 1972, section 3121(a)(1) of such Code is amended (1) by striking out "$9,000" each place it appears and inserting in lieu thereof "the contribution and benefit base (as determined under section 230 of the Social Security Act)", and (2) by striking out "by an employer during any calendar year", and inserting in lieu thereof "by an employer during the calendar year with respect to which such contribution and benefit base is effective".

(3)(A) The second sentence of section 3122 of such Code (relating to Federal service) is amended by striking out "$7,800" and inserting in lieu thereof "$9,000".

(B) Effective with respect to remuneration paid after 1972, the second sentence of section 3122 of such Code is amended by striking out "$9,000" and inserting in lieu thereof "the contribution and benefit base".

(4)(A) Section 3125 of such Code (relating to returns in the case of governmental employees in Guam, American Samoa, and the District of Columbia) is amended by striking out "$7,800" where it appears in subsections (a), (b), and (c) and inserting in lieu thereof "$9,000".

(B) Effective with respect to remuneration paid after 1972, section 3125 of such Code is amended by striking out "$9,000" where it appears in subsections (a), (b), and (c) and inserting in lieu thereof "the contribution and benefit base".

(5) Section 6413(c)(1) of such Code (relating to special refunds of employment taxes) is amended—

(A) by inserting "and prior to the calendar year 1971" after "after the calendar year 1967";

(B) by inserting after "exceed $7,800" the following: "or (E) during any calendar year after the calendar year 1970 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 1972, 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

(C) by inserting before the period at the end thereof the following: "and before 1971, or which exceeds the tax with respect to the first $9,000 of such wages received in such calendar year after 1970 and before 1973, or which exceeds the tax with respect to an amount of such wages received in such calendar year after 1972 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".

(6) Section 6413(c)(2)(A) of such Code (relating to refunds of employment taxes in the case of Federal employees) is amended by striking out "or $7,800 for any calendar

year after 1967" and inserting in lieu thereof "$7,800 for the calendar year 1968, 1969, or 1970, or $9,000 for the calendar year 1971 or 1972, 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 1972 with respect to which such contribution and benefit base is effective".

(7)(A) Section 6654(d)(2)(B)(ii) of such Code (relating to failure by individual to pay estimated income tax) is amended by striking out "$6,600" and inserting in lieu thereof "$9,000".

(B) Effective with respect to taxable years beginning after 1972, section 6654(d)(2)(B)(ii) of such Code is amended by striking out "$9,000" and inserting in lieu thereof "the contribution and benefit base (as determined under section 230 of the Social Security Act)".

(c) The amendments made by subsections (a)(1) and (a)(3)(A), and the amendments made by subsection (b) (except paragraphs (1) and (7) thereof), shall apply only with respect to remuneration paid after December 1970. The amendments made by subsections (a)(2), (a)(3)(B), (b)(1), and (b)(7) shall apply only with respect to taxable years beginning after 1970. The amendment made by subsection (a)(4) shall apply only with respect to calendar years after 1970.

AUTOMATIC ADJUSTMENT OF THE CONTRIBUTION AND BENEFIT BASE

SEC. 122. (a) Title II of the Social Security Act is amended by adding at the end thereof the following new section:

AUTOMATIC ADJUSTMENT OF THE CONTRIBUTION AND BENEFIT BASE

SEC. 230. (a) On or before November 1 of 1972 and each even-numbered year thereafter, the Secretary shall determine and publish in the Federal Register the contribution and benefit base (as defined in subsection (b)) for the first two calendar years following the year in which the determination is made.

(b) The contribution and benefit base for a particular calendar year shall be whichever of the following is the larger:

(1) The product of $9,000 and the ratio of (A) the average 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 a determination under subsection (a) is made for such particular calendar year to (B) the average of the taxable wages of all persons for whom taxable wages were reported to the Secretary for the first calendar quarter of 1971, with such product, if not a multiple of $600, being rounded to the next higher multiple of $600 where such product is a multiple of $300 but not of $600 and to the nearest multiple of $600 in any other case; or

(2) The contribution and benefit base for the calendar year preceding such particular calendar year.

(c)(1) When the Secretary determines and publishes in the Federal Register a contribution and benefit base (as required by subsection (a)), and

(A) such base is larger than the contribution and benefit base in effect for the year in which the larger base is so published, and

(B) a revised table of benefits is not required to be published in the Federal Register under the provisions of section 215(i)(2)(C) which extends such table for such larger base on or before the effective date of such base,

then the Secretary shall publish a revised table of benefits (determined under the provisions of paragraph (2)) in the Federal Register on or before December 1 of the year prior to the effective year of the new contribution and benefit base. Such table shall be deemed to be the table appearing in section 215(a).

(2) The revision of such table shall be determined as follows:

(A) All of the amounts on each line of columns I, II, III, and IV, except the largest amount in column III, of the table in effect before the revision, shall be the same in the revised table; and

(B) The additional amounts for the extension of columns III and IV, and the amounts for purposes of column V, shall be determined in accordance with the provisions of section 215(i)(2)(C)(v) and (vi).

(3) When a revised table of benefits, prepared under the provisions of paragraph (2), becomes effective, the provisions of section 215(b)(4) and (c) and of section 203(a)(4) shall be disregarded; and the amounts that are added to columns III and IV, or are changed in or added to column V, by such revised table, shall be applicable only in the case of an insured individual—

(A) who becomes entitled, after December of the year immediately preceding the effective year of the increased contribution and benefit base (provided by this section), to benefits under section 202(a) or section 223;

(B) who dies after December of such preceding year without being entitled to benefits under section 202(a) or section 223; or

(C) whose primary insurance amount is required to be recomputed under section 215(f)(2).

(b)(1) Section 201(c) of the Social Security Act is amended by inserting before the last sentence the following new sentence: "The report shall further include a recommendation as to the appropriateness of the tax rates in sections 1401(a), 3101(a), and 3111(a) of the Internal Revenue Code of 1954 which will be in effect for the following calendar year, made in the light of the need for the estimated income in relationship to the estimated outgo of the Trust Funds during such year."

(2) Section 1817(b) of such Act is amended by inserting before the last sentence the following new sentence: "The report shall further include a recommendation as to the appropriateness of the tax rates in sections 1401(b), 3101(b), and 3111(b) of the Internal Revenue Code of 1954 which will be in effect for the following calendar year made in the light of the need for the estimated income in relationship to the estimated outgo of the Trust Fund during such year."

Renumber sections 103 through 105 of the reported bill as sections 104 through 106, respectively.

Renumber sections 107 through 119 of the reported bill as sections 108 through 120, respectively.

Renumber section 121 of the reported bill as section 123.

Strike out "103" and insert "104" on page 30, lines 13 and 23, and on page 31, line 1, of the reported bill.

Strike out "section 101(b)" and insert "sections 101(b) and 103(b)" on page 44, line 5, of the reported bill.

Strike out lines 6 through 10 on page 44 of the reported bill and insert the following: amended by striking out the period at the end of paragraph (4) and inserting in lieu thereof "; or", and by inserting after paragraph (4) the following new paragraph:

(5) notwithstanding any other provision of law,

And conform the table of contents.

Mr. MILLS (during the reading). Mr. Speaker, I ask unanimous consent to dispense with further reading of the motion to recommit and that it be printed in the RECORD. It has been discussed.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Arkansas?

There was no objection.

Mr. MILLS. Mr. Speaker, I move the previous question on the motion to recommit.

The previous question was ordered.

The SPEAKER pro tempore. The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

Mr. GERALD R. FORD. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Doorkeeper will close the doors, the Sergeant at Arms will notify absent Members, and the Clerk will call the roll.

The question was taken; and there were—yeas 233, nays 144, not voting 52, as follows:

[Roll No. 135]

YEAS—233

Adair	Frey	O'Hara
Adams	Fulton, Pa.	O'Konski
Addabbo	Galifianakis	Olsen
Anderson, Calif	Gallagher	O'Neill, Mass.
	Gaydos	Patten
Anderson, Ill.	Gilbert	Pelly
Andrews, N. Dak.	Goodling	Pettis
	Green, Oreg.	Pike
Arends	Green, Pa.	Pirnie
Ashbrook	Gross	Podell
Ashley	Grover	Poff
Beall, Md.	Gubser	Powell
Berry	Gude	Pucinski
Betts	Hall	Quie
Biaggi	Halpern	Quillen
Biester	Hamilton	Railsback
Blackburn	Hanley	Randall
Boland	Hansen, Idaho	Reid, Ill.
Bolling	Harrington	Reid, N.Y.
Bow	Harsha	Reuss
Brademas	Harvey	Rodino
Brasco	Hastings	Roe
Bray	Hathaway	Rosenthal
Brock	Hechler, W. Va.	Roth
Broomfield	Heckler, Mass.	Ruppe
Brotzman	Helstoski	Ruth
Brown, Ohio	Hogan	Ryan
Broyhill, N.C.	Horton	St Germain
Broyhill, Va.	Hosmer	Saylor
Buchanan	Howard	Schadeberg
Burke, Fla.	Hull	Scherle
Burton, Calif.	Hunt	Scheuer
Burton, Utah	Hutchinson	Schneebeli
Button	Ichord	Schwengel
Byrnes, Wis.	Johnson, Pa.	Scott
Camp	Jonas	Shriver
Carey	Kastenmeier	Skubitz
Carter	Keith	Smith, Calif.
Cederberg	King	Smith, Iowa
Chamberlain	Koch	Smith, N.Y.
Clancy	Kuykendall	Snyder
Clausen, Don H.	Kyros	Springer
	Langen	Stafford
Cleveland	Latta	Staggers
Collier	Lloyd	Stanton
Collins	Lowenstein	Steiger, Ariz.
Conable	Lujan	Steiger, Wis.
Conte	Lukens	Taft
Corbett	McClory	Talcott
Coughlin	McCloskey	Teague, Calif.
Cowger	McClure	Thompson, Ga.
Crainer	McCulloch	Thomson, Wis.
Crane	McDade	Tiernan
Culver	McDonald, Mich.	Van Deerlin
Cunningham		Vander Jagt
Daddario	McEwen	Waldie
Daniels, N.J.	McKneally	Wampler
Davis, Wis.	Macdonald, Mass.	Watkins
Dellenback		Watson
Denney	Mailliard	Weicker
Derwinski	Mathias	Whalen
Dickinson	May	Whalley
Donohue	Mayne	White
Dowdy	Meeds	Whitehurst
Dulski	Meskill	Widnall
Duncan	Michel	Wiggins
Dwyer	Mikva	Williams
Eckhardt	Miller, Ohio	Wilson, Bob
Edwards, Ala.	Minish	Wold
Erlenborn	Mink	Wolff
Esch	Minshall	Wyatt
Eshleman	Mize	Wydler
Farbstein	Mizell	Wylie
Findley	Monagan	Wyman
Fish	Morse	Yates
Foley	Morton	Yatron
Ford, Gerald R.	Mosher	Zion
Foreman	Myers	Zwach
Fraser	Nelsen	
Frelinghuysen	Obey	

NAYS—144

Abbitt	Fountain	Murphy, N.Y.
Abernethy	Friedel	Natcher
Albert	Fulton, Tenn.	Nedzi
Alexander	Fuqua	Nix
Andrews, Ala.	Garmatz	O'Neal, Ga.
Annunzio	Gettys	Passman
Aspinall	Giaimo	Patman
Baring	Gibbons	Pepper
Barrett	Gonzalez	Perkins
Bennett	Gray	Philbin
Bevill	Griffin	Pickle
Blanton	Griffiths	Poage
Boggs	Hagan	Preyer, N.C.
Brinkley	Haley	Price, Ill.
Brooks	Hammer-schmidt	Price, Tex.
Burke, Mass.		Pryor, Ark.
Burleson, Tex.	Hanna	Purcell
Cabell	Hansen, Wash.	Rarick
Caffery	Hébert	Rees
Casey	Henderson	Rogers, Fla.
Celler	Hicks	Rooney, N.Y.
Chappell	Holifield	Rooney, Pa.
Chisholm	Hungate	Rostenkowski
Clark	Jarman	Roybal
Conyers	Jones, Ala.	Sandman
Corman	Jones, N.C.	Satterfield
Daniel, Va.	Jones, Tenn.	Shipley
Davis, Ga.	Karth	Sisk
de la Garza	Kazen	Slack
Delaney	Kee	Steed
Dennis	Landrum	Stephens
Dent	Lennon	Stubblefield
Diggs	Long, La.	Stuckey
Dingell	Long, Md.	Sullivan
Dorn	McFall	Taylor
Downing	McMillan	Teague, Tex.
Edmondson	Madden	Thompson, N.J.
Edwards, La.	Mahon	Udall
Eilberg	Mann	Ullman
Evans, Colo.	Marsh	Vanik
Evins, Tenn.	Martin	Vigorito
Fallon	Melcher	Waggonner
Fascell	Mills	Watts
Feighan	Mollohan	Whitten
Fisher	Montgomery	Wilson, Charles H.
Flowers	Moorhead	
Flynt	Morgan	Wright
Ford, William D.	Moss	Young
	Murphy, Ill.	Zablocki

NOT VOTING—52

Anderson, Tenn.	Edwards, Calif.	Ottinger
	Flood	Pollock
Ayres	Goldwater	Reifel
Belcher	Hawkins	Rhodes
Bell, Calif.	Hays	Riegle
Bingham	Jacobs	Rivers
Blatnik	Johnson, Calif.	Roberts
Brown, Calif.	Kirwan	Robison
Brown, Mich.	Kleppe	Rogers, Colo.
Burlison, Mo.	Kluczynski	Roudebush
Bush	Kyl	Sebelius
Byrne, Pa.	Landgrebe	Sikes
Clawson, Del	Leggett	Stokes
Clay	McCarthy	Stratton
Cohelan	MacGregor	Symington
Colmer	Matsunaga	Tunney
Dawson	Miller, Calif.	Winn
Devine	Nichols	

So the motion to recommit was agreed to.

The Clerk announced the following pairs:

Mr. Hays with Mr. Ayres.
Mr. Sikes with Mr. Robison.
Mr. Roberts with Mr. Devine.
Mr. Flood with Mr. Roudebush.
Mr. Matsunaga with Mr. Pollock.
Mr. Kluczynski with Mr. Brown of Michigan.
Mr. Johnson of California with Mr. Sebelius.
Mr. Burlison of Missouri with Mr. Belcher.
Mr. Byrne of Pennsylvania with Mr. Reifel.
Mr. Miller of California with Mr. Bell of California.
Mr. Nichols with Mr. Kleppe.
Mr. Rivers with Mr. Rhodes.
Mr. Rogers of Colorado with Mr. Kyl.
Mr. Hawkins with Mr. McCarthy.
Mr. Leggett with Mr. Del Clawson.
Mr. Colmer with Mr. Bush.
Mr. Blatnik with Mr. Winn.
Mr. Anderson of Tennessee with Mr. MacGregor.
Mr. Stratton with Mr. Landgrebe.
Mr. Stokes with Mr. Riegle.
Mr. Edwards of California with Mr. Goldwater.
Mr. Cohelan with Mr. Clay.
Mr. Jacobs with Mr. Kirwan.
Mr. Symington with Mr. Ottinger.
Mr. Tunney with Mr. Dawson.
Mr. Bingham with Mr. Brown of California.

Messrs. WOLFF, GETTYS, GILBERT, MACDONALD of Massachusetts, ASHLEY, REUSS, OLSEN, HANLEY, WHITE, PATTEN, DONOHUE, YATES, MONAGAN and DANIELS of New Jersey changed their votes from "nay" to "yea."

Mr. GIAIMO and Mr. WILLIAM D. FORD changed their votes from "yea" to "nay."

The result of the vote was announced as above recorded.

The doors were opened.

Mr. MILLS. Mr. Speaker, in accordance with the instructions of the House in the motion to recommit, I report back the bill H.R. 17550 with an amendment.

The SPEAKER. The Clerk will report the amendment.

The Clerk read the amendment.

(For amendment, see proceedings of the House today under motion to recommit.)

Mr. MILLS (during the reading). Mr. Speaker, I ask unanimous consent that further reading of the amendment be dispensed with.

The SPEAKER. Is there objection to the request of the gentleman from Arkansas?

There was no objection.

The SPEAKER. The question is on the amendment.

The amendment was agreed to.

The SPEAKER. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

The SPEAKER. The question is on the passage of the bill.

Mr. MILLS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The question was taken; and there were—yeas 344, nays 32, not voting 53, as follows:

[Roll No. 136]

YEAS—344

Abbitt	Bolling	Clausen, Don H.
Adair	Bow	Cleveland
Adams	Brademas	Collier
Addabbo	Brasco	Collins
Albert	Bray	Conable
Alexander	Brinkley	Conte
Anderson, Calif.	Brock	Conyers
	Broomfield	Corbett
Anderson, Ill.	Brotzman	Corman
Andrews, N. Dak.	Brown, Ohio	Coughlin
	Broyhill, N.C.	Cowger
Annunzio	Broyhill, Va.	Cramer
Arends	Buchanan	Crane
Ashbrook	Burke, Fla.	Culver
Ashley	Burke, Mass.	Cunningham
Baring	Burleson, Tex.	Daddario
Barrett	Burton, Calif.	Daniel, Va.
Beall, Md.	Burton, Utah	Daniels, N.J.
Bennett	Button	Davis, Ga.
Berry	Byrnes, Wis.	Davis, Wis.
Betts	Camp	de la Garza
Bevill	Carey	Delaney
Biaggi	Carter	Dellenback
Biester	Casey	Denney
Blackburn	Cederberg	Dennis
Blanton	Celler	Dent
Blatnik	Chamberlain	Derwinski
Boggs	Chisholm	Dickinson
Boland	Clancy	Diggs
	Clark	
Dingell	Jones, Tenn.	Rees
Donohue	Karth	Reid, Ill.
Dowdy	Kastenmeier	Reid, N.Y.
Downing	Keith	Reuss
Dulski	King	Rodino
Duncan	Koch	Roe
Dwyer	Kuykendall	Rogers, Fla.
Eckhardt	Kyros	Rooney, N.Y.
Edmondson	Landrum	Rooney, Pa.
Edwards, Ala.	Langen	Rosenthal
Eilberg	Latta	Rostenkowski
Erlenborn	Lennon	Roth
Esch	Lloyd	Roybal
Eshleman	Long, Md.	Ruppe
Evans, Colo.	Lowenstein	Ruth
Evins, Tenn.	Lujan	Ryan
Fallon	Lukens	St Germain
Farbstein	McClory	Sandman
Fascell	McCloskey	Saylor
Feighan	McClure	Schadeberg
Findley	McCulloch	Scherle
Fish	McDade	Scheuer
Flowers	McDonald, Mich.	Schneebeli
Foley		Schwengel
Ford, Gerald R.	McEwen	Scott
Ford, William D.	McFall	Shipley
	McKneally	Shriver
Foreman	Macdonald, Mass.	Sisk
Fountain		Skubitz
Fraser	Madden	Slack
Frelinghuysen	Mailliard	Smith, Calif.
Frey	Mann	Smith, Iowa
Friedel	Martin	Smith, N.Y.
Fulton, Pa.	Mathias	Snyder
Fulton, Tenn.	May	Springer
Galifianakis	Mayne	Stafford
Gallagher	Meeds	Staggers
Garmatz	Melcher	Stanton
Gaydos	Meskill	Steed
Gettys	Michel	Steiger, Ariz.
Giaimo	Mikva	Steiger, Wis.
Gibbons	Miller, Ohio	Stephens
Gilbert	Minish	Stubblefield
Gonzalez	Mink	Stuckey
Goodling	Minshall	Sullivan
Gray	Mize	Taft
Green, Oreg.	Mizell	Talcott
Green, Pa.	Mollohan	Taylor
Griffiths	Monagan	Teague, Calif.
Gross	Moorhead	Thompson, Ga.
Grover	Morgan	Thompson, N.J.
Gubser	Morse	Thomson, Wis.
Gude	Morton	Tiernan
Hagan	Mosher	Udall
Haley	Moss	Ullman
Hall	Murphy, Ill.	Van Deerlin
Halpern	Murphy, N.Y.	Vander Jagt
Hamilton	Myers	Vanik
Hammer-schmidt	Natcher	Vigorito
	Nedzi	Waldie
Hanley	Nelsen	Wampler
Hanna	Nix	Watkins
Hansen, Idaho	Obey	Watson
Hansen, Wash.	O'Hara	Watts
Harrington	O'Konski	Weicker
Harsha	Olsen	Whalen
Harvey	O'Neal, Ga.	Whalley
Hastings	O'Neill, Mass.	White
Hathaway	Patten	Whitehurst
Hechler, W. Va.	Pelly	Widnall
Heckler, Mass.	Pepper	Wiggins
Helstoski	Perkins	Williams
Henderson	Pettis	Wilson, Bob
Hicks	Philbin	Wilson, Charles H.
Hogan	Pike	
Holifield	Pirnie	Wold
Horton	Podell	Wolff
Hosmer	Poff	Wright
Howard	Powell	Wyatt
Hull	Preyer, N.C.	Wydler
Hungate	Price, Ill.	Wylie
Hunt	Price, Tex.	Wyman
Hutchinson	Pryor, Ark.	Yates
Ichord	Pucinski	Yatron
Jarman	Quie	Zablocki
Johnson, Pa.	Quillen	Zion
Jonas	Railsback	Zwach
Jones, N.C.	Randall	

NAYS—32

Abernethy	Hébert	Patman
Andrews, Ala.	Jones, Ala.	Pickle
Aspinall	Kazen	Poage
Cabell	Kee	Purcell
Caffery	Long, La.	Rarick
Chappell	McMillan	Satterfield
Dorn	Mahon	Teague, Tex.
Edwards, La.	Marsh	Waggonner
Fisher	Mills	Whitten
Flynt	Montgomery	Young
Griffin	Passman	

NOT VOTING—53

Anderson, Tenn.	Belcher	Brooks
	Bell, Calif.	Brown, Calif.
Ayres	Bingham	Brown, Mich.

Burlison, Mo.	Jacobs	Reifel
Bush	Johnson, Calif.	Rhodes
Byrne, Pa.	Kirwan	Riegle
Clawson, Del	Kleppe	Rivers
Clay	Kluczynski	Roberts
Cohelan	Kyl	Robison
Colmer	Landgrebe	Rogers, Colo.
Dawson	Leggett	Roudebush
Devine	McCarthy	Sebelius
Edwards, Calif.	MacGregor	Sikes
Flood	Matsunaga	Stokes
Fuqua	Miller, Calif.	Stratton
Goldwater	Nichols	Symington
Hawkins	Ottinger	Tunney
Hays	Pollock	Winn

So the bill was passed.

The Clerk announced the following pairs:

Mr. Hays with Mr. Ayres.
Mr. Sikes with Mr. Robinson.
Mr. Roberts with Mr. Devine.
Mr. Flood with Mr. Roudebush.
Mr. Matsunaga with Mr. Pollock.
Mr. Kluczynski with Mr. Brown of Michigan.
Mr. Johnson of California with Mr. Sebelius
Mr. Burlison of Missouri with Mr. Belcher.
Mr. Byrne of Pennsylvania with Mr. Reifel.
Mr. Miller of California with Mr. Bell.
Mr. Nichols with Mr. Kleppe.
Mr. Rivers with Mr. Rhodes.
Mr. Rogers of Colorado with Mr. Kyl.
Mr. Hawkins with Mr. McCarthy.
Mr. Leggett with Mr. Del Clawson.
Mr. Colmer with Mr. Bush.
Mr. Brooks with Mr. Winn.
Mr. Anderson of Tennessee with Mr. MacGregor.
Mr. Stratton with Mr. Landgrebe.
Mr. Stokes with Mr. Riegle.
Mr. Edwards of California with Mr. Goldwater.
Mr. Cohelan with Mr. Clay.
Mr. Jacobs with Mr. Kirwan.
Mr. Symington with Mr. Ottinger.
Mr. Tunney with Mr. Fuqua.
Mr. Bingham with Mr. Brown of California.

Mr. BLANTON and Mr. HAGAN changed their votes from "nay" to "yea."

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

DISPENSING WITH THE PRINTING OF THE BILL H.R. 17550

Mr. MILLS. Mr. Speaker, I ask unanimous consent to dispense with the printing in the RECORD of the House bill just passed due to its length and the cost of printing.

The SPEAKER. Is there objection to the request of the gentleman from Arkansas?

There was no objection.

GENERAL LEAVE TO EXTEND

Mr. MILLS. Mr. Speaker, I ask unanimous consent that all Members desiring to do so may have 5 legislative days within which to extend their remarks in the RECORD on the bill just passed.

The SPEAKER. Is there objection to the request of the gentleman from Arkansas?

There was no objection.

SOCIAL SECURITY AMENDMENTS, 1970

SPEECH OF

HON. OGDEN R. REID
OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 21, 1970

The House in Committee of th- Whole House on the State of the Union had under consideration the bill (H.R. 17550) to amend the Social Security Act to provide increases in benefits, to improve computation methods, and to raise the earnings base under the old-age, survivors, and disability insurance system, to make improvements in the medicare, mec'icaid, and maternal and child health programs with emphasis upon improvements in the operating effectiveness of such programs, and for other purposes.

Mr. REID of New York. Mr. Chairman, I rise in strong support of H.R. 17550, the Social Security Amendments of 1970.

While I regret the decision of the Ways and Means Committee not to adopt the Administration's proposal to tie future social security benefit increases to rises in the cost-of-living index, I am heartened by the 5-percent increase in social security benefits, effective January 1, 1971, which is included in this bill.

We have all felt the pinch of inflation in the past few months, but the rising cost of living has been hardest on those living on fixed incomes such as that provided by social security. The legislation before us today would provide additional benefits for 26.2 million Americans who will be on the social security roles at the end of January 1971, when the first increased checks will be issued, and for all those who enter the program thereafter. For example, a retired worker who now receives $112 per month will have his benefit increased to $125; a retired couple who now receive $195 monthly will receive $218; an aged widow who now receives $101 will receive $123. Clearly, these increases are vital if our older Americans are to be able to survive in today's economy, and I urge that they be accepted by my colleagues.

In addition to increasing monthly payments by 5 percent, H.R. 17550 would increase from $1,680 to $2,000 the amount a social security beneficiary can earn in a year and still receive his full benefit. I have urged for years that this limitation on earnings by social security recipients be removed completely, and I will continue to work for that ultimate goal. However, if the earnings limitation is to be retained, I am glad to note that it is at least being increased. With this liberalization of the so-called retirement test, about 900,000 persons will receive additional benefits in 1971 and about 100,000 persons who would receive no benefits under present law will receive some benefits.

Under present law, a widow's or dependent widower's benefit applied for at age 62 or later is only 82½ percent of the primary insurance amount of the wage earner. Under the bill before us, a widow or widower would be entitled to a benefit equal to 100 percent of the primary insurance amount, if first applied for at age 65 or later. This measure will result in additional benefits for about 3.3 million widows and widowers when it goes into effect.

The fourth important provision of H.R. 17550 would apply the same methods of computing benefits for men as those now applied for women—only years up to age 62 will be required to be taken into account in computing average earnings, and benefit eligibility will be figured up to age 62 for both sexes. An estimated 10.2 million men will receive larger benefits under this provision, and approximately 60,000 persons not eligible for social security under present law would be added to the rolls under the change in eligibility requirements.

In my judgment, these increases in benefits and the broadening of eligibility, as well as the constructive changes in the medicare program contained in the bill, represent useful modifications in the social security program at a time of increasing difficulty for our older citizens. I am deeply concerned, however, over the portion of the bill which would reduce Federal medicaid funds and reduce Federal matching funds for nursing home care by one-third after 90 days of benefits in 1 year, and would propose an amendment to change that provision if it were possible.

In my judgment, however, the Congress has an obligation to assist America's senior citizens, many of whom have no source of income other than social security, in a time of rising prices and resulting increased pressure on the pocketbook. I, therefore, urge the House to pass H.R. 17550.

H.R. 17550, SOCIAL SECURITY AMENDMENTS OF 1970

SPEECH OF

HON. GARNER E. SHRIVER

OF KANSAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 21, 1970

Mr. SHRIVER. Mr. Chairman, I take this opportunity to discuss certain pro-

visions of H.R. 17550, the Social Security Amendments of 1970, which has just been passed by the House of Representatives, 343 to 32.

Since 1963, Congress has voted three increases in social security benefits. The most recent of these increases was effective April 1, 1970, when the monthly benefits were raised 15 percent across the board.

But inflation is the constant enemy of the aging. It plays havoc with their fixed incomes. That is why many of us in the House, including myself, have sponsored legislation time and time again to provide for automatic increases in social security benefits whenever the cost of living rises 3 percent or more.

I certainly concur with the motion to recommit which includes a provision for automatic increases in the benefits geared to rising prices and automatic increases in the tax base geared to rising wage levels. If we failed to include this cost-of-living clause in this bill, we would be risking the chance that the 5 percent overall increase we are passing would be wiped out by inflation in less than a year's time.

I support the committee's recommendations providing a general benefit increase of 5 percent effective with the benefits payable for January 1971.

This legislation also takes another important step in liberalizing the retirement test by permitting the beneficiary to earn $2,000 a year rather than $1,680 and receive full benefits.

Under this bill, some 3.3 million widows and widowers on the rolls at the end of January 1971 will receive higher benefits. For example, the benefit for a widow who becomes entitled to a widow's benefits at or after age 65 would be increased from 82½ percent to 100 percent of the amount her deceased husband would receive if his benefits started at or after age 65. This is in keeping with legislation which I have introduced in the past and this action is long overdue.

This is a broad piece of legislation we are considering. It contains many necessary and good provisions, but there are some which will have an adverse effect upon senior citizens.

The proposed cut in Federal matching funds to the States for skilled nursing home care and mental hospitals seems to be inadvisable. It will work a hardship on the elderly who are incapacitated and ill, as well as the institutions who are helping meet their needs.

Under the rule by which this legislation is being considered, we cannot offer amendments. This weakness in the bill should be corrected by the other body during its consideration.

On balance, however, H.R. 17550 is a needed measure and it has my support.

SOCIAL SECURITY CHANGES SORELY NEEDED

HON. J. HERBERT BURKE

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, May 27, 1970

Mr. BURKE of Florida. Mr. Speaker, throughout the country the month of May is being celebrated as Senior Citizen Month and the U.S. House of Representatives indicated their interest on May 21 when we voted for several much needed changes under the Social Security Act.

Certainly the problems facing so many of our elderly people are acute and hopefully the changes will enable them to better face the rising cost of living.

There are currently 26.6 million people on social security rolls with the greatest portion of these beneficiaries, 25.4 million, being senior citizens. Monthly benefits total over $2.16 billion.

In our State of Florida we have 1.1 million senior citizens who receive a total of more than $90 million per month.

Our senior citizens make a tremendous impact on our State with their experience, ability, and financial contributions, but we would have to be blind if we could not see the uphill fight that many of them have in today's society.

With inflation and high taxes raging, our senior citizens find themselves with their backs against the wall. Thus, I feel, it is now imperative that the Senate consider the legislation passed by the House as quickly as possible.

Our senior citizens have been handicapped by the limitations on the amount they can earn, and on the limitation on the amount of benefits they receive each month. What once was thought to be a sufficient supplement has been eroded away by rising living costs until today our elderly are barely able to make ends meet.

With the 15 percent social security increase that became payable in April, social security benefits average $1,392 for an individual and $2,088 a year for a couple 65 years of age.

However, when we take into consideration that the U.S. Labor Department standard indicates $2,920 is the very least a retired couple needs to stay above the poverty line, I, like many in the House of Representatives, have become concerned that many of our elderly who have been caught in this web of inflation will continue to become more entangled financially without further help.

I appreciate the fact that social security was never intended to be a pension, and in fact was instead intended to be a supplement to other savings and income. Yet, with the many economic changes resulting over the years, which have in many ways hurt rather than helped today's elderly, it seems that a complete reappraisal of the problems facing those under social security is in order.

I supported the 15 percent social security increase passed by the Congress in 1969 and also the 5 percent increase which just passed the House. In this current legislation I supported also the House amendment offered by Representative JOHN BYRNES granting social security increases automatically whenever the national cost of living rises 3 percent or more per quarter. I introduced legislation calling for this and was indeed happy that although it was not recommended by the committee, it passed as an amendment to the committee bill.

In both the 90th Congress and then in this Congress, I introduced legislation which would completely remove the earnings limitations now placed on social security recipients. The House approved only a raise in the ceiling from $1,680 to $2,000 a recipient may earn per year without penalty, but I still feel further working inducements should be offered in the future to those willing to work after retirement.

I feel that many citizens who reach their golden years should not, if they choose, continue to work yet it is my opinion that those who do wish to continue to work in order to earn wages to help pull them through tough financial times should be encouraged to do so without penalty. Social security is not welfare and most of those receiving benefits have earned these benefits, and have the right to keep working if they desire.

Truthfully, should the Federal Government have the right to limit any citizen in their earning power? It is even more ironic since it is the wild spending sprees of our Government which has contributed to the inflation that is ensnaring our retirees today.

In any event, the new social security legislation which passed the House will help since it includes:

Benefit increases to 100 percent for widows and widowers entitled to such under the primary insurance if first applied for at age 65 or later.

Authorization for the Secretary of Health, Education, and Welfare to establish specific periods of time after hospitalization for which a patient would be eligible for extended care—I cosponsored this.

Authorization to study the possibility of including chiropractic care under the medicare program.

Authorization for recipients to take part in health maintenance programs with the Government paying up to 95 percent if the party qualifies for both part A and B of medicare.

More authority given to the Secretary of HEW to clamp down on violators of the medicare program.

To pay for the benefit increases passed by the House, the social security tax base will have to be increased from the taxable income limit of $7,800 to $9,000. It was necessary also for the tax on employers and employees to be raised from 4.8 to 5.2 percent.

At this point I might mention that a further bill I introduced would have allowed all medical expenses to be deducted in computing the income tax but this bill was, unfortunately, not passed. It was held by the committee for further study.

In closing, I would like to stress that age is something that comes to us all and the best of plans in one's old age often go astray because of circumstances impossible to anticipate. Our elderly citizens of today have gone through the depression of the 1930's, two world wars, and two others.

They worked hard and paid their taxes. They helped build our Nation to its greatness. They ask not for charity, but only what is deserving to them, and now they do need help and the least we can do is to give them the help they have earned.

SOCIAL SECURITY ESTABLISHMENT—ALL POWERFUL

HON. JOHN R. RARICK

OF LOUISIANA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, May 27, 1970

Mr. RARICK. Mr. Speaker, last Thursday this body set the stage for the complete nationalization of all economic security for the American people. Thus, a bill which started out as a social security reform, H.R. 17550, has now ended up turning the full and complete control of the program over to the Department of Health, Education, and Welfare. The HEW bureaucrats have now been delegated not only the power to adjust the benefits but also to regulate the contribution tax from the workers.

Today, we learn that the Chief Actuary of the Social Security Administration has resigned because the top social security policymakers are dedicated to elimination of all private efforts in economic security; that is, insurance. It would thus appear that Congress has again surrendered its responsibility to another monopolistic bureaucracy.

I include a pertinent newsclipping, as follows:

[From the Washington Post, May 27, 1970]

TOP AIDE ON PENSIONS QUITS JOB

The chief actuary of the Social Security administration has resigned after charging that Democrats in the agency have attempted to undermine the Nixon administration.

The actuary, Robert J. Myers, left the government after 35 years because he said administration officials refused to heed his charges about political sabotage by Social Security officials.

"Certain of the top policymaking officials of the Social Security administration (who are holdovers from the Johnson administration) have strong beliefs in the desirability—even the necessity—of the public sector taking over virtually all economic security provisions for the entire population and thus eliminating private efforts in this area," Myers said in his letter of resignation.

"It is my deeply held conviction . . . that these officials of the Social Security administration have not and will not faithfully serve the Nixon administration," he said. "Rather, they will exert their efforts to expand the Social Security program as much as possible by aiding and supporting any individual or organizations that are of this expansionist conviction."

Myers is reported to have had several runins with Social Security Commissioner Robert M. Ball, appointed to the post by President John F. Kennedy.

In a statement yesterday, Myers accused Ball of attempting "to muffle and intimidate" him regarding three speeches Myers plans to make on the Social Security administration. A Social Seburity spokesman denied the charges.

SOCIAL SECURITY AMENDMENTS OF 1970 AND COST-OF-LIVING INCREASES

SPEECH OF

HON. FLORENCE P. DWYER

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 21, 1970

The House in Committee of the Whole House on the State of the Union had under consideration the bill (H.R. 17550) to amend the Social Security Act to provide increases in benefits, to improve computation methods, and to raise the earnings base under the old-age, survivors, and disability insurance system, to make improvements in the medicare, medicaid, and maternal and child health programs with emphasis upon improvements in the operating effectiveness of such programs, and for other purposes.

Mrs. DWYER. Mr. Chairman, this is a good bill, and I congratulate the committee for bringing it to the floor, but I believe it can be made substantially better by providing for automatic increases in social security benefits commensurate with increases in the cost of living.

Together with many of our colleagues, I have introduced legislation for some time to make benefit increases automatic when the cost-of-living index also increases, and I understand that a recommittal motion will be offered with instructions to add such language to the bill. I shall certainly vote for such a motion.

This is a reform of the social security system which has long been needed, but it becomes especially urgent in periods of inflation when living costs tend to outrun incomes. No group in our society suffers more from inflation than those who are forced to live on fixed, and often inadequate, incomes. For them, every price increase means a consequent reduction in their standard of living. This is especially true of the retired and the elderly for whom social security benefits often comprise all or a substantial part of their incomes. The longer the delay in adjusting social security benefits, the greater the hardship and the farther behind they fall in maintaining a decent living standard.

The automatic benefit increase will help correct this situation in several ways. It will reduce the timelag between price increase and the needed benefit gain. It will eliminate the often lengthy period of debate and consideration in enacting special legislation changing benefit levels. It will provide certainty to the often insecure. It will build into the social security system a new element of fairness and assure the retired, the disabled, and the dependent they will no longer have to bear so heavy a burden of inflation.

This cost-of-living provision, Mr. Chairman, will also help in other respects. It will insure that the earnings test—the amount which social security beneficiaries can earn without the loss of benefits—will also keep pace with increases in real earnings. And in order to assure the financial integrity of the system, it will automatically adjust the wage base of covered workers as their real wages increase, thereby maintaining the existing relationship between the wages of covered workers and the amount of their contributions to the trust fund.

In every respect, our proposal meets the test of equity and justice, and I hope our colleagues will give it the support it deserves. By supporting the recommital motion, of course—and this should be emphasized—Congress will not be foreclosing the right or the responsibility to make additional adjustments in benefit levels in the future. Depending on changes in living standards and economic conditions, we can and should be ready to do whatever is required to assure that senior citizens are fairly treated.

In many other areas, this legislation also makes valuable improvements in the social security and related medicare and medicaid programs. I should like to mention only a few which seem to me to be of special significance:

First, social security payments to the 26.2 million beneficiaries now on the rolls and those who enroll in the future will be increased by 5 percent beginnnig with

[3] United Nations, *Treaty Series*, vol. 480 (1963), No. 6964, p. 43.

payments for the month of January 1971. This is in addition to any future automatic increases.

Second, the earnings test will be liberalized—a reform I have long and strongly urged—by increasing from the present $1,680 to $2,000 a year the amount a person 65 or older can earn and still be eligible for full retirement benefits. The new amount is still inadequate, I believe, and continues to lag far behind the corresponding increases in prices and average earnings, but it does represent an important step forward.

Third, widows will be entitled to 100 percent of the primary benefits to which their husbands would have been entitled rather than the 82½ percent under present law, thus preventing what has often been a drastic reduction in the standard of living of widows following the death of their husbands. Where appropriate, widowers will also be entitled to the benefits of this needed change.

Fourth, women workers will no longer be penalized when they take a reduced annuity at age 62 based on their own work record, but will be entitled to the full wife's benefit when they reach 65. Under present law, wives who had worked for years sometimes received smaller benefits than wives who never worked at all.

This brief summary, Mr. Chairman, cannot, of course, do justice to the great importance of this comprehensive and complex social security bill. Overall, it provides many needed liberalizations of benefits and entitlements, many structural reforms which will improve the medicare, medicaid, and maternal and child health programs. It removes a number of inequities, and it encourages a number of experimental programs and pilot projects which will in turn, lead to other resolutions of the difficult problems still inherent in this vast but vital program.

We have a long way to go, but this bill—as improved by the recommittal motion—will take us a good distance in the right direction.

consideration the bill (H.R. 17550) to amend the Social Security Act to provide increases in benefits, to improve computation methods, and to raise the earnings base under the old-age, survivors, and disability insurance system, to make improvements in the medicare, medicaid, and maternal and child health programs with emphasis upon improvements in the operating effectiveness of such programs, and for other purposes.

Mr. MESKILL. Mr. Chairman, I congratulate the House on the action that it has taken in incorporating many long-needed improvements into our social security laws.

I have long felt that a provision should be made for social security benefits to keep in step with changes in the cost of living and I introduced legislation during the 90th Congress and again during the first session of this Congress making benefit increases automatic whenever the Consumer Price Index rose at least 3 percent during the preceding year. Compassion and commonsense dictate that we not leave adjustments in social security benefits to meet increased cost of living to the arbitrary whim or inclination of future Congresses.

Passage of this amendment, along with a 5-percent across-the-board increase, effective next January 1 will go a long way in easing the minds of those who approach their retirement years skeptical of how they will get along in the face of constantly rising costs.

Although I would prefer to see the earnings limitation upon the amount of outside income which an individual may earn while receiving social security benefits removed completely, the increase from $1,680 to a $2,000 limitation is a welcome step in the right direction.

Passage of H.R. 17550 also served the need of equalizing the treatment men and women receive under social security laws by eliminating benefit computation for women on the basis only of working years through age 62 and permitting them to take into account average earnings through age 65 in determining benefit eligibility.

The newly approved bill is also praiseworthy in its provision enabling widows to receive 100 percent of their husbands' benefits at age 62 instead of only 82½ percent.

In the midst of spiraling inflation, we cannot abandon those citizens who have contributed so much to our country during their working years. They deserve a decent and dignified standard of living, not the dim prospect of having to resort to welfare as many of them have had to in the past.

The House has recognized this fact and acted on it.

SOCIAL SECURITY AMENDMENTS OF 1970

SPEECH OF

HON. THOMAS J. MESKILL

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 21, 1970

The House in Committee of the Whole House on the State of the Union had under

91ST CONGRESS
2D SESSION

H. R. 17550

IN THE SENATE OF THE UNITED STATES

MAY 27, 1970

Read twice and referred to the Committee on Finance

AN ACT

To amend the Social Security Act to provide increases in benefits, to improve computation methods, and to raise the earnings base under the old-age, survivors, and disability insurance system, to make improvements in the medicare, medicaid, and maternal and child health programs with emphasis upon improvements in the operating effectiveness of such programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act, with the following table of contents, may be cited as the "Social Security Amendments of 1970".

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TABLE OF CONTENTS—Continued

TABLE OF CONTENTS—Continued

TITLE II—PROVISIONS RELATING TO MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH—Continued

TABLE OF CONTENTS—Continued

TITLE I—PROVISIONS RELATING TO OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE

INCREASE IN OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

SEC. 101. (a) Section 215(a) of the Social Security Act is amended by striking out the table and inserting in lieu thereof the following:

"TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS

"I (Primary insurance benefit under 1939 Act, as modified)		II (Primary insurance amount under 1969 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—		
----------	$16.20	$64.00	----------	$76	$67.20	$100.80
$16.21	16.84	65.00	$77	78	68.30	102.50
16.85	17.60	66.40	79	80	69.80	104.70
17.61	18.40	67.70	81	81	71.10	106.70
18.41	19.24	68.90	82	83	72.40	108.60
19.25	20.00	70.30	84	85	73.90	110.90
20.01	20.64	71.60	86	87	75.20	112.80
20.65	21.28	72.80	88	89	76.50	114.80
21.29	21.88	74.20	90	90	78.00	117.00
21.89	22.28	75.50	91	92	79.30	119.00
22.29	22.68	76.80	93	94	80.70	121.10
22.69	23.08	78.00	95	96	81.90	122.90
23.09	23.44	79.40	97	97	83.40	125.10
23.45	23.76	80.80	98	99	84.90	127.40
23.77	24.20	82.30	100	101	86.50	129.80
24.21	24.60	83.50	102	102	87.70	131.60
24.61	25.00	84.90	103	104	89.20	133.80
25.01	25.48	86.40	105	106	90.80	136.20
25.49	25.92	87.80	107	107	92.20	138.30
25.93	26.40	89.20	108	109	93.70	140.60

"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 1969 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—		
$26.41	$26.94	$90.60	$110	$113	$95.20	$142.80
26.95	27.46	91.90	114	118	96.50	144.80
27.47	28.00	93.30	119	122	98.00	147.00
28.01	28.68	94.70	123	127	99.50	149.30
28.69	29.25	96.20	128	132	101.10	151.70
29.26	29.68	97.50	133	136	102.40	153.60
29.69	30.36	98.80	137	141	103.80	155.70
30.37	30.92	100.30	142	146	105.40	158.10
30.93	31.36	101.70	147	150	106.80	160.20
31.37	32.00	103.00	151	155	108.20	162.30
32.01	32.60	104.50	156	160	109.80	164.70
32.61	33.20	105.80	161	164	111.10	166.70
33.21	33.88	107.20	165	169	112.60	168.90
33.89	34.50	108.60	170	174	114.10	171.20
34.51	35.00	110.00	175	178	115.50	173.30
35.01	35.80	111.40	179	183	117.00	175.50
35.81	36.40	112.70	184	188	118.40	177.60
36.41	37.08	114.20	189	193	120.00	180.00
37.09	37.60	115.60	194	197	121.40	182.10
37.61	38.20	116.90	198	202	122.80	184.20
38.21	39.12	118.40	203	207	124.40	186.60
39.13	39.68	119.80	208	211	125.80	188.70
39.69	40.33	121.00	212	216	127.10	190.70
40.34	41.12	122.50	217	221	128.70	193.10
41.13	41.76	123.90	222	225	130.10	195.20
41.77	42.44	125.30	226	230	131.60	197.40
42.45	43.20	126.70	231	235	133.10	199.70
43.21	43.76	128.20	236	239	134.70	202.10
43.77	44.44	129.50	240	244	136.00	204.00
44.45	44.88	130.80	245	249	137.40	206.10
44.89	45.60	132.30	250	253	139.00	208.50
		133.70	254	258	140.40	210.60
		134.90	259	263	141.70	212.60
		136.40	264	267	143.30	215.00
		137.80	268	272	144.70	217.60
		139.20	273	277	146.20	221.60
		140.60	278	281	147.70	224.80
		142.00	282	286	149.10	228.80
		143.50	287	291	150.70	232.80
		144.70	292	295	152.00	236.00
		146.20	296	300	153.60	240.00
		147.60	301	305	155.00	244.00
		148.90	306	309	156.40	247.20
		150.40	310	314	158.00	251.20
		151.70	315	319	159.30	255.20
		153.00	320	323	160.70	258.40
		154.50	324	328	162.30	262.40
		155.90	329	333	163.70	266.40
		157.40	334	337	165.30	269.60
		158.60	338	342	166.60	273.60
		160.00	343	347	168.00	277.60
		161.50	348	351	169.60	280.80
		162.80	352	356	171.00	284.80
		164.30	357	361	172.60	288.80
		165.60	362	365	173.90	292.00
		166.90	366	370	175.30	296.00
		168.40	371	375	176.90	300.00
		169.80	376	379	178.30	303.20
		171.30	380	384	179.90	307.20
		172.50	385	389	181.20	311.20
		173.90	390	393	182.60	314.40
		175.40	394	398	184.20	318.40
		176.70	399	403	185.60	322.40
		178.20	404	407	187.20	325.60
		179.40	408	412	188.40	329.60
		180.70	413	417	189.80	333.60
		182.00	418	421	191.10	336.80
		183.40	422	426	192.60	340.80
		184.60	427	431	193.90	344.80
		185.90	432	436	195.20	348.80
		187.30	437	440	196.70	350.40
		188.50	441	445	198.00	352.40
		189.80	446	450	199.30	354.40
		191.20	451	454	200.80	356.00
		192.40	455	459	202.10	358.00
		193.70	460	464	203.40	360.00
		195.00	465	468	204.80	361.60
		196.40	469	473	206.30	363.60
		197.60	474	478	207.50	365.60

"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 1969 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—		
		$198.90	$479	$482	$208.90	$367.20
		200.30	483	487	210.40	369.20
		201.50	488	492	211.60	371.20
		202.80	493	496	213.00	372.80
		204.20	497	501	214.50	374.80
		205.40	502	506	215.70	376.80
		206.70	507	510	217.10	378.40
		208.00	511	515	218.40	380.40
		209.30	516	520	219.80	382.40
		210.60	521	524	221.20	384.00
		211.90	525	529	222.50	386.00
		213.30	530	534	224.00	388.00
		214.50	535	538	225.30	389.60
		215.80	539	543	226.60	391.60
		217.20	544	548	228.10	393.60
		218.40	549	553	229.40	395.60
		219.70	554	556	230.70	396.80
		220.80	557	560	231.90	398.40
		222.00	561	563	233.10	399.60
		223.10	564	567	234.30	401.20
		224.30	568	570	235.60	402.40
		225.40	571	574	236.70	404.00
		226.60	575	577	238.00	405.20
		227.70	578	581	239.10	406.80
		228.90	582	584	240.40	408.00
		230.00	585	588	241.50	409.60
		231.20	589	591	242.80	410.80
		232.30	592	595	244.00	412.40
		233.50	596	598	245.20	413.60
		234.60	599	602	246.40	415.20
		235.80	603	605	247.60	416.40
		236.90	606	609	248.80	418.00
		238.10	610	612	250.10	419.20
		239.20	613	616	251.20	420.80
		240.40	617	620	252.50	422.40
		241.50	621	623	253.60	423.60
		242.70	624	627	254.90	425.20
		243.80	628	630	256.00	426.40
		245.00	631	634	257.30	428.00
		246.10	635	637	258.50	429.20
		247.30	638	641	259.70	430.80
		248.40	642	644	260.90	432.00
		249.60	645	648	262.10	433.60
		250.70	649	650	263.30	434.40
			651	655	264.00	436.40
			656	660	265.00	438.40
			661	665	266.00	440.40
			666	670	267.00	442.40
			671	675	268.00	444.40
			676	680	269.00	446.40
			681	685	270.00	448.40
			686	690	271.00	450.40
			691	695	272.00	452.40
			696	700	273.00	454.40
			701	705	274.00	456.40
			706	710	275.00	458.40
			711	715	276.00	460.40
			716	720	277.00	462.40
			721	725	278.00	464.40
			726	730	279.00	466.40
			731	735	280.00	468.40
			736	740	281.00	470.40
			741	745	282.00	472.40
			746	750	283.00	474.40".

(b) Section 203 (a) of such Act is amended by striking out paragraph (2) and inserting in lieu thereof the following:

"(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 on the basis of the wages and self-employment income of such insured individual and at least one such person was so entitled for December 1970 on the basis of such wages and self-employment income, such total of benefits for January 1971 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 (including this subsection, but without the application of section 222 (b), section 202 (q), and subsections (b), (c), and (d) of this section), as in effect prior to the enactment of the Social Security Amendments of 1970, for each such person for such monuth, by 105

percent and raising each such increased amount, if it is not a multiple of $0.10, to the next higher multiple of $0.10;

but in any such case (i) paragraph (1) of this subsection shall not be applied to such total of benefits after the application of subparagraph (B), and (ii) if section 202(k)(2)(A) was applicable in the case of any such benefits for January 1971, 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 January 1971, or".

(c) Section 215(b)(4) of such Act is amended by striking out "December 1969" each time it appears and inserting in lieu thereof "December 1970".

(d) Section 215(c) of such Act is amended to read as follows:

"Primary Insurance Amount Under 1969 Act

"(c)(1) For the purposes of column II of the table appearing in subsection (a) of this section, an individual's primary insurance amount shall be computed on the basis of the law in effect prior to the enactment of the Social Security Amendments of 1970.

"(2) The provisions of this subsection shall be applicable only in the case of an individual who became entitled to bene-

fits under section 202 (a) or section 223 before January 1971, or who died before such month."

(e) The amendments made by this section shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970 and with respect to lump-sum death payments under such title in the case of deaths occurring after December 1970.

(f) If an individual was entitled to a disability insurance benefit under section 223 of the Social Security Act for December 1970 and became entitled to old-age insurance benefits under section 202 (a) of such Act for January 1971, or he died in such month, then, for purposes of section 215 (a) (4) of the Social Security Act (if applicable), the amount in column IV of the table appearing in such section 215 (a) for such individual shall be the amount in such column on the line on which in column II appears his primary insurance amount (as determined under section 215 (c) of such Act) instead of the amount in column IV equal to the primary insurance amount on which his disability insurance benefit is based.

INCREASE IN BENEFITS FOR CERTAIN INDIVIDUALS AGE 72 AND OVER

SEC. 102. (a) (1) Section 227 (a) of the Social Security Act is amended by striking out "$46" and inserting in lieu thereof "$48.30", and by striking out "$23" and inserting in lieu thereof "$24.20".

(2) Section 227(b) of such Act is amended by striking out "$46" and inserting in lieu thereof "$48.30".

(b) (1) Section 228(b)(1) of such Act is amended by striking out "$46" and inserting in lieu thereof "$48.30".

(2) Section 228(b)(2) of such Act is amended by striking out "$46" and inserting in lieu thereof "$48.30", and by striking out "$23" and inserting in lieu thereof "$24.20".

(3) Section 228(c)(2) of such Act is amended by striking out "$23" and inserting in lieu thereof "$24.20".

(4) Section 228(c)(3)(A) of such Act is amended by striking out "$46" and inserting in lieu thereof "$48.30".

(5) Section 228(c)(3)(B) of such Act is amended by striking out "$23" and inserting in lieu thereof "$24.20".

(c) The amendments made by subsections (a) and (b) shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970.

AUTOMATIC ADJUSTMENT OF BENEFITS

SEC. 103. (a) Section 215 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"Cost-of-Living Increases in Benefits

"(i)(1) For purposes of this subsection–

"(A) the term 'base quarter' means the period of 3 consecutive calendar months ending on September 30,

1971, and the period of 3 consecutive calendar months ending on September 30 of each year thereafter.

"(B) the term 'cost-of-living computation quarter' means any base quarter in which the monthly average of the Consumer Price Index prepared by the Department of Labor exceeds, by not less than 3 per centum, the monthly average of such Index in the later of (i) the 3 calendar-month period ending on September 30, 1971, or (ii) the base quarter which was most recently a cost-of-living computation quarter.

"(2) (A) If the Secretary determines that a base quarter in a calendar year is also a cost-of-living computation quarter, he shall, effective for January of the next calendar year, 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 as specified in subparagraph (B) of this paragraph, by an amount derived by multiplying 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 next higher one-tenth of 1 percent if such percentage is an odd multiple of .05 of 1 percent and to the nearest one-tenth of 1 percent in any other case) as the percentage by which the monthly average of the Consumer Price Index

for such cost-of-living computation quarter exceeds the monthly average of such Index for the base quarter determined after the application of clauses (i) and (ii) of paragraph (1) (B).

"(B) The increase provided by subparagraph (A) with respect to a particular cost-of-living computation quarter shall apply 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, based on the wages and self-employment income of an individual who became entitled to monthly benefits under section 202, 223, 227, or 228 (without regard to section 202 (j) (1) or section 223 (b)), or who died, in or before December of such calendar year.

"(C) 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 December 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 revised previously 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 show the effective date of the primary insurance amounts set forth in column IV of the table immediately prior to its revision.

"(ii) The amounts on each line of column I, and the amounts on each line of column III except as otherwise provided by clause (v) of this subparagraph, shall be the same as the amounts appearing in 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 amount of each line of column IV shall be increased from the amount shown in the table immediately prior to its revision by increasing such amount by the percentage specified in subparagraph (A) of paragraph (2), raising each such increased amount, if not a multiple of $0.10, to the next higher multiple of $0.10.

"(v) If the contribution and benefit base (as

defined in section 230(b)) 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 shall be extended. The amount in the first additional line in column IV shall be the amount in the last line of such column as determined under clause (iv), plus $1.00, rounding such increased amount (if not a multiple of $1.00) to the next higher multiple of $1.00 where such increased amount is an odd multiple of $0.50 and to the nearest multiple of $1.00 in any other case. The amount on each succeeding 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 larger of (I) one-thirtysixth of the contribution and benefit base for the calendar year following the calendar year in which the table of benefits is revised or (II) the last line of such column as determined under clause (iv) plus 20 percent of one-twelfth of the excess of the contribution and benefit base for the calendar year following the calendar year in which the table of benefits is revised over such base for the calendar year in which the table of benefits is revised, rounding such amount (if not a multiple of $1.00) to the next higher multiple of $1.00 where such amount is an odd multiple of $0.50 and to the nearest multiple of $1.00 in any other case.

The amount in each additional line of column III shall be determined so that the second figure in the last line of column III is one-twelfth of the contribution and benefits base for the calendar year following the calendar year in which the table of benefits is revised, and the remaining figures in column III shall be determined in consistent mathematical intervals from column IV. The second figure in the last line of column III before the extension of the column shall be increased to a figure mathematically consistent with the figures determined in accordance with the preceding sentence. The amount on each line of column V shall be increased, to the extent necessary, so that each such amount is equal to 40 percent of the second figure in the same line of column III, plus 40 percent of the smaller of (I) such second figure or (II) the larger of $450 or 50 per centum of the largest figure in column III.

"(vi) 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 that is not a multiple of $0.10 shall be increased to the next higher multiple of $0.10."

(b) Section 203(a) of such Act (as amended by section 101(b) of this Act) is amended—

(1) by striking out the period at the end of paragraph (3) and inserting in lieu thereof ", or", and inserting after paragraph (3) the following new paragraph:

"(4) when two or more persons are entitled (without the application of section 202(j)(1) and section 223(b)) to monthly benefits under section 202 or 223 for December of the calendar year in which occurs a cost-of-living computation quarter (as defined in section 215(i)(1)) on the basis of the wages and self-employment income of such insured individual, such total of benefits for the month immediately following shall be reduced to not less than the amount equal to the sum of the amounts derived by increasing the benefit amount determined under this title (including this subsection, but without the application of section 222(b), section 202(q), and subsections (b), (c), and (d) of this section) as in effect for such December for each such person by the same percentage as the percentage by which such individual's primary insurance amount (including such amount as previously increased) is increased under section 215(i)(2) for such month immediately following, and raising each such increased amount (if not a multiple of $0.10) to the next higher multiple of $0.10."; and

(2) by striking out "the table in section 215 (a)" in the matter preceding paragraph (1) and inserting in lieu thereof "the table in (or deemed to be in) section 215 (a)".

(c) (1) Section 215 (a) of such Act is amended by striking out the matter which precedes the table and inserting in lieu thereof the following:

"(a) The primary insurance amount of an insured individual shall be 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) (C) or section 230 (c), determined as follows:

"(1) Subject to the conditions specified in subsections (b), (c), and (d) of this section and except as provided in paragraph (2) of this subsection, such primary insurance amount shall be whichever of the following amounts is the largest:

"(i) The amount in column IV on the line on which in column III of such table appears his average monthly wage (as determined under subsection (b));

"(ii) The amount in column IV on the line on which in column II of such table appears his primary insurance amount (as determined under subsection (c)); or

"(iii) The amount in column IV on the line on which in column I of such table 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 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 (other than a table provided by section 230) 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."

(2) Effective January 1, 1973, section 215(b)(4) of such Act (as amended by section 101(c) of this Act) is amended to read as follows:

"(4) The provisions of this subsection shall be applicable only in the case of an individual—

"(A) who becomes entitled in or after the effective month of a new table that appears in (or is deemed by subsection (i)(2)(C) or section 230(c) to appear in) subsection (a) to benefits under section 202(a) or section 223; or

"(B) who dies in or after such effective month 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) Effective January 1, 1973, section 215(c) of such Act (as amended by section 101(d) of this Act) is amended to read as follows:

"Primary Insurance Amount Under Prior Provisions

"(c)(1) For the purposes of column II of the 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 effective month of the latest such table.

"(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."

(d) Sections 227 and 228 of such Act (as amended by section 102 of this Act) are amended by striking out "$48.30" wherever it appears and inserting in lieu thereof "the larger of $48.30 or the amount most recently established in lieu thereof under section 215 (i)", and by striking out "$24.20" wherever it appears and inserting in lieu thereof "the larger of $24.20 or the amount most recently established in lieu thereof under section 215 (i)"

INCREASED WIDOW'S AND WIDOWER'S INSURANCE BENEFITS

SEC. 104. (a) Section 202 (e) of the Social Security Act is amended—

(1) by striking out "82½ percent of" wherever it appears in paragraphs (1) and (2); and

(2) by striking out "age 62" in subparagraphs (C) (i) and (C) (ii) of paragraph (1), and in the matter following subparagraph (G) in paragraph (1), and inserting in lieu thereof in each instance "age 65".

(b) Section 202 (f) of such Act is amended—

(1) by striking out "82½ percent of" wherever it appears in paragraphs (1) and (3);

(2) by inserting ", after attainment of age 65," after "was entitled" in paragraph (1) (C); and

(3) by striking out "age 62" in the matter following subparagraph (G) in paragraph (1) and inserting in lieu thereof "age 65".

(c) (1) The last sentence of section 203 (c) of such Act is amended by striking out all that follows the semicolon and inserting in lieu thereof the following: "nor shall any deduction be made under this subsection from any widow's insurance benefit for any month in which the widow or surviving divorced wife is entitled and has not attained age 65 (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 65 (but only if he became so entitled prior to attaining age 62)."

(2) Clause (D) of section 203 (f) (1) of such Act is amended to read as follows: "(D) for which such individual is entitled to widow's insurance benefits and has not attained age 65 (but only if she became so entitled prior to attaining age 60), or widower's insurance benefits and has not attained age 65 (but only if he became so entitled prior to attaining age 62), or".

(d) (1) Section 202 (q) (1) of such Act is amended to read as follows:

"(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 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 insurance benefit, $\frac{25}{36}$ of 1 percent of such amount if such benefit is a wife's or husband's insurance benefit, or $\frac{57}{120}$ 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 the 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;

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) $^{43}/_{240}$ 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 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 age 62."

(2) Section 202 (q) (7) of such Act is amended—

(A) by striking out everything that precedes subparagraph (A) and inserting in lieu thereof the following:

"(7) For purposes of this subsection the 'adjusted reduction period' for an individual's old-age, wife's, husband's, widow's, or widower's insurance benefit is the reduction period 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, excluding from each such period—"; and

(B) by striking out "attained retirement age" in subparagraph (E) and inserting in lieu thereof "attained age 62, and also for any month before the month in which he attained retirement age,".

(3) Section 202 (q) (9) of such Act is amended to read as follows:

"(9) For purposes of this subsection, the term 'retirement age' means age 65."

(e) Section 202 (m) of such Act is amended to read as follows:

"Minimum Survivor's Benefit

"(m) (1) In any case in which an individual is entitled to a monthly benefit under this section (other than under subsection (a)) for any month and no other person is (without the application of subsection (j) (1) and section 223 (b)) entitled to a monthly benefit under this section or section 223 for such month on the basis of the same wages and self-employment income, such individual's benefit amount for such month, prior to reduction under subsections (k) (3) and (q) (1), shall be not less than the first amount appearing in column IV of the table in section 215 (a).

"(2) In the case of such an individual who is entitled

to a monthly benefit under subsection (e) or (f) and whose benefit is subject to reduction under subsection (q) (1), such benefit amount, after reduction under subsection (q) (1), shall not be less than the amount it would be under paragraph (1) after such reduction if such individual had attained (or would attain) retirement age (as defined in subsection (q) (9)) in the month in which he attained (or would attain) age 62.

"(3) In the case of an individual to whom paragraph (2) applies but whose first month of entitlement to benefits under subsection (e) or (f) was before the month in which he attained age 60, such paragraph (2) shall be applied, for purposes of determining the number of months to be used in computing the reduction under subparagraphs (A) and (B) of subsection (q) (1) (but not for purposes of determining the number of months to be used in computing the reduction under subparagraphs (C) and (D) of such subsection), as though such first month of entitlement had been the month in which he attained such age."

(f) In the case of an individual who is entitled (without the application of section 202 (j) (1) and 223 (b) of the Social Security Act) to widow's or widower's insurance benefits for the month of December 1970, the Secretary shall redetermine the amount of such benefits under title II of such Act as if the amendments made by this section had

been in effect for the first month of such individual's entitlement to such benefits.

(g) Where—

(1) two or more persons are entitled (without the application of section 202 (j) (1) of the Social Security Act) to monthly benefits under section 202 of such Act for December 1970 on the basis of the wages and self-employment income of a deceased individual, and one or more of such persons is so entitled under subsection (e) or (f) of such section 202, and

(2) one or more of such persons is entitled on the basis of such wages and self-employment income to increased monthly benefits under subsection (e) or (f) of such section 202 (as amended by this section) for January 1971, and

(3) the total of benefits to which all persons are entitled under section 202 of such Act on the basis of such wages and self-employment income for January 1971 is reduced by reason of section 203 (a) of such Act, as amended by this Act (or would, but for the penultimate sentence of such section 203 (a), be so reduced),

then the amount of the benefit to which each such person referred to in paragraph (1), other than a person entitled under subsection (e) or (f) of such section 202, is entitled

for months after December 1970 shall be adjusted. after the application of such section 203 (a), to an amount no less than the amount it would have been if the person or persons referred to in paragraph (2) had not become entitled to an increased benefit referred to in such paragraph.

(h) The amendments made by this section shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970.

AGE-62 COMPUTATION POINT FOR MEN

SEC. 105. (a) Section 214 (a) (1) of the Social Security Act is amended by striking out "before—" and all that follows down through "except" and inserting in lieu thereof "before the year in which he died or (if earlier) the year in which he attained age 62, except".

(b) Section 215 (b) (3) of such Act is amended by striking out "before—" and all that follows down through "For" and inserting in lieu thereof "before the year in which he died or, if it occurred earlier but after 1960, the year in which he attained age 62. For".

(c) In the case of an individual who is entitled to monthly benefits under section 202 or 223 of the Social Security Act for a month after December 1970, on the basis of the wages and self-employment income of an insured individual who prior to January 1971 became entitled to benefits under section 202 (a), or who prior to January 1971 became

entitled to benefits under section 223 after the year in which he attained age 62, or who died prior to January 1971 in a year after the year in which he attained age 62, the Secretary shall, notwithstanding paragraphs (1) and (2) of section 215 (f) of such Act, recompute the primary insurance amount of such insured individual. Such recomputation shall be made under whichever of the following alternative computation methods yields the higher primary insurance amount:

(1) the computation methods in section 215 (b) and (d) of such Act, as amended by this Act, as such methods would apply in the case of an insured individual who attained age 62 in 1971, except that the provisions of section 215 (d) (3) of such Act shall not apply; or

(2) the computation methods specified in paragraph (1) without regard to the limitation "but after 1960" contained in section 215 (b) (3) of such Act, except that for any such recomputation, when the number of an individual's benefit computation years is less than 5, his average monthly wage shall, if it is in excess of $400, be reduced to such amount.

(d) Section 223 (a) (2) of such Act is amended—

(1) by striking out "(if a woman) or age 65 (if a man)",

(2) by striking out "in the case of a woman" and

inserting in lieu thereof "in the case of an individual", and

(3) by striking out "she" and inserting in lieu thereof "he".

(e) Section 223 (c) (1) (A) of such Act is amended by striking out "(if a woman) or age 65 (if a man)".

(f) Section 227 (a) of such Act is amended by striking out "so much of paragraph (1) of section 214 (a) as follows clause (C)" and inserting in lieu thereof "paragraph (1) of section 214 (a)".

(g) Section 227 (b) of such Act is amended by striking out "so much of paragraph (1) thereof as follows clause (C)" and inserting in lieu thereof "paragraph (1) thereof"

(h) Sections 209 (i), 213 (a) (2), and 216 (i) (3) (A), of such Act are amended by striking out "(if a woman) or age 65 (if a man)".

(i) (1) Section 303 (g) (1) of the Social Security Amendments of 1960 is amended—

(A) by striking out "Amendments of 1965 and 1967" and inserting in lieu thereof "Amendments of 1965, 1967, 1969, and 1970";

(B) by striking out "Amendments of 1967" wherever it appears and inserting in lieu thereof "Amendments of 1970"; and

(C) by inserting "(subject to section 104 (i) (2)

of the Social Security Amendments of 1970)" after "except that" in the last sentence.

(2) For purposes of monthly benefits payable after December 1970, or a lump-sum death payment in the case of an insured individual who dies after December 1970, "retirement age" as referred to in section 303 (g) (1) of the Social Security Amendments of 1960 shall mean age 62.

(j) Paragraph (9) of section 3121 (a) of the Internal Revenue Code of 1954 (relating to definition of wages) is amended to read as follows:

"(9) any payment (other than vacation or sick pay) made to an employee after the month in which he attains age 62, if such employee did not work for the employer in the period for which such payment is made;".

(k) When two or more persons are entitled (without the application of sections 202 (j) (1) and 223 (b) of the Social Security Act) to monthly benefits under section 202 or 223 of such Act for December 1970, on the basis of the wages and self-employment income of an insured individual, and the total of benefits for such persons is reduced under section 203 (a) of such Act (or would, but for the penultimate sentence of such section 203 (a), be so reduced) for the month of January 1971 and such individual's primary insur-

ance amount is increased for such month under the amendments made by this section, then the total of benefits for such persons for and after January 1971 shall not be reduced to less than the sum of—

(1) the amount determined under section 203 (a) (2) of such Act for January 1971, and

(2) an amount equal to the excess of (A) such individual's primary insurance amount for January 1971, as determined under section 215 of such Act (as amended by section 101 of this Act) and in accordance with the amendments made by this section, over (B) his primary insurance amount for January 1971 as determined under such section 215 without regard to such amendments.

(l) The amendments made by this section shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970 and with respect to lump-sum death payments made under such title in the case of deaths occurring after December 1970, except that in the case of an individual who was not entitled to a monthly benefit under title II of such Act for December 1970 such amendments shall apply only on the basis of an application filed in or after the month in which this Act is enacted.

ELECTION TO RECEIVE ACTUARIALLY REDUCED BENEFITS IN ONE CATEGORY NOT TO BE APPLICABLE TO CERTAIN BENEFITS IN OTHER CATEGORIES

SEC. 106. (a) (1) Section 202 (q) (3) (A) of the Social Security Act is amended by striking out all that follows clause (ii) and inserting in lieu thereof the following: "then (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) of this paragraph, in lieu of any reduction under paragraph (1), if the amount of the reduction in such benefit under this paragraph is less than the amount of the reduction in such benefit would be under paragraph (1)."

(2) Section 202 (q) (3) of such Act is further amended by striking out subparagraphs (E), (F), and (G).

(b) Section 202 (r) of such Act is repealed.

(c) (1) (A) Subject to subparagraph (B), subsection (a) of this section and the amendments made thereby shall apply with respect to benefits for months commencing with the sixth month after the month in which this Act is enacted.

(B) Subsection (a) of this section and the amendments made thereby shall apply in the case of an individual whose entitlement to benefits under section 202 of the Social Security Act began (without regard to sections 202 (j) (1) and

223 (b) of such Act) before the sixth month after the month in which this Act is enacted only if such individual files with the Secretary of Health, Education, and Welfare, in such manner and form as the Secretary shall by regulations prescribe, a written request that such subsection and such amendments apply. In the case of such an individual who is described in paragraph (2) (A) (i) of this subsection, the request for a redetermination under paragraph (2) shall constitute the request required by this subparagraph, and subsection (a) of this section and the amendments made thereby shall apply pursuant to such request with respect to such individual's benefits as redetermined in accordance with paragraph (2) (B) (i) (but only if he does not refuse to accept such redetermination). In the case of any individual with respect to whose benefits subsection (a) of this section and the amendments made thereby may apply only pursuant to a request made under this subparagraph, such subsection and such amendments shall be effective (subject to paragraph (2) (D)) with respect to benefits for months commencing with the sixth month after the month in which this Act is enacted or, if the request required by this subparagraph is not filed before the end of such sixth month, with the second month following the month in which the request is filed.

(C) Subsection (b) of this section shall apply with respect to benefits payable pursuant to applications filed on or after the date of the enactment of this Act.

(2) (A) In any case where an individual—

(i) is entitled, for the fifth month following the month in which this Act is enacted, to a monthly insurance benefit under section 202 of the Social Security Act (I) which was reduced under subsection (q) (3) of such section, and (II) the application for which was deemed (or, except for the fact that an application had been filed, would have been deemed) to have been filed by such individual under subsection (r) (1) or (2) of such section, and

(ii) files a written request for a redetermination under this subsection, on or after the date of the enactment of this Act and in such manner and form as the Secretary of Health, Education, and Welfare shall by regulations prescribe,

the Secretary shall redetermine the amount of such benefit, and the amount of the other benefit (reduced under subsection (q) (1) or (2) of such section) which was taken into account in computing the reduction in such benefit under such subsection (q) (3), in the manner provided in subparagraph (B) of this paragraph.

(B) Upon receiving a written request for the redeter-

mination under this paragraph of a benefit which was reduced under subsection (q) (3) of section 202 of the Social Security Act and of the other benefit which was taken into account in computing such reduction, filed by an individual as provided in subparagraph (A) of this paragraph, the Secretary shall—

(i) determine the highest monthly benefit amount which such individual could receive under the subsections of such section 202 which are involved (or under section 223 of such Act and the subsection of such section 202 which is involved) for the month with which the redetermination is to be effective under subparagraph (D) of this subsection (without regard to sections 202 (k), 203 (a), and 203 (b) through (l)) if—

(I) such individual's application for one of such two benefits had been filed in the month in which it was actually filed or was deemed under subsection (r) of such section 202 to have been filed, and his application for the other such benefit had been filed in a later month, and

(II) the amendments made by this section had been in effect at the time each such application was filed; and

(ii) determine whether the amounts which were

actually received by such individual in the form of such two benefits during the period prior to the month with which the redetermination under this paragraph is to be effective were in excess of the amounts which would have been received during such period if the applications for such benefits had actually been filed at the times fixed under clause (i) (I) of this subparagraph, and, if so, the total amount by which benefits otherwise payable to such individual under such section 202 (and section 223) would have to be reduced in order to compensate the Federal Old-Age and Survivors Insurance Trust Fund (and the Federal Disability Insurance Trust Fund) for such excess.

(C) The Secretary shall then notify such individual of the amount of each such benefit as computed in accordance with the amendments made by subsections (a) and (b) of this section and as redetermined in accordance with subparagraph (B) (i) of this paragraph, specifying (i) the amount (if any) of the excess determined under subparagraph (B) (ii) of this paragraph, and (ii) the period during which payment of any increase in such individual's benefits resulting from the application of the amendments made by subsections (a) and (b) of this section would under designated circumstances have to be withheld in order to effect the reduction described in subparagraph (B) (ii). Such indi-

vidual may at any time within thirty days after such notification is mailed to him refuse (in such manner and form as the Secretary shall by regulations prescribe) to accept the redetermination under this paragraph.

(D) Unless the last sentence of subparagraph (C) applies, a redetermination under this paragraph shall be effective (but subject to the reduction described in subparagraph (B) (ii) over the period specified pursuant to clause (ii) of the first sentence of subparagraph (C)) beginning with the sixth month following the month in which this Act is enacted, or, if the request for such redetermination is not filed before the end of such sixth month, with the second month following the month in which the request for such redetermination is filed.

(E) The Secretary, by withholding amounts from benefits otherwise payable to an individual under title II of the Social Security Act as specified in clause (ii) of the first sentence of subparagraph (C) (and in no other manner), shall recover the amounts necessary to compensate the Federal Old-Age and Survivors Insurance Trust Fund (and the Federal Disability Insurance Trust Fund) for the excess (described in subparagraph (B) (ii)) attributable to benefits which were paid such individual and to which a redetermination under this subsection applies.

(d) Where—

(1) two or more persons are entitled on the basis of the wages and self-employment income of an individual (without the application of sections 202 (j) (1) and 223 (b) of the Social Security Act) to monthly benefits under section 202 of such Act for the month preceding the month with which (A) a redetermination under subsection (c) of this section becomes effective with respect to the benefits of any one of them and (B) such benefits are accordingly increased by reason of the amendments made by subsections (a) and (b) of this section, and

(2) the total of benefits to which all persons are entitled under such section 202 on the basis of such wages and self-employment income for the month with which such redetermination and increase becomes effective is reduced by reason of section 203 (a) of such Act as amended by this Act (or would, but for the penultimate sentence of such section 203 (a), be so reduced), then the amount of the benefit to which each of the persons referred to in paragraph (1), other than the person with respect to whose benefits such redetermination and increase is applicable, is entitled for months beginning with the month with which such redetermination and increase becomes effective shall be adjusted, after the application of such section

203 (a), to an amount no less than the amount it would have been if such redetermination and increase had not become effective.

LIBERALIZATION OF EARNINGS TEST

SEC. 107. (a) (1) Paragraphs (1) and (4) (B) of section 203 (f) of the Social Security Act are each amended by striking out "$140" and inserting in lieu thereof "$166.66⅔ or the exempt amount as determined under paragraph (8)".

(2) Paragraph (1) (A) of section 203 (h) of such Act is amended by striking out "$140" and inserting in lieu thereof "$166.66⅔ or the exempt amount as determined under subsection (f) (8)".

(3) Paragraph (3) of section 203 (f) of such Act is amended to read as follows:

"(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 $166.66⅔ or the exempt amount as determined under paragraph (8) multiplied by the number of months in such year. 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."

(b) Section 203 (f) of such Act is further amended by adding at the end thereof the following new paragraph:

"(8) (A) On or before November 1 of 1972 and of each even-numbered year thereafter, the Secretary shall determine and publish in the Federal Register the exempt amount as defined in subparagraph (B) for each month in any individual's first two taxable years which end with the close of or after the calendar year following the year in which such determination is made.

"(B) The exempt amount for each month of a particular taxable year shall be whichever of the following is the larger:

"(i) the product of $166.66\frac{2}{3}$ and the ratio of (I) the average 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 a determination under subparagraph (A) is made for each such month of such particular taxable year to (II) the average of the taxable wages of all persons for whom wages were reported to the Secretary for the first calendar quarter of 1971, with such product, if not a multiple of $10, being rounded to the next higher multiple of $10

where such product is an odd multiple of $5 and to the nearest multiple of $10 in any other case, or

"(ii) the exempt amount for each month in the taxable year preceding such particular taxable year;

except that the provisions in clause (i) shall not apply with respect to any taxable year unless the contribution and earnings base for such year is determined under section 230(b)(1)."

(c) The amendments made by this section shall apply with respect to taxable years ending after December 1970.

EXCLUSION OF CERTAIN EARNINGS IN YEAR OF ATTAINING AGE 72

SEC. 108. (a) The first sentence of section 203(f)(3) of the Social Security Act is amended by inserting "(A)" after "except that", and by inserting before the period at the end thereof the following: ", and (B) 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 equitable manner under regulations of the Secretary)".

(b) The amendment made by subsection (a) shall

apply with respect to taxable years ending after December 1970.

REDUCED BENEFITS FOR WIDOWERS AT AGE 60

SEC. 109. (a) Section 202 (f) of the Social Security Act (as amended by section 104 (b) (2) of this Act) is further amended—

(1) by striking out "age 62" each place it appears and inserting in lieu thereof "age 60"; and

(2) by striking out "or the third month" in the matter following subparagraph (G) in paragraph (1) and inserting in lieu thereof "or, if he became entitled to such benefits before he attained age 60, the third month".

(b) (1) The last sentence of section 203 (c) of such Act (as amended by section 104 (c) (1) of this Act) is further amended by striking out "age 62" and inserting in lieu thereof "age 60".

(2) Clause (D) of section 203 (f) (1) of such Act (as amended by section 104 (c) (2) of this Act) is further amended by striking out "age 62" and inserting in lieu thereof "age 60".

(3) Section 222 (b) (1) of such Act is amended by striking out "a widow or surviving divorced wife who has not attained age 60, a widower who has not attained age

62" and inserting in lieu thereof "a widow, widower or surviving divorced wife who has not attained age 60".

(4) Section 222(d)(1)(D) of such Act is amended by striking out "age 62" each place it appears and inserting in lieu thereof "age 60".

(5) Section 225 of such Act is amended by striking out "age 62" and inserting in lieu thereof "age 60".

(c) The amendments made by this section shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970, except that in the case of an individual who was not entitled to a monthly benefit under title II of such Act for December 1970 such amendments shall apply only on the basis of an application filed in or after the month in which this Act is enacted.

ENTITLEMENT TO CHILD'S INSURANCE BENEFITS BASED ON DISABILITY WHICH BEGAN BETWEEN 18 AND 22

SEC. 110. (a) Clause (ii) of section 202(d)(1)(B) of the Social Security Act is amended by striking out "which began before he attained the age of eighteen" and inserting in lieu thereof "which began before he attained the age of 22".

(b) Subparagraphs (F) and (G) of section 202(d)(1) of such Act are amended to read as follows:

"(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; 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, 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."

(c) Section 202(d)(1) of such Act is further amended by adding at the end thereof the following new sentence: "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."

(d) Section 202 (d) (6) of such Act is amended by striking out "in which he is a full-time student and has not attained the age of 22" and all that follows and inserting in lieu thereof "in which he—

"(A) (i) is a full-time student or (ii) is under a disability (as defined in section 223 (d)), and

"(B) had not attained the age of 22, 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."

(e) Section 202 (s) of such Act is amended—

(1) by striking out "which began before he attained such age" in paragraph (1); and

(2) by striking out "which began before such child attained the age of 18" in paragraphs (2) and (3).

(f) Where—

(1) one or more persons are entitled (without the application of sections 202 (j) (1) and 223 (b) of the Social Security Act) to monthly benefits under section 202 or 223 of such Act for December 1970 on the basis of the wages and self-employment income of an individual, and

(2) one or more persons (not included in paragraph (1)) are entitled to monthly benefits under such section 202 or 223 for January 1971 solely by reason of the amendments made by this section on the basis of such wages and self-employment income, and

(3) the total of benefits to which all persons are entitled under such section 202 or 223 on the basis of such wages and self-employment income for January 1971 is reduced by reason of section 203 (a) of such Act as amended by this Act (or would, but for the

penultimate sentence of such section 203(a), be so reduced),

then the amount of the benefit to which each person referred to in paragraph (1) of this subsection is entitled for months after December 1970 shall be adjusted, after the application of such section 203(a), to an amount no less than the amount it would have been if the person or persons referred to in paragraph (2) were not entitled to a benefit referred to in such paragraph (2).

(g) The amendments made by this section shall apply only with respect to monthly benefits under section 202 of the Social Security Act for months after December 1970, except that in the case of an individual who was not entitled to a monthly benefit under such section 202 for December 1970 such amendments shall apply only on the basis of an application filed after September 30, 1970.

ELIMINATION OF SUPPORT REQUIREMENT AS CONDITION OF BENEFITS FOR DIVORCED AND SURVIVING DIVORCED WIVES

SEC. 111. (a) Section 202(b)(1) of the Social Security Act is amended—

(1) by adding "and" at the end of subparagraph (C),

(2) by striking out subparagraph (D), and

(3) by redesignating subparagraphs (E) through

(L) as subparagraphs (D) through (K), respectively.

(b) (1) Section 202 (e) (1) of such Act is amended—

(A) by adding "and" at the end of subparagraph (C),

(B) by striking out subparagraph (D), and

(C) by redesignating subparagraphs (E) through (G) as subparagraphs (D) through (F), respectively.

(2) Section 202 (e) (6) of such Act is amended by striking out "paragraph (1) (G)" and inserting in lieu thereof "paragraph (1) (F)".

(c) Section 202 (g) (1) (F) of such Act is amended by striking out clause (i), and by redesignating clauses (ii) and (iii) as clauses (i) and (ii), respectively.

(d) The amendments made by this section shall apply only with respect to benefits payable under title II of the Social Security Act for months after December 1970 on the basis of applications filed on or after the date of the enactment of this Act.

ELIMINATION OF DISABILITY INSURED-STATUS REQUIREMENT OF SUBSTANTIAL RECENT COVERED WORK IN CASES OF INDIVIDUALS WHO ARE BLIND

SEC. 112. (a) The first sentence of section 216 (i) (3) of the Social Security Act is amended by inserting before the period at the end thereof the following: ", and 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))".

(b) Section 223(c)(1) of such Act is amended by striking out "coverage." in subparagraph (B)(ii) and inserting in lieu thereof "coverage;", and by striking out "For purposes" and inserting in lieu thereof the following:

"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 section 216(i)(1)). For purposes".

(c) The amendments made by this section shall be 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 in which this Act is enacted, or

(2) before the month in which this Act is enacted if the applicant has not died before such month and if—

(A) notice of the final decision of the Secretary of Health, Education, and Welfare has not been given to the applicant before such month; or

(B) the notice referred to in subparagraph

(A) has been so given before such month 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 such month) and the decision in such civil action has not become final before such month;

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 months before January 1971.

WAGE CREDITS FOR MEMBERS OF THE UNIFORMED SERVICES

SEC. 113. (a) Subsection 229(a) of the Social Security Act is amended—

(1) by striking out "after December 1967" and inserting in lieu thereof "after December 1970"; and

(2) by striking out "after 1967" and inserting in lieu thereof "after 1956".

(b) The amendments made by subsection (a) shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970 and with respect to lump-sum death payments under such title in the case of deaths occurring after December 1970, except that, in the case of any individual who is entitled, on the basis of the wages and self-employment income of any individual

to whom section 229 of such Act applies, to monthly benefits under title II of such Act for December 1970, such amendments shall apply (1) only if an application for recomputation by reason of such amendments 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 1971 or the twelfth month before the month in which such application was filed. Recomputations of benefits as required to carry out the provisions of this paragraph shall be made notwithstanding the provisions of section 215 (f) (1) of the Social Security Act, and no such recomputation shall be regarded as a recomputation for purposes of section 215 (f) of such Act.

APPLICATIONS FOR DISABILITY INSURANCE BENEFITS FILED AFTER DEATH OF INSURED INDIVIDUAL

SEC. 114. (a) (1) Section 223 (a) (1) of the Social Security Act is amended by adding at the end thereof the following new sentence: "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."

(2) Section 223 (a) (2) of such Act is amended by

striking out "he filed his application for disability insurance benefits and was" and inserting in lieu thereof "the application for disability insurance benefits was filed and he was".

(3) The third sentence of section 223 (b) of such Act is amended by striking out "if he files such application" and inserting in lieu thereof "if such application is filed".

(4) Section 223 (c) (2) (A) of such Act is amended by striking out "who files such application" and inserting in lieu thereof "with respect to whom such application is filed".

(b) Section 216 (i) (2) (B) of such Act is amended by adding at the end thereof the following new sentence: "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."

(c) The amendments made by this section shall apply in the case of deaths occurring in and after the year in which this Act is enacted. For purposes of such amendments (and for purposes of sections 202 (j) (1) and 223 (b) of the Social Security Act), any application with respect to an individual whose death occurred in such year but before the date of the enactment of this Act which is filed within 3 months after the date of the enactment of this Act shall be deemed to have been filed in the month in which such death occurred).

WORKMEN'S COMPENSATION OFFSET FOR DISABILITY INSURANCE BENEFICIARIES

SEC. 115. (a) Section 224(a)(5) of the Social Security Act is amended by striking out "80 per centum of".

(b) The amendment made by subsection (a) shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970.

COVERAGE OF FEDERAL HOME LOAN BANK EMPLOYEES

SEC. 116. (a) The provisions of section 210(a)(6)(B)(ii) of the Social Security Act and section 3121(b)(6)(B)(ii) of the Internal Revenue Code of 1954, insofar as they relate to service performed in the employ of a Federal Home Loan Bank, shall be effective—

(1) with respect to all service performed in the employ of a Federal Home Loan Bank after December 1970; and

(2) in the case of individuals who are in the employ of a Federal Home Loan Bank on January 1, 1971, with respect to any service performed in the employ of a Federal Home Loan Bank after December 1965; but this paragraph shall be effective only if an amount equal to the taxes imposed by sections 3101 and 3111 of such Code with respect to the services of all such individuals performed in the employ of Federal Home Loan Banks

after December 1965 are paid under the provisions of section 3122 of such Code by July 1, 1971, or by such later date as may be provided in an agreement entered into before such date with the Secretary of the Treasury or his delegate for purposes of this paragraph.

(b) Subparagraphs (A) (i) and (B) of section 104 (i) (2) of the Social Security Amendments of 1956 are repealed.

POLICEMEN AND FIREMEN IN IDAHO

SEC. 117. Section 218 (p) (1) of the Social Security Act is amended by inserting "Idaho," after "Hawaii,".

COVERAGE OF CERTAIN HOSPITAL EMPLOYEES IN NEW MEXICO

SEC. 118. Notwithstanding any provisions of section 218 of the Social Security Act, the agreement with the State of New Mexico heretofore entered into pursuant to such section may at the option of such State be modified at any time prior to January 1, 1971, so as to apply to the services of employees of a hospital which is an integral part of a political subdivision to which an agreement under this section has not been made applicable, as a separate coverage group within the meaning of section 218 (b) (5) of such Act, but only if such hospital has prior to 1966 withdrawn from a retirement system which had been applicable to the employees of such hospital.

PENALTY FOR FURNISHING FALSE INFORMATION TO OBTAIN SOCIAL SECURITY ACCOUNT NUMBER

SEC. 119. (a) Section 208 of the Social Security Act is amended by adding "or" after the semicolon at the end of subsection (e), and by inserting after subsection (e) the following new subsection:

"(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);".

(b) The amendments made by subsection (a) shall apply with respect to information furnished to the Secretary after the date of the enactment of this Act.

GUARANTEE OF NO DECREASE IN TOTAL FAMILY BENEFITS

SEC. 120. (a) Section 203(a) of the Social Security Act (as amended by sections 101(b) and 103(b) of this Act) is amended by striking out the period at the end of paragraph (4) and inserting in lieu thereof "; or", and by inserting after paragraph (4) the following new paragraph:

"(5) 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 of monthly benefits for all persons on the basis of such wages and self-employment income for months subsequent to such particular month 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 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."

(b) In any case in which the provisions of section 1002(b)(2) of the Social Security Amendments of 1969 apply, the total of monthly benefits as determined under section 203(a) of the Social Security Act shall, for months after 1970, be increased to the amount that would be required in order to assure that the total of such monthly benefits (after the application of section 202(q) of such Act) will not be less than the total of monthly benefits that was applicable (after the application of such sections 203(a) and 202(q)) for the first month for which the provisions of such section 1002(b)(2) applied.

CERTAIN ADOPTIONS BY DISABILITY AND OLD-AGE INSURANCE BENEFICIARIES

SEC. 121. (a) Clause (i) of section 202(d)(8)(E) of the Social Security Act is amended—

(1) by inserting "(I)" after "(i)",

(2) by adding "or" after "child-placement agency,", and

(3) by adding at the end thereof (after and below clause (i)(I) as designated by paragraph (1) of this subsection) the following:

"(II) in an adoption which took place after an investigation of the circumstances surrounding the adoption by a court of competent jurisdiction within the United States, or by a person appointed

by such a court, if the child was related (by blood, adoption, or steprelationship) to such individual or to such individual's wife or husband as a descendant or as a brother or sister or a descendant of a brother or sister, such individual had furnished one-half of the child's support for at least five years immediately before such individual became entitled to such disability insurance benefits, the child had been living with such individual for at least five years before such individual became entitled to such disability insurance benefits, and the continuous period during which the child was living with such individual began before the child attained age 18,".

(b) The amendments made by subsection (a) shall apply with respect to monthly benefits payable under title II of the Social Security Act for months after December 1967 on the basis of an application filed in or after the month in which this Act is enacted; except that such amendments shall not apply with respect to benefits for any month before the month in which this Act is enacted unless such application is filed before the close of the twelfth month after the month in which this Act is enacted.

INCREASE OF EARNINGS COUNTED FOR BENEFIT AND TAX PURPOSES

SEC. 122. (a) (1) (A) Section 209 (a) (5) of the Social Security Act is amended by inserting "and prior to 1971" after "1967".

(B) Section 209 (a) of such Act is further amended by adding at the end thereof the following new paragraphs:

"(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 1970 and prior to 1973, is paid to such individual during any 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 the contribution and benefit base (determined under section 230) with respect to employment has been paid to an individual during any calendar year after 1972 with respect to which such contribution and benefit base is effective, is paid to such individual during such calendar year;".

(2) (A) Section 211 (b) (1) (E) of such Act is

amended by inserting "and beginning prior to 1971" after "1967", and by striking out "; or" and inserting in lieu thereof "; and ".

(B) Section 211 (b) (1) of such Act is further amended by adding at the end thereof the following new subparagraphs:

"(F) For any taxable year beginning after 1970 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 in any calendar year after 1972, (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".

(3) (A) Section 213 (a) (2) (ii) of such Act is amended by striking out "after 1967" and inserting in lieu thereof "after 1967 and before 1971, or $9,000 in the case of a calendar year after 1970 and before 1973, or an amount equal to the contribution and benefit base (as determined under section 230) in the case of any calendar year after 1972 with respect to which such contribution and benefit base is effective".

(B) Section 213 (a) (2) (iii) of such Act is amended by striking out "after 1967" and inserting in lieu thereof "after 1967 and beginning before 1971, or $9,000 in the case of a taxable year beginning after 1970 and before 1973, or in the case of any taxable year beginning in any calendar year after 1972, an amount equal to the contribution and benefit base (as determined under section 230) which is effective for such calendar year".

(4) Section 215 (e) (1) of such Act is amended by striking out "and the excess over $7,800 in the case of any calendar year after 1967" and inserting in lieu thereof "the excess over $7,800 in the case of any calendar year after 1967 and before 1971, the excess over $9,000 in the case of any calendar year after 1970 and before 1973, 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 1972 with respect to which such contribution and benefit base is effective".

(b) (1) (A) Section 1402 (b) (1) (E) of the Internal Revenue Code of 1954 (relating to definition of self-employment income) is amended by inserting "and beginning before 1971" after "1967", and by striking out "; or" and inserting in lieu thereof "; and".

(B) Section 1402 (b) (1) of such Code is further

amended by adding at the end thereof the following new subparagraphs:

"(F) for any taxable year beginning after 1970 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 in any calendar year after 1972, (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) (A) Section 3121 (a) (1) of such Code (relating to definition of wages) is amended by striking out "$7,800" each place it appears and inserting in lieu thereof "$9,000".

(B) Effective with respect to remuneration paid after 1972, section 3121 (a) (1) of such Code is amended (1) by striking out "$9,000" each place it appears and inserting in lieu thereof "the contribution and benefit base (as determined under section 230 of the Social Security Act)", and (2) by striking out "by an employer during any calendar year", and inserting in lieu thereof "by an employer during the calendar year with respect to which such contribution and benefit base is effective".

(3) (A) The second sentence of section 3122 of such Code (relating to Federal service) is amended by striking out "$7,800" and inserting in lieu thereof "$9,000".

(B) Effective with respect to remuneration paid after 1972, the second sentence of section 3122 of such Code is amended by striking out "$9,000" and inserting in lieu thereof "the contribution and benefit base".

(4) (A) Section 3125 of such Code (relating to returns in the case of governmental employees in Guam, American Samoa, and the District of Columbia) is amended by striking out "$7,800" where it appears in subsections (a), (b), and (c) and inserting in lieu thereof "$9,000".

(B) Effective with respect to remuneration paid after 1972, section 3125 of such Code is amended by striking out "$9,000" where it appears in subsections (a), (b), and (c) and inserting in lieu thereof "the contribution and benefit base".

(5) Section 6413 (c) (1) of such Code (relating to special refunds of employment taxes) is amended—

(A) by inserting "and prior to the calendar year 1971" after "after the calendar year 1967";

(B) by inserting after "exceed $7,800" the following: "or (E) during any calendar year after the calendar year 1970 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 1972, 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

(C) by inserting before the period at the end thereof the following: "and before 1971, or which exceeds the tax with respect to the first $9,000 of such wages received in such calendar year after 1970 and before 1973, or which exceeds the tax with respect to an amount of such wages received in such calendar year after 1972 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".

(6) Section 6413 (c) (2) (A) of such Code (relating to refunds of employment taxes in the case of Federal employees) is amended by striking out "or $7,800 for any calendar year after 1967" and inserting in lieu thereof "$7,800 for the calendar year 1968, 1969, or 1970, or $9,000 for the calendar year 1971 or 1972, 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 1972 with respect to which such contribution and benefit base is effective".

(7) (A) Section 6654 (d) (2) (B) (ii) of such Code (relating to failure by individual to pay estimated income tax) is amended by striking out "$6,600" and inserting in lieu thereof "$9,000".

(B) Effective with respect to taxable years beginning after 1972, section 6654 (d) (2) (B) (ii) of such Code is amended by striking out "$9,000" and inserting in lieu thereof "the contribution and benefit base (as determined under section 230 of the Social Security Act)".

(c) The amendments made by subsections (a) (1) and (a) (3) (A), and the amendments made by subsection (b) (except paragraphs (1) and (7) thereof), shall apply only with respect to remuneration paid after December 1970. The amendments made by subsections (a) (2), (a) (3) (B), (b) (1), and (b) (7) shall apply only with respect to taxable years beginning after 1970. The amendment made by subsection (a) (4) shall apply only with respect to calendar years after 1970.

AUTOMATIC ADJUSTMENT OF THE CONTRIBUTION AND BENEFIT BASE

SEC. 123. (a) Title II of the Social Security Act is amended by adding at the end thereof the following new section:

"AUTOMATIC ADJUSTMENT OF THE CONTRIBUTION AND BENEFIT BASE

"SEC. 230. (a) On or before November 1 of 1972 and each even-numbered year thereafter, the Secretary shall determine and publish in the Federal Register the contribution and benefit base (as defined in subsection (b)) for the first two calendar years following the year in which the determination is made.

"(b) The contribution and benefit base for a particular calendar year shall be whichever of the following is the larger:

"(1) The product of $9,000 and the ratio of (A) the average 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 a determination under subsection (a) is made for such particular calendar year to (B) the average of the taxable wages of all persons for whom taxable wages were reported to the Secretary for the first calendar quarter of 1971, with such product, if not a multiple of $600, being rounded to the next higher multiple of $600 where such product is a multiple of $300 but not of $600 and to the nearest multiple of $600 in any other case; or

"(2) The contribution and benefit base for the calendar year preceding such particular calendar year.

"(c) (1) When the Secretary determines and publishes in the Federal Register a contribution and benefit base (as required by subsection (a)), and

"(A) such base is larger than the contribution and benefit base in effect for the year in which the larger base is so published, and

"(B) a revised table of benefits is not required to be published in the Federal Register under the provisions of section 215 (i) (2) (C) which extends such table for such larger base on or before the effective date of such base,

then the Secretary shall publish a revised table of benefits (determined under the provisions of paragraph (2)) in the Federal Register on or before December 1 of the year prior to the effective year of the new contribution and benefit base. Such table shall be deemed to be the table appearing in section 215 (a).

"(2) The revision of such table shall be determined as follows:

"(A) All of the amounts on each line of columns I, II, III, and IV, except the largest amount in column III, of the table in effect before the revision, shall be the same in the revised table; and

"(B) The additional amounts for the extension of columns III and IV, and the amounts for purposes of

column V, shall be determined in accordance with the provisions of section 215 (i) (2) (C) (v) and (vi).

"(3) When a revised table of benefits, prepared under the provisions of paragraph (2), becomes effective, the provisions of section 215 (b) (4) and (c) and of section 203 (a) (4) shall be disregarded; and the amounts that are added to columns III and IV, or are changed in or added to column V, by such revised table, shall be applicable only in the case of an insured individual—

"(A) who becomes entitled, after December of the year immediately preceding the effective year of the increased contribution and benefit base (provided by this section), to benefits under section 202 (a) or section 223;

"(B) who dies after December of such preceding year without being entitled to benefits under section 202 (a) or section 223; or

"(C) whose primary insurance amount is required to be recomputed under section 215 (f) (2)."

(b) (1) Section 201 (c) of the Social Security Act is amended by inserting before the last sentence the following new sentence: "The report shall further include a recommendation as to the appropriateness of the tax rates in sections 1401 (a), 3101 (a), and 3111 (a) of the Internal Revenue Code of 1954 which will be in effect for the fol-

lowing calendar year, made in the light of the need for the estimated income in relationship to the estimated outgo of the Trust Funds during such year."

(2) Section 1817 (b) of such Act is amended by inserting before the last sentence the following new sentence: "The report shall further include a recommendation as to the appropriateness of the tax rates in sections 1401 (b), 3101 (b), and 3111 (b) of the Internal Revenue Code of 1954 which will be in effect for the following calendar year made in the light of the need for the estimated income in relationship to the estimated outgo of the Trust Fund during such year."

CHANGES IN TAX SCHEDULES

SEC. 124. (a) (1) Section 1401 (a) of the Internal Revenue Code of 1954 (relating to rate of tax on self-employment income for purposes of old-age, survivors, and disability insurance) is amended by striking out paragraphs (2), (3), and (4) and inserting in lieu thereof the following:

"(2) in the case of any taxable year beginning after December 31, 1968, and before January 1, 1975, the tax shall be equal to 6.3 percent of the amount of the self-employment income for such taxable year; and

"(3) in the case of any taxable year beginning

after December 31, 1974, the tax shall be equal to 7.0 percent of the amount of the self-employment income for such taxable year."

(2) Section 3101 (a) of such Code (relating to rate of tax on employees for purposes of old-age, survivors, and disability insurance) is amended by striking out paragraphs (2), (3), and (4) and inserting in lieu thereof the following:

"(2) with respect to wages received during the calendar years 1969, 1970, 1971, 1972, 1973, and 1974, the rate shall be 4.2 percent;

"(3) with respect to wages received during the calendar years 1975, 1976, 1977, 1978, and 1979, the rate shall be 5.0 percent; and

"(4) with respect to wages received after December 31, 1979, the rate shall be 5.5 percent."

(3) Section 3111 (a) of such Code (relating to rate of tax on employers for purposes of old-age, survivors, and disability insurance) is amended by striking out paragraphs (2), (3), and (4) and inserting in lieu thereof the following:

"(2) with respect to wages paid during the calendar years 1969, 1970, 1971, 1972, 1973, and 1974, the rate shall be 4.2 percent;

"(3) with respect to wages paid during the cal-

endar years 1975, 1976, 1977, 1978, and 1979, the rate shall be 5.0 percent; and

"(4) with respect to wages paid after December 31, 1979, the rate shall be 5.5 percent."

(b) (1) Section 1401 (b) of such Code (relating to rate of tax on self-employment income for purposes of hospital insurance) is amended by striking out paragraphs (1) through (5) and inserting in lieu thereof the following:

"(1) in the case of any taxable year beginning after December 31, 1967, and before January 1, 1971, the tax shall be equal to 0.6 percent of the amount of the self-employment income for such taxable year; and

"(2) in the case of any taxable year beginning after December 31, 1970, the tax shall be equal to 1.0 percent of the amount of the self-employment income for such taxable year."

(2) Section 3101 (b) of such Code (relating to rate of tax on employees for purposes of hospital insurance) is amended by striking out paragraphs (1) through (5) and inserting in lieu thereof the following:

"(1) with respect to wages received during the calendar years 1968, 1969, and 1970, the rate shall be 0.6 percent; and

"(2) with respect to wages received after December 31, 1970, the rate shall be 1.0 percent."

(3) Section 3111(b) of such Code (relating to rate of tax on employers for purposes of hospital insurance) is amended by striking out paragraphs (1) through (5) and inserting in lieu thereof the following:

"(1) with respect to wages paid during the calendar years 1968, 1969, and 1970, the rate shall be 0.6 percent; and

"(2) with respect to wages paid after December 31, 1970, the rate shall be 1.0 percent."

(c) The amendments made by subsections (a) (1) and (b) (1) shall apply only with respect to taxable years beginning after December 31, 1970. The remaining amendments made by this section shall apply only with respect to remuneration paid after December 31, 1970.

ALLOCATION TO DISABILITY INSURANCE TRUST FUND

SEC. 125. (a) Section 201(b) (1) of the Social Security Act is amended—

(1) by striking out "and (D)" and inserting in lieu thereof "(D)"; and

(2) by striking out "after December 31, 1969, and so reported," and inserting in lieu thereof the following: "after December 31, 1969, and before January 1, 1971, and so reported, (E) 0.90 of 1 per centum

of the wages (as so defined) paid after December 31, 1970, and before January 1, 1975, and so reported, (F) 1.05 per centum of the wages (as so defined) paid after December 31, 1974, and before January 1, 1980, and so reported, and (G) 1.15 per centum of the wages (as so defined) paid after December 31, 1979, and so reported,".

(b) Section 201 (b) (2) of such Act is amended—

(1) by striking out "and (D)" and inserting in lieu thereof "(D)"; and

(2) by inserting after "December 31, 1969," the following: "and before January 1, 1971, (E) 0.675 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1970, and before January 1, 1975, (F) 0.7875 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1974, and before January 1, 1980, and (G) 0.8625 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1979,".

TITLE II—PROVISIONS RELATING TO MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH

PART A—COVERAGE UNDER MEDICARE PROGRAM

PAYMENT UNDER MEDICARE PROGRAM TO INDIVIDUALS COVERED BY FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

SEC. 201. Section 1862 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(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, 1972, 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 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 upon or after attaining age 65, in addition to the health benefits plans available before he attains such age, one or more health benefits plans which offer protection supplementing the combined protection pro-

vided under parts A and B of this title and one or more health benefits plans which offer protection supplementing the protection provided under part B of this title alone, and

"(2) the Government 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 coverage under parts A and B (or part B alone) of this title, or (C) a combination of such contribution and such payment."

HOSPITAL INSURANCE BENEFITS FOR UNINSURED INDIVIDUALS NOT ELIGIBLE UNDER PRESENT TRANSITIONAL PROVISION

SEC. 202. (a) Section 103(a) of the Social Security Amendments of 1965 is amended—

(1) by redesignating clauses (A) and (B) in paragraphs (2) and (4) as clauses (i) and (ii), respectively, and by redesignating paragraphs (1), (2), (3),

(4), and (5) as subparagraphs (A), (B), (C), (D), and (E), respectively;

(2) by striking out all that follows "Anyone who—" and precedes subparagraph (B) (as redesignated by paragraph (1) of this subsection) and inserting in lieu thereof the following:

"(1) (A) has attained the age of 65,";

(3) by adding "or" at the end of subparagraph (E) (as so redesignated);

(4) by striking out "shall (subject to the limitations in this section)" and all that follows down through the period at the end of the first sentence and inserting in lieu thereof the following:

"(2) (A) meets the provisions of subparagraphs (A), (C), and (D) of paragraph (1),

"(B) does not meet the provisions of subparagraph (B) of paragraph (1), and

"(C) has enrolled (i) under section 1837 of the Social Security Act and (ii) under subsection (d) of this section,

shall (subject to the limitations in this section) be deemed, solely for purposes of section 226 of the Social Security Act, to be entitled to monthly insurance benefits under such section 202 for each month, beginning—

"(i) in the case of an individual who meets the

provisions of paragraph (1), with the first month in which he meets the requirements of such paragraph, or

"(ii) in the case of an individual who meets the provisions of paragraph (2), with the day on which his coverage period (as provided in subsection (d)) begins,

and ending with the month in which he dies, or, if earlier, the month before the month in which he becomes (or upon filing application for monthly insurance benefits under section 202 of such Act would become) entitled to hospital insurance benefits under section 226 or becomes certifiable as a qualified railroad retirement beneficiary.";

(5) (A) by striking out "the preceding requirements of this subsection" in the second sentence and inserting in lieu thereof "the requirements of paragraph (1) of this subsection" and (B) by striking out "paragraph (5) hereof" and inserting in lieu thereof "subparagraph (E) of such paragraph"; and

(6) by striking out "paragraphs (1), (2), (3), and (4)" in the third sentence and inserting in lieu thereof "subparagraphs (A), (B), (C), and (D) of paragraph (1)".

(b) Section 103 (b) of such Amendments is amended (1) by inserting "(i)" after "individual" in the second

sentence, and (2) by adding before the period at the end thereof the following: ", or (ii) (with respect to an enrollment under subsection (d) (1)) for any month during his coverage period (as provided in subsection (d))".

(c) Section 103 (c) (1) of such Amendments is amended by striking out "this section" and inserting in lieu thereof "paragraph (1) of subsection (a) of this section".

(d) Section 103 of such Amendments is further amended by adding at the end thereof the following new subsections:

"(d) (1) An individual who meets the conditions of subparagraphs (A) and (B) of paragraph (2) of subsection (a) and has enrolled under section 1837 of the Social Security Act may enroll for the hospital insurance benefits provided under subsection (a).

"(2) The provisions of sections 1837, 1838, 1839, and 1840 (relating to enrollments under part B of title XVIII of the Social Security Act) shall be applicable to the enrollment authorized by paragraph (1) in the same manner, to the same extent, and under the same conditions as such sections are applicable to enrollments under such part B, except that for purposes of this subsection such sections 1837, 1838, 1839, and 1840 are modified as follows:

"(A) the term 'paragraphs (1) and (2) of section 1836' shall be considered to read 'subparagraphs

(A) and (B) of paragraph (2) of section 103 (a) of the Social Security Amendments of 1965';

"(B) the term 'March 1, 1966' shall be considered to read 'March 31, 1971';

"(C) the term 'May 31, 1966' shall be considered to read 'March 31, 1971';

"(D) the term '1969' shall be considered to read '1972';

"(E) subsection (a) (1) of such section 1838 shall be considered to read as follows:

"'(1) in the case of an individual who enrolls for benefits under subsection (a) of section 103 of the Social Security Amendments of 1965 pursuant to subsection (c) of section 1837 (as made applicable by section 103 (d) (2) of such Amendments), January 1, 1971, or, if later, the first day of the month following the month in which he so enrolls; or';

"(F) subsection (b) of such section 1838 shall be considered amended by adding at the end thereof the following new sentence: 'An individual's enrollment under subsection (d) of section 103 of the Social Security Amendments of 1965 shall also terminate (i) when he satisfies subparagraghs (B) and (E) of paragraph (1) of subsection (a) of such section, with such

termination taking effect on the first day of the month in which he satisfies such subparagraphs, or (ii) when his enrollment under section 1837 terminates, with such termination taking effect as provided in the second sentence of this subsection.';

"(G) subsection (a) of such section 1839 shall be considered to read as follows:

"'(a) The monthly premium of each individual for each month in his coverage period before July 1972 shall be $27.';

"(H) the term '1967' when used in subsection (b) (1) of such section 1839 shall be considered to read 'June 1972';

"(I) subsection (b) (2) of such section 1839 shall be considered to read as follows:

"'(2) The Secretary shall, during December of 1971 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 for months occurring in the 12-month period commencing July 1 of the next year. Such amount shall be equal to $27 multiplied by the ratio of (1) the inpatient hospital deductible for such next year, as promulgated under section 1813 (b) (2), to (2)

such deductible promulgated for 1971. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1.'; and

"(J) the term 'Federal Supplementary Medical Insurance Trust Fund' shall be considered to read 'Federal Hospital Insurance Trust Fund'.

"(e) Payment of the monthly premiums on behalf of any individual who meets the conditions of subparagraphs (A) and (B) of paragraph (2) of subsection (a) and has enrolled for the hospital insurance benefits provided under 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."

PART B—IMPROVEMENTS IN THE OPERATING EFFECTIVENESS OF THE MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS

LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

SEC. 221. (a) Title XI of the Social Security Act is amended by adding at the end thereof the following new section:

"LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

"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 health care facilities 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 body 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 in such State within the field of its responsibilities, and

"(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 in such State within the fields of their respective responsibilities, 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 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 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), 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 com-

prehensive 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 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;

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.

"(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 would not be consistent 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 para-

graph (1) and the Federal Hospital Council, the National Advisory Health Council, the Health Insurance Benefits Advisory Council, the Medical Assistance 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."

(b) The amendment made by subsection (a) shall apply only with respect to a capital expenditure the obligation for which is incurred by or on behalf of a health care facility subsequent to whichever of the following is earlier: (A) June 30, 1971, 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.

(c) (1) Section 505 (a) (6) of such Act (as amended by section 229 (b) of this Act) is further amended by inserting ", consistent with section 1122," after "standards" where it first appears.

(2) Section 506 of such Act (as amended by sections 224 (c), 227 (d), 230 (d), and 235 (b) of this Act) is further amended by adding at the end thereof the following new subsection:

"(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."

(3) Clause (2) of the second sentence of section 509 (a) of such Act is amended by inserting ", consistent with section 1122," after "standards".

(4) Section 1861 (v) of such Act is amended by adding at the end thereof the following new paragraph:

"(5) 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."

(5) Section 1902 (a) (13) (D) of such Act (as amended by section 229 (a) of this Act) is further amended by inserting ", consistent with section 1122," after "standards" where it first appears.

(6) Section 1903 (b) of such Act is amended by adding at the end thereof the following new paragraph:

"(3) 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."

REPORT ON PLAN FOR PROSPECTIVE REIMBURSEMENT; EXPERIMENTS AND DEMONSTRATION PROJECTS TO DEVELOP INCENTIVES FOR ECONOMY IN THE PROVISION OF HEALTH SERVICES

SEC. 222. (a) (1) The Secretary of Health, Education, and Welfare, directly or through contracts with public or private agencies or organizations, shall develop and carry out experiments and demonstration projects designed to determine the relative advantages and disadvantages of various

alternative methods of making payment on a prospective basis to hospitals, extended care facilities, and other providers of services for care and services provided by them under title XVIII of the Social Security Act and under State plans approved under titles XIX and V of such Act, including alternative methods for classifying providers, for establishing prospective rates of payment, and for implementing on a gradual, selective, or other basis the establishment of a prospective payment system, in order to stimulate such providers through positive financial incentives to use their facilities and personnel more efficiently and thereby to reduce the total costs of the health programs involved without adversely affecting the quality of services by containing or lowering the rate of increase in provider costs that has been and is being experienced under the existing system of retroactive cost reimbursement.

(2) The experiments and demonstration projects developed under paragraph (1) shall be of sufficient scope and shall be carried out on a wide enough scale to permit a thorough evaluation of the alternative methods of prospective payment under consideration while giving assurance that the results derived from the experiments and projects will obtain generally in the operation of the programs involved (without committing such programs to the adoption of any prospective payment system either locally or nationally).

(3) In the case of any experiment or demonstration project under paragraph (1), 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 methods of payment for services provided; and costs incurred in such experiment or project in excess of those which would otherwise be reimbursed or paid under such titles may be reimbursed or paid to the extent that such waiver applies to them (with such excess being borne by the Secretary). No experiment or demonstration project shall be developed or carried out under paragraph (1) until the Secretary obtains the advice and recommendations of specialists who are competent to evaluate the proposed experiment or project as to the soundness of its objectives, the possibilities of securing productive results, the adequacy of resources to conduct it, and its relationship to other similar experiments or projects already completed or in process; and no such experiment or project shall be actually placed in operation until a written report containing a full and complete description thereof has been transmitted to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate.

(4) Grants, payments under contracts, and other expenditures made for experiments and demonstration projects under this subsection shall be made 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). 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 subsection. With respect to any such grant, payment, or other expenditure, the amount to be paid from each of such trust funds shall be determined by the Secretary, giving due regard to the purposes of the experiment or project involved.

(5) The Secretary shall submit to the Congress no later than July 1, 1972, a full report on the experiments and demonstration projects carried out under this subsection and on the experience of other programs with respect to prospective reimbursement together with any related data and materials which he may consider appropriate. Such report shall include detailed recommendations with respect to the specific methods which could be used in the full implementation of a system of prospective payment to providers of services under the programs involved.

(6) Section 1875(b) of the Social Security Act is amended by inserting "and the experiments and demonstra-

tion projects authorized by section 222 (a) of the Social Security Amendments of 1970" after "1967".

(b) (1) Section 402 (a) of the Social Security Amendments of 1967 is amended to read as follows:

"(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 1970) 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 to organizations and institutions which have the capability of providing comprehensive health care services or 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 programs;

"(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; and

"(E) to determine whether utilization review and medical review mechanisms established on an areawide or communitywide basis would have the effect of provid-

ing more effective controls under such programs over excessive utilization of services.

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 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). 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 shall be determined by the Secretary, giving due regard to the purposes of the experiment or project involved."

(2) Section 402 (b) of such Amendments is amended—

(A) by striking out "experiment" each time it appears and inserting in lieu thereof "experiment or demonstration project";

(B) by striking out "experiments" and inserting in lieu thereof "experiments and projects";

(C) by striking out "reasonable charge" and inserting in lieu thereof "reasonable charge, or to reimbursement or payment only for such services or items as may be specified in the experiment"; and

(D) by inserting before the period at the end thereof the following: "; and no such experiment or project shall be actually placed in operation until a written report containing a full and complete description thereof has been transmitted to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate".

(3) Section 1875(b) of the Social Security Act is amended by striking out "experimentation" and inserting in lieu thereof "experiments and demonstration projects".

LIMITATIONS ON COVERAGE OF COSTS UNDER MEDICARE PROGRAM

SEC. 223. (a) The first sentence of section 1861(v)(1) of the Social Security Act is amended by inserting immediately before "determined" where it first appears the fol-

lowing: "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".

(b) The third sentence of section 1861 (v) (1) of such Act is amended by striking out the comma after "services" where it last appears and inserting in lieu thereof the following: ", 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,".

(c) The fourth sentence of section 1861 (v) (1) of such Act is amended by inserting after "services" where it first appears the following: " (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) ".

(d) The fourth sentence of section 1861 (v) (1) of such Act is further amended by striking out "costs with respect" where they first appear and inserting in lieu thereof the following: "necessary costs of efficiently delivering covered services".

(e) Section 1866(a) (2) (B) of such Act is amended (1) by inserting "(i)" after "(B)", and (2) by adding at the end thereof the following new clause:

"(ii) Where a provider of services customarily furnishes an individual items or services which are 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 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 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 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 in excess of the cost determined to be necessary in the efficient delivery of needed health services under this title."

(f) Section 1861 (v) of such Act (as amended by section 221 (c) (4) of this Act) is further amended by redesignating paragraphs (4) and (5) as paragraphs (5) and (6), respectively, and by inserting after paragraph (3) the following new paragraph:

"(4) If a provider of services furnishes items or services to an individual which are 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."

(g) Section 1866 (a) (2) of such Act is amended by adding at the end thereof the following new subparagraph:

"(D) Where a provider of services customarily fur-

nishes 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, 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."

(h) The amendments made by this section shall be effective with respect to accounting periods beginning after the date of the enactment of this Act.

LIMITS ON PREVAILING CHARGE LEVELS

SEC. 224. (a) Section 1842 (b) (3) of the Social Security Act is amended by adding at the end thereof the following new sentences: "No charge may be determined to be reasonable under this part for services rendered after June 30, 1970, and before July 1, 1971, if it exceeds the higher of (i) the prevailing charge recognized by the carrier for similar services in the same locality in administering this part on June 30, 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 calendar year 1969. With respect to services rendered after June 30, 1971, the charges recognized as prevailing within a locality may be increased in any fiscal year only to the extent found necessary, on the basis of statistical data and methodology acceptable to the Secretary, to cover 75 percent of the customary charges made for similar services in the same locality during the last preceding elapsed calendar year but may not be increased (in the aggregate) beyond the levels described in clause (ii) of the preceding sentence except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such adjustments are justified by economic changes. In the case of medical services, supplies, and equipment that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after June 30, 1970, determined to be reasonable may exceed the lowest charge levels at which such services, supplies, and equipment are widely available in a locality only to the extent and under the circumstances specified by the Secretary."

(b) Section 1903 of such Act is amended by adding at the end thereof the following new subsection:

"(g) Payment under the preceding provisions of this section shall not be made with respect to any amount paid for items or services furnished under the plan after June 30, 1970, 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)."

(c) Section 506 of such Act is amended by adding at the end thereof the following new subsection:

"(f) Notwithstanding the preceding provisions of this section, no payment shall be made to any State thereunder with respect to any amount paid for items or services furnished under the plan after June 30, 1970, 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)."

ESTABLISHMENT OF INCENTIVES FOR STATES TO EMPHASIZE OUTPATIENT CARE UNDER MEDICAID PROGRAMS

SEC. 225. (a) (1) Section 1903 of the Social Security Act (as amended by section 228 of this Act) is further amended by inserting after subsection (d) the following new subsection:

"(e) The amount determined under subsection (a) (1) for any State shall be adjusted as follows:

"(1) With respect to the following services furnished under the State plan after December 31, 1970, the Federal medical assistance percentage shall be increased by 25 per centum thereof, except that the Federal medi-

cal assistance percentage as so increased may not exceed 95 per centum:

"(A) outpatient hospital services and clinic services (other than physical therapy services); and

"(B) home health care services (other than physical therapy services); and

"(2) with respect to the following services furnished under the State plan after December 31, 1970, the Federal medical assistance percentage shall be decreased as follows:

"(A) after an individual has received inpatient hospital services (including services furnished in an institution for tuberculosis) on sixty days (whether or not such days are consecutive) during any calendar year (which for purposes of this section means the four calendar quarters ending with June 30), the Federal medical assistance percentage with respect to any such services furnished thereafter to such individual in the same calendar year shall be decreased by $33\frac{1}{3}$ per centum thereof;

"(B) after an individual has received care as an inpatient in a skilled nursing home on ninety days (whether or not such days are consecutive) during any calendar year, the Federal medical assistance

percentage with respect to any such care furnished thereafter to such individual in the same calendar year shall be decreased by 33⅓ per centum thereof; and

"(C) after an individual has received inpatient services in a hospital for mental diseases on ninety days occurring after December 31, 1970 (whether or not such days are consecutive), the Federal medical assistance percentage with respect to any such services furnished to such individual on an additional two hundred and seventy-five days (whether or not such days are consecutive) shall be decreased by 33⅓ per centum thereof and no payment may be made under this title for any such services furnished to such individual on any day after such two hundred and seventy-five days.

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) Section 1903 (a) (1) of such Act is amended by inserting ", subject to subsection (e) of this section" after "section 1905 (b)".

(b) (1) Section 1121 of such Act is amended by adding at the end thereof the following new subsection:

"(f) (1) If the Secretary determines for any calendar quarter beginning after December 31, 1970, with respect to any State that there does not exist a reasonable cost differential between the cost of skilled nursing home services and the cost of intermediate care facility services in such State, the Secretary may reduce the amount which would otherwise be considered as expenditures for which payment may be made under subsection (c) 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 cost of skilled nursing home services and the 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."

(2) Section 1121 (e) of such Act is amended by adding at the end thereof the following new sentence: "Effective January 1, 1971, the term 'intermediate care facility' shall not include any public institution (or distinct part thereof) for mental diseases or mental defects."

PAYMENT FOR SERVICES OF TEACHING PHYSICIANS UNDER MEDICARE PROGRAM

SEC. 226. (a) (1) Section 1833 (a) (1) of the Social Security Act is amended by striking out "and" before "(B)", and by inserting before the semicolon at the end thereof the following: ", and (C) with respect to expenses incurred for services which are furnished to a patient of a hospital by a physician and for which payment may be made under this part, the amounts paid shall be equal to 100 percent of the reasonable cost, to the hospital or other medical service organization incurring such cost, of such services if (i) (I) such services are furnished under circumstances comparable to the circumstances under which similar services are furnished to

all persons, or all members of a class of persons, who are patients in such hospital and who are not covered by the insurance program established by this part (and not covered under a State plan approved under title XIX), and (II) none of such persons, or members of such class of persons, are required to pay the reasonable charges for such similar services even when they have private insurance covering such similar services (or are otherwise able to pay reasonable charges for all such similar services as determined in accordance with regulations), or (ii) (I) none of the patients in such hospital who are covered by such program are required to pay any charges for services furnished by physicians, or (II) such patients are required to pay reasonable charges for such services but payment of the deductible and coinsurance applicable to such services is not obtained from or on behalf of some or all of them, in addition to the portion of such charges payable as insurance benefits under this part, even though they have private insurance covering such services (or are otherwise able to pay reasonable charges for all such services as determined in accordance with regulations)".

(2) The first sentence of section 1833(b) of such Act is amended by striking out "and" before "(2)", and by inserting before the period at the end thereof the following: ", and (3) such total amount shall not include expenses in-

curred for services to which clause (C) of subsection (a) (1) applies."

(b) Section 1861 (v) (1) of such Act is amended—

(1) by inserting "(A)" after "(1)";

(2) by striking out "(A) take" and "(B) provide" and inserting in lieu thereof "(i) take" and "(ii) provide", respectively.

(3) by inserting "(B)" immediately preceding "Such regulations in the case of extended care services"; and

(4) by adding at the end thereof the following new subparagraph:

"(C) Where a hospital has an arrangement with a medical school under which the faculty of such school provides services at such hospital and under which reimbursement to such school by such hospital is less than the reasonable cost of such services to the medical school, the reasonable cost of such services to the medical school shall be included in determining the reasonable cost to the hospital of furnishing services 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 if such services were furnished by the hospital, and

"(ii) such hospital pays to the medical school the reasonable cost of such services to the medical school."

(c) (1) The amendments made by subsection (a) shall apply with respect to bills submitted and requests for payment made after the date of the enactment of this Act.

(2) The amendments made by subsection (b) shall be effective with respect to accounting periods beginning after the date of the enactment of this Act.

AUTHORITY OF SECRETARY TO TERMINATE PAYMENTS TO SUPPLIERS OF SERVICES

SEC. 227. (a) Section 1862 of the Social Security Act (as amended by section 201 of this Act) is further amended by adding at the end thereof the following new subsection:

"(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 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, 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 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, posthospital 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."

(b) Section 1866(b) (2) of such Act is amended by striking out the period at the end thereof and inserting in lieu thereof the following: ", 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 sub-

stantially 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."

(c) Section 1903 (g) of such Act (as added by section 224 (b) of this Act) is further amended by striking out "shall not be made" and all that follows and inserting in lieu thereof the following: "shall not be made—

"(1) with respect to any amount paid for items or services furnished under the plan after June 30, 1970, 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 June 30, 1970, 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)."

(d) Section 506(f) of such Act (as added by section 224(c) of this Act) is further amended by striking out "no payment shall be made" and all that follows and inserting in lieu thereof the following: "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 June 30, 1970, 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 June 30, 1970, 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)."

ELIMINATION OF REQUIREMENT THAT STATES MOVE TOWARD COMPREHENSIVE MEDICAID PROGRAMS

SEC. 228. Section 1903 (e) of the Social Security Act, and section 2 (b) of Public Law 91-56 (approved August 9, 1969), are repealed.

DETERMINATION OF REASONABLE COST OF INPATIENT HOSPITAL SERVICES UNDER MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

SEC. 229. (a) Section 1902 (a) (13) (D) of the Social Security Act is amended to read as follows:

"(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards which shall be developed by the State and included in the plan and shall not result in any part of the cost of any such services provided to individuals covered by the plan being borne by individuals not so covered or in any part of the cost of any such services provided to individuals not so covered being borne by the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861 (v) as the reasonable cost of such services for purposes of title XVIII;".

(b) Section 505 (a) (6) of such Act is amended to read as follows:

"(6) provides for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards which shall be developed by the State and included in the plan and shall not result in any part of the cost of any such services provided to individuals covered by the plan being borne by individuals not so covered or in any part of the costs of any such services provided to individuals not so covered being borne by the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861 (v) as the reasonable cost of such services for purposes of title XVIII;".

(c) The amendments made by this section shall be effective July 1, 1971 (or earlier if the State plan so provides).

AMOUNT OF PAYMENTS WHERE CUSTOMARY CHARGES FOR SERVICES FURNISHED ARE LESS THAN REASONABLE COST

SEC. 230. (a) Section 1814 (b) of the Social Security Act is amended to read as follows:

"Amount Paid to Providers

"(b) The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1813, be—

"(1) the lesser of (A) the reasonable cost of such services, as determined under section 1861 (v), or (B) the customary charges with respect to such services; or

"(2) 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 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."

(b) Section 1833 (a) (2) of such Act is amended to read as follows:

"(2) in the case of services described in section 1832 (a) (2)—80 percent of—

"(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)."

(c) Section 1903(g) of such Act (as added by section 224(b) and amended by section 227(c) of this Act) is further amended by striking out the period at the end of paragraph (2) and inserting in lieu thereof "; or", and by adding after paragraph (2) the following new paragraph:

"(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."

(d) Section 506(f) of such Act (as added by section 224(c) and amended by section 227(d) of this Act) is further amended by striking out the period at the end of paragraph (2) and inserting in lieu thereof "; or", and by adding after paragraph (2) the following new paragraph:

"(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."

(e) Clause (2) of the second sentence of section 509 (a) of such Act (as amended by section 221 (c) (3) of this Act) is further amended by inserting "(A)" before "the reasonable cost", and by inserting after "under the project," the following: "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".

(f) The amendments made by subsections (a) and (b) shall apply to services furnished by hospitals and extended care facilities in accounting periods beginning after June 30,

1970, and to services furnished by home health agencies in accounting periods beginning after June 30, 1970. The amendments made by subsections (c), (d), and (e) shall apply with respect to services furnished in calendar quarters beginning after June 30, 1970.

INSTITUTIONAL PLANNING UNDER MEDICARE PROGRAM

SEC. 231. (a) The first sentence of section 1861 (e) of the Social Security Act is amended—

(1) by striking out "and" at the end of paragraph (7);

(2) by redesignating paragraph (8) as paragraph (9); and

(3) by inserting after paragraph (7) the following new paragraph:

"(8) has in effect an overall plan and budget that meets the requirements of subsection (z); and".

(b) Section 1861 (f) (2) of such Act is amended to read as follows:

"(2) satisfies the requirements of paragraphs (3) through (9) of subsection (e);".

(c) Section 1861 (g) (2) of such Act is amended to read as follows:

"(2) satisfies the requirements of paragraphs (3) through (9) of subsection (e);".

(d) The first sentence of section 1861(j) of such Act is amended—

(1) by striking out "and" at the end of paragraph (9);

(2) by redesignating paragraph (10) as paragraph (11); and

(3) by inserting after paragraph (9) the following new paragraph:

"(10) has in effect an overall plan and budget that meets the requirements of subsection (z); and".

(e) Section 1861(o) of such Act is amended—

(1) by striking out "and" at the end of paragraph (4);

(2) by redesignating paragraph (5) as paragraph (6); and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) has in effect an overall plan and budget that meets the requirements of subsection (z); and".

(f) Section 1861 of such Act is further amended by adding at the end thereof the following new subsection:

"Institutional Planning

"(z) An overall plan and budget of a hospital, extended care 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;

"(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."

(g) (1) Section 1814(a) (2) (C) and section 1814

(a) (2) (D) of such Act are each amended by striking out "and (8)" and inserting in lieu thereof "and (9)".

(2) Section 1863 of such Act is amended by striking out "subsections (e) (8), (f) (4), (g) (4), (j) 10), and (o) (5)" and inserting in lieu thereof "subsections (e) (9), (f) (4), (g) (4), (j) (11), and (o) (6)".

(h) Section 1865 of such Act is amended—

(1) by striking out "(except paragraph (6) thereof)" in the first sentence and inserting in lieu thereof "(except paragraphs (6) and (8) thereof)", and

(2) by striking out the second sentence and inserting in lieu thereof the following: "If such Commission, as a condition for accreditation of a hospital, (1) requires a utilization review plan as defined in section 1861 (k) or imposes another requirement which serves substantially the same purpose, or (2) requires institutional plans as defined in section 1861 (z) 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) or 1861 (e) (8), as the case may be."

(i) The amendments made by this section shall apply with respect to any provider of services for fiscal years (of

such provider) beginning after the fifth month following the month in which this Act is enacted.

PAYMENTS TO STATES UNDER MEDICAID PROGRAMS FOR INSTALLATION AND OPERATION OF CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS

SEC. 232. (a) Section 1903 (a) of the Social Security Act is amended by redesignating paragraph (3) as paragraph (4), and by inserting after paragraph (2) the following new paragraph:

"(3) an amount equal to—

"(A) 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such mechanized claims processing and information retrieval systems as the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of title XVIII, including the State's share of the cost of installing such a system to be used jointly in the administration of such State's plan and the plan of any other State approved under this title, and

"(B) 75 per centum of so much of the sums expended during such quarter as are attributable to

the operation of systems of the type described in subparagraph (A) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by the plan of the specific services so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services; plus".

(b) The amendments made by subsection (a) shall apply with respect to expenditures under State plans approved under title XIX of the Social Security Act made after June 30, 1970.

ADVANCE APPROVAL OF EXTENDED CARE AND HOME HEALTH COVERAGE UNDER MEDICARE PROGRAM

SEC. 233. (a) Section 1862 of the Social Security Act (as amended by sections 201 and 227 (a) of this Act) is further amended by adding at the end thereof the following new subsection:

"(e) (1) In any case where post-hospital extended care services or post-hospital home health services are furnished to an individual and—

"(A) a physician provides the certification referred to in subparagraph (C) or (D) of section 1814(a)(2), as the case may be, and the condition of the individual with respect to which such certification is made is a condition designated in regulations,

"(B) such physician (in the case of such extended care services) submitted to the extended care facility which is to provide such services, prior to the admission of such individual to such facility, a plan for the furnishing of such services, or (in the case of such home health services) submitted to the home health agency which is to furnish such services, prior to the first visit to such individual, a plan specifying the type and frequency of the services required, and

"(C) there is compliance with such other requirements and procedures as may be specified in regulations,

the provisions of paragraphs (1) and (9) of subsection (a) shall not apply (except as may be provided in section 1814(a)(7)) for such periods of time, with respect to such conditions of the individual, as may be prescribed in regulations.

"(2) In specifying the conditions included under paragraph (1) and the periods for which paragraphs (1) and (9) of subsection (a) shall not apply, the Secretary shall take into account the medical severity of such conditions,

the period over which such conditions generally require the services specified in subparagraphs (C) and (D) of section 1814(a)(2), the length of stay in an institution generally needed for the treatment of such conditions, and such other factors affecting the type of care to be provided as the Secretary deems pertinent.

"(3) 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 such paragraph."

(b) The amendments made by this section shall be effective with respect to admissions to extended care facilities, and home health plans initiated, on or after January 1, 1971.

PROHIBITION AGAINST REASSIGNMENT OF CLAIMS TO BENEFITS

SEC. 234. (a) Section 1842(b) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

"(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 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."

(b) Section 1902 (a) of such Act is amended—

(1) by striking out "and" at the end of paragraph (29);

(2) by striking out the period at the end of paragraph (30) and inserting in lieu thereof "; and"; and

(3) by inserting after paragraph (30) the following new paragraph:

"(31) 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 phy-

sician, 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."

(c) The amendment made by subsection (a) shall apply with respect to bills submitted and requests for payments made after the date of the enactment of this Act. The amendments made by subsection (b) shall be effective July 1, 1971 (or earlier if the State plan so provides).

UTILIZATION REVIEW REQUIREMENTS FOR HOSPITALS AND SKILLED NURSING HOMES UNDER MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

SEC. 235. (a) (1) Section 1903 (g) of the Social Security Act (as added by section 224 (b) and amended by sections 227 (c) and 230 (c) of this Act) is further amended by striking out the period at the end of paragraph (3) and inserting in lieu thereof "; or", and by adding after paragraph (3) the following new paragraph:

"(4) with respect to any amount expended for care or services furnished under the plan by a hospital or skilled nursing home unless such hospital or skilled nursing home 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 procedures and the same review committee or group) as a condition of payment under this title."

(2) Section 1902(a)(30) of such Act is amended by inserting "(including but not limited to utilization review plans as provided for in section 1903(g)(4))" after "plan" where it first appears.

(b) Section 506(f) of such Act (as added by section 224(c) and amended by sections 227(d) and 230(d) of this Act) is further amended by striking out the period at the end of paragraph (3) and inserting in lieu thereof "; or", and by adding after paragraph (3) the following new paragraph:

"(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."

(c) (1) The amendments made by subsections (a) (1) and (b) shall apply with respect to services furnished in calendar quarters beginning after June 30, 1971.

(2) The amendment made by subsection (a) (2) shall be effective July 1, 1971.

ELIMINATION OF REQUIREMENT THAT COST-SHARING CHARGES IMPOSED ON INDIVIDUALS OTHER THAN CASH RECIPIENTS UNDER MEDICAID BE RELATED TO THEIR INCOME

SEC. 236. (a) Section 1902 (a) (14) of the Social Security Act is amended to read as follows:

"(14) provide that in the case of individuals receiving aid or assistance under State plans approved under titles I, X, XIV, and 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 services furnished him under the plan;".

(b) The amendment made by subsection (a) shall be

effective January 1, 1971 (or earlier if the State plan so provides).

NOTIFICATION OF UNNECESSARY ADMISSION TO A HOSPITAL OR EXTENDED CARE FACILITY UNDER MEDICARE PROGRAM

SEC. 237. (a) Section 1814(a)(7) of the Social Security Act is amended by striking out "as described in section 1861(k)(4)" and inserting in lieu thereof "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".

(b) The amendment made by subsection (a) shall apply with respect to services furnished after the second month following the month in which this Act is enacted.

USE OF STATE HEALTH AGENCY TO PERFORM CERTAIN FUNCTIONS UNDER MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

SEC. 238. (a) Section 1902(a)(9) of the Social Security Act is amended to read as follows:

"(9) provide—

"(A) that the State health agency 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;".

(b) Section 1902(a) of such Act (as amended by section 234(b) of this Act) is further amended—

(1) by striking out "and" at the end of paragraph (30);

(2) by striking out the period at the end of paragraph (31) and inserting in lieu thereof "; and"; and

(3) by inserting after paragraph (31) the following new paragraph:

"(32) provide—

"(A) that the State health 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 health agency, or, if the services of another State or local agency are being utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), such other agency, 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."

(c) Section 505(a) of such Act is amended—

(1) by striking out "and" at the end of paragraph (13);

(2) by striking out the period at the end of paragraph (14) and inserting in lieu thereof "; and"; and

(3) by adding after paragraph (14) the following new paragraph:

"(15) provides—

"(A) that the State health 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 health agency, or, if the services of another State or local agency are being utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), such other agency, will perform the function of determining whether institutions and agencies meet the requirements for participation in the program under the plan under this title."

(d) The amendments made by this section shall be effective July 1, 1971.

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

SEC. 239. (a) Title XVIII of the Social Security Act is amended by adding after section 1875 the following new section:

"PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

"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, with respect to any health maintenance organization, a combined part A and

part B, prospective, per capita rate of payment for services provided for enrollees in such organization who are entitled to hospital insurance benefits under part A and enrolled for medical insurance benefits under part B.

"(2) Such rate of payment shall be determined annually in accordance with regulations, taking into account the health maintenance organization's premiums with respect to its other enrollees (with appropriate actuarial adjustments to reflect the difference in utilization between its members who are under age 65 and its members who are age 65 and over) and such other pertinent factors as the Secretary may prescribe in regulations, and shall be designed to provide payment at a level not to exceed 95 per centum of the amount that the Secretary estimates (with appropriate adjustments to assure actuarial equivalence) would be payable for services covered under this title if such services were to be furnished by other than health maintenance organizations.

"(3) The payments to health maintenance organizations under this subparagraph 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 product of (A) the number of covered enrollees of such organization for such month, and (B) the monthly premium

rate for supplementary medical insurance for such month as has been determined and promulgated under section 1839 (b) (2). The remainder of such payment shall be paid by the former trust fund.

"(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 enrollees on a per capita prepayment basis;

"(2) provides with respect to enrollees to whom this section applies (through institutions, entities, and persons meeting the applicable requirements of section 1861) all of the services and benefits covered under parts A and B of this title;

"(3) provides physicians' services directly through physicians who are either employees or partners of such organization or under an arrangement with an organized group or groups of physicians which is or are reimbursed for services on the basis of an aggregate fixed sum or on a per capita basis;

"(4) 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;

"(5) has enrolled members at least half of whom consist of individuals under age 65;

"(6) has arrangements for assuring 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

"(7) has an open enrollment period at least once every two years, under which it accepts eligible persons (as defined under subsection (d)) without underwriting restrictions and on a first-come first-accepted basis up to the limit of its capacity (unless to do so would result in failure to meet the requirement of paragraph (5)).

"(c) The benefits provided to an individual under this section shall consist of—

"(1) 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

"(2) entitlement to have payment made by such health maintenance organization to him or on his behalf for such emergency services (as defined in regulations) 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.

"(d) Subject to the provisions of subsection (e), every individual who is entitled to hospital insurance benefits under part A and is enrolled for medical insurance benefits under part B shall be eligible to enroll with a 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 de-

scribed in subsection (c), its premium rate for such enrollees shall not exceed the actuarial value of the cost-sharing provisions applicable under part A and part B.

"(2) If the health maintenance organization provides its enrollees under this section with additional services over those described in subsection (c), it shall furnish such enrollees with information as to the division of its premium rate between the portion applicable to such additional services and the portion applicable to the services described in subsection (c), subject to the limitation that the latter portion may not exceed the actuarial value of the cost-sharing provisions applicable under part A and part B."

(b) Section 1866 of such Act is amended by adding at the end thereof the following new subsection:

"(f) For purposes of this section, the term 'provider of services' shall include a health maintenance organization if such organization meets the requirements of section 1876."

(c) Notwithstanding the provisions of section 1833 of the Social Security Act, any health maintenance organization which has entered into an agreement with the Secretary pursuant to section 1866 of such Act shall, for the duration of such agreement, be entitled to reimbursement only as provided in section 1876 of such Act.

(d) The effective date of any agreement with any health

maintenance organization pursuant to section 1866 of such Act shall be specified in such agreement pursuant to regulations.

(e) (1) Section 1814 (a) of such Act is amended by striking out "Except as provided in subsection (d)," and inserting in lieu thereof the following: "Except as provided in subsection (d) or in section 1876,".

(2) Section 1833 (a) of such Act is amended by striking out "Subject to" and inserting in lieu thereof the following: "Except as provided in section 1876, and subject to".

(3) Section 1866 (b) (2) of such Act is amended by inserting after "1861" in clause (B) the following: "(or of section 1876 in the case of a health maintenance organization)".

(f) The amendments made by this section shall be effective with respect to services provided on or after January 1, 1971.

PART C—MISCELLANEOUS AND TECHNICAL PROVISIONS

COVERAGE PRIOR TO APPLICATION FOR MEDICAL ASSISTANCE

SEC. 251. (a) Section 1902 (a) of the Social Security Act (as amended by sections 234 (b) and 238 (b) of this Act) is further amended—

(1) by striking out "and" at the end of paragraph (31);

(2) by striking out the period at the end of paragraph (32) and inserting in lieu thereof "; and"; and

(3) by inserting after paragraph (32) the following new paragraph:

"(33) 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."

(b) The amendments made by subsection (a) shall be effective July 1, 1971.

HOSPITAL ADMISSIONS FOR DENTAL SERVICES UNDER MEDICARE PROGRAM

SEC. 252. (a) Section 1814 (a) (2) of the Social Security Act is amended by striking out "or" at the end of subparagraph (C), by adding "or" after the semicolon at the end of subparagraph (D), and by inserting after subparagraph (D) the following new subparagraph:

"(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;".

(b) Section 1861(r) of such Act is amended by inserting after "or any facial bone" the following: ", or (C) the certification required by section 1814(a)(2)(E) of this Act,".

(c) Section 1862(a)(12) of such Act is amended by inserting before the semicolon the following: ", 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".

(d) The amendments made by this section shall apply with respect to admissions occurring after the second month following the month in which this Act is enacted.

EXEMPTION OF CHRISTIAN SCIENCE SANATORIUMS FROM CERTAIN NURSING HOME REQUIREMENTS UNDER MEDICAID PROGRAMS

SEC. 253. (a) Section 1902(a) of the Social Security Act is amended by adding at the end thereof the following new sentence: "For purposes of paragraphs (26), (28)(B), (D), and (E), and (29), and of section 1903(g)(4), the terms 'skilled nursing home' and 'nursing home' do not include a Christian Science sanatorium operated, or

listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts."

(b) Section 1908(g)(1) of such Act is amended by inserting after "Secretary" the following: ", but does not include a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts".

(c) The amendments made by this section shall be effective on the date of the enactment of this Act.

PHYSICAL THERAPY SERVICES UNDER MEDICARE PROGRAM

SEC. 254. (a)(1) Section 1861(p) of the Social Security Act is amended by adding at the end thereof (after and below paragraph (4)(B)) the following new sentence: "Under regulations, the term 'outpatient physical therapy services' also includes physical therapy services furnished an individual by a physical therapist (in his office or in such individual's home) who meets licensing and other standards prescribed by the Secretary in regulations, otherwise than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health agency, if the furnishing of such services meets such conditions relating to health and safety as the Secretary may find necessary."

(2) Section 1833 of such Act is amended by adding at the end thereof the following new subsection:

"(g) In the case of services described in the next to last sentence of section 1861 (p), with respect to expenses incurred in any calendar year, no more than $100 shall be considered as incurred expenses for purposes of subsections (a) and (b)."

(3) Section 1833 (a) (2) of such Act (as amended by section 230 (b) of this Act) is further amended by striking out the period at the end of subparagraph (B) and inserting in lieu thereof "; or", and by adding after subparagraph (B) the following new subparagraph:

"(C) if such services are services to which the next to last sentence of section 1861 (p) applies, the reasonable charges for such services."

(4) Section 1832 (a) (2) (C) of such Act is amended by striking out "services." and inserting in lieu thereof "services, other than services to which the next to last sentence of section 1861 (p) applies."

(b) (1) Section 1861 (p) of such Act (as amended by subsection (a) (1) of this section) is further amended by adding at the end thereof the following new sentence: "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 extended care facility."

(2) Section 1835 (a) (2) (C) of such Act is amended by striking out "on an outpatient basis".

(c) Section 1861 (v) of such Act (as amended by sections 221 (c) (4) and 223 (f) of this Act) is further amended by redesignating paragraphs (5) and (6) as paragraphs (6) and (7), respectively, and by inserting after paragraph (4) the following new paragraph:

"(5) Where physical therapy services are furnished by a provider of services or other organization specified in the first sentence of section 1861 (p), or by others under an arrangement with such a provider or other organization, the amount included in any payment to such provider or organization under this title as the reasonable cost of such services shall not exceed an amount equal to the salary which would reasonably have been paid for such services to the person performing them if they had been performed in an employment relationship with such provider or organization rather than under such arrangement."

(d) (1) The amendments made by subsections (a) and (b) shall apply with respect to services furnished on or after January 1, 1971.

(2) The amendments made by subsection (c) shall be effective with respect to accounting periods beginning on or after January 1, 1971.

EXTENSION OF GRACE PERIOD FOR TERMINATION OF SUPPLEMENTARY MEDICAL INSURANCE COVERAGE WHERE FAILURE TO PAY PREMIUMS IS DUE TO GOOD CAUSE

SEC. 255. (a) Section 1838(b) of the Social Security Act is amended by striking out "(not in excess of 90 days)" in the third sentence, and by adding at the end thereof the following new sentence: "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."

(b) The amendments made by subsection (a) shall apply with respect to nonpayment of premiums which become due and payable on or after the date of the enactment of this Act or which became payable within the 90-day period immediately preceding such date; and for purposes of such amendments any premium which became due and payable within such 90-day period shall be con-

sidered a premium becoming due and payable on the date of the enactment of this Act.

EXTENSION OF TIME FOR FILING CLAIM FOR SUPPLEMENTARY MEDICAL INSURANCE BENEFITS WHERE DELAY IS DUE TO ADMINISTRATIVE ERROR

SEC. 256. (a) Section 1842(b)(3) of the Social Security Act (as amended by section 224(a) of this Act) is further amended by adding at the end thereof the following new sentence: "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."

(b) The amendment made by subsection (a) shall 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. 257. (a) Section 1837 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(f) In any case where the Secretary finds that an individual's enrollment or nonenrollment in the insurance program established by this part is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Department of Health, Education, and Welfare, 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."

(b) The amendment made by subsection (a) shall be effective as of July 1, 1966.

ELIMINATION OF PROVISIONS PREVENTING ENROLLMENT IN SUPPLEMENTARY MEDICAL INSURANCE PROGRAM MORE THAN THREE YEARS AFTER FIRST OPPORTUNITY

SEC. 258. Section 1837 (b) of the Social Security Act is amended to read as follows:

"(b) No individual may enroll under this part more than twice."

WAIVER OF RECOVERY OF INCORRECT PAYMENTS FROM SURVIVOR WHO IS WITHOUT FAULT UNDER MEDICARE PROGRAM

SEC. 259. (a) Section 1870(c) of the Social Security Act is amended by striking out "and where" and inserting in lieu thereof the following: "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".

(b) The amendment made by subsection (a) shall apply with respect to waiver actions considered after the date of the enactment of this Act.

REQUIREMENT OF MINIMUM AMOUNT OF CLAIM TO ESTABLISH ENTITLEMENT TO HEARING UNDER SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

SEC. 260. (a) Section 1842(b)(3)(C) of the Social Security Act is amended by inserting after "a fair hearing by the carrier" the following: ", in any case where the amount in controversy is $100 or more,".

(b) The amendment made by subsection (a) shall apply with respect to hearings requested (under the procedures established under section 1842(b)(3)(C) of the

Social Security Act) after the date of the enactment of this Act.

COLLECTION OF SUPPLEMENTARY MEDICAL INSURANCE PREMIUMS FROM INDIVIDUALS ENTITLED TO BOTH SOCIAL SECURITY AND RAILROAD RETIREMENT BENEFITS

SEC. 261. (a) Section 1840(a)(1) of the Social Security Act is amended by striking out "subsection (d)" and inserting in lieu thereof "subsections (b)(1) and (c)".

(b) Section 1840(b)(1) of such Act is amended by inserting "(whether or not such individual is also entitled for such month to a monthly insurance benefit under section 202)" after "1937", and by striking out "subsection (d)" and inserting in lieu thereof "subsection (c)".

(c) Section 1840 of such Act is further amended by striking out subsection (c), and by redesignating subsections (d) through (i) as subsections (c) through (h), respectively.

(d)(1) Section 1840(e) of such Act (as so redesignated) is amended by striking out "subsection (d)" and inserting in lieu thereof "subsection (c)".

(2) Section 1840(f) of such Act (as so redesignated) is amended by striking out "subsection (d) or (f)" and inserting in lieu thereof "subsection (c) or (e)".

(3) Section 1840(h) of such Act (as so redesignated)

is amended by striking out "(c), (d), and (e)" and inserting in lieu thereof "(c), and (d)".

(4) Section 1841 (h) of such Act is amended by striking out "1840 (e)" and inserting in lieu thereof "1840 (d)".

(e) Section 1841 of such Act is amended by adding at the end thereof the following new subsection:

"(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 in making deductions 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 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."

(f) The amendments made by this section shall apply with respect to premiums becoming due and payable after the fourth month following the month in which this Act is enacted.

PAYMENT FOR CERTAIN INPATIENT HOSPITAL SERVICES FURNISHED OUTSIDE THE UNITED STATES

SEC. 262. (a) Section 1814 (f) of the Social Security Act is amended to read as follows:

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

"(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 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 in a place within the United States 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)."

(b) Section 1861 (e) of such Act is amended—

(1) by striking out "except for purposes of sections 1814 (d) and 1835 (b)" and inserting in lieu thereof "except for purposes of sections 1814 (d), 1814 (f), and 1835 (b)";

(2) by inserting ", section 1814 (f) (2)," immediately after "For purposes of sections 1814 (d) and 1835 (b) (including determinations of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections)"; and

(3) by inserting after the third sentence the following new sentence: "For purposes of section 1814 (f) (1), such term includes an institution which (i) is a hospital for purposes of section 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."

(c) Section 1862 (a) (4) of such Act is amended by striking out "emergency".

(d) The amendments made by this section shall apply to services furnished with respect to admissions occurring after December 31, 1970.

STUDY OF CHIROPRACTIC COVERAGE

SEC. 263. The Secretary, utilizing the authority conferred by section 1110 of the Social Security Act, shall conduct a study of the coverage of services performed by chiropractors under State plans approved under title XIX of such Act in order to determine whether and to what extent such services should be covered under the supplementary medical insurance program under part B of title XVIII of such Act, giving particular attention to the limitations which should be placed upon any such coverage and upon payment therefor. Such study shall include one or more experimental, pilot, or demonstration projects designed to assist in providing under controlled conditions the information necessary to achieve the objectives of the study. The Secretary shall report the results of such study to the Congress within two years after the date of the enactment of this Act, together with his findings and recommendations based on such study (and on such other information as he may consider relevant

concerning experience with the coverage of chiropractors by public and private plans).

MISCELLANEOUS TECHNICAL AND CLERICAL AMENDMENTS

SEC. 264. (a) Clause (A) of section 1902(a)(26) of the Social Security Act is amended by striking out "evaluation" and inserting in lieu thereof "evaluation)", and by striking out "care)" and inserting in lieu thereof "care".

(b) Section 1908(d) of such Act is amended by striking out "subsection (b)(1)" and inserting in lieu thereof "subsection (c)(1)".

(c) Section 408(f) of such Act is amended by striking out "522(a)" and inserting in lieu thereof "422(a)".

TITLE III—MISCELLANEOUS PROVISIONS

MEANING OF TERM "SECRETARY"

SEC. 301. As used in this Act, and in the provisions of the Social Security Act amended by this Act, the term "Secretary," unless the context otherwise requires, means the Secretary of Health, Education, and Welfare.

Passed the House of Representatives May 21, 1970.

Attest: W. PAT JENNINGS,

Clerk.

91ST CONGRESS
2D SESSION

H. R. 17550

AN ACT

To amend the Social Security Act to provide increases in benefits, to improve computation methods, and to raise the earnings base under the old-age, survivors, and disability insurance system, to make improvements in the medicare, medicaid, and maternal and child health programs with emphasis upon improvements in the operating effectiveness of such programs, and for other purposes.

MAY 27, 1970
Read twice and referred to the Committee on Finance

Commissioner's Bulletin

SOCIAL SECURITY ADMINISTRATION

Number 108 May 22, 1970

1970 SOCIAL SECURITY LEGISLATION

To Administrative, Supervisory,
and Technical Employees

Yesterday the House of Representatives passed H. R. 17550, the "Social Security Amendments of 1970," by a vote of 344 to 32, after adding amendments to provide for the automatic adjustment of benefits, the contribution and benefit base and the retirement test exempt amount. These automatic adjustment provisions had been included in the Administration's proposals for improvements in the social security program, but were not included in the bill reported to the House by the Ways and Means Committee.

Under the automatic-adjustment-of-benefits provision added on the floor of the House, the first possible automatic increase would be for January 1973, based on the increase in the cost of living from the third quarter of 1971 to the third quarter of 1972. (Under the Administration bill, the first possible increase would have been for January 1972, based on the increase in the cost of living from the third quarter of 1970 to the third quarter of 1971.) The first possible automatic increase in the contribution and benefit base would be for 1973. The increase would be determined in 1972, with the increase based on the increase in wages from 1971 to 1972. The first possible increase in the annual exempt amount under the retirement test would be for 1973, with the increase being determined in 1972 based on increases in wages from 1971 to 1972. In adding the provision for automatic adjustment of the retirement test, the House also extended the $1-for-$2 deduction provision so that it would apply to all earnings above $2000.

The rule under which the bill was debated on the floor permitted only Committee amendments. Several such amendments, all minor and limited in scope, were added.

Under the House bill, the actuarial balance of the OASDI program would be within the limits of traditionally acceptable variation from exact actuarial balance, that is, it would have a minus balance of no more than 0.10 percent of taxable payroll. The hospital insurance program would have an actuarial balance of -0.06 percent of taxable payroll.

Robert M. Ball
Commissioner

Statement by the President
on Approval of Proposed Legislation
by the House of Representatives

Yesterday the House of Representatives passed a bill that is a major milestone on the road to reform of the social security system. This is the bill that would tie social security payments to the cost of living and thus protect them from the uncertainties of politics and shifts of the economy once and for all. I want to thank the Members of the House who voted to approve this proposal, which I have been urging since my campaign of 1968.

People receiving social security benefits have been among those hardest hit by a 5-year inflation of their cost of living. This reform would give them the peace of mind that comes from the certainty that the purchasing power of their benefit checks will not be eroded.

The bill passed by the House would provide a 5 percent rise in social security payments beginning the first of next year, financed by the social security system itself. I urge the Senate to approve this legislation, which is both fiscally sound and urgently needed to help the elderly and the disabled and their dependents make ends meet.

May 22, 1970

Calendar No. 1443

91st Congress, 2d Session - - - - - Senate Report No. 91-1431

SOCIAL SECURITY AMENDMENTS OF 1970

REPORT

OF THE

COMMITTEE ON FINANCE

U.S. SENATE

TO ACCOMPANY

H.R. 17550

AN ACT TO AMEND THE SOCIAL SECURITY ACT TO PROVIDE INCREASES IN BENEFITS, TO IMPROVE COMPUTATION METHODS, AND TO RAISE THE EARNINGS BASE UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, TO MAKE IMPROVEMENTS IN THE MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS WITH EMPHASIS UPON IMPROVEMENTS IN THE OPERATING EFFECTIVENESS OF SUCH PROGRAMS, AND FOR OTHER PURPOSES

TOGETHER WITH

SEPARATE, ADDITIONAL VIEWS

DECEMBER 11, 1970.—Ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE

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Note

A detailed table of contents of each of the general areas described above can be found at the beginning of the various parts of this report.

Calendar No. 1443

91ST CONGRESS
2d Session

SENATE

REPORT
No. 91-1431

SOCIAL SECURITY AMENDMENTS OF 1970

DECEMBER 11, 1970.—Ordered to be printed

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

REPORT

together with

SEPARATE, ADDITIONAL VIEWS

[To accompany H.R. 17550]

The Committee on Finance, to which was referred the bill (H.R. 17550) to amend the Social Security Act to provide increases in benefits, to improve computation methods, and to raise the earnings base under the old-age, survivors, and disability insurance system, to make improvements in the medicare, medicaid, and maternal and child health programs with emphasis upon improvements in the operating effectiveness of such programs, 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

The bill (H.R. 17550) as passed by the House of Representatives would increase social security benefits by 5 percent and achieve other reforms of the cash benefits program. It would also make significant changes in the medicare and medicaid programs, generally to emphasize cost consciousness in the operation of these major health programs. Finally, the House bill would restructure the financing provisions of present law to insure the continued solvency of the old-age, survivors, and disability trust fund (the cash benefit program) and to restore a balance in the hospital insurance trust fund (under the medicare program).

The committee bill provides for a 10-percent increase in social security benefits and would increase the minimum benefit to $100 per month. Presently the minimum is $64 per month. It also provides for a new system of peer review of services rendered under the medicare and medicaid programs and establishes a new office of Inspector

General for Health Care Administration to monitor those programs in the interest of efficiency and consistency with Congressional intent. In addition, it provides for a new program of insuring against the costs of catastrophic illness.

The committee bill also modifies various provisions of the House bill and adds several new features to the portions of the bill relating to cash benefits and medicare and medicaid.

The financing features of the House bill would be modified by the committee bill to reflect the additional funds needed to pay for the higher level of benefits recommended by the committee. The solvency of the trust funds is of great concern to the Committee on Finance, just as it was to the Committee on Ways and Means of the House.

In addition to this work, the committee bill adds significant new titles to the House bill. One of these recommends enactment of the Trade Act of 1970, which accomplishes much needed reform in our tariff and trade laws, including provisions for relief for injured industries, firms, and workers.

Another new title added to the bill by the committee authorizes important tests of various welfare and workfare plans prior to enactment by Congress of new departures in welfare reform. These tests relate to the program of Aid to Families with Dependent Children; they do not concern themselves with the programs of aid to the aged, the blind, and the disabled. With respect to these adult categories, the committee bill provides for a nationwide guaranteed minimum income of $130 per month for a single person and $200 per month for a married couple. Important changes are also proposed by this title in the operation of the work incentive program. These changes should help ease the trend to greater and greater dependence on welfare for sustenance by family heads who are able to work but are ill-equipped to obtain jobs today. The committee bill increases the Federal commitment for expansion of child care services, through an increase in Federal matching and the creation of a Federal Child Care Corporation designed to provide an effective delivery system for these much-needed services.

Still another title of the bill provides for substantial increases in pensions to veterans with non-service-connected disabilities. Pension benefits are related to need; as social security payments are increased, the veteran's need for a pension decreases although by a considerably smaller amount than social security goes up. The amendment in this new title would prevent decreases in pensions for virtually all veteran pensioners and widows under the current law.

Finally, the committee bill includes a new title containing tax amendments generally related to programs dealt with by the bill. One calls for reporting to the Internal Revenue Service of health care payments by insurance companies and similar payments under the medicare and medicaid and other Federal health programs. Another upgrades the retirement income credit to reduce the disparity in tax treatment between persons receiving taxable retirement incomes and those receiving tax-free social security or railroad retirement benefits.

All the committee amendments are described more fully in the following parts of this report. The total value of benefits provided by the bill approximate $10 billion in the first full year of operation, making this the largest social insurance bill, in terms of dollars, that Congress has ever acted on.

II. SUMMARY OF PRINCIPAL PROVISIONS OF THE BILL

Summary of Principal Provisions of the Bill

CONTENTS

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

The committee made a number of changes in the provisions of the House-passed bill affecting the social security cash benefit programs. In a number of cases, the committee bill would modify or eliminate provisions of the House bill affecting select groups of beneficiaries; these changes would help make possible a 10-percent across-the-board benefit increase compared with the 5-percent increase in the House bill. Other provisions in the committee bill include a $100 minimum benefit, an increase in the benefits for widows and widowers, an age-62 computation point for men, liberalization of the retirement test, an increase in the maximum benefits payable to a family, a reduction in the waiting period for disability benefits, and other less far-reaching but nonetheless important changes.

Increase in Social Security Benefits

Social security payments to the nearly 26 million beneficiaries on the rolls at the end of January 1971, and to those who come on the rolls after that date, would be increased by 10 percent, with a new minimum benefit of $100. (The House-passed bill would have increased benefits by 5 percent, with a minimum benefit of $67.20.)

The benefit increase would be effective for the month of January 1971, but would not be paid until April, and would mean additional benefit payments of $5.0 billion in the first full year.

Increased Widows' and Widowers' 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 are aimed at providing benefits to a widow equal to the benefits her husband was receiving, or would have received. It was brought to the committee's attention, however, that in some cases the widow, under the House bill, would actually receive a benefit substantially higher than her husband received before his death. Under the House bill, a widow would be entitled to 100% of the amount her deceased husband would receive if he became a beneficiary after reaching age 65. On the other hand, if he actually began receiving benefits before reaching age 65, his bene-

fits would be actuarially reduced. For example, a man eligible for $150 monthly if he retires at age 65 will receive reduced benefits of $135 when he retires 18 months before reaching age 65. Under the House bill, his widow age 65 or older would be eligible for monthly benefits of $150; under the committee bill, she would receive $135, as did her husband. Generally, under the committee bill the widow would receive either 100% of the benefit her husband was actually receiving at the time of his death or, if he was not receiving benefits, 100% of the benefit he would have been eligible for at age 65.

About 2.7 million widows and widowers on the rolls at the end of January 1971 would receive additional benefits, and $649 million in additional benefit payments would be made in the first full year.

Effective date.—January 1, 1971.

Cost-of-Living Increases

The House-passed bill would have provided for cost-of-living increases in benefits and for related increases in the tax base and in the exempt amount under the retirement test which would have subordinated the role of Congress in determining benefit levels. The committee has revised these provisions in order to stress the role of the Congress in setting social security tax and benefit levels. Under the committee bill, social security benefits would rise automatically in the event the cost of living goes up and Congress failed to legislate on social security benefits or taxes. The social security earnings limitation would increase automatically as covered earnings increase. The full cost of these automatic increases would be met equally by increases in tax rates and in the tax base, with the function of determining the base and the rates performed by the Secretary of Health, Education, and Welfare. The committee bill would provide that the automatic benefit increases would not go into effect if in the year before the year in which the increase was to be effective Congress and the President had approved a change in social security benefit levels, or a change in the schedule of social security tax rates, or a change in the social security tax base.

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 and up to age 62 for women. These differences which provide special advantages for women would be eliminated under the committee bill and under the House-passed bill by applying the same rules to men as now apply to women.

The House-passed change would apply immediately to those already on the rolls as well as to those coming on in the future. Under the committee's bill, there would be a gradual transition to the new procedures so that the provision would apply only to those becoming entitled to benefits in the future; the number of years used in determining insured status and in computing benefits for men would be reduced in 3 steps so that men reaching age 62 in 1973, and later, would have only years up to age 62 taken into account in determining insured status and average earnings.

In the first full year, an additional $6 million in benefits would be paid out under this provision. Under the change in benefit eligibility requirements for men, some 2,000 people—workers, their dependents, and survivors not eligible under present law—would be added to the rolls in the first year.

Effective date.—January 1, 1971.

Increase in Maximum Family Benefits

The committee bill provides that families coming on the rolls after a benefit increase is enacted, as well as families already on the rolls at the time the increase is enacted, would be guaranteed the full amount (10 percent under the committee bill) of the current and future general benefit increases. Under the committee bill, maximum family benefits would range from 1.5 to 1.88 times the worker's benefit amount payable at age 65.

Effective date.—January 1, 1971.

Actuarial Reduction for Women

Under present law when a woman applies before age 65 for a retirement benefit based on her own earnings, her benefits are actuarially reduced to take account of the longer period over which benefits will be paid. If she subsequently applies for a wife's benefit after reaching age 65, her wife's benefit is also reduced to reflect the fact that she began to receive benefits before age 65. The House-passed bill would eliminate actuarial reduction in such cases; the committee bill would retain the provisions of present law.

Benefits for Divorced Women

The committee bill retains the provisions of present law which require that in order to qualify for benefits as a divorced wife, divorced widow or a surviving divorced mother a woman must show that: (1) she was receiving at least one-half of her support from her former husband, or (2) she was receiving substantial contributions from her former husband, or (3) there was a court order in effect providing for substantial contributions to her support by her former husband.

The House-passed bill would delete these requirements.

Waiting Period for Disability Benefits

Under present law there is a six-month waiting period before a disabled person is eligible for social security disability insurance benefits. The committee added to the House bill a provision to reduce the waiting period for disability benefits by two months, so that benefits would be payable on the basis of a four-month waiting period, rather than a six-month period.

About 140,000 people—disabled workers and their dependents and disabled widows and widowers—would be able to receive a benefit for January 1971 as a result of this provision. About $185 million in additional benefits would be paid out during the first full year.

Effective date.—January 1, 1971.

Childhood Disability Benefits

The committee bill, like the House bill, would provide childhood disability benefits for the disabled child of an insured retired, deceased, or disabled worker, if his disability began before age 22, rather than before 18 as under present law. The committee added a new provision to permit a person who was entitled to childhood disability benefits to become re-entitled if he again becomes disabled within 7 years after his prior entitlement to such benefits was terminated.

About 13,000 people—disabled children and their mothers—would immediately become eligible for benefits, primarily as a result of extending the age limit to 22. About $13 million in additional benefits would be paid out during the first full year.

Effective date.—January 1, 1971.

Disability Benefits Affected by the Receipt of Workmen's Compensation

The committee deleted the provision in the House bill modifying the workmen's compensation offset provisions to raise the ceiling on income from combined workmen's compensation and disability insurance benefits from 80 percent to 100 percent of the disabled worker's average current earnings before the onset of his disability.

Disability Insurance Benefits for the Blind

The House-passed bill contained a provision which would eliminate the general recency-of-work requirement for people who meet the definition of blindness in the Social Security Act. The committee bill revises the requirements for paying disability insurance benefits to blind people. Under the committee revision, disability insurance benefits would be payable to any blind person (as defined in the law) who has credit for 6 quarters of social security coverage, without regard to his ability to work.

About 225,000 people, blind workers and their dependents, would become immediately eligible for monthly benefits. About $225 million in additional benefits would be paid out during the first full year.

Effective date.—January 1, 1971.

Adoption of Child by Retired or Disabled Worker

The committee broadened the provision of the House-passed bill which would change the provisions of present law relating to the payment of benefits to a child (other than a natural child or a stepchild) who is adopted by a disability insurance beneficiary after the latter becomes entitled to benefits. Under the committee bill, the child, adopted when a disabled or retired worker is entitled to benefits, would be able to get child's benefits based on the worker's earnings 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 1, 1971.

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 as the self-employed members must presently do. The provision 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.

Trust Fund Expenditures for Rehabilitation Services

The committee added to the House bill a provision to authorize an increase in the amount of social security trust fund monies that may be used to pay for the costs of rehabilitating social security disability beneficiaries. The amount would be increased from 1 percent of the previous year's disability benefits to 1¼ percent for fiscal year 1972 and to 1½ percent for fiscal year 1973 and subsequent years.

Underpayments

The committee added a provision to 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 under title II of the Social Security Act.

Wage Credits for Members of the Uniformed Services

Present law provides for noncontributory social security wage credits of up to $100 a month, in addition to credit for basic pay, for military service performed after 1967. The committee bill, like the House bill, would provide that the additional wage credits would be extended to service in the period from 1957 (when military service was first covered under social security) through 1967. In addition, the committee bill would make a change in the way the additional credit is computed from $100 for each month of service to $300 for each quarter of service. The additional wage credits would affect approximately 130,000 beneficiaries immediately; about $35 million in additional benefits would be paid out in the first full year.

Effective date.—January 1, 1971.

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

Special Payments to People Age 72 and Older

Under present law the special payments of $46 a month for an individual and $69 for a couple made to people age 72 and over who have not worked under the program long enough to qualify for regular cash benefits. Under the bill, the payments would be increased by 5 percent to $48.30 a month for an individual and $72.50 for a couple.

The benefit increase would be effective for the month of January 1971 but would not be paid until April.

Reduced Benefits for Widowers at Age 60

The 1965 amendments lowered from 62 to 60 the age of eligibility for widows but left the age of eligibility for dependent widowers at age 62. The bill provides that widowers who have attained age 60 would be eligible for reduced benefits, as widows are under present law.

Effective date.—January 1, 1971.

Liberalization of the Retirement Test

The committee bill, like the House bill, provides an increase from $1,680 to $2,000 in the amount a beneficiary under age 72 may earn in a year and still be paid full social security benefits for the year.

Under present law, each $2 earned between $1,680 and $2,880 results in a $1 reduction in benefits; each dollar earned above $2,880 reduces benefits by $1. The bill would provide for a $1 reduction for each $2 earned with respect to all earnings above $2,000, not just those between $2,000 and $3,200.

For 1971 about 650,000 beneficiaries would receive additional benefits, and about 380,000 persons who would receive no benefits under present law would receive some benefits. Additional benefit payments for the first full year would be about $404 million.

Effective date.—Taxable years ending after 1970.

Disability Insurance Benefits Applications Filed After Death

The committee bill would permit disability insurance benefits (and dependents' benefits based on the worker's entitlement to disability benefits) to be paid to the disabled worker's survivors if an application for benefits is filed within 3 months after the disabled worker's death.

Effective date.—Deaths in and after year of enactment.

Penalty for Furnishing False Information To Obtain a Social Security Number

Under present law, penalties are not provided for individuals who give false information in order to secure multiple social security

numbers with an intent to conceal their true identities. This has led to a number of problems in private industry and in the administration of Government programs. Therefore, the committee bill, like the House bill, would provide criminal penalties if an individual willfully furnishes false information with the intent to deceive the Secretary of Health, Education, and Welfare for the purpose of obtaining more than one social security number or of establishing a social security record under a different name. Upon conviction, an individual shall be fined not more than $1,000, or imprisoned for not more than one year, or both.

Other Cash Benefit Amendments

The committee also deleted the House-passed amendment providing social security coverage for Federal Home Loan Bank employees and adopted amendments relating to widows who remarry, retroactive payments for certain disabled people, temporary employees of the Government of Guam, policemen and firemen in Idaho and policemen in Missouri, certain public hospital employees in New Mexico, registrars of voters in Louisiana, certain U.S. citizens who are self-employed outside the United States and certain part-time and student employees of State and local governments in Nebraska. Other amendments included in the committee's bill relate to the treatment of earnings of self-employed people paying taxes on a fiscal year basis, recomputation of benefits based on combined railroad and social security earnings and payment to a child entitled on the record of more than one worker.

B. Medicare and Medicaid

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

Relationship Between Medicare and Federal Employees Benefits

The committee bill would require that effective January 1, 1972, no payment would be made under medicare for the same services covered under a Federal employees health benefits plan, unless in the meantime, the Secretary of Health, Education, and Welfare certifies that the Federal employees health benefits program has been modified to make available coverage supplementary to medicare benefits and that Federal employees and retirees age 65 and over will continue to have the benefit of a Government contribution toward their health insurance premiums.

Hospital Insurance for the Uninsured

People reaching age 65 who are ineligible for hospital insurance benefits under medicare would be able to enroll, on a voluntary basis, for hospital insurance coverage under the same conditions under which people can enroll under the supplementary medical insurance part of medicare. Enrollment for supplementary medical insurance is also required. Those who enroll would pay the full cost of the protection—estimated at $27 a month at the beginning of the program, and rising as hospital costs rise. States and public organizations, through agreements with the Secretary, would be permitted to purchase such protection on a group basis for their retired (or active) employees age 65 or over.

Limitation on Recognition of Physicians' Fee Increases

Charges determined to be reasonable under the present criteria in the medicare, medicaid, and maternal and child health law would be limited by providing: (*a*) that after enactment of the bill medical charge levels recognized as prevailing may not be increased beyond the 75th percentile of actual charges in a locality during the previous elapsed calendar year; (*b*) that for fiscal year 1972 and thereafter the prevailing charge levels recognized for a locality may be increased, in the aggregate, only to the extent justified by indexes reflecting changes in costs of practice of physicians and in earnings levels; and (*c*) that for medical supplies, equipment, and services that, in the judgment of the Secretary, generally do not vary significantly in quality from one supplier to another, charges allowed as reasonable may not exceed the lower levels at which such supplies, equipment and services are widely available in a locality.

Termination of Payments to Suppliers of Services Who Abuse the Medicare Program

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

Repeal of Medicaid Provision Requiring Expanded Programs

The requirement in present law that States have comprehensive medicaid programs by 1977 would be repealed.

State Determination of Reasonable Hospital Costs

States would be permitted to pay hospitals on the basis of their own determination of reasonable cost, provided there is assurance that the medicaid program would pay the actual cost of hospitalization of medicaid recipients.

Government Payment No Higher Than Charges

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

Federal Matching for Modern Claims Processing Systems

Federal matching at the 90-percent rate would be available under medicaid for the States to set up mechanized claims processing and informational retrieval systems. Federal matching for the continuing operation of such systems would be at the 75-percent rate.

Prohibition of Reassignments

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

Utilization Review in Medicaid

Hospitals and skilled nursing homes participating in the medicaid and maternal and child health programs would be required to have the same type of utilization review committee with the same functions as are required in the medicare program. (Any such committee actually performing such functions for medicare purposes would apply these to medicaid cases.)

Medicaid Deductibles for the Medically Indigent

Present law requires medicaid cost sharing provisions for the medically-indigent to vary directly with the amount of the recipient's income.

This has created an impossible administrative situation for States desiring to apply uniform reasonable copayment requirements (for example, 50 cents or $1 per prescription).

The amendment would permit States to employ reasonable cost-sharing provisions with respect to health services for the medically indigent without requiring variations because of differences in income levels of different medically indigent recipients.

Terminating Payment Where Hospital Admission Not Necessary Under Medicare

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

Role of State Health Agencies in Medicaid

State health or other appropriate State medicaid agencies would be required to perform certain functions under the medicaid and maternal and child health programs relating to the quality of the health care furnished to recipients.

Retroactive Coverage Under Medicaid

States would be required to cover under medicaid the cost of health care provided to an eligible individual during the 3-month period before the month in which he applied for medicaid.

Certification of Hospitalization for Dental Care

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

Christian Science Sanatoriums Under Medicaid

Christian Science sanatoriums would be exempted from the medicaid requirement that they have a licensed nursing home administrator and from other inappropriate skilled nursing home requirements.

Grace Period for Paying Medicare Premium

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

Extension of Time for Filing Medicare Claims

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

Waiver of Enrollment Requirements in Cases of Administrative Error

Where an individual's enrollment rights under part B of medicare have been prejudiced because of inaction or error on the part of the Government, the Secretary would be authorized to provide equitable relief to the individual.

Enrollment Under Medicare

Eligible individuals would be permitted to enroll under medicare's supplementary medical insurance program during any prescribed enrollment period. Beneficiaries would no longer be required to enroll within 3 years following first eligibility or a previous withdrawal from the program. Relief would be provided where administrative error has prejudiced an individual's right to enroll in medicare's supplementary medical insurance program.

Waiver of Medicare Overpayment

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

Medicare Fair Hearings

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

Collection of Medicare Premium by Railroad Retirement Board

Where a person is entitled to both railroad retirement and social security monthly benefits, his premium payment for supplementary medical insurance benefits would be deducted from his Railroad Retirement benefit in all cases.

2. PROVISIONS OF THE HOUSE BILL MODIFIED BY THE COMMITTEE

Limitation on Federal Payment for Disapproved Expenditures

Reimbursement amounts to providers of health services under the medicaid, medicare, and maternal and child health programs for capital costs, such as depreciation and interest, would not be made with respect to large capital expenditures which are inconsistent with State or local health facility plans. The committee added a provision which would require States which apply this provision to establish an appeals mechanism at the State level for purposes of considering adverse decisions.

Experiments and Projects in Prospective Reimbursement and Incentives for Economy

The Secretary of Health, Education, and Welfare would be required to develop experiments and demonstration projects designed to test various methods of making payment to providers of services on a prospective basis under the medicare, medicaid and maternal and child health programs. In addition, the Secretary would be authorized to conduct experiments with methods of payment or reimbursement designed to increase efficiency and economy. The committee added a provision which would allow the Secretary to include in such projects community mental health centers, and ambulatory care facilities.

Limits on Costs Recognized as Reasonable

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

Limitation on Federal Medicaid Matching

The House bill provided for a one-third cutback in Federal medicaid matching after a medicaid patient had received 90 days of care in a skilled nursing home or 90 days in a mental hospital or 60 days in a general hospital in a year. The committee substituted for the House section a provision which would authorize the Secretary of HEW to reduce the matching selectively in those States where he finds inadequate medical audit and utilization review. The cutback in matching would be related to the degree of excessive costs resulting from inadequate review and audit.

Payment for Supervisory Physicians in Teaching Hospitals

The committee modified the provision in the House bill which would provide for payment for services of certain teaching physicians on a cost basis and would make fee-for-service reimbursement contingent on general billing for such services to all patients and collection from those able to pay. Under the committee modification, reimbursement of physician time in the teaching service would be determined on a cost or cost-equivalent basis. Reimbursement for such services would be made on a reasonable-charge basis if the hospital had, in the 2-year period ending in 1967, and subsequently, customarily charged all patients and collected from a majority of patients on a fee-for-service basis, or if a bonafide private patient relationship had been established.

Institutional Planning and Budgeting

Health institutions under the medicare program would be required to have a written plan reflecting an operating budget and a capital expenditure budget. The committee clarified this provision to stipulate that the operating budget would not have to be a detailed item budget.

Modifications in Extended Care and Home Health Benefits

The committee modified the provision of the House bill which would authorize the Secretary of Health, Education, and Welfare to establish presumptive periods of coverage on the basis of a physician's certification for patients admitted to an extended care facility or started on a home health plan. The committee provides that, to the extent feasible, pre-admission review of extended care admissions would be required and unless disapproved, coverage upon admission would continue for the lesser of (1) the initially certified period, (2) until notice of disapproval, or (3) 10 days. Where certifications and evidence were provided on a timely basis, any subsequent determination (for purposes of determining medicare payment liability) that the patient no longer required covered care would be effective 2 days after notification to the facility. The committee provides for a similar approach to the determination of coverage of home health services.

Payments to Health Maintenance Organizations

Medicare beneficiaries could choose to have their care provided by a health maintenance organization (a prepaid group health or other capitation plan). Medicare would contract with such organization, and would reimburse them on a capitation basis at a rate equivalent to 95 percent of the per capita costs of medicare beneficiaries in the area with actuarial adjustments taking into account variations in patient mix. Profits accruing to the organization, beyond their retention rate for non-medicare members would be passed to the medicare enrollees in the form of expanded benefits. The committee substantially tightened the provision so as to define more specifically the quality standards and reimbursement mechanisms which would apply to the organizations as well as including additional safeguards against potential abuse and exploitation.

Physical and Other Therapy Services Under Medicare

The committee removed the provision in the House bill which would authorize reimbursement up to $100 for physical therapy services in a therapist's office.

The committee modified the limitation on reimbursement for institutional therapy services by changing the limitation from a "salary equivalent" to a "salary related" basis, and also extended the limitation to apply to other therapists, dieticians, social workers and medical records librarians for their services provided in an institutional setting.

Medicare Benefits for People Living Near U.S. Border

The House bill provides that medicare beneficiaries living in the border areas of the United States would be entitled to covered inpatient hospital care if the hospital they use is closer to their residence than a comparable U.S. hospital and if it has been accredited by a hospital approval program with standards comparable to medicare standards. The committee added to the House bill a provision extending coverage in these cases to physicians' and ambulance services furnished in conjunction with covered foreign hospital care.

3. NEW PROVISIONS ADDED BY THE COMMITTEE

Professional Standards Review Organizations

The committee provided for the establishment of Professional Standards Review Organizations formed by organizations representing substantial numbers of practicing physicians in local areas to assume responsibility for comprehensive and ongoing review of services provided in the medicare and medicaid programs. The purpose of the amendment is to assure proper utilization of care and services provided in medicare and medicaid through a formal professional mechanism representing the broadest possible cross-section of 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 and carrying out of the vitally important review activities in the two highly-expensive programs. The amendment provides for the use by the PSRO of effective utilization review committees in hospitals and medical organizations.

Conform Medicare and Medicaid Standards for Nursing Facilities

The committee added to the House bill a provision which would require that health, safety, environmental, and staffing standards for extended care facilities be uniform with those established for skilled nursing homes under medicaid.

Inspector General for Health Administration

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 programs on a continuing and comprehensive basis to determine their efficiency, economy, and consonance with the law.

Proficiency Evaluation of Otherwise Disqualified Health Care Personnel

The committee bill would require the Secretary of Health, Education, and Welfare to develop and employ proficiency examinations to determine whether health care personnel, not otherwise meeting spe-

cific formal criteria now included in medicare regulations, have sufficient training, experience, and professional competence to be considered qualified personnel for purposes of the medicare program.

Penalty for Fraudulent Acts Under the Medicare and Medicaid Programs

The committee added to the House bill a provision which would broaden the present penalty provisions relating to the making of a false statement or representation of a material fact in any application for medicare payments, to include the soliciting, offering, or acceptance of kickbacks or bribes, including the rebating of a portion of a fee or a charge for a patient referral, by providers of health care services. The penalty for such acts, as well as the acts currently subject to penalty under medicare, would be imprisonment up to one year, a fine of $10,000, or both. In addition, the committee bill provides that similar penalty provisions apply under medicaid.

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

Inclusion of American Samoa and the Trust Territory of the Pacific Islands Under Title V

The committee bill would include the Trust Territory of the Pacific Islands and American Samoa as eligible to receive funds under the maternal and child health and crippled children programs (title V).

Provide for Reasonable Approval of Rural Hospitals

The committee added to the House bill a provision which would authorize the Secretary of Health, Education, and Welfare to waive, on an annual basis, the requirement that an access hospital have registered professional nurses on duty around the clock, but only if he finds that the hospital: (a) has made, and is continuing to make, a bona fide effort to comply with the nursing staff requirement but is unable to employ the qualified personnel necessary because of nursing personnel shortages in the area and has an RN on the daytime shift; (b) is located in a geographical area in which hospital facilities are in short supply; and (c) nonparticipation of the "access" hospital would seriously reduce the availability of hospital services to beneficiaries residing in the area. The waiver authority would expire December 31, 1975.

Consultants for Extended Care Facilities

The committee added to the House bill a provision to authorize State agencies to provide consultative services to those extended

care facilities which request them in such specialty areas as maintenance of medical records and the formulation of policies governing the provision of dietary and social services. Medicare payment would be made directly to the State agency for the costs incurred in rendering these consultative services. The provision of such services by the State would satisfy the medicare requirements relating to the use of consultants in the appropriate specialty areas.

Public Access to Records Concerning Institutions' Qualifications

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 (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 if, after a reasonable lapse of time (not to exceed 90 days), such deficiencies were not corrected.

Simplified Reimbursement of Extended Care Facilities

The committee provision would authorize the Secretary of Health, Education, and Welfare to adopt (and adjust as specified), as reasonable-cost payments for extended care facilities in any State, the rates developed in that State under medicaid for reimbursement of skilled nursing care, if the Secretary finds that they are based upon reasonable analyses of costs of care in comparable facilities.

Authority for Establishing Liens To Permit Recovery of Overpayments

The committee added a provision to the House bill to facilitate the recoupment of overpayments to providers of services by authorizing the Secretary of Health, Education, and Welfare, when he determines it to be necessary for purposes of recovering an overpayment to a provider, to establish a lien in favor of the Government in the amount of the overpayment, preserving in the course of such action the right of the provider to contest the amount of the overpayment and to seek release of the lien to clear title.

Direct Laboratory Billing

The committee bill would authorize direct payment to laboratories for diagnostic tests at a negotiated rate provided that such rate does not exceed the amount which is payable under present law.

Refunding of Excess Medicare Premiums

The committee bill would authorize the refunding of excess medicare premiums paid prior to a beneficiary's death.

Waiver of Recovery of Erroneous Payment

The committee provision would limit medicare's right of recovery of an erroneous payment to a three-year period from the date of the payment, where the institution or person involved acted in good faith. Similarly, the Secretary of H.E.W. would specify a reasonable period of time (not to exceed 3 years) after which medicare would not be required to accept claims for underpayment or nonpayment.

Provider Reimbursement Appeals Board

The committee amendment would establish an appeals board to hear appeals on reimbursement decisions made by intermediaries, under certain conditions, and where the amount at issue was $10,000 or more.

Prosthetic Lenses Furnished by Optometrists

The committee amended the definition of physician in medicare to include a licensed doctor of optometry, but only with respect to establishing the medical necessity of prosthetic lenses.

Chiropractors

The committee amendment would delete the study of chiropractic services called for in the House bill and would substitute a provision which would provide for the coverage under medicare of services involving manipulation of the spine by licensed chiropractors, if the chiropractor meets certain minimum standards established by the Secretary of Health, Education, and Welfare. The same limitations on chiropractic services would also be applicable to States providing such care under medicaid.

Colostomy Supplies

The committee provided for the inclusion of materials directly related to the care of colostomies as a reimbursable expense under medicare.

Section 1902(d)

The committee added a provision to the House bill which would repeal section 1902(d) which requires States to maintain their level of fiscal expenditures from year-to-year in their medicaid programs.

Separately, the committee also provided that the 1902(d) maintenance of fiscal effort provision would not apply to Missouri effective for the year beginning July 1, 1970.

Increase in Maximum Federal Medicaid Matching for Puerto Rico

The $20 million ceiling on Federal medicaid matching for Puerto Rico would be raised to $30 million under the committee provision.

Health Screening of Children

The committee would authorize the Secretary to establish orderly priorities in the implementation of the presently required health care screening for children programs, with initial priority being given to pre-school children.

Relationship Between Medicaid and Comprehensive Health Programs

The committee bill would permit a State to make arrangements with comprehensive health care programs for the delivery of services on a pre-paid basis to medicaid recipients, subject to the approval of the Secretary.

Intermediate Care Facilities

Under the committee amendment, the intermediate care provision would be transferred from title XI to title XIX. An ICF would be required to have at least one full-time licensed practical nurse on its staff, and care in ICF's would be subject to professional audit and utilization review requirements. The mentally retarded receiving active treatment in public institutions meeting appropriate standards established by H.E.W. would be eligible for Federal matching funds.

Termination of Nursing Home Administrators Advisory Council

The committee would terminate the Advisory Council on December 31, 1970. Under present law the council would be terminated December 31, 1971.

Coverage of Mentally Ill Children Under Medicaid

The committee bill would authorize coverage of inpatient care in State and local mental institutions for medicaid recipients under age 21, provided that the care consists of active treatment, that it is provided in an accredited institution, and that the State maintain its own level of fiscal expenditure for care of the mentally ill under 21.

Definition of "Physician" in Medicaid

The committee bill would define "physician" in title XIX to mean a doctor of medicine or a doctor of osteopathy.

75 Percent Medicaid Matching Funds for Professional Medical Personnel

The present 75 percent Federal medicaid matching rate for professional medical personnel in State agencies would be expanded to also include such personnel who, on a contract or similar basis, undertake independent professional and medical audits of medicaid patients.

C. Catastrophic Health Insurance Program

The committee added to the House bill an amendment which would establish a program of catastrophic health insurance under the Social Security Act for all persons under age 65 who are insured under social security, their spouses and dependent children, as well as all persons under age 65 who are entitled to retirement, survivors, or disability benefits under title II of the act. The health services to be covered, and the applicable exclusions, are the same as under the medicare program, except that there would be no upper limit on covered hospital or extended care days or home health visits. Under the catastrophic health insurance program, benefits would be payable toward the costs of inpatient hospital services and post-hospital extended care services above an annual deductible of 60 days of inpatient hospital care for each individual, subject to a daily coinsurance amount. The program would also cover 80 percent of reasonable costs incurred for home health care and hospital outpatient services, and 80 percent of reasonable charges incurred for other covered medical services above an annual deductible amount which would initially be set at $2,000 per family and which would rise in accordance with any increases in the physicians' services component of the Consumer Price Index. The program could be administered through regular medicare administrative procedures and subject to all utilization, cost, quality and administrative controls applicable under that program. Coverage under the program would be effective beginning January 1, 1972, and the financing provisions necessary to pay for the additional benefits would become effective at the same time.

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D. Financing of Social Security Trust Funds

In order to pay for the additional costs of the social security changes proposed in the committee bill, including the new catastrophic illness insurance and the existing actuarial deficit in the hospital insurance program, the social security tax base would be increased from $7,800 a year to $9,000 a year, starting January 1, 1971, as in the House-passed bill.

In addition, a new schedule of taxes would be provided. Like the schedule of taxes proposed in the House bill, the committee bill would decrease the taxes paid under the cash benefits program over the next few years, and increase the taxes paid under the hospital insurance program. Also, the committee bill provides an additional tax of 0.3 percent in 1972, rising to 0.4 percent in 1980 to pay for the catastrophic illness insurance provided in the bill.

The following table compares the tax rates and the maximum taxes under present law under the House-passed bill and under the committee bill:

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

Year	Employees and employers, each					Self-employed				
	OASDI (percent)	HI (percent)	CI (percent)	Total (percent)	Maximum tax	OASDI (percent)	HI (percent)	CI (percent)	Total (percent)	Maximum tax
Present law: [1]										
1970	4.2	0.6	----	4.8	$374.40	6.3	0.6	----	6.9	$538.20
1971–72	4.6	0.6	----	5.2	405.60	6.9	0.6	----	7.5	585.00
1973–75	5.0	0.65	----	5.65	440.70	7.0	0.65	----	7.65	596.70
1976–79	5.0	0.7	----	5.7	444.60	7.0	0.7	----	7.7	600.60
1980–86	5.0	0.8	----	5.8	452.40	7.0	0.8	----	7.8	608.40
1987 and after	5.0	0.9	----	5.9	460.20	7.0	0.9	----	7.9	616.20
House bill: [2]										
1970	4.2	0.6	----	4.8	374.40	6.3	0.6	----	6.9	538.20
1971–74	4.2	1.0	----	5.2	468.00	6.3	1.0	----	7.3	657.00
1975–79	5.0	1.0	----	6.0	540.00	7.0	1.0	----	8.0	720.00
1980 and after	5.5	1.0	----	6.5	585.00	7.0	1.0	----	8.0	720.00
Senate Finance Committee bill: [2]										
1971	4.4	0.8	----	5.2	468.00	6.6	0.8	----	7.4	666.00
1972	4.4	0.8	0.3	5.5	495.00	6.6	0.8	0.3	7.7	693.00
1973–74	4.4	0.9	0.3	5.6	504.00	6.6	0.9	0.3	7.8	702.00
1975–79	5.0	1.0	0.35	6.35	571.50	7.0	1.0	0.35	8.35	751.50
1980–85	5.5	1.1	0.4	7.0	630.00	7.0	1.1	0.4	8.5	765.00
1986 and after	6.1	1.1	0.4	7.6	684.00	7.0	1.1	0.4	8.5	765.00

[1] Tax rates apply to annual earnings up to $7,800.

[2] Assumes tax rates apply to annual earnings up to $9,000 after 1970.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—H.R. 17550 AS REPORTED BY SENATE FINANCE COMMITTEE

1ST-YEAR BENEFIT COSTS AND NUMBER OF PERSONS AFFECTED UNDER THE BILL AS PASSED BY THE HOUSE OF REPRESENTATIVES AND AS REPORTED BY THE SENATE FINANCE COMMITTEE

Provision	1st-year benefit costs[1] (millions)		Present law beneficiaries immediately affected[2] (thousands)		Newly eligible persons[3] (thousands)	
	House bill	Senate Finance Committee bill	House bill	Senate Finance Committee bill	House bill	Senate Finance Committee bill
Total	$3,970	$6,535	(4)	(4)	$504	$624
General benefit increase	1,729	5,003	$26,300	$26,300	6	6
Modified retirement test	404	404	650	650	380	380
Age 62 computation point	1,040	6	10,200	----	60	----
Increased benefits for widows and widowers	689	649	3,300	2,700	----	----
Shorten disability waiting period to 4 months	(5)	185	(5)	140	(5)	----
Noncontributory credits for military service after 1956	35	35	130	130	----	----
Children disabled at ages 18 to 21	11	13	----	----	13	13
Liberalized provisions for blind workers	25	240	----	----	30	225
Election to receive larger future benefits by certain beneficiaries eligible for more than 1 actuarially reduced benefit	17	(5)	100	(5)	----	(5)
Liberalized workmen's compensation offset	7	(5)	55	(5)	5	(5)
Eliminate support requirement for divorced wives and surviving divorced wives	13	(5)	----	(5)	10	(5)

[1] Represents additional benefit payments in fiscal year 1972.
[2] Present law beneficiaries whose benefit for the effective month would be increased under the provision.
[3] 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.
[4] Figures not additive because a beneficiary may be affected by more than 1 provision.
[5] Provision not included.

E. Trade Act of 1970

Purposes

The committee's trade amendment (Title III of this bill) is derived, with changes, from H.R. 18970 which passed the House of Representatives on November 19, 1970.

In brief, the general purposes of the Committee's trade amendment are:

(1) To provide to the President limited tariff-reducing authority for compensatory purposes until July 1, 1975;

(2) To strengthen our unfair trade practice statutes and thus enable industry and workers who are adversely affected by unfair foreign trade practices to receive a fair opportunity for relief;

(3) To revise the adjustment assistance and tariff adjustment procedures and criteria in the Trade Expansion Act of 1962, and provide a fair opportunity for injured industries, firms, and workers to receive adequate and prompt relief;

(4) To establish import quotas on textiles and footwear, unless: (a) the President finds them not to be in the national interest or (b) voluntary agreements limiting such imports are consummated with foreign governments, or (c) the President finds that imports do not disrupt the U.S. market;

(5) To revise the national security provisions of the Trade Expansion Act to preclude the use of duties or tariffs whenever the President has determined that imports of a particular product or material are threatening to impair the national security;

(6) To strengthen the independent status of the U.S. Tariff Commission; and

(7) To make various other changes in our tariff and trade laws which will streamline the procedures dealing with specific import or export problems.

Trade Agreement Authority

The President's trade agreement authority under the Trade Expansion Act of 1962 terminated at the close of June 30, 1967. The President has been without such authority since that time and in his trade message to the Congress, of November 18, 1969, he requested renewal of the authority, including new authority to reduce duties.

The committee amendment would extend the President's authority to enter into new trade agreements under the Trade Expansion Act of 1962 to July 1, 1975. The President is given new authority to reduce duties by 20 percent, or 2 percentage points, below the rates of duty which will exist when the final stage of the Kennedy Round reduction

becomes effective on January 1, 1972. The committee amendment would limit the President's authority to enter into and carry out new trade agreements to those situations in which compensatory concessions are necessary to offset the effects of an increase in U.S. duties or imposition of other restrictions by the U.S. Government on the products of a foreign country which were bound under a trade agreement. Should reductions in duty under the new authority be agreed to prior to the final stages of the Kennedy Round, the remaining stages of Kennedy Round reductions and the new reductions agreed to are to be aggregated and made effective in at least two stages.

Other Presidential Authority

Concern has been expressed about the barriers to trade which have developed despite the Kennedy Round of trade negotiation. In 1962, the Committee on Finance added section 252 to the Trade Expansion Act to provide new authority and direction to the President to act against import restrictions or other acts of foreign countries which unjustifiably or unreasonably burden or discriminate against U.S. commerce. The Trade Act of 1970 broadens the President's authority to deal with foreign trade barriers and streamlines the procedures for handling specific complaints.

The Trade Act of 1970 also amends the President's authority to safeguard the national security by providing that any adjustment of imports under the national security authority shall not be accomplished by the imposition or increase of any duty or of any fee or charge having the effect of a duty. In addition, time limitations are imposed on the Director of the Office of Emergency Preparedness in making determinations on applications for action under the national security provision.

Tariff Adjustment and Adjustment Assistance

The need for making less rigid the criteria for determining serious injury from increased imports is met in title III both for tariff adjustment for industries and adjustment assistance in the case of firms or groups of workers.

Tariff Adjustment.—In present law, the criteria for determining serious injury are the same for tariff adjustment for industries and for adjustment assistance for firms and workers. The committee agrees with the House and the Administration that the present criteria are too stringent. Under the new provisions, the Tariff Commission, in the case of tariff adjustment, or the President, in the case of adjustment assistance, is to determine whether increased imports "*contribute substantially*" toward causing or threatening to cause serious injury. In the case of tariff adjustment, the committee provided that increased imports must be related in whole or in part to the duty or other customs treatment reflecting tariff concessions agreed to by the United States.

If serious injury is found to an industry, those Commissioners finding injury are to make an additional determination under the new provision. This additional determination will be in the affirmative if the Commission finds that imports of the article are: (1)

acutely or severely injuring a domestic industry or (2) threatening to acutely or severely injure a domestic industry.

A majority of the Commissioners present and voting is to be required for an affirmative injury determination and a majority of those Commissioners finding injury under the criteria provided must determine the type of import restriction required to remedy the injury.

When the Commission finds and reports to the President an affirmative injury determination, the President is required to take such action as he deems necessary to prevent or remedy the injury so found unless he determines that such action is not in the national interest. In the case of an additional affirmative determination by the Commission on the question of acute or severe injury, the President is required to impose the import restrictions found by the Commission to be necessary to prevent or remedy the acute or severe injury unless he determines that such action would not be in the national interest. As is presently provided, if the President does not make effective the remedy determined by the Tariff Commission, he must report to the Congress within 60 days of the receipt of the Tariff Commission's report and findings. In such case, the existing provisions of law with respect to Congressional implementation of the Tariff Commission finding as to the action necessary to prevent or remedy the injury would continue to apply.

Section 352 of the Trade Expansion Act with regard to orderly marketing agreements is amended to provide that the President may, at any time, negotiate such agreements on articles subject to tariff adjustment or upon which he has received an affirmative injury determination.

New review procedures on pending tariff adjustment action are provided. In any report by the Tariff Commission reviewing such tariff adjustment actions, it must include information on steps taken by firms in the industry to compete more effectively with imports. In addition, in any review of tariff adjustment actions by the Tariff Commission, as a result of which the President may determine to extend, in whole or in part, or terminate such action, the Commission will be required to determine whether the existing restrictions on imports are sufficient to prevent or remedy injury to the domestic industry.

Adjustment Assistance.—The Trade Act of 1970 also revises the procedures for petitions by firms or groups of workers to provide that petitions by firms or groups of workers are to be made to the President rather than the Tariff Commission. The Tariff Commission will continue to provide the President with a factual report to assist the President in making his determination as to eligibility of firms and groups of workers to apply for adjustment assistance.

The amendment provides increased trade adjustment allowances payable to adversely affected workers. Under existing law, the allowance is 65 percent of the worker's average weekly wage or 65 percent of the average weekly manufacturing wage, whichever is lower. The amendment increases each of these percentages to 75 percent.

The amendment provides that if the President does not provide tariff adjustment for an industry after an affirmative injury determination by the Tariff Commission, he is required to provide that the firms and workers in that industry may request certification of eligibility for adjustment assistance.

The Committee also provided the Tariff Commission with a period of 90 days after the date of enactment of this Act to make the necessary changes in its rules and regulations and to so organize its staff to expeditiously process the tariff adjustment and adjustment assistance petitions filed under the provisions of this Act. No new petition may be filed under section 301(a) of the Trade Expansion Act until the Tariff Commission issues new rules and regulations, which must be within 90 days after enactment.

Quotas on Certain Textile and Footwear Articles

We believe that the tariff adjustment amendments described above will be sufficient to deal with competitive situations facing many domestic producers in the economy. However, the effects of rapidly increasing imports on two basic industries are such as to require extraordinary measures. Part B of title III of this bill deals with the extremely serious threat to the textile and apparel industry and to the nonrubber footwear industry.

Under part B of title III, the total quantities of imports of certain textile and footwear articles are to be limited by category and by country beginning in the year 1971. For that year, imports are to be limited to the annual average quantities imported during the three calendar years 1967 through 1969. For the years after 1971, the total quantity of imports of each category of textile articles or footwear articles is to be limited to the quantity determined for the foreign country for the preceding year plus an increase determined by the President. Any such increase is to be limited to a percentage not over 5 percent of the total quantity permitted to be entered in the immediately preceding year as the President determines to be consistent with the purposes of the quota provisions.

The President is authorized to exempt from quotas imports of articles: (1) which he determines are not disrupting the U.S. market, (2) when he determines that the national interest requires such action, or (3) when he finds that the supply of such articles in the domestic market is insufficient to meet demand at reasonable prices.

In addition, the President is authorized to negotiate agreements under which imports of textiles and footwear would be controlled on a voluntary basis. Imports covered by such agreements would also be exempt from quantitative limitations as would imports of cotton textile articles as a result of the existing Long Term Arrangements on Cotton Textiles.

Determinations with respect to the establishment of or change in quantitative limitations or exemptions from such limitations, other than determinations made by the President for national interest reasons, would be subject to the rulemaking provisions of the Administrative Procedure Act.

The quota limitations provided in the bill would terminate on July 1, 1976, unless the President finds that the extension of the quantitative limitations for periods not to exceed 5 years would be in the national interest.

Other Tariff and Trade Provisions

The magnitude and the nature of U.S. foreign trade has changed remarkably over the past decade. Although both imports and exports separately account for about 4 percent of the gross national product, they now exceed $80 billion. The committee is concerned that the rules of competition governing this volume of trade be fair to all concerned. Consequently, the committee has tightened the domestic procedures with respect to such international trade practices as dumping and subsidization of exports. Greater recognition as to the role of the Tariff Commission as an independent agency is emphasized in amendments made to the Tariff Act of 1930. The committee directs the Executive and the Tariff Commission to conduct a series of studies aimed at developing basic principles of free and fair trade, insuring reciprocity for U.S. commerce, and fair international labor standards. Provision is also made for the solution of specific trade problems which cannot be remedied under existing provisions of law.

ANTIDUMPING ACT OF 1921

The Antidumping Act is amended to provide that the Secretary of the Treasury must take initial action within 4 months after the question of dumping has been presented to him. In exceptional cases the Secretary would have an additional 90 day period to reach such a finding, if he published in the Federal Register, within 60 days after the complaint is received, the reasons why additional time is absolutely necessary. Under the committee amendment, this would require the withholding of appraisement within that period should the Secretary of the Treasury have reason to suspect that sales at less than fair value are, or are likely to be, taking place. Should the Secretary of the Treasury's initial action involve a tentative negative determination, the Secretary would be authorized to withhold appraisement within three months after the notice of negative determination has been made if he should reverse his initial negative determination. In addition, the Antidumping Act is amended to provide criteria for a determination of dumping with regard to imports from State controlled economies. The amendment reflects existing Customs practices.

COUNTERVAILING DUTY PROVISION

The countervailing duty provision is amended to require the Secretary of the Treasury to make a determination within 12 months after the question is presented to him as to whether a bounty or grant has been bestowed on imports into the United States.

Under the bill, subsidized duty-free imports are also to be subject to the countervailing duty provisions but only if the Tariff Commission should determine that such subsidized imports are injuring a domestic industry. The countervailing duty provision is also amended to provide the Secretary of the Treasury with discretionary authority with respect to the imposition of a countervailing duty on an article subject to quantitative limitation or subject to agreements under which the volume of exports to the United States is limited. Countervailing duties would be imposed when the Secretary determines that such

limitations are not an adequate substitute for a countervailing duty with respect to the article in question.

TARIFF COMMISSION

In view of the added investigative and statutory burden on the Tariff Commission which will result from this legislation and in view of the concern of the committee to protect the independent nature of the Tariff Commission, the committee provided, in effect, that the Tariff Commission's budget shall be directly appropriated by the Congress (as is the budget of other independent agencies such as the General Accounting Office), and that the Executive shall not have authority to reorganize the Commission. The committee bill also would direct the Tariff Commission to do a number of studies which could lay the groundwork for a fresh approach to U.S. trade problems and agreements.

COMPREHENSIVE STUDIES BY THE PRESIDENT AND TARIFF COMMISSION

There are a number of outstanding problems in the field of international trade which require intensive study. One such problem is the apparent lack of balance and reciprocity in the General Agreement on Tariffs and Trade. The presently constituted GATT agreement contains certain provisions that were written in 1947 when the United States had an overwhelmingly dominant position in world trade. They were designed at that time to put more dollars into the hands of the then war-torn European countries. The international economic positions of Europe, Japan, and the United States have changed so radically since the end of World War II that a new executive agreement incorporating the provisions of commercial reciprocity in all trade and investment matters appears to be desirable. As a first step toward the realization of this goal, the committee's bill authorizes and directs the executive branch and the Tariff Commission to conduct a series of studies dealing with the U.S. position in world trade and the rules under which trading nations can freely and fairly compete in world markets. It would be expected that this series of studies will lead to concrete negotiating proposals to the Congress and ultimately to new agreements and machinery for coping with all trade and investment problems.

FOREIGN TRADE STATISTICS

The committee trade amendment also provides for the collection and publication of U.S. import statistics which will show c.i.f. value and thus include the cost of insurance, freight and other charges associated with c.i.f. value. This is the practice recommended to all countries by the United Nations and the International Monetary Fund for computing balance of trade statistics. Over 100 countries have adopted the so-called *c.i.f.* basis of measuring imports; only the United States and a few other countries use the free on board (f.o.b.) system, under which imports are tabulated on the basis of their value at the foreign port. The committee felt that the c.i.f. system will be more comparable to the method of publishing import statistics used by most other coun-

tries. Moreover, the committee's bill provides that U.S. exports, which are financed directly by Government grants and credits, should be shown separately from other exports on all monthly statistics which are published by the Department of Commerce.

MISCELLANEOUS TRADE PROVISIONS

The committee trade amendment also would provide certain tariff-rate quota controls on imports of glycine and related products and on mink furskins.

The committee also provided a quarterly allocation of meat import quotas and closes a loophole concerning "prepared" fresh, chilled, and frozen beef and veal. The committee amendment does not extend the meat quota provisions to any other products not currently under quota.

The committee amendment also provides that additional invoice information will be required from foreign shippers for the purpose of statistical classification of imports.

The committee amendment also would reduce the rate of duty on parts of ski bindings.

A new provision of law would authorize the President to impose a suspension of trade with a nation which permits the uncontrolled or unregulated production of or trafficking in certain drugs in a manner to permit these drugs to fall into illicit commerce for ultimate disposition and use in this country.

F. Amendments to Public Assistance Programs and Work Incentive Program

1. AID TO THE AGED, BLIND, AND DISABLED

National Minimum Income Standards for the Needy Aged, Blind, and Disabled

The committee bill would establish a national minimum income level for persons who receive cash assistance under federally matched State welfare programs for the needy aged, blind, and disabled. States would be required to provide a level of assistance sufficient to assure persons in these categories a total monthly income from all sources of at least $130 for a single individual or $200 for a couple. In the aged category this provision would result in increased assistance for eligible single aged individuals in about 31 States and for eligible aged couples in about 36 States. Concurrently with establishing these national minimum standards for assistance to the aged, blind, and disabled, the committee bill would make persons receiving such assistance ineligible to participate in the food stamp program. In effect, the bill would give needy persons more cash in lieu of food stamps.

Pass-Along of Social Security Increases to Welfare Recipients

Under other provisions of the bill, social security benefits would be increased by 10 percent, with the minimum basic social security benefit increased to $100 from its present $64 level. If no modification were made in present welfare law, however, many needy aged, blind, and disabled persons would get no benefit from these substantial increases in social security since offsetting reductions would be made in their welfare grants. To assure that such individuals would enjoy at least some benefit from the social security increases, the committee bill requires States to raise their standards of need for those in the aged, blind, and disabled categories by $10 per month for a single individual and $15 per month for a couple. As a result of this provision, recipients of aid to the aged, blind, or disabled, who are also social security beneficiaries, would enjoy an increase in total monthly income of at least $10 ($15 in the case of a couple).

Definitions of Blindness and Disability

The committee bill provides for the establishment of nationally uniform definitions of blindness and disability for purposes of the federally matched programs of assistance to the blind and disabled. The definitions adopted are those already applied in the disability insurance program established under title II of the Social Security Act.

The term "disability" would be defined by the committee bill 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," with further clarification of the meaning of "substantial gainful activity."

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." Also included in this definition would be the particular sight limitation which is referred to as "tunnel vision."

Under present law each State is free to prescribe its own definition of blindness and disability, and the committee bill would permit States to continue assistance to individuals who are now on the rolls under the existing State definition, but who would not be considered blind or disabled under the new Federal definitions.

Prohibition of Liens in the Program of Aid to the Blind

The committee bill would prohibit any State from imposing a lien on a blind individual's property as a condition of his receiving Federally-matched Aid to the Blind welfare payments. Present law leaves the matter of liens up to the discretion of the States.

Fiscal Relief for the States

The committee bill includes a provision which generally would not require States in future years to spend more for assistance to the aged, blind, and disabled than 90 percent of their expenditures for this purpose in calendar year 1970. The 10 percent savings would be paid from Federal funds as would the full amount of any increased expenditures resulting from mandatory provisions of the bill (such as the $10 pass-along of social security increases and the $130 national minimum standard for assistance to the aged, blind, and disabled). Increases in caseloads resulting from normal program growth would also be fully paid for with Federal funds, but increased expenditures resulting from liberalizations in State welfare programs not required by Federal law would not be covered by the 90 percent limitation. Such optional State liberalizations would be financed in accord with the regular Federal-State matching provisions.

2. CHILD CARE

Although present law includes provisions designed to make child care services available to needy families with children, these services are still unavailable to many who need them. The lack of child care is particularly serious for those who wish to participate in work or training programs, or who undertake employment in an effort to become economically independent. The committee bill would promote the development of additional services both by providing for more favorable matching to the States for child care services and by establishing a new mechanism for the delivery of these services, the Federal Child Care Corporation.

Federal Matching Share

The bill provides for an increase from 75 percent to 90 percent in the Federal matching share for child care services provided by the States under title IV part A of the Social Security Act. The Secretary of Health, Education, and Welfare would be authorized to pay 100 percent of the cost of child care for a limited period of time in cases where he determined that necessary care would otherwise be unavailable. The 90 percent matching rate would be available to the States for child care for families receiving Aid to Families with Dependent Children and also for past and potential recipients, if the State has adopted the optional program for these groups. States would be required to maintain their present efforts so that additional Federal funds would result in expanded child care services.

Federal Child Care Corporation

As a mechanism to expand the availability of child care services, the bill would establish a Federal Child Care Corporation. The Corporation would have as its first priority making available child care services to children of parents eligible for such services under the AFDC program and who need them in order to participate in employment or training. However, it would also have the broader function of making child care available for any family which may need it, regardless of welfare status.

The bill provides for $50 million as initial working capital for the Corporation. This amount would be in the form of a loan by the Secretary of the Treasury and would be placed in a revolving fund. The money would be used by the Corporation to begin arranging for child care services. Initially, the Corporation would contract with existing public, private nonprofit, and proprietary facilities to serve as child care providers. To expand services, the Corporation would also give technical assistance and advice to organizations interested in establishing facilities under contract with the Corporation. In addition, the Corporation could provide child care services in its own facilities.

Fees would be charged for all services provided or arranged for by the Corporation. The fees would go into the revolving fund to provide capital for further development of services and to repay the initial loan. They would be set at a level which would cover the costs to the Corporation of arranging child care.

The bill also includes a provision which authorizes the Corporation to issue bonds for construction if, after the first two years of operation, the Corporation 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. Construction is to be undertaken only if child care services cannot be provided in existing 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 Corporation would have to meet the Life Safety Code of the National Fire Protection Association. Any facility in which child care is provided by the Corporation, either di-

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rectly or by contract, would have to meet the Federal standards, but would not be subject to any licensing or other requirements imposed by States or localities.

The Corporation, while providing a mechanism for expanding the availability of child care services, would not provide funds to subsidize child care. Those who are able to pay would be charged the full cost of services. The cost of child care needed by families on welfare would be paid by State welfare agencies.

State welfare agencies would be free to use the services of the Corporation in providing child care to welfare recipients, but would not be required to do so.

The Corporation would also have the authority to conduct programs of in-service training, either directly or by contract.

The bill requires the Corporation to submit a report to each Congress on the activities of the Corporation, including data and information necessary to apprise the Congress of the actions taken to improve the quality of child care services and plans for future improvement.

The Corporation would be headed by a Board of Directors consisting of three members, to be appointed by the President with the consent of the Senate. The members of the Board would hold office for a term of three years.

A National Advisory Council on Child Care would be established to provide advice and recommendations to the Board on matters of general policy and with respect to improvements in the administration of the Corporation. 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 12 individuals, appointed by the Board.

3. IMPROVEMENTS IN THE WORK INCENTIVE PROGRAM

The Work Incentive Program was created by the Congress as a part of the Social Security Amendments of 1967. It represents an attempt to cope with the problem of rapidly growing dependency on welfare by providing welfare recipients with the training and job opportunities needed to help them become financially independent.

Experience under the program has shown that a number of modifications are desirable. The committee's bill is designed to strengthen and improve the program.

On-the-Job Training and Public Service Employment

A major criticism of the present Work Incentive Program has been the lack of development of on-the-job training and public service employment. On-the-job training and public service employment offer the best opportunity for employment of welfare recipients because they provide training in actual job situations. Unfortunately, less than two percent of the welfare recipients enrolled in the Work Incentive Program today are participating in on-the-job training and public service employment. The committee amendment would require that at least 40 percent of the funds spent for the Work Incentive Program be used for on-the-job training and public service employment.

The committee bill would also simplify the financing and increase the Federal share of the cost of public service employment (formerly called special work projects) by providing 100 percent Federal funding for the first year and 90 percent Federal sharing of the costs in subsequent years (if the project was in effect less than three years, Federal sharing for the first year would be cut back to 90 percent).

Tax Incentive for Hiring WIN Participants

As an incentive for employers in the private sector to hire individuals placed in employment through the Work Incentive Program, another feature of the amendment would provide a tax credit equal to 20 percent of the wages and salaries of these individuals. The credit would only apply to wages paid to these employees during their first 12 months of employment, and it would be recaptured if the employer terminated employment of an individual during the first 12 months of his employment or before the end of the following 12 months. This recapture provision would not apply if the employee became disabled or left work voluntarily. (The tax credit is described more fully in Part H of this summary.)

Registration of Welfare Recipients and Referral for Work and Training

Under present law, all "appropriate" welfare recipients must be referred by the welfare agency to the Labor Department for participation in the Work Incentive Program. Certain categories of persons are statutorily considered inappropriate. Persons may volunteer to participate in the Work Incentive Program even if the State welfare agency finds them inappropriate for mandatory referral.

Another criticism of the program has been that the State application of those standards of "appropriateness" for the program have resulted in widely differing rates of referrals and program participation. The committee's bill would eliminate this situation with a series of amendments. First, it would require welfare recipients to register with the Labor Department as a condition of welfare eligibility unless they fit within one of the following categories:

1. Children who are under age 16 or attending school;
2. Persons who are ill, incapacitated or of advanced age;
3. Persons so remote from a WIN project that their effective participation is precluded;
4. Persons whose presence in the home is required because of illness or incapacity of another member of the household; and
5. Mothers with children of preschool age.

At least 15 percent of the registrants in each State would be required to be prepared by the welfare agency for training and referred to the Work Incentive Program each year; States failing to meet this percentage would be subject to a decrease in Federal matching funds for aid to families with dependent children. The committee bill would also establish clear statutory direction in determining which individuals would receive employment or training by generally requiring the Departments of Labor and Health, Education, and Welfare to accord

priority in the following order, taking into account employability potential:

1. Unemployed fathers;
2. Dependent children and relatives age 16 or over who are not in school, working or in training;
3. Mothers who volunteer for participation; and
4. All other persons.

Thus, under the amendment, mothers would not be required to participate until every person who volunteered was first placed.

Liberalized Federal Matching for Training

The committee bill increases from 80 percent to 90 percent the rate of Federal matching for WIN training expenditures. Welfare agency expenditures for social, vocational rehabilitation, and medical services which are provided to directly support an individual's participation in WIN would also be matched at the 90 percent rate. Under existing law, these services are now generally matched by the Federal Government at the 75 percent rate.

Labor Market Planning and Program Coordination

The committee bill would require the Secretary of Labor to establish local labor market advisory councils whose function would be to identify present and future local labor market needs. The findings of these councils would have to serve as the basis for local training plans under the Work Incentive Program to assure that training was related to actual labor market demands.

The committee also mandates coordination between the Departments of Labor and Health, Education, and Welfare and their counterparts at the local level. The committee bill would require a separate WIN unit in local welfare agencies and joint participation by welfare and manpower agencies in preparing employability plans for WIN participants and in program planning generally.

Earned Income Disregard

Under present law States are required, in determining need for Aid to Families with Dependent Children, to disregard the first $30 monthly earned 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.

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.

4. FAMILY PLANNING SERVICES

Under present law, family planning services must be offered all appropriate welfare recipients; 75 percent Federal matching is available in meeting the cost of family planning services. The committee bill would provide 100 percent Federal funding for family planning services offered recipients of Aid to Families with Dependent Children. In addition, there would be 100 percent Federal funding, at the State's option, for those who were once welfare recipients or who are likely to become welfare recipients.

5. EMERGENCY ASSISTANCE FOR MIGRANT FAMILIES

The bill would require the States to establish State-wide programs to provide emergency assistance to needy migrant families with children. The Federal matching rate would be 75 percent. Under present law the establishment of programs for migrant families is optional with the States, and the Federal share is 50 percent. As under the existing program, assistance could be in the form of money payments or payments in kind. Assistance would be limited to a period not to exceed 30 days in any 12-month period.

6. OBLIGATION OF A DESERTING FATHER

Present law requires that the State welfare agency 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 Internal Revenue Service records in locating deserting parents.

The committee added to these provisions an amendment which would make it a Federal misdemeanor for a father to cross State lines in order to avoid his family responsibilities.

In addition, the committee bill also provides that an individual who has deserted or abandoned his spouse, child, or children shall owe a monetary obligation to the United States equal to the Federal share of any welfare payments made to the spouse or child during the period of desertion or abandonment. In those cases where a court has issued an order for the support and maintenance of the deserted spouse or children, the obligations of the deserting parent would be limited to the amount specified by the court order. If the State has obtained a court order, the Federal Government would attempt to recover both the Federal and non-Federal share of welfare payments to the deserting father's family. If the State has not obtained a court order, the

Federal Government would only attempt to recover the Federal share of the welfare payments. The deserting parent's obligation could be collected in the same manner as any other obligation against the United States.

The bill also would authorize Federal officials knowing the whereabouts of a deserting parent to furnish this information to such parent's spouse (or to the guardian of his child) in cases in which a court order for child support has been issued against him.

7. CLARIFICATION OF CONGRESSIONAL INTENT REGARDING WELFARE STATUTES

Denial of Eligibility for Aid to Families with Dependent Children Where There Is a Continuing Parent-Child Relationship

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. In a recently decided opinion, the Supreme Court ruled that a State could not consider a child ineligible for welfare when there was a substitute parent with no legal obligation to support the child. The Court 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 committee bill would clarify Congressional intent by permitting States to take into account the presence of a man in the house if there exists between the man and the dependent child a continuing parent-child relationship. For purposes of determining whether such relationship exists between a child and an adult individual, only the following factors could be taken into account:

(1) They 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.

A child-parent relationship could be determined to exist only on the basis of an evaluation of these factors taken together with any evidence which may refute any inference related to these factors.

Duration of Residence Requirement

The committee bill requires States to impose a one-year duration of residence requirement in determining eligibility for welfare. However, Federal matching would not be denied solely because a State failed to meet this requirement. If a welfare recipient moved to a State with a one-year duration of residence requirement, his State of origin would be required to continue his welfare payments (as long as he remained eligible) for up to 12 months, by which time the individual could establish eligibility for welfare in his new State of residence.

Limitation on Duration of Welfare Appeals Process

Recently the Supreme Court ruled that assistance payments could not be terminated before a recipient is afforded an evidentiary hearing. The committee bill would require that States reach decisions on an individual appeal within 30 days. The committee bill also requires the repayment of amounts which it is determined a recipient was not entitled to receive. Any amounts not repaid could be considered an obligation of the recipient to be withheld from any future assistance payments to which the individual may be entitled.

States Permitted to Seek to Establish Name of Putative Father

A recent court decision held 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 (AFDC). 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 Court reached this conclusion despite the explicit requirement in Federal law that States attempt to establish paternity when a child is born out of wedlock.

The committee's bill would clarify congressional intent by specifying that the requirement that welfare be furnished "promptly" may not preclude a State from seeking the aid of a mother in identifying the father of a child born out of wedlock.

Requiring Welfare Recipient to Permit Caseworker in the Home

The committee amendment permits States, if they wish, to require as a condition of welfare eligibility that recipients allow a caseworker to visit the home. Home visits would have to be made at a reasonable time and with reasonable advance notice.

8. REGULATIONS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

The committee bill would curb the regulatory authority of the Department of Health, Education, and Welfare in several particulars.

"Declaration Method" of Determining Eligibility Permitted But Not Required

The Committee bill would preclude the Secretary of Health, Education, and Welfare from requiring by regulation that States use a simplified declaration method in determining eligibility for welfare. As under present law, States would be free to use this method if they so wished, but they could not be required to do so by regulation.

Definition of Unemployment

Under present law, Aid to Families with Dependent Children may be paid to a family headed by an unemployed father, at the option of the State (23 States now offer such assistance). However, there is no Federal definition of "unemployment" in the statute. The committee approved an amendment defining a father as unemployed for welfare purposes if he has worked less than 10 hours in the last week or less than 80 hours in the last 30 days.

9. USE OF FEDERAL FUNDS TO UNDERMINE FEDERAL PROGRAMS

The committee added a section to the general provisions of the Social Security Act specifying that no Federal funds may be used to pay, directly or indirectly, the compensation of any individual who in any way participates in Federally supported legal action designed to nullify congressional statutes or policy under the Social Security Act.

10. USE OF SOCIAL SECURITY NUMBERS

The committee bill requires that on and after January 1, 1972, State welfare agencies use the social security number of each welfare recipient as an identification number in the administration of public assistance programs.

11. TESTING OF WELFARE REFORM ALTERNATIVES

The committee bill provides for a broad program of testing of various approaches to reform of the welfare system. The Secretary of Health, Education, and Welfare would be authorized to conduct up to four tests of possible alternatives to the AFDC program. One or two of these tests would involve "family assistance" type programs, and one or two of the tests would involve "workfare" programs. In addition, the bill provides for a pilot project of a program of rehabilitation of welfare recipients to be administered by vocational rehabilitation personnel.

The "family assistance" tests would follow the traditional welfare approach of providing money payments to families with incomes below certain levels, but would extend this assistance to all families with fathers including the so-called "working poor"—low-income families headed by a fully employed male—who are not eligible for AFDC. As under AFDC, a portion of earnings would be disregarded to provide work incentives, and nondisabled adults (with certain exceptions) would be required to accept employment or training.

The "workfare" tests would make a sharp distinction between welfare and "workfare." Families with preschool age children where the father is dead, absent, or disabled would be presumed unemployable and would be eligible for cash welfare payments. Other low income families would not be eligible for such payments but would be guaranteed work opportunity, with training and other preparation for employment where necessary. Participants in these "workfare" programs would have their wages supplemented if they are below the minimum wage. Allowances would also be paid to those in training. Child care and other services would be provided as necessary.

The pilot project to test the administration of welfare programs by vocational rehabilitation personnel would involve assistance payments according to regular AFDC standards. These payments would, however, be administered through the facilities and personnel of the Rehabilitation Services Administration which would also apply its rehabilitation techniques to welfare recipients in an attempt to encourage and assist adult individuals with a potential for work to prepare for and obtain employment.

The various tests would run for a minimum of two years, involve State sharing in costs at a level not in excess of State sharing in the costs of AFDC, and involve continuing consultation among the Department of Health, Education, and Welfare which would conduct the tests, the General Accounting Office, and the Congress. Each test would have to cover all eligible families within a State or a part of a State, and for the duration of the test no AFDC payments could be made to families residing in the test area. Each "family assistance" test would have to run concurrently with a "workfare" test and the two test areas would have to be comparable with respect to various relevant factors including population, per capita income, and unemployment rate.

G. Veterans' Pension Increase

The committee bill incorporates the text of S. 3385, a bill to increase pension benefits to veterans and widows by up to 9 percent. The committee bill would also increase the income limitations, from $2,000 to $2,300 in the case of a veteran or widow alone, and from $3,200 to $3,600 in the case of a married veteran or widow with a child.

H. Miscellaneous Amendments

1. TAX AMENDMENTS

Denial of Tax Deduction With Respect to Certain Medical Referral Payments

Present law provides that no tax deduction is to be allowed for illegal bribes or kickbacks where, as a result of the payment, there is successful criminal prosecution. If the bribe or kickback does not constitute a criminal act (presumably even if there is a loss of license), or if the taxpayer is not successfully prosecuted, the deduction is allowable.

This provision deletes the requirement in present law of a criminal conviction in the case of bribes and kickbacks before a deduction for such a payment is denied. In lieu thereof, the provision provides that no deduction is to be allowed for a bribe or kickback which is illegal under either Federal or State law, if these laws subject the party involved to liability for criminal or civil penalties (including the loss of license). In the case of a payment which is illegal under State law, the deduction will be denied on the basis of such illegality only if the law is generally enforced. Other sections of this bill provide that medical referral fees under the medicare or medicaid programs are illegal. It is made clear that referral fees are to be treated as bribes or kickbacks for purposes of this provision.

Required Information Relating to Excess Medicare Tax Payments by Railroad Employees

Present law provides that a railroad employee 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 enable a railroad employee to claim his excess medicare tax as a credit on his income tax return, all railroad employers are required to include on the W–2 forms given to their employees, the amount of compensation covered by railroad retirement and the hospital tax deducted.

Because of the inability of most railroads to furnish the required information by January 31 (primarily because of a broader wage concept under railroad retirement) and the fact that only a relatively few employees are eligible for this refund, this provision changes the requirement that railroad employers supply separate hospital tax information on the W–2 forms for all of their employees. In lieu

thereof, the provision requires that railroad employers include on, or with, the W–2 form furnished to its employees, a notice with respect to the allowance of the credit or refund of the tax on railroad-covered wages in those cases where the employee has also received other wages covered under the social security program. Upon the request of an employee, railroad employers are required to furnish to the employee a written statement showing the amount of the 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 the medicare program.

Reporting of Medical Payments

Present law provides that a person who makes specified kinds of payments in the course of a trade or business to another person, amounting to $600 or more in a calendar year, must file an information return showing the amount paid and the name, address, and identifying number of the recipient. Although, under this general requirement, persons engaged in a trade or business are required to report direct payments to providers of health care services (often described as "assigned" payments), there is no authority under present law to require the reporting of payments made to patients themselves ("unassigned" payments), even though in the normal circumstances, they are paid over to providers of health care services, or represent reimbursement of earlier payments.

The bill provides specifically, in addition to the general requirement of present law, that all payments in the course of a trade or business made to providers of health care services in the case of direct or "assigned" payments must be reported. Further, in the case of "unassigned" or indirect payments, reporting will be required in those cases where the Federal Government administers the health program or funds the program to a substantial extent. The reporting requirement specifically includes professional service corporations, proprietary hospitals, and other payees who may act as conduits for providers of health care services.

The provision also requires the Secretary of the Treasury and the Secretary of Health, Education, and Welfare to study the extent to which "unassigned" and "assigned" claims are used to obtain payments from insurance organizations and to report each year to the Senate Committee on Finance and the House Committee on Ways and Means any significant shift from the use of "assigned" claims to "unassigned" claims. In addition, the provision requires that the Secretary of Health, Education, and Welfare keep records showing the identity of each provider of medical or health care items or services under the medicare and medicaid programs, the types of items or services provided and the aggregate amounts paid to the providers under each program. Health care providers are required to be identified by their taxpayer identifying numbers. The Secretary of Health, Education, and Welfare must submit to the Senate Committee on Finance and the House Committee on Ways and Means annually a report identifying each person who is paid a total of $25,000 or more during the preceding year under the medicare and medicaid programs.

These reports are due to be submitted for the calendar year, beginning with 1970, not later than June 30 of the following calendar year.

Tax Credit for Portion of Salary Paid Participants in Work Incentive Programs

Under present law there are no special tax provisions relating to the costs of employee training programs. These costs are treated as any other business expense and may be deducted if they are ordinary and necessary in carrying on the taxpayer's trade or business.

This provision provides a special tax incentive for employers who hire individuals under a work incentive program (WIN) established under section 432(b)(1) of the Social Security Act. The taxpayer would be allowed, as a credit against his income tax liability, and in addition to his regular business deduction, an amount equal to 20% of the wages and salaries paid to the employee during the first 12 months of his employment. Any unused tax credits could be carried back to the three preceding taxable years (but only to a taxable year beginning after December 31, 1968) and then could be carried forward to the next seven succeeding taxable years.

However. if the taxpayer terminated the employment of the individual at any time during the first 12 months of employment, or at any time during the next 12 months, any tax credit allowed under this provision would be recaptured. The credit would be recaptured by increasing the taxpayer's tax liability, in the year of termination, by an amount equal to previous tax credits allowed with respect to the employee. The recapture provision would not apply if the employee voluntarily left the employment of the taxpayer, or if the employee became disabled. Further, a credit would not be allowed for any expenses of training outside the United States or if the employee is closely related to the taxpayer.

Retirement Income Credit

Present law provides a retirement income credit of 15 percent of eligible retirement income up to a maximum of $1,524 for a single person and $2,286 for married couples where each is fully eligible in his or her own right. The credit is designed to provide comparable tax treatment to those who receive tax-exempt social security benefits and those who receive taxable pensions. Consequently, the maximum base for the credit is reduced by social security benefits received and by earnings in excess of $1,200—a reduction of 50 cents for each dollar of earnings between $1,200 and $1,700 and dollar for dollar for earnings in excess of $1,700.

Because of increases in social security benefits since the present maximum base for the credit was established, this provision increases the base for the credit to more closely approximate the current levels of social security benefits. It increases the $1,524 to $1,872 and the $2,286 to $2,808. In addition, the amount that can be earned without reducing the base for the credit is raised from $1,200 to $1,680 and the range within which the base is reduced 50 cents for each dollar of earnings is raised to $1,680 to $2,880.

2. OTHER AMENDMENTS

The committee also added provisions relating to the authorization of the managing trustee of the social security trust funds to accept gifts made unconditionally to the Social Security Administration, authorizing loans for the installation of sprinkler systems necessary for facilities to meet medicare standards, increasing the grade level of the Commissioner of Social Security, requiring the consent of the Senate to future appointments to the position of Administrator of Social and Rehabilitation Services, and extension of the provision for disregarding certain social security benefit increases under welfare programs.

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

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

Increase in Special Payments to People Age 72 or Older

(Sec. 102 of the bill)

The bill would increase by 5 percent the special cash payments that are made under present law to people age 72 and older who are not insured for regular cash benefits under the social security system.

Under the 1965 amendments to the social security law, special monthly payments were provided for certain people who reached age 72 before 1969 on the basis of less work than is needed to qualify for regular cash benefits. The cost of the payments under this provision is met out of the old-age and survivors insurance trust fund.

Special monthly payments were also provided, under an amendment to the law enacted in 1966, for persons with no social security credits who reached age 72 before 1968 and for persons who reach age 72 after 1968 and before 1972 who have earned credit for some work but who do not qualify for payments under either the regularly insured or transitionally insured feature in the law. Payments made to the uninsured aged are reduced by the amount of any pension, retirement benefit, or annuity that a person is receiving under any other governmental pension system. Also, the payments are suspended for any month for which the person receives a payment under a federally aided public assistance program. Most of the cost of the payments under this provision is met from general revenues.

Under the increase provided in the bill, the payments under both of these special provisions would be increased by 5 percent, from $46 to $48.30 for an individual and from $69 to $72.50 for a couple, effective for January 1971. About 6,000 people who do not now get the special payments because they are now getting payments either under another governmental pension system that are as large as the special payment under present law or because they are getting welfare payments would qualify for payments, and about 600,000 people would qualify for higher payments, under this provision.

An estimated $16 million in additional payments would be paid out in the first full year; about $14 million of this amount would be paid from general revenues.

The benefit increase would be effective for January 1971. However, like the regular benefit increase—discussed below—the increased amounts would not be paid until April.

Liberalization of the Retirement Test

(Secs. 105 and 106 of the bill)

Under present law, if a beneficiary under age 72 earns more than $1,680 in a year, $1 less in benefits is paid for each $2 of earnings between $1,680 and $2,880 and for each $1 of earnings above $2,880. However, full benefits are paid, regardless of the amount of annual earnings, for any month in which the beneficiary neither works for wages of more than $140 nor renders substantial services in self-employment.

Under the committee bill, a beneficiary would receive the full amount of his benefits each month if his annual earnings did not exceed $2,000 and his benefit would be reduced by $1 for each $2 of earnings above $2,000.

The committee bill, like the House bill, would increase from $140 to $166.66⅔ the amount of wages a beneficiary may earn in a given month and still get full benefits for that month, regardless of his annual earnings. The changes would update the retirement test to take into account the increase in earnings levels since the present $1,680 annual exempt amount became effective (in 1968) and make possible an increase in annual income for many of the beneficiaries who work.

The bill would also retain the retirement test provision in the House bill that would apply in the year in which a worker reaches age 72. Under present law, benefits are not withheld under the test for months when the person is age 72 or older. However, in the year in which a beneficiary reaches age 72, earnings in and after the month in which he reaches age 72 are counted in determining whether benefits are reduced or withheld for the months before he reached age 72. Many beneficiaries believe that earnings after they reach age 72 are not counted under the retirement test; as a result, they may find that they have been overpaid. 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 for retirement test purposes. In applying this provision, the earnings of a self-employed beneficiary would be prorated equally to the months in his taxable year.

About 650,000 beneficiaries who will receive some benefits for months in 1971 under present law would receive additional benefits, and about 380,000 persons who would receive no benefits under present law would receive some benefits. Additional benefit payments in the first full year would be about $404 million.

The provision would be effective for taxable years ending after 1970.

Dependent Widower's Benefits at Age 60

(Sec. 107 of the bill)

Under present law, an aged widow can become entitled to widow's insurance benefits at age 60, but an aged dependent widower cannot become entitled to dependent 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 aged widows. Accordingly, the bill would lower the age of eligibility for aged dependent widower's benefits from 62 to 60. The benefits payable to an aged dependent widower who starts getting benefits before age 62 would be actuarially reduced, as are the benefits under present law for aged widows who come on the benefit rolls before age 62.

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

Application for Disability Benefits After Disabled Worker's Death

(Sec. 111 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 benefit rights are lost. As a result, the living expenses and additional costs incurred by the disabled worker during the period of his disablement may remain unpaid and become obligations of his survivors.

The committee has, therefore, approved the provision of the House bill which would permit disability insurance benefits to be paid if an application is filed within 3 months after the month in which a disabled worker dies. Benefit payments which would have been payable upon application by the disabled worker would then be payable for up to twelve months prior to the month in which an application is filed. An application filed within the extended period would also permit entitlement to dependent's benefits to be established.

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

Penalty for Furnishing False Information To Obtain a Social Security Account Number

(Sec. 114 of the bill)

Under present law, criminal penalties are provided for any person who makes a false representation to obtain payment of social security benefits which are not due him. These penalties may be applied, for

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

The use of false names, aided by a social security number issued in false names, has led to a number of problems in both private business and the administration of Government programs. Therefore, the bill as passed by the House and approved by the committee would provide criminal penalties if an individual, with intent to deceive the Secretary of Health, Education, and Welfare as to his true identity knowingly and willfully furnishes false information on an application for a social security number for the purpose of obtaining more than one number or of establishing a social security record under a different name. Upon conviction, an individual shall be fined not more than $1,000 or imprisoned for not more than one year, or both. The penalty would not be applicable, however, if the person obtaining more than one social security number provides sufficient information to permit the Social Security Administration to identify all the numbers issued to such person so that all of his wage credits may be combined.

Guarantee That No Family Would Have Its Total Family Benefits Decreased as a Result of an Increase in the Worker's Benefit

(Sec. 115 of the bill)

In the past, when general benefit increases have been enacted, it has been possible in certain cases for a family that comes on the benefit rolls after the increase is effective, and who is entitled to retroactive benefits in the period before the increase is effective, to have its total family benefits decreased slightly below what they would be if the family had been on the rolls in the month before the benefit increase became effective. A decrease of this sort can also occur when a worker's benefit is increased as a result of a recomputation of his benefit to include additional earnings. The decreases occur in cases where the family maximum provision applies and the worker's benefit is actuarially reduced (because it started before age 65).

A special provision was included in the 1969 amendments to prevent a decrease in total family benefits from occurring under the general benefit increase that was included in those amendments. But the provision was only temporary in effect—it applied only to the general benefit increase under the 1969 amendments, and did not apply to recomputations required in the future because the beneficiary had additional earnings.

The bill includes a provision under which no family would have its total family benefits decreased because of an increase in the worker's benefit resulting from a recomputation of the worker's benefit to include additional earnings. (The 10-percent increase in the maximum family benefits provided under the committee bill will avoid any decrease in family benefits as a result of the general benefit increase.)

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

Social Security Cash Benefits

(Sec. 101 of the bill)

Since the Social Security Act first became law, the Congress has taken action a number of times to assure that benefit levels remain realistic and adequate. Their adequacy has been evaluated in the context of changes in the cost of living, changes in earnings levels, and changes in living standards. Most recently, a 15-percent across-the-board benefit increase was included in legislation approved by the Congress last year, with the increase applicable to benefits payable beginning January 1970.

The committee recommends that social security benefits be further increased across the board by 10 percent, effective January 1971. This contrasts with the 5-percent increase provided in the House bill. The committee bill would modify or eliminate a number of provisions in the House bill affecting select groups of beneficiaries; a portion of the funds provided for these special benefits in the House bill would pay part of the cost of providing an across-the-board increase of 10 percent for social security beneficiaries.

Another major change included in the committee bill would provide a $100 minimum primary insurance amount—the amount paid when benefits start at age 65 or later—compared with a $64 minimum under present law and a $67.20 minimum benefit under the House bill.

Under the present law, monthly benefits for workers who retire at age 65 in 1971 will range from $64 to $193.70; under the House-passed bill these amounts would range from $67.20 to $203.40; under the committee bill the amounts would range from $100 to $213.10. Additional illustrations of the monthly benefits payable under present law, under the House-passed bill, and under the committee bill are shown in the table below.

ILLUSTRATIVE MONTHLY BENEFITS PAYABLE UNDER PRESENT LAW, UNDER THE HOUSE BILL, AND UNDER THE COMMITTEE BILL

Average monthly earnings[1]	Worker[2]			Couple[2,3]			Widow-mother and 2 children		
	Present law	House bill	Committee bill	Present law	House bill	Committee bill	Present law	House bill[4]	Committee bill
$76[5]	$64.00	$67.20	$100.00	$96.00	$100.80	$150.00	$96.00	$100.80	$150.00
$113[5]	90.60	95.20	100.00	135.90	142.80	150.00	135.90	142.80	150.00
$150	101.70	106.80	111.90	152.60	160.20	167.90	152.60	160.20	167.90
$250	132.30	139.00	145.60	198.50	208.50	218.40	202.40	208.50	222.70
$350	161.50	169.60	177.70	242.30	254.40	266.60	280.80	280.80	308.90
$450	189.80	199.30	208.80	284.70	299.00	313.20	354.40	354.40	389.90
$550	218.40	229.40	240.30	327.60	344.10	360.50	395.60	395.60	435.20
$650	[6] 250.70	263.30	275.80	[6] 376.10	395.00	413.70	[6] 434.40	434.40	482.70
$750	(7)	[6] 283.00	[6] 295.80	(7)	[6] 424.50	[6] 443.70	(7)	[6] 474.40	[6] 517.70

[1] Figured generally over 5 less than the number of years elapsing after 1936 or 1950, or age 21, if later, and up to the year of death, disability, or attainment of age 65 for men (62 under the House bill for those on the rolls and those who come on in the future; 62 for those who reach age 62 in 1973 or after with the years graded in for men who reach age 62 in 1971 and 1972 under the committee bill) and 62 for women.

[2] For a worker who is disabled or who is age 65 or older at the time of retirement and a wife age 65 or older at the time when she comes on the benefit rolls.

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

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

[5] Under present law, and under the House bill, average monthly earnings of $76 or less result in a minimum benefit; under the committee bill, average monthly earnings of $113 or less result in a minimum benefit.

[6] Generally payable to people who retire at age 65 in 2006.

[7] Not applicable, since the highest possible average earnings is $650.

Some 25.7 million beneficiaries on the rolls in January 1971 would have their benefits increased under this provision. An estimated $5 billion in additional benefits would be paid in the first full year.

The benefit increase would be effective for January 1971. However, because of the time required to make the changes in the Social Security Administration's records and procedures needed to pay the increased benefits, the first check at the higher rates would be for next March, payable in April. In addition, a separate check covering the retroactive increase for January and February would also be issued in April.

Increase in Maximum Family Benefits

(Secs. 101 and of 131 the bill)

Ever since 1940, when monthly benefits were first provided for dependents and survivors, there has been a limitation on the total monthly benefits payable to a family on a worker's earnings record. The purpose of the limitation is to relate family benefits to the approximate take-home pay of the worker. The limitation—the so-called family maximum—is related to the worker's average monthly earnings under the program; under present law it is 80 percent of the first $436 of average monthly earnings (two-thirds of the maximum possible average monthly earnings—$650 under the $7,800 contribution and benefit base), plus 40 percent of the next $214 of average monthly earnings, but not less than 1½ times the primary insurance amount.

The committee believes that the effect of the family maximum provisions when there is a benefit increase results in certain inequities which should not be allowed to continue. Under the present law, the family maximum is related to a worker's average earnings, which do not change when benefits are increased. Therefore, it has been necessary to provide, with each across-the-board benefit increase, assurance that families on the benefit rolls do not lose benefits and that the family as a whole will get increased payments. The way this has been done in the past has created a situation in which people on the benefit rolls when a benefit hike becomes effective get an increase while people in identical circumstances who come on the rolls in the next month do not. For example, a 3-person family who was on the benefit rolls prior to the effective date and which was getting a maximum family benefit of $300 a month would have had its total benefits increased under the House-passed bill to $315 a month. But a family with the same number of beneficiaries whose benefit was based on the same average earnings as the first family, but who came on the rolls a few days later, would have the total benefit limited by the family maximum, which would not have been changed. The family, therefore, would get only $300 a month. This situation should not occur and the committee bill would adopt a new policy of treating families who come on the rolls after the benefit increase in the same way that families on the rolls before the increase are treated.

Thus, the committee bill provides (in the benefit table and in the section relating to cost-of-living increases) that families coming on the rolls after a benefit increase is enacted, as well as families already on the rolls at the time the increase is enacted, would be guaranteed the full amount (10 percent under the committee bill) of the current and future

general benefit increases. Under the committee bill, maximum family benefits would range from 1.5 to 1.88 times the worker's benefit amount payable at age 65. The level-cost of the change would be 0.04 percent of taxable payroll.

The provision would be effective January 1, 1971.

Cost-of-Living Increases

(Sec. 131 of the bill)

The committee has revised the House-passed provisions which would provide for automatic increases in social security benefit levels, the tax base and the exempt amount under the retirement test. The committee bill stresses the predominant role of Congress in determining when economic and social conditions have changed so as to require a change in benefit levels (and related changes in tax levels and in the retirement test exempt amount). Under the committee bill, Congress would retain the primary role in determining benefit levels with the automatic provisions serving as a back-up to assure that in the absence of Congressional action, the real value of benefits would not be seriously eroded by rising prices. In addition, the cost of any automatic benefit increases would have no effect on the financial and actuarial status of the social security trust funds.

The House-passed bill would require the Secretary of Health, Education, and Welfare to determine each year, on the basis of the average Consumer Price Index for the third calendar quarter, whether the rise in the Index was sufficient, under the terms of the bill, to cause an automatic increase in benefits for the following January. In October or November—which might very well be after Congress had adjourned—the Secretary would announce his findings. Under the terms of the House-passed bill an increase would be forthcoming only when the Consumer Price Index had risen by at least three percent. An increase in the retirement test exempt amount would be based on the increase in average earnings taxable for social security. The cost of these automatic increases would be met through automatic increases (not more often than every other year) in the social security tax base, based on increases in average taxable earnings.

The committee bill would provide that when the cost-of-living, as measured by the Consumer Price Index, went up benefits would be increased as follows:

1. the first base period would be the Consumer Price Index for January 1971 and a new base period (the second quarter of the year preceding the year in which there is a cost-of-living increase in benefits and—in the case of any legislated increase—the effective month of the legislated increase) would be established after each subsequent benefit increase;
2. each year the Secretary of Health, Education, and Welfare would compare the Consumer Price Index for the base period with the average index for the second calendar quarter and if the index had risen by at least 3 percent, he would promulgate regulations increasing benefits for the following January, and subsequent months, by the same percentage as the rise in the price index;

3. except that no such automatic increase would take effect for a year if in the preceding year the Congress had acted to:
   A. Change the schedule of tax rates, or
   B. Change the tax base, or
   C. Provide a general increase in benefit levels.

In addition, the exempt amount under the retirement test would be increased according to the rise in average wages taxable for social security purposes.

The cost of these automatic increases would be met by increases in tax rates and the tax base. Under the committee bill, each time there was an automatic cost-of-living increase in benefits, social security taxes would be increased to meet the full cost of the increase.

Each time there was an automatic increase the Secretary of Health, Education, and Welfare would be required to determine the full cost—under the 75-year-level-cost procedures used in estimating the long-range cost of the cash benefits program—of the automatic increases and to promulgate, effective for the same month that the benefit increase was effective, new tax rates and a new tax base. An integral part of such promulgation would be a full and detailed explanation of the actuarial assumptions and methodology used in arriving at the new tax rates and the new tax base. In setting the tax rates and the tax base, the Secretary would be required to increase the tax rates so as to provide approximately 50 percent of the additional revenue required with the remaining 50 percent being derived from an increase in the tax base. In recognition of the practical difficulties which might come up in making this division, the Secretary would be authorized to round the tax base increase to the nearest multiple of $300 and the employee and employer rates, each, to the nearest five one-hundredths of one percent (one-tenth of one percent for the combined employer-employee rate).

The committee bill would require that the Secretary promulgate benefit increases, and consequent tax base and tax rate increases, by August 15. Inasmuch as this requirement, which is three months earlier than under the House-passed bill, was adopted in order to provide time for Congress to consider whether the automatic increases should go into effect or some other action should be taken, it is the committee's intention that the Secretary inform the Congress early in the quarter whenever he determines that an automatic increase will take place.

The committee wishes to make clear its intention that the full cost (as estimated at the time the increase is promulgated) of each automatic increase is to be financed by additional taxes imposed at the same time that benefits are increased and that no part of any calculated actuarial surplus could be used to meet any part of the cost of any automatic increase. For example, if at the time an automatic cost-of-living increase is in order the cash benefits program has an estimated actuarial surplus of 0.05 percent of taxable payroll and the cost of the benefit increase is estimated at 0.40 percent of taxable payroll, the cost of the increase is to be financed by increasing the tax base to a level that, on a long-range basis, will provide excess income approximately equal to 0.20 percent of taxable payroll and by increasing for every year into the future the combined employer-employee tax rate by approximately 0.20 percent and preserving the

calculated actuarial surplus of 0.05 percent of taxable payroll. The Committee regards the Secretary's role as one with no discretion over the amount of the increase in the tax base or the tax rate. His role is simply to perform the actuarial calculations necessary.

It is estimated that under these automatic provisions the social security tax base might rise by an average of about $750 a year and that the combined employer-employee tax rates might rise by an average of 0.01 percent a year.

Increase in Widows' and Widowers' Insurance Benefits

(Sec. 103 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 percentage 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 to 82.5 percent, where it has remained up to the present.

It is the committee's opinion that an aged widow should not receive less than the amount which was or would have been paid to her husband as retirement benefits. Currently, the average benefit for an aged widow is $103 a month, while the average benefit for a retired worker is $118. In addition, surveys of social security beneficiaries have shown that, on the average, women getting aged widow's benefits have less income (other than social security) than most other beneficiaries.

The committee bill would provide an increase in the benefits of widows and widowers who become entitled to benefits after reaching age 62. Under the bill, the benefit for a widow who becomes entitled to widow's benefits at or after age 65 would be increased from the 82½ percent payable under present law to 100 percent of the amount her deceased husband would receive.

Both the House bill and the committee bill are intended to provide benefits to a widow equal to the benefits the widow's deceased husband was receiving or would have received. In certain cases, however, the House bill would actually provide higher benefits to a widow than those her deceased husband was receiving; the committee bill would modify the House provision so that this would not occur.

Under present law, the House bill, and the committee bill, if a worker applies for retirement benefits before reaching age 65 his benefits are actuarially reduced. For example, a man whose earnings record would entitle him to monthly benefits of $150 at age 65 will receive $135 monthly if he begins receiving benefits 18 months before his 65th birthday.

Under the House bill, the widow's benefits—if they begin at age 65—would be 100 percent of the benefits her deceased husband would have been eligible for if he retired at age 65—even if he was actually receiving less than this at the time of his death. Using the example cited above, the widow would receive monthly benefits of $150—11 percent more than her husband received monthly. Under the committee bill, she would receive $135.

Under the committee bill, a widow whose benefits start at age 65, or after, would receive 100 percent of her deceased husband's primary insurance amount (the amount he would have been entitled to receive if he began his retirement after age 65) or, if his benefits began before age 65, the lower amount he would have been receiving if he were alive.

Under the committee's bill and under the House bill the benefit for a widow or widower who comes on the rolls between 60 and 65 will be reduced (in a way similar to the way 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 it will be paid. For example, the benefit amount for a widow becoming entitled to widow's benefits at age 63 would be 88.6 percent of her husband's age-65 benefit; for a widow becoming entitled at age 64, the amount would be equal to 94.3 percent of her husband's age-65 benefit.

Under the bill, the benefit amount for January 1971 for a widow (or widower) who came on the benefit rolls before 1971 will be redetermined as though the new provisions had been in effect when she came on the rolls. Thus the widow already on the rolls who started getting benefits before she reached age 65 will have the 100-percent widow's benefit reduced to take account of the longer period for which she will be paid benefits. In order to facilitate the administrative determination of 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 primary insurance amount on which the widow's (or widower's) benefits are based for January 1971.

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 not be less than the minimum benefit ($100 under the committee bill) payable to a retired worker at age 65. If the widow starts getting benefits before she reaches age 62, her benefit would be actuarially reduced to take account of the additional period during which she will be receiving benefits.

The 10-percent increase in benefits with the new minimum of $100 and the changes in the benefit provisions for widows would result in an increase from $103 to $136 in the average benefit payable to a widow—$33 more than under present law.

About 2.7 million widows (and widowers) on the benefit rolls in Janurary 1971 would receive additional benefits; about $649 million in additional benefits would be paid in the first full year.

The provision would be effective for January 1971. However, due to the time needed by the Social Security Administration to make the needed recomputations, the increased payments would be made, retroactively, later in the year.

Age 62 Computation Point for Men

(Sec. 104 of the bill)

Under present law, retirement benefits for men are figured differently, and less advantageously, than are benefits for women. For a man the period for determining the number of years of earnings that is used in figuring the average monthly earnings on which his benefit

is based ends with the beginning of the year in which he reaches age 65. For a woman the period ends with the beginning of the year in which she reaches age 62. Thus, 3 more years are used in computing benefits for a man than are used for a woman of the same age. This difference in the treatment of men and women can result in significantly lower benefits being paid to a retired man than are paid to a retired woman with the same earnings.

For example, take the case of a man and a woman each of whom reaches age 65 and retires in 1971, and each of whom has maximum creditable earnings under the program in each year up to 1971. The woman's benefit would be $200.30 a month under present law, while the man's benefit would be only $193.70 a month. If both workers reach age 62 in 1971, the woman's benefit would be $155 a month while the man's benefit would be only $148.80 a month.

The bill would change the way a man's retirement benefit is figured to make the computation the same as the computation of a woman's benefit. As a result, the benefits for most men would be higher than under present law and higher benefits would be paid to the dependents of retired men and to the survivors of men who die after age 62.

Under the House bill, the reduction in the number of years of earnings taken into account would apply both to persons presently receiving benefits and also to future beneficiaries. The committee bill differs by applying the new provision prospectively only, and by providing a 3-year transition period. Under the committee bill, the number of years used in computing benefits for men will be reduced in 3 steps so that men reaching age 62 in 1973 or later would have only years up to age 62 taken into account in determining average earnings. Men who reach age 62 in 1972 would have only years up to age 63 taken into account; men who reach age 62 in 1971 would have only years up to age 64 taken into account.

Consistent with this provision of the committee bill, the House-passed bill would also be modified to provide a 3-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, and thus allow men to become fully insured on the basis of less covered employment than is now required. The first step in this reduction would be effective for January 1971 with subsequent reductions becoming effective in 1972 and 1973.

Due to the change in the insured status requirement for men, about 2,000 persons—workers, dependents, and survivors—not eligible for benefits under present law would be able to claim benefits in the first full year.

Additional benefits of about $6 million would be paid during the first full year, under this provision.

Payment of Disability Benefits to Blind Persons

(Sec. 109 of the bill)

The committee's bill extends the provision of the House bill which would modify the disability insurance provisions to improve cash benefit protection for the blind.

To be insured for disability protection under present law a worker must be fully insured and generally must have a total of 20 quarters

of coverage out of the 40 calendar quarters ending with the quarter in which he becomes disabled. An alternative for workers disabled while young provides that a worker under age 31 is insured if he has quarters of coverage in half the quarters after age 21 and up to and including the quarter of disablement, with a minimum of six quarters of coverage. The House bill would eliminate for blind people the 20-out-of-40 requirement and the alternative for young workers so that a blind person could qualify for disability benefits if he is fully insured. The committee bill would lower the disability insured-status requirements further 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 aged 55 or over, unable to engage in substantial gainful activity requiring skills or abilities comparable to those used in 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 (being fully insured to meet one of the requirements for disability benefits) becomes entitled to old-age benefits. The bill would permit blind persons who have six quarters of coverage to continue to receive disability insurance benefits beyond age 65, and since these are disability benefits rather than retirement benefits they would not be subject to deductions 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.

About 225,000 persons—blind workers and their dependents—would become immediately eligible for monthly benefits. About $240 million in additional benefits would be paid during the first full year.

The provision would be effective January 1971.

Wage Credits for Members of the Uniformed Services

(Sec. 110 of the bill)

Under present law, social security coverage is provided on a contributory basis for those serving in the uniformed services in years after 1956, but it is limited to a serviceman's basic pay and does not reflect the cash value of wages in kind, such as food and shelter, which is generally covered under social security with respect to other employment. The 1967 social security amendments, therefore, provided noncontributory wage credits (in addition to the contributory coverage of basic pay), up to $100 for each month of military service after 1967, to take account of the wages in kind that servicemen receive.

The committee bill, like the House bill, would extend the 1967 provision to cover service during the period 1957–67. This would assure realistic social security 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 some workers (and their families) whose benefits are based on only basic pay for years of military service during the period from 1957 through 1967.

In addition, the committee bill would change the way the wage credit is computed. Under present law a serviceman receives a noncontributory wage credit of $100 for any calendar quarter in which his basic pay 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. In most cases the credit is $300 a calendar quarter. Under the committee bill, the noncontributory wage credits would be $300 for every calendar quarter of military service in which the serviceman is paid basic pay.

The committee is advised that this change will result in some slight administrative savings and will expedite the processing of some claims for social security benefits from servicemen and their survivors. 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. The additional wage credits would affect approximately 130,000 beneficiaries immediately and result in additional benefits of about $35 million being paid in the first full year.

Policemen and Firemen

(Sec. 112 of the bill)

The Social Security Act contains special provisions concerning coverage of policemen and firemen. In States not named in section 218(p)(1) of the act, the State may not extend social security coverage (under its agreement with the Secretary of Health, Education, and Welfare) to *policemen* who are in positions covered under a State or local retirement system. Coverage is available for *firemen* under a retirement system in States not named in the Social Security Act, but only if (1) the Governor certifies that the overall benefit protection of the group of firemen involved will be improved by their inclusion under social security, and (2) a referendum is held in which a majority of the firemen favor coverage. If a State *is* named in section 218(p)(1) of the Social Security Act, policemen and firemen under a State or local retirement system may be covered under social security on the same basis as other State and local employees, whose coverage is subject to various conditions designed to safeguard their interests.

The bill as it passed the House would include Idaho in the list of States in which social security coverage may be extended to policemen and firemen on the same basis as to other State and local employees.

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. The committee modified the House bill by making the provision also applicable to policemen (but not to firemen) in Missouri

Coverage of Certain Hospital Employees in New Mexico

(Sec. 113 of the bill)

The bill as passed by the House and agreed to by the committee would permit the State of New Mexico 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 the provisions of the Social Security Act which specify 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 presents a serious obstacle to obtaining social security coverage for the employees in question 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.

Under the committee bill, the State would have until January 1, 1972, to provide this coverage, rather than until January 1, 1971, as under the House-passed bill.

Childhood Disability Benefits

(Sec. 108 of the bill)

The committee bill, like the House-passed bill, would improve social security protection for people who become totally disabled before reaching an age at which they are likely to be self-supporting. 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's bill would permit the payment of childhood disability benefits when the disability begins before age 22, rather than before age 18.

When a dependent son or daughter becomes disabled between ages 18 and 22, he generally continues to be dependent on his parents. The committee believes that it is appropriate and desirable to provide social security benefits to these children should the insured parent die, become disabled, or retire.

The committee added a new provision to the House bill to permit re-entitlement to childhood disability benefits for a person who had been entitled to childhood disability benefits if he becomes disabled again within 7 years after his benefits were terminated because of a period of substantial gainful employment or medical recovery. This new provision would assure a former childhood disability beneficiary benefit protection either as a worker or as a dependent and might remove a disincentive for childhood disability beneficiaries to attempt to become self-supporting. This change would be consistent with present law which provides benefit re-entitlement to disabled widows and widowers if they become disabled again.

The provisions which extend childhood disability benefits for those disabled before age 22 and which permit re-entitlement to childhood disability benefits if a beneficiary becomes disabled again within 7 years after his entitlement to such benefits was terminated would be applicable not only prospectively but also in the case of people who have already met the conditions proposed for entitlement to benefits and would be effective with respect to benefits for months after December 1970. About 13,000 people—disabled children and their mothers—would immediately become eligible for benefits. About $13 million in additional benefits would be paid out during the first full year.

Adoption of Child by Retired or Disabled Worker or by a Step-Grandparent

(Secs. 116 and 132 of the bill)

The committee bill modifies the provision of the House-passed bill relating to benefits for children adopted by disability insurance beneficiaries to provide uniform rules relating to benefits for children adopted by social security beneficiaries.

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 (1) the adoption took place within 2 years after the worker became entitled to old-age benefits, (2) the child was receiving one-half of his support from the worker for the year before the worker became entitled to benefits, and (3) either the child was living with the worker in or before the month in which the worker filed application for old-age benefits or the worker had instituted adoption proceedings in or before that month. There is no provision in the law for the child to get child's benefits when he is adopted by a worker more than two years after the worker became 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 disability 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 he became disabled or the child was living with the worker in that month.

The committee believes that the above provisions are unnecessarily complex and that the law should be changed so that eligibility of children adopted by retired workers and children adopted by disabled workers would be determined under common rules. At the same

time, 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 when 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 provision added to the bill by the committee, 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 one-year period during which he would otherwise be required to have been living with and receiving 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.

Under the present law, a child's social security benefits end when he is adopted unless he is adopted by: (1) a brother or sister, (2) a stepparent, (3) a grandparent, or (4) an aunt or uncle.

Under the present interpretation of the term "grandparent," when a child is adopted by his grandparent's spouse (a step-grandparent) the child's benefits are terminated. On the other hand, if he is adopted by the grandparent, or the grandparent joins in the adoption by the step-grandparent, the child's benefits are not terminated. The committee bill would remove this distinction by adding a step-grandparent to the list of named relatives who may adopt a child without causing his benefits to end.

The provision would be effective January 1, 1971.

3. PROVISIONS ADDED BY THE COMMITTEE

Waiting Period for Disability Benefits

(Sec. 127 of the bill)

The committee's bill adds a new provision which would reduce the waiting period for disability insurance benefits by two months. Under present law, entitlement to monthly disability benefits cannot begin until a worker has been disabled for 6 consecutive full calendar months. For example, if a worker becomes disabled on January 10, the waiting period is the 6 full months February through July, and his first month of entitlement to benefits is August. (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's bill.) The Department of Health, Education, and Welfare informed the committee that: about one-fourth of the workers in private industry are covered under State temporary disability programs which provide protection during the early stages of long-term disability but do not provide benefits for longer than 26 weeks, less than 2 percent of workers with long-term total disabilities received workmen's compensation, and many workers who have protection against loss of income due to sickness or disability under employer plans (such as group policies, sick-leave plans, or union-management plans) lose their benefits well before the 6th month of total disability.

The committee's change is intended to relieve the financial hardship that occurs when a worker becomes disabled and the family is without earnings during the 6-month waiting period. Therefore, the committee's bill would reduce the waiting period by two months, so that entitlement to disability benefits would begin after a four-month waiting period.

About 140,000 people—disabled workers and their dependents and disabled widows and widowers—would be able to receive a benefit for January 1971 as a result of this provision. Virtually all of these persons would become eligible for benefits for February or March 1971 under present law, upon completion of the 6-month waiting period. About $185 million in additional benefits would be paid out during the first full year.

The provision would be effective January 1, 1971.

Improve Coverage of U.S. Citizens Who Retain Residence in the United States and are Self-Employed Outside the United States

(Sec. 121 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. 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, in some instances has an adverse effect on the social security protection of the worker and his family.

The committee's bill provides that for social security purposes U.S. citizens who are self-employed outside the United States and who retain their residence in the United States will compute their net earnings from self-employment in the same way as those who are

self-employed in the United States; that is the present exclusion for income tax purposes will no longer apply with respect to the self-employment tax.

The provisions in the committee's bill would not affect the exclusions taken by U.S. citizens who have established thier residence in a foreign country. The committee has included in the bill a provision which will assure that an individual who has established his residence in a foreign country may not obtain social security coverage under the amendment.

The provision would be effective for taxable years beginning after 1970.

Exclusion From Coverage of Certain Employees of the State of Nebraska

(Sec. 122 of the bill)

The committee added a provision to the House bill which would permit Nebraska 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. Nebraska could have excluded both types of services at the time it provided social security coverage for employees of State or local governments, but did not do so. There are valid reasons for excluding from coverage employees in these two categories, and the State now wishes to exercise the option it could have made at the time social security coverage was provided for State and local government employees. However, under present law it cannot do so without terminating the coverage of all employees in the affected group.

Under the bill, Nebraska could exclude these two types of employment by modifying its coverage agreement with the Secretary of Health, Education, and Welfare before January 1, 1973.

Coverage of Certain Employees of Guam

(Sec. 123 of the bill)

No employees of the Government of Guam are 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 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 employees who are excluded from coverage under the government retirement system.

The committee's bill would add a provision to cover on a compulsory basis the services of temporary employees (except hospital patients employed by the hospital or prisoners employed by the prison) 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 could not be covered under this amendment.

The provision would be effective for services performed after 1970.

Retroactive Payment of Disability Benefits

(Sec. 130 of the bill)

Under a 1967 Senate 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 prior to 1968 that have been established under the 1967 amendment prior to the enactment of the Social Security Amendments of 1970.

Widows Who Remarry

(Sec. 129 of the bill)

Under the present law, when a woman getting widow's benefits marries, her benefit is reduced to the amount that would have been paid to her as a wife or, if the man she marries is entitled to old-age benefits, to the amount of the wife's benefit based on his earnings when a higher amount is payable. While this provision is generally satisfactory, it results in a financial hardship, and perhaps a deterrent to marriage, when a widow marries a retired person who is not entitled to social security or any other public pension. To reduce this financial hardship and obstacle to remarriage, the committee bill would permit a widow who remarries to continue to receive her full widows' benefit when she marries a man who is not entitled to—and who if he had reached eligibility age would not be entitled—a social security benefit or to any other public retirement benefit.

The provision would be effective January 1, 1971.

Refund of Social Security Tax to Members of Certain Religious Faiths Opposed to Insurance

(Sec. 128 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 reasons 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 similar treatment for employees to that now available only in the case of 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 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 pay-

ments are to be made to him on the basis of the wages or self-employment 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 1970 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 HEW to no longer meet the requirements applicable to it.

Increase Trust Fund Money Available for Reimbursement of Cost of Rehabilitating Disability Beneficiaries

(Sec. 120 of the bill)

The committee's bill adds a new provision which is intended to increase the number of social security disability beneficiaries who are rehabilitated to a degree that permits them 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 has been informed that increasing the funds available for rehabilitation services should result in an increase in the number of beneficiaries who are rehabilitated. Thus, the bill would increase the trust fund money available for rehabilitation in two steps—to 1.25 percent for fiscal year 1972, and to 1.5 percent for fiscal year 1973 and subsequent years. The Department of Health, Education, and Welfare advised the committee that the savings to the trust funds resulting from this recommended provision will exceed the additional costs of the rehabilitation services.

Prior to enactment of the trust fund reimbursement provision in 1965, the social security disability beneficiary rolls were not a significant source for selection of potential rehabilitants under the regular vocational rehabilitation program since social security disability beneficiaries are generally more severely disabled than other disabled people. The number of social security disability beneficiaries who received rehabilitation services under the trust fund reimbursement provision has grown from 10,462 in 1967 to 32,851 in 1969. The Department estimates that the average value of future benefits that would have been payable to a disabled beneficiary if he had not been rehabilitated amounts to more than $15,000, or a gross saving of about $62 million for the more than 4,000 disabled bene-

ficiaries who received rehabilitation services under the trust fund reimbursement provision and who had been removed from the social security benefit rolls through fiscal year 1969. On the basis of experience thus far, it is estimated that there will be a saving to the trust funds of about $1.60 for every $1 invested in the rehabilitation program.

The committee has requested the Social Security Administration to make an in-depth examination of its experience under the provision for financing rehabilitation costs from the trust funds and to submit a report of its findings to the Congress prior to January 1, 1972. The report should include comprehensive information on the number and characteristics of beneficiaries receiving rehabilitation services and those reported by State agencies as rehabilitated. The committee is particularly interested in having information as to the status of reported rehabilitations at points of time after rehabilitation, the amount of work they have done, the length of time they have worked, the amounts they have earned, and information about the rate of return of these people to the benefit rolls, including the reasons why, numbers, and percentages. The report should also include estimates of the savings to the social security trust funds resulting from rehabilitation of beneficiaries in relation to trust fund expenditures for rehabilitation purposes, and all other information which would be useful in evaluating the effectiveness of rehabilitating disability insurance beneficiaries.

Benefits for a Child Entitled on the Record of More Than One Worker

(Sec. 124 of the bill)

Under present law, a child entitled to social security benefits based on the earnings record of more than one worker gets benefits on only one earnings record—the record of the worker that produces the highest primary insurance amount.

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

This situation can arise because children who are entitled on the earnings record of a retired or disabled worker get a benefit equal to 50 percent of the worker's primary insurance amount, while children entitled on the earnings record of a deceased worker get a benefit equal to 75 percent of the deceased worker's primary insurance amount.

When the present provision was enacted, a child's benefit was always 50 percent of the worker's primary insurance amount, whether the worker was living or dead, so that the highest possible benefit was always the benefit based on the highest primary insurance amount. Subsequent changes increased the surviving child's benefit to 75 percent of the primary insurance amount.

The committee bill would add a provision to the House bill to provide that a child who is entitled to social security child's insurance

benefits on the earnings record of more than one worker will get benefits based on the earnings record which would result in paying him the highest amount, if the payment would not reduce the benefit of any other individual who is entitled to benefits on any of the earnings records on which the child is entitled. (Entitlement of a child on the earnings record that will give the child the highest benefit can result in a reduction of the benefits for others entitled on the same earnings record because of the requirement to keep the total benefits within the family maximum.)

The provision would be effective January 1, 1971.

Recomputation of Benefits Based on Combined Railroad and Social Security Earnings

(Sec. 125 of the bill)

A social security beneficiary in a given year may receive benefits based only on earnings in prior years. In order to assure that a beneficiary's social security benefits fully reflect his earnings under the social security system, his primary insurance amount is automatically recomputed from year to year if he has current earnings. When this provision of the Social Security Act was modified in 1967, recomputation was provided for "if an individual has wages or self-employment income for a year after 1965." This wording has inadvertantly created a problem in one special type of case involving persons 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. If he retired before 1966 and had no earnings after 1965, 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.

A specific exception in the law is needed to make it clear that survivor's benefits will be based on the worker's combined social security and railroad earnings, as they were under the law in effect prior to the Social Security Amendments of 1967 (and as they are when they are payable under the railroad system).

The committee bill would add a new provision to the House-passed bill to 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.

Underpayments

(Sec. 126 of the bill)

Under present law, if a beneficiary dies before receiving all of the 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 is often not made because some survivors find it too costly to take the 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 deleted 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.

The committee's bill would add a provision to the House bill to facilitate the disposition of underpayments of cash social security benefits due a beneficiary who has died.

The new provision would provide that if there is no surviving relative in the categories listed in present law, and no legal representative of the estate, cash benefits due a deceased beneficiary could be paid to any other relative (by blood, marriage, or adoption) of the deceased who may be determined by the Secretary of Health, Education, and Welfare, under regulations promulgated by him, to be the appropriate person to receive the benefits on behalf of the estate.

Employees of the State of Louisiana Serving as Registrars of Voters

(Sec. 133 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—1971—in which to decide if they wished to continue their social security coverage and if by the end of the year they decide that they do not wish to do so, this coverage would be terminated effective January 1, 1973. 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.

4. PROVISIONS OF THE HOUSE BILL THAT WERE DELETED BY THE COMMITTEE

Election to Receive Actuarially Reduced Benefits

(Sec. 106 of the House bill)

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

claims benefits before age 65 has both of his benefits actuarially reduced.

Under the House bill, a person eligible for benefits as a retired worker and also as a spouse could choose to take only one of the benefits and claim the other one later, or she could take both benefits at the same time. Also under the bill the reduction that is made in one benefit would not lower the amount of a benefit that is taken later.

The committee bill would delete the House-passed provision. The purpose of actuarially reduced benefits is to provide some benefits for people prior to regular retirement age without additional cost to the program. If a person could take a benefit based on his own earnings record that was reduced because it was paid before age 65 and later get an unreduced wife's or husband's benefit on the earnings record of a spouse, it would defeat the purpose of the actuarial reduction provision, and add to the cost of the program.

Benefits for Divorced Women

(Sec. 111 of the House bill)

The committee bill retains the provisions of present law which require that in order to qualify for benefits as a divorced wife, divorced widow, or surviving divorced mother a woman must show that (1) she was receiving at least one-half of her support from her former husband, or (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 from her former husband. The House-passed bill would delete these provisions.

Benefits paid to a divorced woman under the social security program are intended to provide a partial replacement of support that is lost when her former husband retires, becomes disabled, or dies. The committee believes that where a divorced woman is not getting alimony or continuing support from her former husband and where there is no written agreement or court order providing for her support the woman does not lose a source of support, or potential support, when her former husband retires, becomes disabled, or dies. The committee believes, therefore, that the support requirements in present law are consistent with the basic principles of the social security program.

Disibility Benefits Affected by the Receipt of Workmen's Compensation

(Sec. 115 of the House bill)

The committee deleted the provision in the House bill which would have raised the ceiling on income from combined workmen's compensation and social security disability insurance benefits from 80 percent to 100 percent of the disabled worker's average current earnings before the onset of his disability. The objective of the offset 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.

The committee considers it somewhat doubtful that the increased ceiling proposed in the House bill would still meet the objective of the offset provisions.

Coverage of Federal Home Loan Bank Employees

(Sec. 116 of the House bill)

The committee bill deletes the provision in the House bill that would extend social security coverage to the approximately 500 current employees and all future employees of the Federal Home Loan Banks. The employees are now covered under a staff retirement plan. The Federal Home Loan Bank Board has requested that social security coverage be extended to these employees. The committee believes that social security coverage should not be extended to them without further study of the benefit levels which would result.

IV. MEDICARE AND MEDICAID

Medicare and Medicaid

CONTENTS

IV. MEDICARE AND MEDICAID

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

PAYMENT UNDER THE MEDICARE PROGRAM TO INDIVIDUALS COVERED BY FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

(Sec. 201 of the bill)

Under present law, Federal employees and retirees age 65 and over who are enrolled for Federal employees health benefits (FEHB) are also covered under the medicare hospital insurance plan (part A) if they have worked in employment covered by social security or railroad retirement and are eligible for monthly cash benefits under these programs. In addition, Federal employees, whether or not eligible for part A benefits, may enroll in the medicare voluntary supplementary medical insurance plan (part B) which is available to essentially all persons age 65 and over. Part A hospital insurance protection under medicare is earned during a 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. Part B medical insurance protection is available at 50 percent of cost, for which the enrollee pays a monthly premium—currently $5.30 monthly—matched by the Federal Government.

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 as they did when they were active employees (although the coverage may be more valuable since older people use more medical services). The Federal Government currently pays about 24 percent of the overall cost of FEHB protection, with its share increasing to 40 percent effective January 1, 1971.

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 duplicating the benefits.

Unlike most employers, the Federal Government has not arranged the health insurance protection it makes available to its employees age 65 and over (active or retired) so that such protection would be supplementary to medicare benefits.

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

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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 retiree entitled under medicare cancels his enrollment under a FEHB plan because of the high total cost of his health care protection, he will lose the high level of protection he previously enjoyed under the FEHB program at an age where his health care costs can be expected to increase substantially.

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

In order to assure a better coordinated relationship between the FEHB program and medicare and to assure that Federal employees and retirees age 65 and over will eventually have the full value of the protection offered under medicare and FEHB, the Finance Committee approves the provision in the House bill which would provide that effective January 1, 1972, the medicare program (both parts A and B) would not pay for any otherwise covered service if such service is covered under a FEHB plan. 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 that there is available to each Federal employee or retiree age 65 and over one or more Federal health benefit plans which offer protection supplementing the combined protection of parts A and B of medicare, and the protection of part B alone and that the Government is making a contribution toward the health insurance of each Federal employee or retiree age 65 and over, which is at least equal to the contribution it makes for high option coverage under Government-wide FEHB plans. This contribution could be in the form of a Federal contribution toward the supplementary FEHB protection or a payment to or on behalf of such employee or retiree to offset the cost of his purchase of medicare protection, or a combination of the two. It is the hope and the intent of the committee that the Secretary will be able to make this certification before January 1972.

Hospital Insurance Benefits for Uninsured Individuals Not Eligible Under Present Transitional Provisions

(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.

Since the transitional provision is designed to provide hospital insurance coverage for only a part (though a large part) of the uninsured aged and to eventually phase out, a portion of the aged, though small in number (as of January 1, 1970, this portion numbered approximately 305,000 or 1½ percent of the aged population), are and will be, for one reason or another, excluded from hospital insurance coverage. (The 305,000 people include 55,000 recent immigrants, who would continue to be excluded from coverage; 145,000 active or retired Federal employees, who are not eligible under the transitional provision; and 105,000 others.) Although these ineligibles include a substantial number of people who were eligible for social security coverage but who did not elect (or whose employers did not elect) to be covered (including employees of State and local governments), they also include several other groups: (1) wives who have never worked under covered employment and whose husbands are eligible for hospital insurance under the transitional provision, (2) women who are not insured on their own account and who cannot qualify for dependent's benefits (such as dependent aged sisters of insured workers and the dependents of uninsured workers), and (3) workers, such as agricultural and domestic workers, whose earnings may have been so low or sporadic they were unable to acquire insured status.

Further, it has become very difficult for many in this group to obtain private hospital insurance comparable to coverage under 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 technical 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, including civil service annuitants and their spouses, who are not entitled to such coverage under existing law. A State or any other public or private organization would be permitted to purchase such protection on a group basis for its retired or active employees age 65 and over. The intent is that the cost of such coverage would be fully financed by those who elect to enroll for this protection. Enrollees would pay a monthly premium based on the cost of hospital insurance protection for the uninsured group; such premium would be $27 a month beginning with July 1971 and up to and including June 1972, 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 certain subversive crimes would be excluded from participation under this provision, just as they are excluded from enrolling for supplementary medical insurance.

The committee's bill also would require that in order for persons to be eligible to enroll for hospital insurance they must be enrolled 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 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).

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 generally about the 83d percentile of customary charges for that service in the physician's locality. To illustrate, if customary charges for an appendectomy in a locality were at five levels, with 10 percent of the services rendered by physicians whose customary charge was $150, 40 percent rendered by physicians who charge $200, 40 percent rendered by physicians who charge $250 and 5 percent rendered by

physicians who charge $300 and with the remaining 5 percent rendered by physicians charging in excess of $300, the prevailing limit would be $250, since this is the level that would cover at least 83 percent of the cases. However, if 15 percent, rather than 5 percent, of the services were rendered by physicians whose customary charge was at the $300 level with 5 percent charging above that level, the prevailing charge limit would be $300, since this would then be the level that would cover at least 83 percent of the cases.

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

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

Under the committee's bill, the prevailing charges recognized for a locality could be increased in fiscal year 1972 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.

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 1969. The increase in the indexes that occurs in a succeeding calendar year would constitute the maximum allowable aggregate increase in prevailing charges above the original base 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 ceilings for recognition of increases in prevailing fee limits on presently available indexes of changes in consumer prices and earnings 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 proportions indicated for 1966 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 in a carrier area would be 40 percent of the area increase in the BLS Consumer Price Index (all items less medical care) plus 60 percent of the area increase in the

earnings reported to the social security program. The increase in the BLS Consumer Price Index (which includes a service component and other prices reflecting, to some degree, office salaries paid by physicians) would be considered to indicate the justifiable increase in fees to take account of increases in costs met by the physician in his practice and the increase in earnings would be considered to indicate the justifiable increase in fees to keep the physician's earnings in line with the earnings of others. Thus, if during calendar year 1970 the area increase in prices 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 1972 would be 4.2 percent:

$$(.40\times.03)+(.60\times.05)=.042$$

The carrier would apply the prevailing charge criteria now in the law (but setting the prevailing charge limit at the 75th percentile of customary charges rather than at the 83d percentile permitted under present policies) to data on charges in calendar year 1970 to determine the increases in prevailing charges that it would be appropriate to recognize during fiscal year 1972. In the illustration cited earlier, where 20 percent of appendectomies in a locality were rendered by physicians who customarily charged $300 or more and 80 percent of such services were rendered by physicians customarily charging at or below $250, the prevailing charge level for that service would be $250 (the level that would cover at least 75 percent of the cases), rather than the prevailing charge level of $300 (the level that would cover at least 83 percent of the cases) that would be set under present policies. If the aggregate increase in prevailing charges so determined was less than 4.2 percent, the adjustments' would be permitted and the portion of the allowable aggregate increase not used in that fiscal year could be carried forward and used in future fiscal years. However, if the aggregate increase in prevailing charges found otherwise appropriate exceeded 4.2 percent, such increases would be reduced to the extent necessary to bring the aggregate of all increases within the 4.2 ceiling—that is, if the new prevailing charge limits that were indicated for fiscal year 1972 by the 75th percentile of calendar year 1970 charges multiplied by the frequency of the related services in calendar year 1970 exceeded, in total, the prevailing charge limits indicated for fiscal year 1971 by the 75th percentile of calendar 1969 charges multiplied by the frequency of the related services in calendar 1969 by 8.4 percent, then each of the prevailing charge increases indicated for fiscal year 1972 by the 75th percentile of calendar year 1970 charges would be reduced by one-half so that the aggregate increase allowed would be within the 4.2 ceiling.

It is, of course, contemplated under the bill that the Secretary would use, both initially and over the long run, the most refined indexes that can be developed. However, 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 of 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 prices and earnings, the rise in fees would be allowed in full.

The committee believes it desirable to provide the Secretary with appropriate leadtime for implementation of the proposed ceilings on recognition of prevailing charge increases and to provide a conservative base for its application. For this reason, the committee bill includes an interim provision for the remainder of fiscal year 1971 requiring, in effect, an extension of present policies to contain program costs. Under this interim provision the medical charge levels currently recognized as prevailing in a locality could be increased after enactment of the bill and during fiscal year 1971, only to the extent found necessary, on the basis of statistical data and methodology acceptable to the Secretary, to bring the charge levels recognized as prevailing in a locality to the 75th percentile of the customary charges (weighted by frequency rendered) made for similar services in the same locality during calendar year 1969. However, if currently allowed charges exceed this 75th percentile, no decrease in charges would be required by the new legislation. And, as noted earlier, the prevailing charges calculated as representing the 75th percentile in calendar year 1969 will establish the base from which the rate increase in prevailing charge levels will be measured. The economic index that would go into effect starting with fiscal year 1972 would be applied to this base to establish limits in future years.

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 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 these service benefit plans, 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 $1.00) 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 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 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 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 follow-up visits or multiple visits are justifiable as being non-routine.

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 that exceeds these new limits. This would be consistent with the situation in the present medicaid program.

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

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

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

The proposed amendment is substantially along the lines of the present regulation, and is effective upon enactment.

Authority of Secretary To Terminate Payments to Suppliers of Services

(Sec. 227 of the bill)

Present law does not provide authority for the Secretary to withhold future payments for services furnished by an institutional provider of services, a physician, or any other supplier who either abuses the program or endangers the health of beneficiaries, although pay-

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

The committee approves the House provision 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. 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). Professional members of the program review team would not be responsible for reviewing cases involving overcharging. Only the professional members of the program review teams would review cases involving the furnishing of excessive, inferior, or harmful services in order to assure that only professionals will review other professionals under this provision.

It is not expected that any large number of suppliers of health services will be suspended from the medicare program because of abuse. 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 July 1, 1971.

Elimination of Requirement That States Move Toward Comprehensive Medicaid Programs

(Sec. 228 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. For example, one State recently cut back on money going to medical schools in order to finance unexpected increases in the cost of medicaid. There is evidence that some States have moved more rapidly in the direction of expanding their medicaid programs, and consequently increasing their costs, because of the influence of section 1903(e).

The committee agrees with the action of the House which removes section 1903(e) from the act. When the operations of the State medicaid programs have been substantially improved and there is assurance that program extensions will not merely result in more medical costs inflation, the question of expansion of the program could then be reconsidered.

Determination of Reasonable Cost of Inpatient Hospital Services Under Medicaid and Maternal and Child Health Programs

(Sec. 229 of the bill)

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

The Committee on Finance approves the provision of the House bill which retains the intent of the original provision— to avoid having hospitals or their private patients subsidize inpatient care for the poor—

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

The bill would apply the same determination of reasonable costs to maternal and child health programs. The provisions would be effective July 1, 1971, or earlier if the State plan so provides.

Amount of Payments Where Customary Charges for Services Furnished Are Less Than Reasonable Cost

(Sec. 230 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 agrees with the House that it is inequitable for the medicare, medicaid, and the child health programs to pay more for services than the provider charges to the general public. To the extent that a provider's costs are not reflected in charges to the public generally, such costs are expected to be met from income other than revenues from patient care—for example, from endowment or investment income. The bill would provide, therefore, that reimbursement for services under the medicare, medicaid, and child health programs could not exceed the lesser of the reasonable cost of such services as determined 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 compensation for such services. In such cases fair compensation for a service could not exceed, but could be less than, the amount that would be paid under present law.

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 provid-

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

Payments to States Under Medicaid Programs for Installation and Operation of Claims Processing and Information Retrieval Systems

(Sec. 232 of the bill)

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

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

Your committee also recognizes the importance of this activity by providing Federal matching funds at the 75 percent rate for the operation (including contract operation) of a system approved by the Secretary.

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

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

Prohibition Against Reassignment of Claims to Benefits

(Sec. 234 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 HEW makes such reassigned payments under medicare without specific legislative authority.

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

The committee agrees with, but has made technical changes in, the provision in the House bill which seeks to overcome these difficulties by prohibiting payment for a service where the request for payment is made pursuant to an assignment to anyone other than the physician or other person who furnishes the service, except that the committee has provided that payment may be made, under conditions to be prescribed by the Secretary, to the employer of the physician or other

person if he is required as a condition of his employment to turn over his fees to his employer, or to a facility which is the sole organization which has the right to charge for the service.

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

This provision as it applies to medicare would be effective with respect to bills submitted and requests for payment made on or after March 1, 1971. For medicaid the provision would be effective July 1, 1971, or earlier if the State plan so provides.

Utilization Review Requirements for Hospitals and Skilled Nursing Homes Under Medicaid and Maternal and Child Health Programs

(Sec. 235 of the bill)

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

The Committee on Finance approves 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 committee which meets the standards established under medicare. It is not intended that where medicaid requires more stringent or comprehensive utilization review than does medicare, such requirements be reduced by virtue of operation of this section. States could, if they wish, impose more stringent requirements; e.g., they might request that the committee review medicaid patient stays earlier than medicare cases since the medicaid population is generally younger than that covered under medicare.

This provision would be effective July 1, 1971.

Elimination of Requirement That Cost-Sharing Charges Imposed on Individuals Other Than Cash Recipients Under Medicaid Be Related to Their Incomes

(Sec. 236 of the bill)

Under present law, a State cannot impose deductibles or other cost-sharing devices on cash assistance recipients. In addition, while deductibles or copayments can be imposed with respect to the medically indigent, they must be "reasonably related to the recipient's income and resources."

The Committee on Finance agrees with the House bill which would remove the restriction relating to the medically indigent in order to

allow States to explore the cost advantages that may result from the direct savings and possible decrease in utilization that cost-sharing devices of a specified amount for all the medically indigent might create. Even a small charge gives the recipient a sense of participation and can reduce any tendency toward excessive use of services. Experience with many programs covering prescription drugs has shown that a modest copayment can control excessive utilization. The committee believes that States should have the option of introducing copayment provisions for the purpose of reducing the overutilization of services.

It would be expected that States would impose flat deductibles or copayments primarily with respect to these items of health care or services which are provided in large part at the initiative of the patient. States would be permitted to have such a copayment for such services for all of its medically indigent.

The ban on use of deductibles or copayments for cash assistance recipients would be retained.

This provision would be effective January 1, 1971.

Notification of Unnecessary Admission to a Hospital or Extended Care Facility Under Medicare Program

(Sec. 237 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 provision 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. 238 of the bill)

Under present law, one State agency may have the responsibility for certifying health facilities for participation in the medicare pro-

gram 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 same agency shall perform these functions for medicare, medicaid, and the maternal and child health programs. The House bill specified "State health agency" as the responsible State body. However, in some States—such as Louisiana—another agency performs the certification function for medicare. The committee has therefore included a technical amendment to authorize use of the appropriate State medical agency rather than limiting the designation to "State health agency."

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

To encourage the development of the capabilities upon which these improvements would be based, the committee bill provides that Federal participation in medicaid payments be contingent upon the establishment of a plan, acceptable to the Secretary, for utilization review, the establishment of standards relating to the quality of care furnished to medicaid recipients, and review of the quality of services provided. Federal matching at the 75-percent rate is 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 July 1, 1971.

Coverage Prior to Application for Medicaid

(Sec. 251 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 Committee on Ways and Means and believes that such coverage is reasonable and desirable and recommends that the States be required to provide protection for that 3-month period. Therefore, the committee's bill requires all States to provide coverage for care and services furnished in or after the third month prior to application for those individuals who were otherwise eligible when the services were received.

This provision would be effective July 1, 1971.

Hospital Admissions for Dental Services Under the Medicare Program

(Sec. 252 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 determination of the necessity for inpatient hospital admission for dental services 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.

Exemption of Christian Science Sanatoriums From Certain Nursing Home Requirements Under Medicaid

(Sec. 253 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 and other inappropriate requirements of the medicaid program. Such sanatoriums will be expected to continue to meet all applicable safety standards.

This provision would be effective upon enactment.

Extension of Grace Period for Termination of Supplementary Medical Insurance Coverage Where Failure To Pay Premiums Is Due to Good Cause

(Sec. 255 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 on Finance 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. 256 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 purpose, services furnished in the last 3 months of a year are deemed to have been furnished in the following year.) The present time limit is adequate for the vast majority of supplementary medical insurance claims. In some few cases, however, beneficiaries have failed to file a timely claim due to a mistake or other action on the part of the Government or one of its agents. For example, misinformation from an official source or delay in establishing supplementary medical insurance entitlement has resulted in late filing of claims.

The committee agrees with the House provision 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. 257 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's bill includes a provision which would eliminate the 3-year limit on enrollment. That provision is discussed immediately following discussion of this provision.)

There have been some relatively rare cases in which it has been discovered that due to an action, inaction, or error on the part of the Government an individual is in fact enrolled, or is in fact not enrolled, under supplementary medical insurance when both the individual and the Government had until then believed that the reverse was true. Such cases include instances where an individual filed an enrollment request timely 2, 3, or more years ago, but it was inadvertently misfiled, and never acted upon. When the request is discovered, the individual, who did not know he had supplementary medical insurance coverage is presented with a substantial bill for premiums; or if he is a beneficiary, he may find that his benefit check is reduced or withheld altogether to pay premiums for supplementary medical insurance coverage which he never knew he had. Another type of case involves the person who enrolled in good faith and was allowed medical insurance on the basis of evidence showing that he had attained age 65; several years later new evidence is discovered which shows he was only age 64 at the time of enrollment—that is, new evidence shows that he was not eligible to enroll when he did. In such situations the Government is forced to disallow the supplementary medical insurance coverage, refund all premiums received, recover any supplementary medical insurance benefits paid, and notify the person that if he wishes supplementary medical insurance coverage he may enroll in the next general enrollment period. Although these cases are rare, they can cause 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. 258 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.

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 requests for enrollment filed after enactment of the bill.

Waiver of Recovery of Incorrect Payments From Survivor Who Is Without Fault

(Ses. 259 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 defeat the purposes of the cash social security title (title II) of the Social Security Act or would be against equity and good conscience. If such individual dies, recovery action is initiated as necessary from any other individual who is receiving cash social security benefits on the same earnings record as the decreased 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 indi-

vidual 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's bill would rectify this anomaly by permitting any individual who is liable for repayment of a medicare overpayment to qualify for waiver of recovery of the overpaid amount if he is without fault and if such recovery would defeat the purposes of title II or would be against equity and good conscience.

The provision would be effective upon enactment for overpayments outstanding at that time.

Requirement of Minimum Amount of Claim To Establish Entitlement to Hearing Under Supplementary Medical Insurance Program

(Sec. 260 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's bill would require that a minimum amount of $100 be at issue before an enrollee in the supplementary medical insurance program will be granted a fair hearing by the carrier.

The provision would be effective with respect to hearings requested after the enactment of the bill.

Collection of Supplementary Medical Insurance Premiums From Individuals Entitled to Both Social Security and Railroad Retirement Benefits

(Sec. 261 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 enroll-

ment. 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.

This provision would be effective for premiums becoming due and payable after June 30, 1971.

2. PROVISIONS OF THE HOUSE BILL WHICH WERE SUBSTANTIALLY MODIFIED BY THE COMMITTEE

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 believes that the connection between sound health facility planning and the prudent use of capital funds must be recognized if any significant gains in controlling health costs are to be made. Thus, 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 care planning agencies. On the areawide level, 127 planning agencies are receiving Federal grants: 36 of such agencies are operational. It is estimated that 140 areawide planning agencies will be receiving grants by the end of fiscal 1971 and that more than 70 of such agencies will be operational.

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

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

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 would be effective with respect to obligations for capital expenditures incurred after June 30, 1971, or earlier, if requested by the State.

Report on Plan for Prospective Reimbursement; Experiments and Demonstration Projects To Develop Incentives for Economy in the Provision of Health Services

(Sec. 222 of the bill)

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 in cost reimbursement as presently employed 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 financial incentives, as well as the risk of possible loss inherent in that method, to plan, innovate and generally to manage effectively in order to achieve greater financial reward 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 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 will 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 Jauuary 1, 1973, a full report of the results of the experiments and demonstration projects, as well as an evaluation of the experience of other programs with respect to prospective reimbursement. The report is to include detailed recommendations with respect to the specific methods that might be used in the full implementation of a prospective reimbursement system.

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 experimental 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 offer the promise of program savings without any loss in the quality of care.

The committee has modified the House provision so as to make clear that this authority with respect to experiments and demonstrations also encompass community mental health centers and, as discussed below, certain ambulatory health care facilities.

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

The Secretary is to submit to the Committee on Ways and Means and the Committee on Finance plans for each experiment or project, authorized under these provisions, a description, in detail, of its nature, methodology, and objectives. The intent is that there be an opportunity for congressional study before the experiment or project is put into operation.

Recently, a new type of health care facility—the ambulatory surgical center—has come into existence. This type of facility is operated 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 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 engaged in providing surgical or other services to ambulatory patients. If, as a result of this study, the Secretary finds that coverage of presently noncovered 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.

These provisions will be effective upon enactment of the bill.

Limitations on Coverage of Costs Under the Medicare Program

(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, 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 gross 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.

In commenting on the wide variations in per diem direct expenses for hospitals in New York City, J. Douglas Colman, president of the Associated Hospital Service of New York, noted in a paper prepared in connection with the National Conference on Medical Costs held on June 27–28, 1967; that:

> Some of the variations can be explained by varying characteristics of the patient census, by location, by scope of services offered, or by variations in the efficiency of physical plant. But none of these, nor any combination of them, satisfactorily account for the range of variation shown. For example, the range for voluntary teaching hospitals in New York City alone is from 38 percent above to 20 percent below the median per diem cost for this group of hospitals. One must conclude that at least a part of this variation reflects variations in efficiency.

The data being cited by Mr. Colman indicated that direct costs of "hotel" services (food and room costs) in hospitals in New York City varied from $17 to $32 per patient day with a median of $23, but three hospitals were at the level of $30 or more, more than 25 percent above the median. Nursing service costs varied from $11 to $20 per patient day with a median of $12 and the hospital with the highest nursing costs had nursing costs almost $3 per day above the hospital with the next highest nursing costs.

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

Similarly, when the high costs flow from gross inefficiency in the delivery of needed health care services the institution should not be shielded from the economic consequences of its inefficiency. (The committee modified the House provision so as to apply a test of "gross" inefficiency rather than inefficiency.) Health care institutions, like other entities in our economy, should be encouraged to perform efficiently, and when they fail to do so should expect to suffer the financial consequences. Unfortunately, a reimbursement mechanism that responds to whatever costs a particular institution incurs presents obstacles to the achievement of these objectives. It is believed that they can only be accomplished by reimbursement mechanisms that limit reimbursement to the costs that would be incurred by a reasonably prudent and cost-conscious management.

Present law provides authority to disallow incurred costs that are not reasonable. However, there are a number of problems that inhibit effective exercise of this authority. The disallowance of costs that are substantially out of line with those of comparable providers after such costs have been incurred creates financial uncertainty for the provider, since, as the system now operates, the provider has no way of knowing until sometime after it incurs expenses whether or not they will be in

line with expenses incurred by comparable providers in the same period. Furthermore, present law generally limits exercise of the authority to disallow costs to instances that can be specifically proved on a case-by-case basis. Clear demonstration of the specific reason that a cost is high is generally very difficult. And, since a provider cannot charge a beneficiary more than the program's deductible and coinsurance amounts for covered services, exercise of either type of authority can leave the provider without reimbursement for some costs of items or services it has already incurred for patients treated some time ago. Under these circumstances the provider would have to obtain funds from some other source to make up for its deficit.

The committee approves the House provision which would give the Secretary new authority to set limits on costs recognized for certain classes of providers in various service areas. This new authority differs from existing authority in several ways and meets the particular problems identified above. First, it would be exercised on a prospective, rather than retrospective, basis so that the provider would know in advance the limits to Government recognition of incurred costs and have the opportunity to act to avoid having costs that are not reimbursable. Second, the evaluation of the costs necessary in delivering covered services to beneficiaries would be exercised on a class and a presumptive basis—relatively high costs that cannot be justified by the provider as reasonable for the results obtained would not be reimbursable—so that implementation of the proposed authority would appear more feasible than present authority. Third, since the limits would be defined in advance, provision would be made for a provider to charge the beneficiary for the costs of items or services in excess of or more expensive than those that are determined to be necessary in the efficient delivery of needed health services. Public notice would be provided where such charges are imposed by the institution and the beneficiary would be specifically advised of the nature and amount of such charges prior to admission so that there is opportunity for the public, doctors, and their medicare patients to know what additional payment would have to be made.

The committee is aware of the magnitude of the task this proposal will impose on the Social Security Administration and on the other components of the Department of Health, Education, and Welfare that will be involved in implementing the authority it grants. Difficulties may be encountered as a result of deficiencies in the adequacy and timeliness of cost data and as a result of limitations in current methodology for comparing costs of health care institutions, measuring health care output and estimating the costs necessary to the efficient delivery of health care. On the other hand, the committee does not believe that the Congress should delay in enacting provisions controlling escalation of hospital and other health care costs until perfect methods of collecting and evaluating cost data are attained. What is intended by the committee's proposal is that limits on recognition of costs as reasonable under medicare, medicaid, and the child health programs be put into effect to the extent presently feasible and that these limits be refined and extended over time as developing cost data and methodology permits.

The committee recognizes that the initial ceilings imposed will of necessity be imprecise in defining the actual cost of efficiently deliver-

ing needed health care. Further, the committee recognizes that these provisions will apply to a relatively small number of institutions. The data that is 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 the classification for purposes of cost limits applied to them and to obtain relief from the effect of the cost limits on the basis of evidence of the need for such an exception.

Providers will be permitted to collect costs in excess of the medicare ceilings from the beneficiary (except in the case of admission by a physician who has a direct or indirect financial interest in a facility) where these costs flow from items or services in excess of 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 determination of the cost of the excess items or services for which the beneficiary may be charged will be determined 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.

These provisions would be effective with respect to accounting periods beginning after June 30, 1971.

Limitations on Federal Medicaid Matching

(Sec. 225 of the bill)

The committee is concerned over the fact that there exists in many areas of the country a substantial degree of overutilization of institutional care. This has been repeatedly demonstrated by investigations of the General Accounting Office and in HEW Audit Agency reports. Additionally, many States have not properly complied with utilization review and independent medical audit requirements.

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 House of Representatives shared this concern. In order to discourage and prevent overutilization, the House bill provided for a one-third cutback in Federal matching for patient stays which exceed (*a*) 60 days in a general or TB hospital; (*b*) 90 days in a skilled nursing home; and (*c*) 90 days in a mental hospital. In addition, there would be no Federal matching after an additional 275 days of care in a mental hospital during an individual's lifetime.

Despite general agreement with the objectives of the House bill the committee believes that the approach of the House bill is inadequate because it fails to differentiate between those States which are adequately controlling utilization and those which are not; thereby unjustifiably penalizing some States.

Therefore, the committee substituted for the House provision an amendment which would authorize the Secretary to reduce the Federal matching percentage on a selective basis with respect to those States where he finds overutilization, inadequate independent medical and professional audits, inadequate utilization review procedures or other inappropriate use of facilities (including intermediate care) or services. To facilitate arrangements for necessary independent professional and medical audits, the committee in another amendment authorizes 75 percent Federal matching toward the costs of professional personnel involved, including those under contract. Present law limits the 75 percent matching to professional personnel costs of employees of the State

agency only. The committee bill would provide that percentage reductions would be made with respect to improperly or inadequately monitored care or services and would be graded on a basis reasonably related to the estimated extent of the increased program costs resulting as a consequence of inadequate or improper controls on services. In making these determinations, the Secretary would utilize audit reports, estimates, statistical samples and other information available to him.

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 effectively established such controls.

The amendment would be effective upon enactment.

Payment for Supervisory Physicians in Teaching Hospitals

(Sec. 226 of the bill)

A major problem in the administration of the medicare program has arisen concerning the payment, under part B, on a fee-for-service basis for the services of "supervisory" physicians in teaching hospitals. These payments are estimated to involve more than $100 million annually. In general, such payments were not customary prior to medicare and it was not intended that medicare cover noncustomary charges.

The Comptroller-General of the United States shares the concern of the committee. He has submitted several reports to the committee relating to medicare payments for teaching physicians which document and detail the dimension of the problem confronting medicare in this area.

Teaching hospitals have a large number of "institutional" patients. The services to institutional patients are often actually provided by interns and residents. The salaries of these interns and residents are recognized in full under part A of medicare as a hospital cost. Medicare regulations (not the statute) offered teaching institutions and teaching physicians an opportunity to obtain funds through billing the institutional patient as if he were a private patient. Medicare may, when it also pays for the "supervisory" physician under part B, end up actually paying for the same service twice—first when it pays the salaries of the interns and residents who provide care and second, when the teaching physician submits his bill. This demand on part B funds results essentially in millions of aged people subsidizing medical education through their part B premiums.

H.R. 17550 as passed by the House has a section on payment for physicians' services in the teaching setting which attempts to deal with this problem. The approach in the House bill is to define the conditions under which fee for service will not be payable (basically where nonmedicare patients are not required to pay a charge by a teaching physician). Where a fee for service is not payable, the House bill provides for reimbursement on an actual costs basis under part B.

The difficulty with the approach in the House bill is that it might tend to encourage teaching hospitals and teaching physicians to introduce or expand the practice of billing by teaching physicians of nonmedicare patients on a fee-for-service basis.

The Association for Hospital Medical Education (AHME) testified in hearings before the committee that the services rendered to "institutional patients" have usually been rendered by residents and interns in training under the general supervision of full- or part-time "supervisory" physicians. The AHME further noted that there have been instances where the care rendered by interns and residents to institutional patients who are medicare beneficiaries has been reimbursed under part A, and reimbursement for the same service has been sought by the "supervisory physician under part B." The committee agrees with their statement that this double reimbursement is unequivocally wrong.

The recommendation concerning appropriate payment for teaching services made by the Association for Hospital Medical Education seems to provide a sounder basis for reasonable solution of this costly problem than that provided under the House bill.

Accordingly the committee has approved and the Department of HEW endorses an amendment providing 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 for all full-time physicians (other than house staff) at the hospital or, where such salaries do not provide a proper basis, at like institutions in the area. The average salary equivalent, which would be distilled into a single hourly rate covering all physicians regardless of specialty, would be applied to the actual time contributed by the teaching physician in direct patient care or supervisory voluntary service on a regularly scheduled basis to nonprivate patients. Such services would be billed for by the organized medical staff of the hospital and reimbursed to a fund designated by the organized medical staff.

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

There are also teaching physicians whose compensation is paid by a medical school. With respect to reimbursement for their direct or supervisory services for nonprivate medicare patients, payments

should be made on the basis of actual or salary-equivalent costs. The funds so received may be assigned by such physicians to an appropriate fund designated by the medical school for use in compensating teacher physicians, or for educational purposes. Where States elect to compensate for services of teaching or supervisory physicians under medicaid, Federal matching should be limited to reimbursement not in excess of that allowable under medicare.

Fee-for-service would continue to be payable for medicare beneficiaries who are bona fide "private patients." This would ordinarily be a patient who was seen by the physician in his office prior to hospital admission; for whom he arranged admission to the hospital, whose principal physicians' service were provided by him, who was visited and treated by him during his hospital stay; who would ordinarily turn to him for 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 physician. Of course, appropriate safeguards should be established to preclude fee-for-service payment on the basis of pro forma or token compliance with these private patient criteria.

The committee recognizes, however, that this concept of a private patient is not a complete definition primarily because it does not take account of the customary arrangements for reimbursing consultants and specialists who are not serving as the patient's attending physician, but who may provide a service to the patient for which a fee-for-service payment is appropriate and for which services the patient is 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. Furthermore, in some cases hospitals that normally do not bill for physician services have special centers, such as a center for severely burned people, where patients able to pay are regularly admitted and pay charges. It would be intended that medicare follow the pattern of the private patient in such centers.

The second exception to the cost-reimbursement coverage of teaching physician services is intended to permit the continuation of fee-for-service reimbursement for professional services provided to medicare patients in institutions which traditionally billed all patients (and 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 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 a cost basis, as it could have been paid under the original medicare law, if the election would be advantageous to the program in that it might reduce billing difficulties and costs.

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.

Unlike the House bill, the committee amendment calls for the cost-reimbursement payments for inpatient services to be made under part A of the program wherever the patient is eligible under part A. To assure equitable payment and no loss to the hospital on services to medicare patients where the cost reimbursement approach is applicable, cost-reimbursement payments would be made under part B where a part B enrollee is not insured under part A or where an insured inpatient has exhausted his part A hospitalization coverage.

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. While the House bill would also simplify administration, it would still be necessary under that bill to make such a distinction for purposes of determining the respective liabilities of the part A and part B trust funds.

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

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

Institutional Planning Under Medicare Program

(Sec. 231 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.

However, the committee has modified the House provision so that the required annual operating budgets may be prepared by groupings of cost or income rather than a detailed itemization for each type of cost or income. The 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 represenatives 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.

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 June 30, 1971.

Advance Approval of Extended Care and Home Health Coverage Under Medicare

(Sec. 233 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 home health benefit is payable on behalf of patients who need essentially the same type of nursing care on an intermittent basis. Skilled nursing care has generally been defined as the provision of identifiable skilled nursing procedures, although some authorities have argued that this definition does not adequately take into account the supervisory role

of a skilled nurse under whose presence and supervision a relatively unskilled person can participate in providing a skilled service. The usual administrative process for determining eligibility for payment involves retrospective review of the services actually furnished to the patient.

The committee believes that in practice, the administration of extended care and home health benefits has proved difficult and has led to considerable dissatisfaction. The complexity of the extended-care coverage determination, and the fact that it must often be made retroactively, tends to create confusion regarding the type of care which is reimbursable and may encourage physicians to either delay discharge from the hospital, where coverage is less likely to be questioned, or to recommend a less economical, though financially more predictable, course of treatment. The aggregate effect is to reduce the value of the extended care benefit as a continuation of hospital care in less intensive—and less expensive—setting as soon as it is medically feasible for the patient to be discharged from the hospital. Patients receiving care at home or who might be ready for discharge if sufficient assistance were available at home face a somewhat similar situation with respect to home health benefits. The uncertainty of coverage of services may impede effective discharge planning or the formulation of a comprehensive health care plan for a homebound patient.

The House sought to alleviate the problem by including a provision authorizing the Secretary to establish presumptive periods of coverage according to diagnosis and other medical factors for patients admitted to an extended care facility or started on a home health plan. While this approach seeks to alleviate much of the administrative complexity by focusing determinations on the totality of needs of certain categories of patients, rather than evaluation of specific nursing procedures, it introduces certain new administrative problems. The wide range of illnesses common to the aged, as well as the frequent occurrence of "combination diagnoses" makes specific categorization difficult.

The committee's bill, therefore, includes a provision designed to (1) respond more effectively to the needs of beneficiaries, including those for whom a short period of institutional care under continuing skilled supervision is needed to restore self-sufficiency and (2) substantially eliminate retroactive determinations. Under the committee's bill, emphasis in determining coverage would be placed on advance evaluation of the patient's need for a type of institutional care which requires the continuing availability of skilled nursing and related skilled services, in contrast to present law which requires continuing need for skilled nursing and other related skilled services. In all cases, the attending physician would be expected to certify the need for such care and provide a plan of treatment to the extended care facility or home health agency in advance of admission or start of care.

In lieu of predetermined periods of extended care coverage based on diagnoses, the committee's bill encourages and anticipates, that to the maximum extent feasible, preadmission evaluation and approval on an individual-case basis of the need for extended care. Such reviews could be performed by the Professional Standards Review Organization, hospital utilization review committee, or other appropriate group. Unless disapproved in advance, coverage upon admission would con-

tinue for the lesser of either the initially certified and approved period, until notice of disapproval, or 10 days. The physician and facility would be expected to forward supporting documentation for continued coverage of patients usually at least 3 days prior to expiration of the initially approved period or upon request of the review group. Where certifications and evidence are provided on a timely basis, any subsequent determination (for purposes only of determining medicare payment liability) that the patient no longer requires covered care would be effective beginning the third day after notification to the facility, thus giving the patient and his physician an opportunity to make other arrangements to meet the patient's needs.

Administration of the home health benefit would follow essentially the same approach. Review of the proposed plan of treatment, prior to its implementation, would be made wherever possible and could be performed by a PSRO, the utilization review committee of the institution from which the patient is being discharged (for part A home health benefits) or other qualified group. In the absence of a negative finding or a specific limitation, payment would ordinarily be made for up to 10 visits before additional review of the patient's needs was required. (The 10-visit limitation would apply on a calendar-year basis for part B home health benefits.) Where evidence and certifications were submitted promptly, determinations that the patient no longer needs the type of home care covered by medicare would be made prospectively.

As indicated, coverage of up to 10 home health visits would be presumed for both part A and part B. Where the patient has 10 days of coverage presumed for purposes of part A, he may *not* immediately thereafter have a new presumed period begin under part B. However, when a patient first has presumed coverage under part B and then needs to go to the hospital, presumed part A visits following institutionalization *would be* permissible (adding up to as many as 20 visits). The fact that the patient required hospitalization is an indicator of a change in his condition that would not be present where the patient merely switches from part A to part B coverage while remaining at home.

This provision would be effective with respect to admissions to extended care facilities, and home health plans initiated, after June 30, 1971.

Payments to Health Maintenance Organizations

(Sec. 239 of the bill)

Under present law, organizations providing comprehensive health services on a per capita prepayment basis cannot be reimbursed by medicare through a single prospective 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, whether it is made on a cost or charge basis, must be related, retrospectively, to the costs to the organization of providing specific services to beneficiaries, so that some of the financial incentives which such organizations may have in their regular nonmedicare business to keep costs low and to control utilization of serv-

ices 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 which occurs to an extent in the present, usual approach to payment for services in the health field, either by private patients, private insurance, or the Government, is that, in effect, payment is made to the provider for each individual service performed, so that other things being equal, there is an economic incentive on the part of those who make the decisions on which services are needed to provide more services—services which may not be essential, and even unnecessary services. Another area of concern is that, ordinarily, an individual must largely find his own way among various types and levels of services with only partial help from a single hospital, a nursing home, a home health agency, various specialists, and so on in terms of referral to appropriate sources of care. The pattern of operation of certain organizations (such as the Kaiser Health Care Foundation and H.I.P.) which provide services on a per capita prepayment basis may lend itself to possible solution of both of these problems with respect to the care of individuals enrolled with them. Because the organization receives a fixed annual payment from enrollees, regardless of the volume of services rendered, there is a financial incentive to 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 and providing a bonus or similar profit-sharing arrangements when costs are kept low. Moreover, such existing organizations assume responsibility for deciding on the services which the patient should receive. 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.

The committee believes it is desirable for medicare to relate itself to prepayment health care organizations in a way which conforms more nearly to their usual way of doing business. The objective is to reinforce, in the case of medicare beneficiaries, the financial incentives—if professional incentives are insufficient—which health maintenance organizations have with respect to their other enrollees.

The health maintenance organization provision of the bill, strongly endorsed and advocated by the Department, is intended to contribute to reductions in the cost of health care delivery and to improve quality of care under the medicare program. The committee is concerned that, to the contrary, the health maintenance organization provision could turn out to be an additional area of potential abuse which might have the effect of increasing health care costs—paying a larger profit than is now or should be, paid to these organizations—and decreasing the quality of service available or rendered.

However, if the safeguards the committee has added are properly administered, it may be that the stated goals of the provision can be achieved. In any event, this new program is unquestionably an area

where the Office of the Inspector General (which would be established under a committee amendment to the bill) can make a major contribution toward assuring that health maintenance organizations are operated consistent with principles of efficiency and economy and, particularly, that they comply strictly with the statute and the legislative intent of the Congress.

Accordingly, while it has reservations about the proposal, the committee has adopted, with certain tightening changes, the amendment in the House bill under which medicare payment to a so-called Health Maintenance Organization (HMO) with respect to beneficiaries enrolled with it could be made on a prospective per capita basis, encompassing services covered under both hospital insurance and supplementary medical insurance. (Group practice prepayment plans could, of course, choose to continue to be reimbursed under the provisions of existing law if they wished.) The additions and modifications made by the committee reflect its desire to assure that health maintenance organizations are afforded opportunity to demonstrate their capacity to provide comprehensive care economically and efficiently without endangering either the health interests of program beneficiaries or the integrity of the trust funds.

Under the House bill, a prospective rate of payment would be determined annually in accordance with regulations of the Secretary, taking into account the organization's premiums with respect to nonmedicare enrollees (with appropriate actuarial adjustments to reflect the difference in utilization patterns and other relevant factors between those under 65 and those over 65). This payment would be no more than 95 percent of the estimated amount (with appropriate adjustments—such as age and morbidity differentials—to assure actuarial equivalence) that would be payable if such covered medicare services were furnished outside of the framework of a health maintenance organization.

The committee bill would modify in several ways the House bill's provisions for determining payment to HMO's. First, rather than limiting payment to the lesser of (a) an adjusted premium amount or (b) 95 percent of the estimated amount that would be payable if the covered services were to be furnished by other than health maintenance organizations, the committee bill would authorize payment at the 95 percent of the actuarial equivalent rate but only if the health maintenance organization provides the Secretary with satisfactory assurances that any excess over the adjusted premium payment will be returned to beneficiaries in the form of expanded benefits or reduction in amounts charged as the equivalent of medicare's deductibles and coinsurance. HMO's will thus have funds, where performance is efficient and necessary care has been properly provided, to improve benefit protection or reduce premium costs for medicare enrollees and thereby possibly attract further enrollment. Under this modification beneficiaries, who upon enrollment with an HMO forgo coverage of most nonemergency out-of-plan services, would have some incentives for enrollment.

Second, with respect to the health maintenance organization's premiums which would be taken into account in medicare's payment determination, the committee bill adds a provision intended to alleviate a

concern that the proposed payment determination might reward profiteering by relating payment to premiums that contain an unjustifiably high retention (margin over direct benefit and administrative costs.) The Committee limits the retention to the lesser of: (i) the retention rate (excluding the administrative expenses) as a percentage of the net premium for people under age 65, or (ii) 150 percent of the dollar amount of retention (excluding administrative expenses) per capita for enrollees who are under age 65 of the HMO.

Third, the 95 percent payment rate, which would be authorized where the Secretary has received the necessary assurances from the health maintenance organization, would be based on estimated benefit costs only plus an estimated allowance for administrative expenses reasonably related to the actual expenses of such a HMO and the expenses of comparable organizations. This approach recognizes that a health maintenance organization's administrative expenses can be expected to be lower than those of carriers and intermediaries because HMO's need not perform all of the functions of carriers and intermediaries. For example, HMO's generally do not pay small individual physician fee-for-service claims.

Fourth, there would be an overall ceiling on payment to a health maintenance organization equal to 95 percent of the estimated amount for benefit cost and administrative expenses, including only carrier and intermediary administrative costs (exclusive of auditing expenses), payable if covered services were to be furnished by other than health maintenance organizations. This ceiling, and the 95 percent payment rate mentioned in the preceding paragraph, would be based upon the reimbursement amount per capita for the Nation adjusted for variations in unit benefit cost due to service areas, reasonable availability of services, and underwriting rules. The service area concept encompasses the geographical locality where the health maintenance organization is providing the service, and in which there is a reasonable cross section of different types of institutions and practitioners and utilization rates. Where there is an abnormal scarcity of services or excessive services for persons not in the HMO in a particular locality, but the needs of HMO members are fully met, the actuarial equivalent cost would be determined by established actuarial methods which include the consideration of costs in comparable locations where the covered services are reasonably available. In negotiating and reviewing rates of payment, the committee expects that such negotiations will be conducted, on the part of the government, on an arms-length basis by qualified and expert personnel. The actuarial determinations should be performed by qualified actuaries experienced in health care program costing. This expertise also would be needed to appraise whether enrollment of poorer risks, such as institutionalized persons or persons of low income, was less than in proportion to the population in the service area and to determine the effects on costs. Similarly special limitations of the HMO on access of members to care, on limitations on the provision of teaching and community services should also be taken into account in considering cost equivalence.

Fifth, the committee has included an additional safeguard which would authorize the Secretary to adjust, retroactively, any payments

made to a health maintenance organization on the basis of projected national average costs, if it is later determined that such projections were based on erroneous data or if actual experience differs substantially from the assumptions upon which the projections were made. Such adjustments, which could result in either increase or decrease in program payments, must be determined within 3 years following the close of the accounting period to which the adjustment applies.

Under this basis for payment, the health maintenance organization should be encouraged to manage its resources and provide a level of service within a predictable premium income; extensions and improvements in service could thus also be provided to beneficiaries from utilization and other savings which the organization may be able to make over more traditional methods of providing services.

For ease of calculation of amounts to be paid from the two trust funds, payments to health maintenance organizations would be made from both the hospital insurance and supplementary medical insurance trust funds with the portion from the supplementary medical insurance trust fund being the product of the total monthly premium (beneficiary and Federal Government amounts combined) times the number of medicare beneficiaries enrolled in the organization rather than an actuarially determined part B cost within the HMO. The remainder of the HMO payment would be made from the hospital insurance trust fund.

Under the House bill, the individuals with respect to whom such payment would be made are medicare beneficiaries entitled to both hospital insurance and supplementary medical insurance who are enrolled with a health maintenance organization. Since some potential health maintenance organizations have substantial numbers of members who, because of noncoverage under social security in the past, are not eligible for hospital insurance benefits (or who would be eligible for such benefits only by paying their full cost as provided under another proposed amendment), the committee has added a provision which would allow payments to be made for medical insurance benefits alone for enrolled beneficiaries who are not entitled to hospital insurance benefits. Eligible enrolled beneficiaries would, with two exceptions, receive medicare-covered services only through the health maintenance organization. One exception, contained in the House bill, would cover those emergency services as are furnished by other physicians and providers of services; the health maintenance organization would be responsible for paying the costs of such emergency services. The committee would also require a health maintenance organization to pay the cost of otherwise covered and necessary maintenance therapy which an enrollee receives outside the organization because of nonaccessibility or availability of the service directly from the organization. If an enrolled individual received other types of nonemergency care through some means other than the health maintenance organization, he would have to meet the entire expense of such care. The fact that members received some care outside the HMO would be taken into account in calculating the actuarial equivalent cost of the services furnished by the HMO.

To qualify to receive payment in this way, a health maintenance organization would have to be one which provides: (1) either directly or through satisfactory arrangements with others, health services

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

The organization would have to have an open enrollment period at least annually under which it accepts enrollees (including undertaking during open enrollment periods specific and active efforts to contact, inform, and enroll institutionalized beneficaries) on a nondiscriminatory basis up to the limits of its capacity. An organization which does not accept applications for enrollment from a significant and representative proportion of eligible applicants during two consecutive open enrollment periods may be terminated if adequate justification is not provided.

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 there are a minimum of 10,000 enrollees (both medicare and nonmedicare) initially, or, that the HMO can reasonably be expected to attain such minimum enrollment within a period not exceeding 3 years with progressive continuing increases in enrollment toward the minimum during that period; (3) that the organization must have satisfactory procedures assuring that the health services required by its enrollees are received promptly and appropriately and that they are of proper quality.

The various elements of a health maintenance organization, such as hospital, extended care facility, or clinical laboratory, would each continue to have to meet the conditions of participation or other quality standards which apply to such organizations under present law. The committee has added to the House bill a provision which makes it clear that institutions owned or utilized by a health maintenance organization must adhere to the health facility planning requirements which would be applied to other providers of services under provisions of another amendment. Where applicable, appropriate reductions will be made in payments to any health maintenance organization which renders services to beneficiaries through a hospital or other institutions with respect to which the Secretary determines that payment for capital expenditures must be excluded.

With respect to all of the above minimum requirements, it is expected that they will be carefully and fully applied so as to avoid establishment of pro forma HMO's by organizations essentially interested in securing greater levels of reimbursement than are otherwise payable under the regular medicare program and without reducing program costs through increases in effectiveness and efficiency.

Under the House bill, an organization would not qualify under this provision unless at least half of its membership is under age 65. The committee agrees that the membership distribution requirement is a desirable objective in order to assure that the health maintenance organization operates in true competition with other health care delivery mechanisms, but rigid imposition might be detrimental to newly developing organizations and organizations located in retirement areas or deliberately established as part of an effort to bring adequate health care to inner-city or rural areas. Therefore, the committee has modified the House requirement to permit the Secretary to initially waive the one-half enrollment requirement for up to 5 years if compliance would otherwise cause substantial reduction in enrollment, provided the organization furnishes evidence of sustained and substantial efforts to achieve the required enrollment distribution or, in rare instances, to waive the requirement completely if it is determined that failure to meet the requirement is due to geographic or other circumstances beyond the organization's control.

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

Beneficiaries enrolled with a health maintenance organization who are dissatisfied with decisions of the organization as to 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, generally, disenrollment would take effect at the same time after the disenrollment request as is the case now with respect to disenrollment under the supplementary medical insurance program.

Under provisions of the House bill, a health maintenance organization would be treated as a "provider of services," i.e., would be treated in the same manner that hospitals, extended care facilities and certain

other individual agencies and organizations that participate in the program. Such a status connotes a continuing relationship contingent upon compliance with health quality, fiscal, and technical conditions of participation. However, effective administration of the health maintenance organization provision will require an active and comprehensive role by the Secretary in reviewing and evaluating performance of such organizations in relation to the total range of program interests including responsiveness to beneficiary needs as well as adherence to fiscal and quality standards. The committee has therefore amended the House provision to establish a contractual relationship between the Secretary and a health maintenance organization. Such a contract would be renewable annually in the absence of reasonable advance notice by either party of intention to terminate at the end of the current term, except that the Secretary could terminate the contract at any time (after reasonable notice and opportunity for hearing) if he finds that the organization has failed substantially to carry out the contract or is carrying it out in a manner inconsistent with efficient, effective, and economical administration of this section.

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

The committee also notes that some potential qualified health maintenance organizations currently have enrollees who may desire to continue membership in the organization but who do not wish to agree to receive covered services only from that organization. Since it would seem inequitable to require such individuals to either disenroll immediately or involuntarily accept a limitation on their access to covered services, the committee has added a provision under which a health maintenance organization could continue through June 1974 to be reimbursed for covered care provided to beneficiaries who were members prior to July 1971 but who do not elect the option. Program payments in such cases would be determined on a prospective per capita basis similar to that used for enrollees who elect the option, with appropriate payment reductions for projected out-of-plan use of covered services by such enrollees.

The provision would become effective with respect to services provided on or after July 1, 1971.

Physical and Other Therapy Services Under Medicare

(Sec. 254 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 its outpatients. The physical therapist may be either an employee of the participating facility or he may be self-employed and furnish his services under arrangements with and under the supervision of the facility.

The 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 bill would be exceedingly 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 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 has provided an effective date, for this subsection, applying to services furnished after June 30, 1971.

The House bill also includes a provision for controlling program expenditures and for preventing abuses. Under the provision in the House bill, the reasonable cost of physical therapy services furnished by a provider of services, or by others under an arrangement with such provider, may not exceed an amount equal to the salary which would have reasonably been paid to a physical therapist if he had

performed the services as an employee. While the committee agrees that effective controls are necessary, it believes that the House provision limiting reimbursement for physical therapy services to a salary-equivalent amount does not take into account expenses a therapist not working as a full-time employee would have. These expenses may include costs of maintaining an office, travel-time and expense, and similar costs. The committee bill, therefore, modifies the House provision to limit reimbursement to a "salary-related" basis which would permit determinations of reasonable cost for physical therapist services to allow for additional expenses which may be incurred by therapists who are not full-time employees of a facility. The Secretary would determine which additional expenses would be allowed. The committee bill would further modify this provision of the House bill to extend this reimbursement limitation to cover other therapy services (such as occupational therapy and speech therapy) furnished by a provider of services or by others under an arrangement with a participating provider, and to services provided by other specialists such as social workers, medical records librarians, dieticians, etc.

The above provision would be effective with effect to accounting periods beginning on or after July 1, 1971.

Payment for Certain Inpatient Hospital and Medical Services Furnished Outside the United States

(Sec. 262 of the bill)

The House-approved bill provides, with respect to admissions after December 31, 1970, 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 was closer to, or substantially more accessible from his residence than the nearest hospital in the United States which was suitable and available for his treatment. For such beneficiaries, benefits would be payable without regard to whether an emergency existed or where the illness or accident occurred. Only 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 services are not made by the hospital, two-thirds of the hospital's total charges.

The committee is fully in agreement with the objective of the House bill but it is concerned that the hospital services that would be covered under this proposal, along with the coverage provided under present law for emergency hospital services outside the United States, would not adequately protect medicare beneficiaries against other medically necessary health care costs which they may incur while receiving covered foreign inpatient hospital care. Therefore, the committee has amended the House-approved bill to 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.

The committee's bill would limit payment for physicians' services to the period of time during which the individual is eligible to have payment made for the foreign inpatient 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 committee's bill would provide that benefits for foreign physicians' and ambulance services would be payable only in accordance with the itemized bill method of reimbursement provided for under present law.

This provision would apply to services furnished with respect to hospital admissions occurring after June 30, 1971.

3. NEW PROVISIONS ADDED BY THE COMMITTEE

Provide That Services of Optometrists in Furnishing Prosthetic Lenses Not Require a Physician's Order

(Sec. 203 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. However, in its report accompanying the bill, the Committee on Ways and Means directed the Department of Health, Education, and Welfare to study the present coverage of optometric services in the interest of removing any existing inequity.

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 and should be eliminated. The patient's freedom to choose either an ophthalmologist

or an optometrist to furnish him with prosthetic lenses should no longer be restricted by this requirement.

The committee bill would recognize the ability of an optometrist to determine a beneficiary's need for prosthetic lenses by amending the definition of the term "physician" in title XVIII to include a doctor of optometry authorized to practice optometry by the State in which he furnishes services. An optometrist would be recognized as a "physician" only for the purpose of attesting to the patient's need for prosthetic lenses. (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.

The amendment would become effective upon enactment.

Coverage of Supplies Related to Colostomies

(Sec. 204 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 of Chiropractic Services

(Sec. 205 and 280 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 under other plans 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, chemistry, 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 material 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 and after July 1, 1971.

Conform Medicare and Medicaid Standards for Nursing Facilities

(Sec. 240 of the bill)

At the present time, the conditions of participation for extended care facilities under medicare and the standards required of skilled nursing homes under medicaid are identical in some respects and similar in others. In large part, medicaid skilled nursing homes were substantially upgraded as a consequence of the specific statutory requirements applicable to such homes which were included in the Social Security Amendments of 1967.

While the emphasis of the care under the two programs may differ somewhat—medicare focusing on the short-term care patient and medicaid on the long-term patient—patients 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 it would be desirable to apply a single set of standards relative to health, safety, environmental conditions, and staffing, with respect to skilled nursing facilities under both medicare and medicaid. As provided in the House bill, States would also be expected to consolidate certification activities for both programs in a single State agency. The committee intends that the single State agency carry out its responsibilities to the greatest extent possible through means of a single consolidated survey to determine a facility's qualifications for medicare and medicaid.

The committee amendment is not intended to result in any dilution or weakening of standards for skilled nursing facilities. For that reason, the amendment provides that a higher standard as judged by the Secretary of Health, Education, and Welfare in one program—whether the standard is a current requirement or one required in the future—shall be applicable to the other program as well. Any waiver of a standard applicable to both programs may be applied only if acceptable under both programs. Additionally, a State may continue to require higher standards of skilled nursing facilities than those mandated by Federal statute and regulation. In case a State imposes additional requirements in its own right, then, as under present section 1863 of the Social Security Act, those standards shall apply to both medicare and medicaid skilled nursing facilities in that State.

The above provisions are effective July 1, 1971.

Provide for Simplified and More Economical Reimbursement of Extended Care Facilities

(Sec. 241 of the bill)

Under present law, extended care facilities, as well as other providers of service, are reimbursed for the reasonable cost of covered services furnished to medicare beneficiaries. Since actual cost cannot be accurately determined until after the close of an accounting period, a facility is reimbursed with interim payments based upon its estimated costs. However, upon analysis of an annual cost report submitted by providers which identifies the actual costs incurred through cost finding and cost apportionment, a retroactive adjustment is made for any difference between the interim payments made and the program's share of the provider's actual costs, to the extent they are deemed reasonable.

Under medicaid, States generally establish (in advance) per diem or similar basic rates payable for patients receiving skilled nursing home care. Such rates ordinarily reflect estimates of the costs of providing routinely required care to eligible recipients.

The committee recognizes that the existing reasonable cost approach of the medicare program has created certain difficulties for extended care facilities. It is aware that complaints have been voiced about the complexity of medicare cost-finding and recordkeeping requirements and that problems might result from the standpoint of effective

financial management because of the facility's failure to know in advance the actual payments that will be received. The committee is also cognizant of the fact that the existing reimbursement formula, as applied, with its retrospective adjustment provision, may offer little or no incentive to contain costs or to control the type and extent of services furnished since actual costs incurred are almost always reimbursed.

On the other hand, under the medicaid program States generally establish (in advance) per diem or monthly rates for patients receiving skilled nursing care. These facilities generally know in advance the income they can expect to derive from services furnished to eligible patients and this knowledge probably contributes to more effective budgeting and planning.

The type of facility, requirements for participation, and range of services provided, do not differ substantially as between a fully qualified extended care facility in medicare and a fully qualified skilled nursing home in medicaid.

The committee bill, therefore, authorizes the Secretary to apply, in establishing reasonable cost payments for extended care facilities for any State (on a total, class, size, or other appropriate basis) the rates developed in the State under medicaid for basic reimbursement of skilled nursing care, provided he finds, based upon information and data supplied by a State, that such rates are reasonably related to the costs of care (room, board, routine nursing and other routine services) in facilities generally comparable to those participating in medicare.

The committee recognizes that various types of reimbursement methods developed by States under medicaid might be found to satisfy the above requirement where they are based upon estimates (through sampling or other techniques) of the costs of skilled nursing care in comparable facilities. For example, although frequently a single or overall State rate of reimbursement for skilled nursing care covered by medicaid is established, in some States varying rates of reimbursement are established for different categories of institutions or for different classes of patients. In other States, actual costs are reimbursed subject to certain maximum limitations. In each of these the State rates may or may not be reasonably related to the cost of services in groups of facilities participating in medicare.

Where a State's basic rates of reimbursement for skilled nursing care under medicaid are predicated upon analyses of costs for care in such facilities and the Secretary is satisfied that the analyses undertaken by the State adequately reflect the reasonable costs of care, reimbursement for posthospital extended care under medicare should be based upon or limited to the same rates of payment. The criterion to be applied by the Secretary is that the State's rates of payment be appropriately related to reasonable costs. The Secretary would be permitted to adjust a rate where appropriate, to reimburse for specific factors related to medicare requirements (such as bed availability, 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 10 percent) so as to simplify reimbursement. Thus, conceivably, where facilities in a State demon-

strate to the Secretary and the State advises that medicaid in that State compensates on a basis of more patients in a room than does medicare or does not include payment for a service covered by medicare, he might reimburse such institutions on the basis of the medicaid rate plus a percentage adjustment. These percentage adjustments should be made on a geographic basis or on the basis of classes of facilities and not on an institution-by-institution basis.

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 rates 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.

A facility located in a State whose medicaid rates of reimbursement for skilled nursing care are not adopted by the Secretary on a total, class, size, or other appropriate basis applicable to that facility will continue to be reimbursed under normal medicare methods.

The amendment would be effective with respect to accounting periods beginning on or after July 1, 1971.

Provide for Reasonable Approval of Rural Hospitals

(Sec. 242 of the bill)

According to policy established by the Social Security Administration, a hospital or extended care facility is certified for participation in medicare if it is in full compliance (meets all the requirements of the Social Security Act and is in accordance with all regulatory requirements for participation), or if it is in "substantial" compliance (meets all the statutory requirements and the most important regulatory conditions for participation). Thus, while an institution may be deficient with respect to one or more standards of participation, it may still be found to be in substantial compliance, if the deficiencies do not represent a hazard to patient health or safety, and efforts are being made to correct the deficiencies.

It has been recognized that there is a need to assure continuing availability of medicare-covered institutional care in rural areas, many of which may have only one hospital, without jeopardizing the health and safety of patients. To achieve this objective, the approach has been adopted by Social Security of certifying "access" hospitals while documenting their deficiencies and requiring upgrading of plant and staff. State agencies have also been required to provide consultation and assistance to these facilities in an effort to help them achieve compliance with the standards. Certain "access" hospitals, to the extent that they are capable, have succeeded in overcoming deficiencies; however, other hospitals have not demonstrated sufficient willingness to take the steps necessary to correct deficiencies and have instead

been willing to continue as "access" hospitals with all the limitations in quality care that this status entails. In other areas, some rural hospitals despite good faith efforts have been unable to secure required personnel or otherwise comply.

To deal with the dilemma created by the need to assure the availability of hospital services of adequate quality in rural areas and the fact that existing shortages of qualified nursing personnel generally make it difficult for some rural hospitals to meet the nursing staff requirements of present law, the committee's bill would authorize the Secretary, under certain conditions, to waive the requirement that an access hospital have registered professional nurses on duty around the clock. This requirement could be waived only if the Secretary finds that the hospital:

(a) has a registered nurse at least on the daytime shift and has made and is continuing to make a bona fide effort to comply with the registered nursing staff requirement with respect to other shifts (which, in the absence of an R.N., are covered by licensed practical nurses) but is unable to employ the qualified personnel necessary because of nursing personnel shortages in the area; and

(b) is located in an isolated geographical area in which hospital facilities are in short supply and the closest other facilities are not readily accessible to people of the area; and

(c) nonparticipation of the "access" hospital would seriously reduce the availability of hospital services to medicare beneficiaries residing in the area.

Under the provision, the Secretary would regularly review the situation with respect to each hospital, and the waiver would be granted on an annual basis for not more than a one-year period. The waiver authority would be applicable only with respect to the nursing staff requirement; no waiver authority would be provided under the amendment with respect to any other conditions of participation relating to health and safety.

The proposed waiver authority would expire December 31, 1975.

Intermediate Care Facilities

(Secs. 243 and 269 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 provide a means for appropriate placement of patients professionally determined to be in need of health-related supportive institutional care but not care at the skilled nursing home, or mental hospital level.

The intermediate care benefit was not intended to cover care which was essentially residental or boarding home in nature. It was not intended to provide a refuge for substandard nursing homes which would not or could not meet medicaid standards. It was not intended as a placement device whereby States could reduce costs through wholesale and indiscriminate transfer of patients from skilled nursing homes to intermediate care without careful and independent medical review of each patient's health care needs.

Many thousands of patients are in skilled nursing homes who do not need that level of care, according to recent General Accounting Office and HEW audit reports. Thousands of those people are in skilled nursing homes because their States have not as yet established intermediate care programs.

The committee has therefore, included an amendment to clarify congressional intent with respect to intermediate care and to make such care, where appropriate, more generally available as an alternative to costlier skilled nursing home or hospital care.

The committee amendment is designed to make it clear that intermediate care coverage is for persons with health-related conditions who require care beyond residential care or boarding home care, and who, in the absence of intermediate care would require placement in a skilled nursing home or mental hospital.

The committee amendment would require an intermediate care facility to have at least one full-time licensed practical nurse on its staff and to meet such other standards, prescribed by the Secretary, as are deemed necessary to assist in meeting the needs of the types of patients expected to be placed in such institutions.

The amendment also provides for the transfer of the intermediate care provisions from title XI of the Social Security Act to title XIX (medicaid). This action will enable the medically indigent, presently ineligible for intermediate care, to receive such care when it has been determined as appropriate to their health care needs. This change should also serve to end the practice, in some States, of keeping medically indigent patients in skilled nursing homes where they could more appropriately be cared for in intermediate care facilities. Such States do so because, under present law, Federal matching funds are available toward the costs of skilled nursing home care provided medically indigent persons but not for care of those people in intermediate care facilities.

The committee amendment would also authorize Federal matching under medicaid for care of the mentally retarded in public institutions which are classified as intermediate care facilities. Matching would be available only in a properly qualified institution meeting standards (in addition to those required of an ICF) established by the Department for mentally retarded persons (other than those primarily receiving custodial care) receiving an active program of health-related treatment or rehabilitation. States would not be eligible for the additional Federal matching funds unless they maintained the level of State and local funds expended for care of the mentally retarded. The purpose here is to improve medical care and treatment of the mentally retarded rather than to simply substitute Federal dollars for State dollars.

The committee agrees with the House of Representatives that intermediate care is by definition less extensive than skilled nursing home care and that the cost of intermediate care should generally be significantly less per diem than skilled nursing home care in the same area.

In view of the rapidly increasing expenditures for intermediate care and in view of the extension of intermediate care to the medically-indigent, the committee has added another provision to its amend-

ment requiring regular independent professional review of patients in intermediate care facilities. Teams, headed by either a physician or a registered nurse, would regularly review, on site, the nature of the care required and provided to each intermediate care recipient. That review would be undertaken on a patient-by-patient basis and may not be performed at a distance or without reference to the specific circumstances of the individual patient.

The committee reiterates the concern it has previously expressed with respect to the failure of many States to properly undertake the independent medical audit of skilled nursing home and mental hospital patients to assure that each patient for whom Federal funds is provided is in the right place at the right time receiving the right care. This shortcoming among the States has characterized placement and review of intermediate care patients heretofore. Each skilled nursing home, each mental hospital patient, and each intermediate care patient must be individually reviewed by an independent team to assure proper placement. Wholesale and general review for purposes of what is virtually cursory compliance with Federal requirements must not be permitted by the Department of Health, Education, and Welfare. Where such independent audits and other utilization review requirements are not properly carried out, the committee expects that the Secretary will, in accordance with section 225 of the bill, promptly act to reduce Federal matching rates toward costs of the institutional care involved until proper compliance is forthcoming from a State.

The amendment is effective July 1, 1971.

Direct Laboratory Billing of Patients

(Sec. 244 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 of 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 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.

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 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.

The amendment is effective upon enactment.

Professional Standards Review Organization

(Sec. 245 of the bill)

INTRODUCTION

According to the most recent estimates the costs of the medicare hospital insurance program will overrun the estimates made in 1967, by $216 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 $10.60 per person on July 1, 1970. Medicaid costs are also rising at similar 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. The House bill contains a number of desirable provisions which the Committee on Finance believes will be successful in helping 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 focused its attention on methods of assuring proper utilization of these services. The committee feels that utilization controls are particularly important in light of the hearings conducted by the Subcommittee on medicare and medicaid. A number of witnesses testified that a significant number of the health services provided under medicare and medicaid are in excess of those which would be found medically necessary. In view of the per diem costs of hospital and nursing home care, and the costs of medical and surgical procedures, the economic impact of this overutilization becomes extremely significant. Aside from its economic impact the committee is also 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 is 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 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 indicates 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 present 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.

Based on a sample of hospitals conducted in the middle of 1968, the Social Security Administration found:

(1) Ten percent of the hospitals were not conducting a review of extended-stay cases.

(2) Forty-seven percent of hospitals were not reviewing any sample of admissions (a basic statutory requirement).

(3) Forty-two percent of hospitals did not even maintain an abstract of the medical record or other summary form which could provide a basis for evaluating utilization by diagnosis or other common factor.

In one State, the health agency conducted a detailed program review in November 1968. Their findings were that half of the hospitals and all of the extended-care facilities failed to perform any sample review of cases which were not in the long-stay category (a statutory requirement).

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 indicates that in many cases intermediaries have not been performing these functions, 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 feels 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 must be based on the premise that only physicians can 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]

[1] Report of the Health Manpower Commission, November 1967, p. 48.

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 would at the same time contain 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 care as guidelines for review activities, as opposed to the present usage of arbitrarily determined checkpoints. The present review process, without 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. 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 services (but not payments) provided through the medicare and medicaid programs. The Department of Health, Education, and Welfare endorses this change in law.

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 (usually called foundations).

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 of Health, Education, and Welfare 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 overutilization and unnecessary utilization of health care services. Such efforts should not be terminated in any area until such time as a professional standards review organization 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.

Additionally, the committee was impressed with the scope and results of the review activity and quality control efforts of the New York City Department of Health with respect to medicaid. While professional standards review organizations should be given priority in undertaking review responsibility, the present activities of the New York City Department of Health, and similar public agencies should not be terminated, or otherwise limited, until such time as professional standards review mechanisms are functioning at least equally as effectively as those of the public agencies. Again, to the extent the PSRO and the medicare program can benefit from utilizing the services of such an organization, the PSRO would be empowered to continue its effectiveness.

ESTABLISHMENT OF PSRO'S

The amendment requires the Secretary of HEW, 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, 1972. 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 many 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. The Secretary would provide prototype plans of organization and operation to prospective PSRO's in each area. The prototypes would be developed in consulta-

tion 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.

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 should 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 but no physician should 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 of any PSRO nor should there be any discrimination in assignments to perform PSRO duties based on membership or non-membership 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 maximum extent feasible, it is intended that a physician not be involved 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 of HEW 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. 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 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 of approximately 2 years during which it would develop and expand its review activities and capacity. 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 to waive any other professional review requirements 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 professional standards review organizations will function in effective and dedicated fashion under the guidance of concerned physicians. In instances where there might be

only nominal or half hearted 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 of Health, Education, and Welfare.

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 professional standards review organization 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 professional standards review organization 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.

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The Secretary would be responsible for determining the most efficient means of developing the profiles of services and other necessary data required.

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 be authorized 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 Professional Standards Review Organization would be authorized to acknowledge and accept for its purposes, review activities of local medical societies, or other medical 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. In order to assure the broadest possible participation in PSRO activities by physicians in an area, it is expected that 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 Professional Standards Review Organization 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 advance approval was required and provision of services was disapproved in advance of admission 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. In such cases, the provider or practitioner looks to the policyholder for payment directly.

Where advance approval by the review organizations for institutional admission was required and provision of the services was approved by the PSRO, 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 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 financing the care being contemplated.

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 specifications 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. The profiles presently maintained under existing regulations by the State agencies, carriers and intermediaries 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.

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 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 economical and efficient computer and other resources already existing in carriers and intermediaries would be utilized to the greatest extent feasible and that operations would be consolidated and coordinated wherever possible. In a similar fashion, the PSRO should 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 provide profiles 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. 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 professional standards review organizations.

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 to retain and consult with other types of health care practitioners to assist in reviewing services which their fellow practitioners provide. In the event it was not feasible or appropriate to undertake review arrangements with such a group, arrangements may be made with a qualified practitioner for necessary review referrals. 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 services 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 deteriorate 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 professional standards review organizations 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, providers, and others involved in the delivery of care, would be exempt from civil liability arising from adherence to the recommendations of the review organization 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 six days, but an individual practitioner might only hospitalize his patient for four days. In this case the doctor might be motivated to keep his patient in the hospital for an extra two 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 four 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 professional standards review organization 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 of Health, Education, and Welfare is expected to promptly act to terminate the contract with the organization involved unless it immediately undertakes voluntary corrective measures.

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.

DEMONSTRATION OF PSRO UNDERWRITING

The committee amendment authorizes the Secretary on a demonstration basis to enter into agreements with willing PSRO's to test the

feasibility and potential economies which might be gained through allowing PSRO's to underwrite and assume responsibility for payment for medicare and medicaid claims. These demonstrations are worthy of trial; the arrangements are such that physicians involved would have economic incentives to practice efficiently and effectively. In a demonstration program, a PSRO would undertake responsibility for review and the arranging of payment for all care and services for which beneficiaries or recipients in its geographic area were eligible. The PSRO could be reimbursed on a capitation, prepayment, insured, or related basis. Contracts would be entered into on a 1-year renewable incentive basis.

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 Professional Standards Review Organization 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 professional standards review organizations to assure conformance and compliance with congressional intent.

Proficiency Testing for Health Personnel

(Sec. 264 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, 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 waivered basis. Undoubtedly, a substantial proportion of these practical nurses have years of experience and are competent; obviously, other waivered 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 waivered licensed practical nurses exist with respect to physical therapists, medical technologists, and psychiatric technicians.

The committee has, therefore, included an amendment which requires the Secretary to explore, develop, and apply appropriate means of determining the proficiency of health personnel disqualified or limited in responsibility under present regulations. The committee expects that the Secretary will regularly report to it and to the

Committee on Ways and Means of the House of Representatives concerning the Department's progress in this area.

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 equipped 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.

Determinations of proficiency will not apply with respect to personnel initially licensed by a State or seeking initial qualification as a health care person after December 31, 1975. Such individuals will be expected to meet appropriate formal training criteria. But during the 5-year duration of the program of proficiency determinations, prospective health care personnel and educational institutions should have adequate time and opportunity to plan and arrange for proper and acceptable training.

The amendment would be effective upon enactment.

Inspector-General for Health Administration

(Sec. 265 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, which now cost $15 billion annually, 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 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, 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 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 or reinstatement was issued by the Inspector General except that the Secretary might, at any time subsequent to 30 days after such suspension of a proposed regulation, issue an order revoking the suspension. The Secretary might immediately revoke (so as to render ineffective and inoperative) any suspension ordered with respect to an existing regulation.

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. When the Inspector General issued any order of suspension or reinstatement, he would promptly notify the Committees on Ways and Means of the House of Representatives and the Committee on Finance of the Senate 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.

The Committee on Finance is convinced that 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. Armed as he would be with authority to suspend a regulation, practice, or procedure which he finds is not in harmony with congressional intent, or which will, in his considered opinion, lead to inefficiency or waste, the voice of the Inspector General will be given. great weight in the highest decision making councils of the Department.

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.

The amendment is effective upon enactment.

Increase in Maximum Federal Medicaid Matching for Puerto Rico

(Sec. 266 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 rate were established.

The committee recognizes the efforts made by Puerto Rico to provide comprehensive health care. Among the 54 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 35 percent in fiscal year 1969.

The committee therefore provided 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.

Early and Periodic Diagnosis and Screening

(Sec. 267 of the bill)

Under section 1905(a)(4)(B) of the Social Security Act, States are required to provide diagnostic and screening services for all medicaid eligibles under 21. The committee has been advised that the Department of Health, Education, and Welfare has delayed issuance of regulations required to implement the above section because of the great cost which full implementation and application of the screening requirement would entail for both the Federal and State Governments.

The committee has included an amendment under which young children eligible for medicaid may be given priority in the provision of periodic diagnosis and screening. The Secretary would be authorized to establish, through regulations, orderly priorities for implementation of section 1905(a)(4)(B), giving initial priority in the provision of early and periodic diagnosis, screening and treatment to young children where States are unable to provide these services to their entire eligible population under 21.

The committee believes that the establishment of priorities will permit orderly and graded implementation of the requirement in all States.

The amendment is effective upon enactment.

Medicaid Coverage of Mentally-Ill Children

(Sec. 268 of the bill)

Under present law, medicaid payments for the mentally-ill in public mental institutions are generally limited to persons age 65 or over.

The committee amendment would authorize Federal matching under medicaid to also include eligible children, age 21 or under, receiving active care and treatment in an accredited institution for mental diseases. The definitions of active care and treatment and 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 effective date of the amendment is July 1, 1971.

Consultants for Extended Care Facilities

(Sec. 270 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 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.

The amendment is effective upon enactment.

Termination of Nursing Home Administrator's Advisory Council, December 31, 1970

(Sec. 271 of the bill)

The 1967 Social Security Amendments required State licensure of nursing home administrators. The statute also established the National Advisory Council on Nursing Home Administration in order to study, develop, and advise the Secretary and the States concerning matters relating to the qualifications, training, and other areas related to a proper program of licensure. The Council was scheduled to terminate on December 31, 1971.

The committee has noted, however, that the Council has essentially completed its work and has passed a resolution to that effect. Therefore, the committee included an amendment providing for termination of the National Advisory Council on Nursing Home Administration as of December 31, 1970. It is expected that the existing Medical Assistance Advisory Council would assume responsibility for any continuing need for advice and assistance with respect to licensing of nursing home administrators.

Maintenance of Effort—Medicaid

(Sec. 272 of the bill)

Pursuant to section 1902(d) of the Medicaid statute a State cannot reduce its expenditures for the State share of medicaid from one year to the next. Failure to comply with this requirement means ineligibility for Federal medicaid matching.

The committee has been concerned about the effect of section 1902 (d) on States which may be faced with fiscal crises.

The State of Missouri has a particularly immediate and urgent fiscal problem and is unable to meet the 1902(d) requirements.

Many needy people would be denied necessary care in Missouri if its medicaid plan is formally found out of compliance with section 1902(d). Therefore, the committee amendment would exempt the State of Missouri from the application of section 1902(d)(1) retroactive to July 1, 1970.

Further, the committee believes that the maintenance of effort provision in medicaid now functions as a barrier to orderly development and operation of State programs, and that the States are best able to determine the changing need of their people. For these reasons the committee has provided for repeal of section 1902(d) upon enactment.

Penalties for Fraudulent Acts and False Reporting Under Medicare and Medicaid

(Sec. 273 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 one 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 the committee bill, 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 providers of health care services. (Another amendment in title VI of this bill revives the Federal income tax statutes to deny a tax deduction with respect to such payments.) Under the bill, 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, one year of imprisonment, or both.

Continuing investigation and review of reports by the committee 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. Consequently, the committee bill includes a specific provision under title XVIII and title XIX of the Social Security Act whereby anyone who knowingly and willfully makes, or induces or seeks to induce, the making of a false statement of material fact with respect to the conditions and operation of a health care facility or agency in order to secure certification or approval to participate in the medicare and medicaid programs will be subject to imprisonment for up to 6 months, a fine not to exceed $2,000, or both.

The amendment is effective upon enactment.

Public Disclosure of Information Concerning an Institution's Deficiencies

(Sec. 274 of the bill)

At present, information as to whether a hospital or extended care facility participating in the medicare program fully meets the statutory and regulatory requirements relating to conditions for participation, or whether it has significant deficiencies, is generally available only to the facility involved, appropriate State agencies, and the Administration. Physicians and the public in general are currently unaware as to which institutions among those participating in the Medicare program have significant deficiencies and which are making serious efforts to overcome those deficiencies. The committee believes that in the absence of public knowledge about the nature and extent of deficiencies of individual facilities, it is exceedingly difficult for physicians and the public to effectively direct their concern about shortcomings to the deficient facilities and to bring pressures for improvement to bear on those facilities.

The committee believes that easy public access to timely information about deficiencies (such as in areas of staffing, sanitation, fire and other safety requirements) would help significantly to encourage facilities to correct their deficiencies and, at the same time, enable physicians and patients to make sound judgments about their own use of available facilities in the community. The committee bill, therefore, requires the Secretary of Health, Education, and Welfare to make information on the significant deficiencies of individual providers a matter of public record readily available on request at all social security district offices and centrally at Social Security Administration headquarters. The Secretary would make this information available only after the provider has been fully informed about the significant deficiencies that have been identified and has been given a reasonable amount of time (not to exceed 90 days) to correct the deficiencies. It is expected that the Secretary will take the necessary administrative steps to assure that the information made available is updated periodically as appropriate.

The amendment is effective upon enactment.

Authority for Establishing Liens to Permit Recovery of Overpayments

(Sec. 275 of the bill)

Under present law, where a provider of services has been overpaid, the Department of Health, Education, and Welfare is authorized to withhold future payments which are otherwise due to the provider in order to recoup the amount of the overpayment. Where no further payments are due because, for example, the provider has withdrawn from the program, the Department has experienced difficulty in attempting to recover the amount overpaid.

The committee is concerned because, in dealing with the problem of recovery of overpayments to providers of services, it has found that an effective administrative remedy to protect the interests of the Government does not exist in certain cases. These cases involve (1) providers who have terminated their participation in the program, and who refuse to refund any money to meet the debt incurred by an overpayment; and (2) providers who continue to participate in the Medicare program, but who have very low utilization by Medicare beneficiaries with the result that little or no Medicare payments are due the provider.

If a provider refuses to refund, the Department's recourse in such a situation is to send demand letters at prescribed intervals and, if this action does not result in a refund, to refer the case to the General Accounting Office for collection. If GAO is unsuccessful in obtaining refund, the case may be referred to the Department of Justice for legal action. The committee is concerned, however, that until the case is referred to the Department of Justice, no effective administrative action can be taken to prevent dissipation or diversion of assets by the provider while recovery efforts are being conducted. During this time, the provider has had Government funds at his disposal on which he does not have to pay interest. Furthermore, he has time to dispose of his assets so that if legal action is ever undertaken to collect the debt, there may not be any assets available to meet the obligation.

If, however, a lien in favor of the Government in the amount of the overpayment was placed upon the property of the provider, the assets of the provider would be conserved while the Government is taking the necessary collection action.

The committee bill, therefore, would provide authority, where a determination of an overpayment has been made, or the overpayment issue is being contested, for establishing a lien in favor of the U.S. Government in the amount of the overpayment upon all property belonging to the provider overpaid. Where a lien is filed the provider would have the right to challenge the overpayment determination or issue by requesting a hearing by the Secretary of Health, Education and Welfare and where requested such hearing should be promptly provided. Liens would be filed locally. In addition, the provider would have a right to judicial review of the Secretary's final decision to apply a lien after a hearing, if he is dissatisfied with the decision.

The amendment would become effective upon enactment.

Inclusion of American Samoa and the Trust Territory of the Pacific Islands Under Title V

(Sec. 276 of the bill)

American Samoa and the Trust Territory of the Pacific Islands are currently excluded from receiving Federal funds under the provisions of the Crippled Children and Maternal and Child Health Programs (title V).

All other territories and possessions of the United States are presently eligible for the benefits of these programs. The provision of pubic health services to mothers and children with crippling disease is one of the areas of greatest weakness in public health programs in Micronesia, and this is reflected in a high infant mortality rate.

The committee bill would include American Samoa and the Trust Territory of the Pacific Islands as eligible to receive an allotment of funds under title V of the Social Security Act.

The amendment is effective with respect to fiscal years beginning on and after July 1, 1971.

Relationship Between Medicaid and Comprehensive Health Care Programs

(Sec. 277 of the bill)

Present law provides that under title XIX all eligible recipients should receive the same scope of services; that those services should be available throughout the 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 chose.

State agencies often cannot make pre-payment arrangements which might result in more efficient and economical delivery of health serv-

ices, because the prospective arrangements might violate title XIX 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.

The committee bill would amend section 1902(a)(23) to permit a State to make arrangements for the delivery of health services on a prepaid basis in an area, including arrangements with neighborhood health centers, where such services are available and to the extent they are provided, without a requirement that such arrangement necesarily be provided all Medicaid eligibles in the State with the approval of the Secretary.

The amendment is effective upon enactment.

Refunding of Excess Medicare Premiums

(Sec. 278 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.

It has come to the committee's attention that early in the program it was recognized that excess part B premiums paid by a deceased enrollee could be best disposed of, in those cases where there is no legal representative of the deceased's estate, by adding them to benefits subsequently payable on the same Medicare claims number, or to those relatives who would (except for age or dependency requirements) be eligible on the same record. However, the Office of General Counsel has advised that this could not be done in the absence of necessary authority in the law. Consequently, the much more cumbersome claims procedure has had to be used. Where there is no claim for the excess premium payments, no refund is made.

A similar problem is likely to exist with respect to premiums paid in advance under the provision of the bill which would provide, at a cost of $27 per month per enrollee, hospital insurance coverage for people who are age 65 and over and who are not eligible for such coverage under present law.

The committee bill, therefore, would provide authority for the Secretary to dispose of excess supplementary medical insurance premiums and excess hospital insurance premiums in the same manner as unpaid medical insurance benefits are treated.

Definition of Physician Under Medicaid

(Sec. 279 of the bill)

The committee has amended section 1905(a)(5) of Medicaid so as to clarify the definition of a physician as being a duly licensed doctor of medicine or osteopathy.

Services of other types of health care practitioners are authorized in subsequent provisions of Section 1905(a).

Reimbursement Appeals by Providers of Services

(Sec. 281 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 bill, therefore, provides for the establishment of the Provider Reimbursement Appeals Board. The Board will be composed of 5 members, properly qualified in the Medicare field, appointed by the Secretary of Health, Education, and Welfare. At least one member of the Board will be a certified public accountant. The Secretary will select 2 of the members from qualified and acceptable nominees of the providers.

Any provider of services (or groups of such providers) which has filed timely cost reports may appeal an adverse final decision of the fiscal intermediary to the Board where the amount at issue aggregates $10,000 or more. In addition, any provider which has not received a final cost determination from the fiscal intermediary within 90 days of filing its annual cost report, if such report is substantially in proper order, or within 90 days from an acceptable supplemental filing, where the initial filing was deficient, may appeal to the Board where the amount at issue is $10,000 or more.

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).

The decision of the Provider Reimbursement Appeals Board shall be final, subject to review and affirmation by the Secretary. The Secretary shall have 60 days to review the decision. If the Board's decision is unfavorable to the provider and is not affirmed by the Secretary

or if a decision favorable to the provider is reversed by the Secretary within the 60-day period, the provider shall have the right to review by the United States District Court in which it is located or in the United States District Court for the District of Columbia, as an aggrieved party under the Administrative Procedure Act, notwithstanding any other provision in section 205 of this title.

The amendment would become effective with respect to accounting periods ending after June 30, 1971.

Statute of Limitations—Waiver of Recovery of Incorrect Payments Under the Medicare Program

(Sec. 282 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, provided that, after 3 years have expired, there 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.

The committee recognizes that in making decisions as to the medical necessity for services and the level of care which may be provided an individual in an institutional setting, often the provider of services or other person has placed reasonable reliance upon the physician's decision as to the need for the services provided or for the individual's admission to a medical facility. Further, the committee recognizes that the individual who receives the services may have little basis for evaluating the appropriateness of the level of care provided him and that it can be inequitable in such situations to find that he is at fault with respect to any incorrect payments that may be made by medicare for the services he received.

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.

Additionally, the Secretary would be authorized to deny claims for reimbursement made after lapse of a reasonable period of time specified by him in regulation, of not less than 1 year nor more than 3 years.

The amendment is effective upon enactment.

Extension of 75 Percent Federal Matching for Medical Personnel Under Contract

(Sec. 283 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 title XIX 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. States are compensated at a 50-percent level for general administration of the title XIX program.

The committee has extended the 75-percent matching rate to include additional skilled medical personnel and direct supporting staff other than those of the State agency itself. States would thus be able, by contract arrangements, to use professional medical 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.

The amendment is effective upon enactment.

4. ADDITIONAL MATTERS OF CONCERN TO THE COMMITTEE

Uniform Medicare Reimbursement

Under present medicare regulations, providers have the option to be reimbursed under the Departmental Method or Combination Method of apportionment of costs between medicare and others who pay for care. (Under the option a change from one method to another requires a timely written request filed ahead of time by the provider and approval by its intermediary.) To determine medicare reimbursement under the Departmental Method, the ratio of beneficiary charges to total patient charges for the services of each department is applied to the cost of the department. Under the Combination Method, the cost of routine services for medicare beneficiaries is determined on an average cost per diem basis and to this is added the cost of ancillary services determined by apportioning the total cost of ancillary services on the basis of the ratio of medicare beneficiary charges for ancillary services to total patient charges for such services.

Both the Comptroller-General of the United States and the HEW Audit Agency have recommended that the use of the combination method should be eliminated because certain pediatric and obstetrical costs are included in the total ancillary service costs against which the medicare portion of charges are applied to arrive at program reimbursement. If charges are below cost for the pediatric and obstetrical services that are involved and charges are above cost for medicare ancillary services as a whole, as appears to be the case in many hospitals, some of the loss on these nonmedicare services is shifted to medicare. There are no rational grounds for preserving the unintended reimbursement of such costs where it is feasible to avoid such payment. Furthermore, the statute requires that medicare pay only for the actual costs associated with the elderly.

The committee is also aware that the Combination Method of apportionment while less accurate than the Departmental Method of apportionment has been retained for medicare reimbursement to avoid imposing the greater complexity of the Departmental Method on institutions incapable of handling it. The statute permits the determination of an institution's reimbursable costs using various methods and through the use of estimates, and the choice of methods requires a balancing of accuracy as to the reimbursable amount against the cost and difficulty of obtaining it. At the same time, the committee has also noted that under present regulations and cost reporting procedures (which allow large as well as small institutions to use the combination method at their option) much of the cost finding required by medicare is the same for providers using either the Departmental Method or the Combination Method, and many small providers find this cost finding requirement quite difficult to meet. Moreover, when the original medicare reimbursement regulations were developed, it was believed by the Department of HEW that even some relatively large hospitals would have difficulty completing the required cost finding and would also be unable to apportion costs under the Departmental Method because of poor recordkeeping practices, and this initial provision for simplifying reimbursement even for the largest institutions seems reasonable for the past.

It is recognized that medicare cost finding and cost reporting requirements have contributed to an upgrading in recordkeeping and accounting systems and it does not seem unreasonable now to expect all larger institutions which generally receive larger medicare payments to use the more accurate Departmental Method of apportionment of costs between medicare and other payers. On the other hand, the committee is concerned that for smaller providers program cost finding requirements should be simplified wherever possible and wherever equitable.

Therefore, the committee and the Department concur that the Department should simplify its cost finding and cost reporting requirements for smaller institutions (e.g. those having less than 100 beds) and require the use of the Combination Method by those institutions without an option to use the Departmental Method. At the same time larger institutions (e.g. those with 100 beds or more) should be required to carry out cost finding under more sophisticated methods and to apportion costs under the more accurate Departmental Method.

By requiring simplified cost finding and the Combination Method for smaller institutions and the Departmental Method for larger institutions the program would: eliminate the provider option which gives a provider an advantage in reimbursement based on informed selection of method (not necessarily on any justifiable merit); eliminate the need for providers to try out more than one method to see which is more favorable; relate the degree of cost finding and cost determinations to the relative administrative expertise of providers (there is a correlation between accounting systems and expertise and institution size); result in better cost reimbursement determinations for the larger institutions which receive the greater part of Medicare payments; and permit better cost analyses for making program payment determinations because all providers of a given size would use the same method of cost finding and be reimbursed under the same method of apportionment. Moreover, it is expected that implementing these requirements would reduce the recordkeeping and auditing costs of both the institutions and the program.

The Department has stated that it will move ahead as expeditiously as possible, after appropriate consultation, to develop and implement through regulations, forms, and instructions the new cost finding and cost reporting requirements to be applied after due notice. Such requirements are expected to apply to institutional fiscal years beginning on or after July 1, 1971. It is reasonable to continue to explore possible revisions in cost finding and cost apportionment to always seek the best balance of accuracy and equity.

Medicare Carriers and Intermediaries

Carriers and intermediaries are the private insurance companies and Blue Cross and Blue Shield plans who serve as agents of the Government in administering medicare. In keeping with its continuing concern that medicare's administrative performance be substantially improved, the committee reiterates the original Congressional intent that inefficient and uneconomical medicare carriers and intermediaries be promptly terminated and replaced as soon as possible by more capable organizations including, if no other alternative is suitable, the Department itself. In general, this intent has not been complied with. It is fully expected that it will be followed from here on even if, in the short-run, additional start-up and related costs are necessarily incurred.

V. CATASTROPHIC HEALTH INSURANCE PROGRAM

Catastrophic Health Insurance Program

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V. CATASTROPHIC HEALTH INSURANCE PROGRAM

The Committee on Finance is concerned about the devastating effect which a catastrophic illness can have on families unfortunate enough to be affected by such an illness. Over the past decades science and medicine have taken great strides in their ability to sustain and prolong life. Patients with kidney failure, which until recently would have been rapidly fatal, can now be maintained in relative good health for many years with the aid of dyalysis and transplantation. Patients with spinal cord injuries and severe strokes can now often be restored to a level of functioning which would have been impossible years ago. Modern burn treatment centers can keep victims of severe burns alive and can offer the victim restorative surgery which can in many instances erase the after effects of such burns.

These are but a few examples of the impact which recent progress in science and medicine has had. This progress, however, has had another impact. These catastrophic illnesses and injuries which heretofore would have been rapidly fatal and hence not too expensive financially, now have an enormous impact on a family's finances. The newly developed methods of treating catastrophic illnesses and injuries involve long periods of hospitalization, often in special intensive care units, and the use of complex and highly expensive machines and devices. The net cost of a catastrophic illness or injury can be and usually is staggering. Hospital and medical expenses of many thousands of dollars can rapidly deplete the resources of nearly any family in America. These families are then faced not only with the devastating effect of the illness itself, but also with the necessity of accepting charity or welfare. Catastrophic illnesses do not strike often, but when they do the effects are disastrous—particularly in the context of soaring health care costs.

The Committee on Finance believes that Government and social insurance programs should be able to respond to the progress made in medical science. Medicine and science are now often able to mitigate the physical effects of a catastrophic illness or injury, and the committee believes that govcernment, through our established social insurance mechanism should act to mitigate the financial effects of such catastrophes.

The committee has adopted an amendment which would establish a Catastrophic Health Insurance Program.

The program would be designed to complement private health insurance which has played the major role in insuring against basic health expenses. About 80 percent of people under age 65 have insurance against hospitalization expenses, but these policies all have a limit on hospital days which they will cover. The most common policies cover 60 days of care. Similarly, existing private policies designed to cover medical expenses have upper limits of coverage. Private major medical insurance plans are available, but are held by only

20 to 30 percent of the population. In addition, even the major medical plans have maximum benefits per spell of illness, usually ranging from $5,000 to $20,000.

The committee's Catastrophic Health Insurance Program would be structured to take maximum advantage of the experience gained by medicare. The program would use medicare's established administrative mechanism wherever possible, and would incorporate all of medicare's cost and utilization controls.

Eligibility

The committee amendment establishes a new Catastrophic Health Insurance Program (CHIP) as part of the Social Security Act financed by payroll contributions from employees, employers and the self-employed. Under the committee's provision all persons under age 65 who are fully or currently insured under the social security program, their spouses and dependent children would be eligible for CHIP protection. All persons under age 65 who are entitled to retirement, survivors, or disability benefits under social security as well as their spouses and dependent children would also be eligible for CHIP. This constitutes about 95 percent of all persons under age 65.

Persons over 65 would not be covered as they are protected under the medicare program which, in spite of its limitation on hospital and extended-care days, is a program with a benefit structure adequate to meet the significant health care needs of all but a very small minority of aged beneficiaries. The largest noncovered groups under age 65 are Federal employees, employees covered by the Railroad Retirement Act, and State and local governmental employees who are eligible for social security but not covered due to the lack of an agreement with the State. (There are a small number of people who are still not covered by social security or other retirement programs; the majority of these are domestic or agricultural workers who have not met the necessary social security coverage requirements.)

Federal employees are, however, eligible for both basic and major medical catastrophic health insurance protection under the Federal Employees Health Benefits Act, with the Federal Government paying 40 percent of the costs of such coverage. To assure equitable treatment of those Federal employees who also are eligible for social security, a special provision of the committee bill would require the Federal Employees Health Benefits program to make available to Federal employees who have sufficient social security coverage to be eligible under CHIP, a plan which supplements CHIP coverage; if such a plan is not made available to Federal employees, no CHIP payments will be available for services otherwise payable under the FEHB plan.

Buy-in for State and Local Employees

Under the committee bill, State and local employees who are not covered by social security could receive coverage under CHIP if the State and local governments exercise an option to buy into the program to cover them on a group basis. When purchasing this protection, States

would ordinarily be expected to include all employees and eligible annuitants under a single agreement with the Secreary. A determination by the State as to whether an individual is an annuitant or member of a retirement system or is otherwise eligible to have such coverage purchased on his behalf would, for purposes of the agreement to provide CHIP protection, be final and binding upon the Secretary. Each State which enters into an agreement with the Secretary of Health, Education, and Welfare to purchase CHIP protection will be required to reimburse the Federal Catastrophic Health Insurance Trust Fund for the payments made from the fund for the services furnished to those persons covered under CHIP through the State's agreement with the Secreatry, plus the administrative expenses incurred by the Department of Health, Education, and Welfare in carrying out the agreement. Payments will be made from the fund to providers of services for covered services furnished to these persons on the same basis as for other persons entitled to benefits under CHIP. Conditions are also specified under which the Secretary or the State could, after due notice, terminate the agreement.

Benefits

The benefits that would be provided under CHIP would be the same as those currently provided under parts A and B of medicare, except that there would be no upper limitations on hospital days, extended care facility days, or home health visits. Present medicare coverage under part A includes 90 days of hospital care and 60 days of post-hospital extended care in a benefit period, plus an additional lifetime reserve of 60 hospital days; and 100 home health visits during the year following discharge from a hospital or extended care facility. Part B coverage includes physicians' services, 100 home health visits annually, outpatient physical therapy services, laboratory and X-ray services and other medical and health items and services such as durable medical equipment.

The major benefits excluded from medicare, and consequently excluded from this proposal, are nursing home care, prescription drugs, hearing aids, eyeglasses, false teeth and dental care. Medicare's limitations on inpatient care in psychiatric hospitals, which limit payment to active treatment subject to a 190 day lifetime maximum, and the program's annual limitation on outpatient services in connection with mental, psychoneurotic and personality disorders are also retained. An additional exclusion would be for items or services which the Secretary of Health, Education, and Welfare rules to be experimental in nature.

Deductibles and Coinsurance

The committee believes that in keeping with the intent of this program to protect against health costs so severe that they usually have a catastrophic impact on a family's finances, a deductible of substantial size should be required. The committee's proposal has two entirely separate deductibles which would parallel the inpatient hospital deductible under part A and the $50 deductible under part B of medicare.

The separate deductibles are intended to enhance the mesh of the program with private insurance coverage. In order to receive both hospital and medical benefits, both deductibles must be met. If a person were to meet the hospital deductible alone, he would become eligible only for the hospital and extended care benefits. Similarly, if a family were to meet the $2,000 medical deductible, they would become eligible only for the medical benefits.

Hospital Deductible and Coinsurance

There would be a hospital deductible of 60 days hospitalization per year per individual.

After an individual has been hospitalized for a total of 60 days in one year, he would become eligible for payments toward hospital expenses associated with continued hospitalization. The program would thus begin payment with the 61st day of his hospitalization in that year. Only those posthospital extended care services which he receives subsequent to having met the 60-day deductible would be eligible for payment.

After the hospital deductible has been met, the program would pay hospitals substantially as they are presently paid under medicare, with the individual being responsible for a coinsurance amount equal to one-fourth of the medicare inpatient hospital deductible applicable at that time. Extended care services which are eligible for payment would be subject to a daily coinsurance amount equal to one-eighth of the medicare inpatient hospital deductible. In January 1971, this coinsurance will amount to $15 a day for inpatient hospital services and $7.50 a day for extended care services.) Thus the coinsurance could rise yearly in proportion to any increase in hospital costs.

Medical Deductible and Coinsurance

There would be a supplemental medical deductible initially established at $2,000 per year per family. The Secretary of Health, Education, and Welfare would, between July 1 and October 1 of each year (beginning in 1972), determine and announce the amount of the supplemental medical deductible for the following year.

The deductible would be the greater of $2,000 or $2,000 multiplied by the ratio of the physicians' services component of the Consumer Price Index for June of that year to the level of that component for December 1971. Thus, the deductible could rise yearly in proportion to any increase in the price of physicians' services.

After a family has incurred expenses of $2,000 for physicians' bills, home health visits, physical therapy services, laboratory, and X-ray services and other covered medical and health services the family would become eligible for payment under the program toward these expenses. For purposes of determining the deductible, a family would be defined as a husband and wife and all minor and dependent children.

After the medical deductible had been met, the program would pay for 80 percent of eligible medical expenses, with the patient being responsible for coinsurance of 20 percent.

Deductible Carryover

As in part B of medicare, the plan would have a deductible carryover feature—applicable to both the dollar deductible and the hospital-day deductible—under which expenses incurred (or hospital days used) but not reimbursed during the last calendar quarter of a year would also count toward the satisfaction of the deductibles for the ensuing year. For example, an individual admitted to a hospital with a cardiac condition on December 10, 1972, and continuously hospitalized through February 19, 1973, would not, in the absence of the carryover provision, meet the hospital-day deductible unless he were to be hospitalized for at least another 10 days in 1973. With a carryover provision, however, the individual described above would meet the hospital deductible on January 30, 1973. Similarly, if a family's first eligible medical expenses in 1972 amount to $1,200 and were incurred during the months of November and December, and an additional $3,000 in eligible medical expenses are incurred in 1973, the family would, in the absence of a carryover provision, be eligible for payment towards only $1,000 of their expenses in 1973. With a carryover provision, however, the family described above would be eligible for payment toward $2,200 of their expenses in 1973.

Administration

Payments made to patients, providers, and practitioners under this program would be subject to the same reimbursement, quality, health and safety standards, and utilization controls as exist in the medicare program. Reimbursement controls would include the payment of audited "reasonable costs" to participating institutions and agencies, and "reasonable charges" to practitioners and other suppliers. However, the committee expects that appropriate modifications will be made to take into account the special features of this program, including a modification to exclude "bad debts" from those costs eligible in computing reasonable cost payments to institutions.

The utilization of services would be subject to review by present utilization review committees established in hospitals and extended care facilities and by the professional standards review organizations established under another committee amendment. The committee believes that all of the above controls should be applied to reimbursement of expenses for services rendered under the proposed catastrophic illness insurance program. In addition, the Office of the Inspector General for Health Administration established under another committee amendment would be expected to closely monitor the administration of the program and can be expected to provide valuable information with respect to increasing the efficiency of the program.

The proposal contemplates using the same administrative mechanisms used for the administration of medicare including, where appropriate, medicare's carriers and intermediaries. Using the same administrative mechanisms as medicare will greatly facilitate the operation of this program. The proposal also would encompass use of medicare's statutory quality standards, in that the same conditions of participation which apply to institutions participating in medicare would apply to those institutions participating in CHIP. These standards

serve to upgrade the quality of medical care and their application under this program should have a similar salutary effect.

The Social Security Administration, utilizing its network of district offices, would determine the insured status of individuals and relationships within families which are necessary to establish entitlement to CHIP benefits. The determination of whether the deductible expenses had been met would also be handled by the Social Security Administration in cooperation with carriers and intermediaries. The proposed administrative plan envisions establishing a $2,000 minimum expense amount before individual bills would be accepted. This would protect the administrative agencies from being inundated with paperwork.

Financing

The first year's cost of the program is estimated at $2.5 billion on an incurred basis and $2.2 billion on a cash basis. The committee provision would finance the program on a $9,000 wage base with the following contribution schedule: 1972–74, 0.3 of one percent of taxable payroll on employees and 0.3 on employers; 1975–79, 0.35; 1980 and after, 0.4. Rates for the self-employed would also be 0.3, 0.35, and 0.4 respectively.

The contributions would be placed in a separate Federal Catastrophic Health Insurance Trust Fund from which benefits and administrative expenses related to this program would be paid. The complete separation of catastrophic health insurance financing and benefit payments is intended to assure that the catastrophic health insurance program will in no way impinge upon the financial soundness of the retirement, survivors, or disability insurance trust funds or medicare's hospital and supplementary medical insurance trust funds. Such separation will also focus public and congressional attention closely on the cost and the adequacy of the financing of the program.

To provide an operating fund at the beginning of the program (in recognition of the lag in time between the date on which the taxes are payable and their collection), and to establish a contingency reserve, a Government appropriation would be available (on a repayable basis without interest) during the first 3 calendar years of the program. The amount which could be drawn in any such calendar year could not exceed the estimated amount of 6 months of benefit payments during that year.

Relationship With Medicaid

The catastrophic illness insurance program would be supplemental to the medicaid program with regard to public assistance recipients and the medically indigent in the same way in which it will be supplemental to private insurance for other citizens. Thus, medicaid will continue to be the State-Federal program that is intended to cover the basic health needs of categorical assistance recipients and the medically indigent. The benefit structure of medicaid varies from State to State, but in general it is a basic rather than a catastrophic benefit package.

In addition, medicaid will continue to play a substantial role in financing the cost of nursing home care, which represents a cata-

strophic cost to many people, especially the aged. The catastrophic health insurance program will, of course, lessen the burden on the medicaid program to some degree, since those covered by medicaid who are eligible would have a large proportion of their catastrophic expenses covered by this program, leaving only the deductible and coinsurance amounts for the medicaid program to pay. This factor will not only enable the States to contain the costs of their programs, but may also encourage them to improve coverage of basic services.

Conclusion

The committee estimates that more than one million families of the approximately 49 million families in the United States annually incur medical expenses which will qualify them to receive benefits under the program. Of course, nearly all American families will receive the benefit of insurance protection against the costs of catastrophic illnesses. The program is not intended to meet the health costs which the population incurs for short-term hospitalization and acute illness. This program is intended to insure against those highly expensive illnesses or conditions which, although a potential threat to every family, actually strike only a relatively few. The committee believes that individuals should, during their working years, be able to obtain protection against the devastating and demoralizing effects of such costs.

These provisions and the taxes to pay for them would become effective January 1, 1972.

VI. FINANCING OF SOCIAL SECURITY TRUST FUNDS

Financing of Social Security Trust Funds

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VI. 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 bill would make provision for meeting the cost of the expanded program. At the present time, the social security cash benefits program is in close actuarial balance, while the hospital insurance program has a serious actuarial deficiency; that is, unless hospital insurance taxes are raised substantially, the hospital insurance trust fund will become exhausted in 1972. To meet the cost of the expanded cash benefits program and the new catastrophic illness insurance program and to bring the hospital insurance program into actuarial balance, the schedule of contribution rates would be revised and the contribution and benefit base—the maximum amount of annual earnings subject to contributions and used in computing benefits—would be increased.

Increase in the Contribution and Benefit Base

The proposed increase in the contribution and benefit base from $7,800 to $9,000 in 1971 would not only provide higher benefits at higher earnings levels, but also would help to finance the changes made by the bill. An increase in the base results in a reduction in the overall cost of the social security program as a percent of taxable payroll. This occurs because the benefits provided are a higher percentage of earnings at the lower levels than at the higher levels, while the contribution rate is a flat percentage of earnings. When the base is increased, higher benefits are provided on the basis of the higher earnings that are taxed and credited, but the cost of providing these higher benefits is less than the additional income from the combined employee and employer contributions on earnings above the former maximum and up to the new maximum amount.

Changes in the Contribution Rates

Under the schedule of contribution rates that the committee recommends (shown below), the contribution rate for the cash benefits part of the program scheduled for 1971–72 would be decreased from 4.6 percent each for employees and employers to 4.4 percent each. The rate for 1973–74 under present law would be decreased from 5 to 4.4 percent each. The rate for 1975–79 would be 5 percent, the same as under present law. The rate for 1980–85 would be 5.5 percent each, the same as it would be under the House bill. After 1985, the contribution rate would be 6.1 percent each [instead of 5 percent each as under present law].

For the self-employed, the rate scheduled for 1971–72 for cash benefits would be decreased from 6.9 to 6.6 percent. The rate for

1973–74 under present law would be decreased from 7 to 6.6 percent. After 1974, the self-employed contribution would increase to 7 percent, the same as the highest rate scheduled under present law and under the House bill.

The committee recommends a change in the contribution rate schedule for the hospital insurance program. The contribution rate would be increased from 0.6 percent each for employees, employers, and the self-employed to 0.8 percent in 1971–72, to 0.9 percent in 1973–74, to 1.0 percent in 1975–79, and to 1.1 percent for years after 1979. Under present law the rate is scheduled to increase gradually from the present 0.6 to 0.9 percent for 1987 and after, while under the House bill it would increase immediately to 1 percent in 1971 and thereafter.

The committee bill also provides for a contribution rate which would finance adequately the committee's provision for catastrophic illness insurance. The contribution rate for this protection would be 0.3 percent each for employees, employers, and the self-employed for 1972–74, after which the rate would increase to 0.35 percent in 1975–79, and to 0.4 percent for years after 1979.

CONTRIBUTION RATES UNDER PRESENT LAW AND H.R. 17550

[In percent]

Period	OASDI			HI			CI	Total		
	Present law	House bill	Committee bill	Present law	House bill	Committee bill	committee bill	Present law	House bill	Committee bill
	Employer—Employee, each									
1971	4.6	4.2	4.4	0.6	1	0.8	.....	5.2	5.2	5.2
1972	4.6	4.2	4.4	.6	1	.8	0.3	5.2	5.2	5.5
1973–74	5.0	4.2	4.4	.65	1	.9	.3	5.65	5.2	5.6
1975	5.0	5.0	5.0	.65	1	1.0	.35	5.65	6.0	6.35
1976–79	5.0	5.0	5.0	.7	1	1.0	.35	5.7	6.0	6.35
1980–85	5.0	5.5	5.5	.8	1	1.1	.4	5.8	6.5	7.0
1986	5.0	5.5	6.1	.8	1	1.1	.4	5.8	6.5	7.6
1987 and after	5.0	5.5	6.1	.9	1	1.1	.4	5.9	6.5	7.6
	Self-employed									
1971	6.9	6.3	6.6	0.6	1	0.8	.....	7.5	7.3	7.4
1972	6.9	6.3	6.6	.6	1	.8	0.3	7.5	7.3	7.7
1973–74	7.0	6.3	6.6	.65	1	.9	.3	7.65	7.3	7.8
1975	7.0	7.0	7.0	.65	1	1.0	.35	7.65	8.0	8.35
1976–79	7.0	7.0	7.0	.70	1	1.0	.35	7.70	8.0	8.35
1980–86	7.0	7.0	7.0	.80	1	1.1	.4	7.8	8.0	8.50
1987 and after	7.0	7.0	7.0	.90	1	1.1	.4	7.9	8.0	8.50

MAXIMUM ANNUAL SOCIAL SECURITY TAXES UNDER PRESENT LAW, THE HOUSE BILL AND THE COMMITTEE BILL

Period	Employer-employee, each			Self-employed		
	Present law	House bill	Committee bill	Present law	House bill	Committee bill
1971	$405.60	$468.00	$468.00	$585.00	$657.00	$666.00
1972	405.60	468.00	495.00	585.00	657.00	693.00
1973–74	440.70	468.00	504.00	596.70	657.00	702.00
1975	440.70	540.00	571.50	596.70	720.00	751.50
1976–79	444.60	540.00	571.50	600.60	720.00	751.50
1980–85	452.40	540.00	630.00	608.40	720.00	765.00
1986	452.40	585.00	684.00	616.20	720.00	765.00
1987 and after	460.20	585.00	684.00			

Change in Allocation to the Disability Insurance Trust Fund

The bill would revise the allocation of contribution income to the disability insurance trust fund. Under present law, 1.10 percent of taxable wages and 0.825 of 1 percent of self-employment income are allocated to the disability insurance trust fund. Under the committee bill, the allocation for 1971 would be reduced to 0.90 percent of taxable wages and 0.675 of 1 percent of self-employment income, and would remain at a level below the present law allocation until 1980. The allocations under present law, the House-passed bill, and the committee bill are shown on the following table:

[In percent]

Calendar year	Present law		House-approved bill		Committee bill	
	Taxable wages	Self-employment income	Taxable wages	Self-employment income	Taxable wages	Self-employment income
1971	1.10	0.825	0.90	0.6750	0.90	0.6750
1972–74	1.10	.825	.90	.6750	.95	.7125
1975–79	1.10	.825	1.05	.7875	1.05	.7350
1980–85	1.10	.825	1.15	.8625	1.35	.8600
1986 and after	1.10	.825	1.15	.8625	1.45	.8300

The revision in the allocation will adequately finance the disability provisions in the committee bill and reduce the expected growth in the disability insurance trust fund over the next several years. The committee believes that this growth is not necessary and that the allocation can be reduced below that specified in present law until 1980.

B. ACTUARIAL COST ESTIMATES FOR THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM

Summary of Actuarial Cost Estimates

The old-age, survivors, and disability insurance system, as modified by the committee bill, has an estimated cost for benefit payments and administrative expenses that is closely in balance with contribution income. This also was the case for the 1950 and subsequent amendments at the time they were enacted.

The old-age and survivors insurance system as modified by the committee bill shows an actuarial balance of −0.14 percent of taxable payroll under the intermediate-cost estimate. This seems an acceptable balance, especially considering that this estimate is based on conservative assumptions, that a range of variation is necessarily present in long-range actuarial cost estimates and, further, that rounded tax rates are used in actual practice. Accordingly, the old-age and survivors insurance program, as it would be changed by the committee bill, is actuarially sound.

The separate disability insurance trust fund, established under the 1956 act, shows an actuarial balance of −0.01 percent of taxable payroll under the provisions that would be in effect after enactment of the committee bill. This is, of course, close to exact actuarial balance. Accordingly, the disability insurance program, as it would be modified by the committee bill, is actuarially sound.

Financing Policy

CONTRIBUTION RATE SCHEDULE FOR OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE IN THE COMMITTEE BILL

The contribution schedule for old-age, survivors, and disability insurance contained in the committee bill, as to the combined employer-employee rate, is lower than that under present law by 0.4 percent in 1971–72, and by 1.2 percent in 1973–74, is the same in 1975–79, and is 1.0 percent higher in 1980–85, and 2.2 percent higher in 1986 and after. The maximum earnings base to which these tax rates are applied is $9,000 per year for 1971 and after under the committee bill, the same as in the House-approved bill, as compared with $7,800 under present law. These tax schedules are as follows:

(Percent)

Calendar year	Combined employer-employee rate			Self-employed rate		
	Present law	House-approved bill	Committee bill	Present law	House-approved bill	Committee bill
1970	8.4	8.4	8.4	6.3	6.3	6.3
1971–72	9.2	8.4	8.8	6.9	6.3	6.6
1973–74	10.0	8.4	8.8	7.0	6.3	6.6
1975–79	10.0	10.0	10.0	7.0	7.0	7.0
1980–85	10.0	11.0	11.0	7.0	7.0	7.0
1986 and after	10.0	11.0	12.2	7.0	7.0	7.0

The allocated rates to the two trust funds that are applicable to the combined employer-employee contribution rate for the committee bill, as compared with present law and the House-approved bill, are as follows:

[In percent]

Calendar year	Old-age and survivors insurance			Disability insurance		
	Present law	House-approved bill	Committee bill	Present law	House-approved bill	Committee bill
1970	7.30	7.30	7.30	1.10	1.10	1.10
1971	8.10	7.50	7.90	1.10	.90	.90
1972	8.10	7.50	7.85	1.10	.90	.95
1973–74	8.90	7.50	7.85	1.10	.90	.95
1975–79	8.90	8.95	8.95	1.10	1.05	1.05
1980–85	8.90	9.85	9.65	1.10	1.15	1.35
1986 and after	8.90	9.85	10.75	1.10	1.15	1.45

The corresponding allocated rates for the self-employed contribution rate are as follows:

[In percent]

Calendar year	Old-age and survivors insurance			Disability insurance		
	Present law	House-approved bill	Committee bill	Present law	House-approved bill	Committee bill
1970	5.475	5.4750	5.4750	0.825	0.8250	0.8250
1971	6.075	5.6250	5.9250	.825	.6750	.6750
1972	6.075	5.6250	5.8875	.825	.6750	.7125
1973–74	6.175	5.6250	5.8875	.825	.6750	.7125
1975–79	6.175	6.2125	6.2650	.825	.7875	.7350
1980–85	6.175	6.1375	6.1400	.825	.8625	.8600
1986 and after	6.175	6.1375	6.1700	.825	.8625	.8300

It should be remembered that the workers and employers contribute a combined, rounded rate for the two programs (old-age and survivors insurance and disability insurance), and not the above complex fractional rates separately. Such fractional rates are merely used by the Treasury Department to divide up the aggregate tax receipts between the two trust funds.

The schedule of allocation rates for the disability insurance trust fund in the committee bill has been obtained in the following manner.

The combined employer-employee rates, rounded to the nearest 0.05 percent of taxable payroll, were determined for the short-range years

that would produce the same relative accumulation of funds as in the Old-Age and Survivors Insurance Trust Fund. The remainder of the schedule was calculated to produce, as close as possible, an exact actuarial balance on the basis of rates rounded to 0.05 percent of taxable payroll.

The self-employed tax allocation was determined by allocating to the Disability Insurance Trust Fund the same proportion of the self-employed rate as was determined for the combined employer-employee rate. The resulting rates were rounded to the nearest 0.0005 percent of taxable payroll.

The allocation rates for the old-age and survivors insurance trust fund were obtained by merely subtracting the allocation rates for the disability insurance trust fund from the appropriate total tax rates.

SELF-SUPPORTING NATURE OF SYSTEM

The Congress has always carefully considered the cost aspects of the old-age, survivors, and disability insurance system when amendments to the program have been made. In connection with the 1950 amendments, the Congress stated the belief that the program should be completely self-supporting from the contributions of covered individuals and employers. Accordingly, in that legislation the provision permitting appropriations to the system from general revenues of the Treasury was repealed. This policy has been continued in subsequent amendments. The Congress has very strongly believed that the tax schedule in the law should make the system self-supporting as nearly as can be foreseen and thus actuarially sound.

ACTUARIAL SOUNDNESS OF SYSTEM

The concept of actuarial soundness as it applies to the old-age, survivors, and disability insurance system differs considerably from this concept as it applies to private insurance and private pension plans, although there are certain points of similarity with the latter. In connection with individual insurance, the insurance company or other administering institution must have sufficient funds on hand so that if operations are terminated, it will be in a position to pay off all the accrued liabilities. This, however, is not a necessary basis for a national compulsory social insurance system and, moreover, is frequently not the case for well-administered private pension plans, which may not, as of the present time, have funded all the liability for prior service benefits.

It can reasonably be presumed that, under Government auspices, such a social insurance system will continue indefinitely into the future. The test of financial soundness, then, is not a question of whether there are sufficient funds on hand to pay off all accrued liabilities. Rather, the test is whether the expected future income from tax contributions and from interest on invested assets will be sufficient to meet anticipated expenditures for benefits and administrative costs over the long-range period considered in the actuarial valuation. Thus, the concept of "unfunded accrued liability" does not by any means have the same significance for a social insurance system as it does for a plan established under private insurance principles, and it is quite

proper to count both on receiving contributions from new entrants to the system in the future and on paying benefits to this group during the period considered in the valuation. The additional assets and liabilities must be considered in order to determine whether the system is in actuarial balance.

Accordingly, it may be said that the old-age, survivors, and disability insurance program is actuarially sound if it is in actuarial balance. This will be the case if the estimated future income from contributions and from interest earnings on the accumulated trust fund investments will, over the long-range period considered in the valuation, support the disbursements for benefits and administrative expenses. Obviously, future experience may be expected to vary from the actuarial cost estimates made now. Nonetheless, the intent that the system be self-supporting (and actuarially sound) can be expressed in law by utilizing a contribution schedule that, according to the intermediate-cost estimate, results in the system being in balance or substantially close thereto.

The committee believes that it is a matter for concern if the old-age, survivors, and disability insurance system shows any significant actuarial insufficiency. Since 1965 (when the cost estimates were first made on a 75-year basis), the view has been held that, if such actuarial insufficiency has been no greater than 0.10 percent of payroll, it is at the point where it is within the limits of permissible variation. However, reevaluation of the costs of the program—in light of rising wage levels—since then have shown that a somewhat higher variation may be allowable.

Furthermore, traditionally when there has been an actuarial insufficiency exceeding the limits indicated, any subsequent liberalizations in benefit provisions were fully financed by appropriate changes in the tax schedule or through raising the earnings base, and at the same time the actuarial status of the program was improved.

The changes provided in the committee bill are in close conformity with these financing principles.

Basic Assumptions for Cost Estimates

General basis for long-range cost estimates

Benefit disbursements may be expected to increase continuously for at least the next 50 to 70 years because of such factors as the aging of the population of the country and the slow but steady growth of the benefit roll. Similar factors are inherent in any retirement program, public or private, that has been in operation for a relatively short period. Estimates of the future cost of the old-age, survivors, and disability insurance program are affected by many elements that are difficult to determine. Accordingly, the assumptions used in the actuarial cost estimates may differ widely and yet be reasonable.

The long-range cost estimates (shown for 1980 and after) have usually been presented on a range basis so as to indicate the plausible variation in future costs depending upon the actual trends developing for the various cost factors. It has not been possible, in the time available, to prepare such range estimates for this report, but rather only an intermediate-cost estimate, which is used to indicate the basis for the

financing provisions. This estimate is based on assumptions that are intended to represent close to full employment, with average annual earnings at about the level prevailing in 1970. The use of 1970 average earnings results in conservatism in the estimate since the trend is expected to be an increase in average earnings in future years (as will be discussed subsequently). In 1971, the aggregate amount of earnings taxable under the program with the proposed $9,000 earnings base is estimated at $469 billion. Of course, for future years the total taxable earnings are estimated to increase, because there will be larger numbers of covered workers.

The cost estimates are extended beyond the year 2000, since the aged population itself cannot mature by then. The reason for this is that the number of births in the 1930's was very low as compared with both prior and subsequent experience. As a result, there will be a dip in the relative proportion of the aged from 1995 to about 2015, which would tend to result in low benefit costs for the old-age, survivors, and disability insurance system during that period. For this reason the year 2000 is by no means a typical ultimate year insofar as costs are concerned.

MEASUREMENT OF COSTS IN RELATION TO TAXABLE PAYROLL

In general, the costs are shown as percentages of taxable payroll. This is the best measure of the financial cost of the program. Dollar figures taken alone are misleading. For example, a higher earnings level will increase not only the outgo of the system but also, and to a great extent, its income. The result is that the cost relative to payroll will decrease. As an illustration of the foregoing points, consider an individual who has covered earnings at a rate of $400 per month. Under the committee bill such an individual would have a primary insurance amount of $194.40 If his earnings rate should be 50 percent higher (i.e. $600), his primary insurance amount would be $258.10. Under these conditions, the contributions payable with respect to his earnings would increase by 50 percent, but his benefit rate would increase by only 33 percent. Or to put it another way, when his earnings rate was $400 per month, his primary insurance amount represented 48.6 percent of his earnings, whereas, when his earnings increased to $600 per month, his primary insurance amount relative to his earnings decreased to 43.0 percent.

GENERAL BASIS FOR SHORT-RANGE COST ESTIMATES

The short-range cost estimates (shown for the individual years 1970–75) are not presented on a range basis since—assuming that employment and earnings will increase each year it is believed that the demographic factors involved (such as mortality, fertility, retirement rates, etc.) can be reasonably closely forecast, so that only a single estimate is necessary. A gradual rise in the earnings level in the future (about 5–6 percent per year), somewhat below that which has occurred in the past few years, is assumed. As a result of this assumption, contribution income is somewhat higher than if level earnings were assumed, while benefit outgo is only slightly affected.

LEVEL-COST CONCEPT

An important measure of long-range cost is the level-equivalent contribution rate required to support the system for the next 75 years (including not only meeting the benefit costs and administrative expenses, but also the maintenance of a reasonable contingency fund during the period, which at the end of the period amounts to 1 year's disbursements), based on discounting at interest. If such a level rate were adopted, relatively large accumulations in the trust funds would result, and in consequence there would be a sizable eventual income from interest. Even though such a method of financing is not followed, this concept may be used as a convenient measure of long-range costs. This is a valuable cost concept, especially in comparing various possible alternative plans and provisions, since it takes into account the heavy deferred benefit costs.

FUTURE EARNINGS AND CONSUMER PRICE INDEX ASSUMPTIONS

The long-range estimates for the old-age, survivors, and disability insurance program presented in this report are based on the assumption that the consumer price index and the average earnings covered by the program will remain level in the future. This does not mean covered payrolls are assumed to be the same each year; rather they will rise steadily as the covered population at the working ages is estimated to increase. If in the future the level of earnings and the consumer price index should continue to increase, as they have done in the past, the program would slowly accumulate actuarial surpluses. Under the financing procedures that were adopted by the committee to cover the cost of the automatic increases in benefits, the long-range level-cost of the automatic increases in benefits would be covered by increases in the tax rates and in the taxable earnings base that would be promulgated by the Secretary of the Department of Health, Education, and Welfare to become effective at the same time as the benefit increases.

The automatic benefit increases are designed as a backup to specific legislated increases to assure that rises in the cost of living will not, over a period of time, reduce the purchasing power of social security benefits. Therefore, realistic estimates of the cost of these benefits over a significant number of years are not possible. However, it is estimated that in the next decade the average cost of an annual cost-of-living increase might require an increase of about $750 in the tax base and an increase of about 0.1 percent in the combined employee-employer tax rates.

INTERRELATIONSHIP WITH RAILROAD RETIREMENT SYSTEM

An important element affecting old-age, survivors, and disability insurance costs arose through amendments made to the Railroad Retirement Act in 1951. These provide for a combination of railroad retirement compensation and old-age, survivors, and disability insurance covered earnings in determining benefits for those with less than 10 years of railroad service and also for all survivor cases.

Financial interchange provisions are established so that the old-age and survivors insurance trust fund and the disability insurance trust fund are to be placed in the same financial position in which they would have been if railroad employment had always been covered under the program. It is estimated that, over the long range, the net effect of these provisions will be a relatively small loss to the old-age, survivors, and disability insurance system since the reimbursements from the railroad retirement system will be somewhat smaller than the net additional benefits paid on the basis of railroad earnings.

REIMBURSEMENT FOR COSTS OF PRE-1957 MILITARY SERVICE WAGE CREDITS

Another important element affecting the financing of the program arose through legislation in 1956 that provided for reimbursement from general revenues for past and future expenditures in respect to the noncontributory credits that had been granted for persons in military service before 1957. These financing provisions were modified by the 1965 amendments. The cost estimates contained here reflect the effect of these reimbursements (which are included as contributions), based on the assumption that the required appropriations will be made in the future in accordance with the relevant provisions of the law. These reimbursements are intended to be made on the basis of a constant annual amount (as determined by the Secretary of Health, Education, and Welfare) for each trust fund payable over the period up to the year 2015 (with such amount subject to adjustment every 5 years).

REIMBURSEMENT FOR COSTS OF ADDITIONAL POST-1956 MILITARY SERVICE WAGE CREDITS

Under the committee bill, individuals in active military service during 1957–67 will receive additional wage credits in excess of their cash pay (but within the maximum creditable earnings base) in recognition of their remuneration that is payable in kind (e.g., quarters and meals). These additional credits are at the rate of $300 per calendar quarter. (Under the 1967 amendments, additional noncontributory wage credits of up to $100 per month were granted for military service performed after 1967. The committee bill also modifies the way in which these credits are determined, from $100 per month to $300 per quarter.) The additional costs that arise from these credits are to be financed from general revenues on an "actual disbursements cost" basis, with reimbursement to the trust funds on as prompt a basis as possible (and with interest adjustments to make up for any delay due to the time needed to make the necessary actuarial calculations from sample data and for the necessary appropriations to be made).

In many instances, the availability of these additional wage credits will not result in additional benefits because the individual will have maximum credited earnings without them or because the year in which such credits are granted will be a drop-out year in the computation of his average monthly wage. In the immediate-future years, the cost of these additional credits to the general fund will be relatively small (only about $35 million a year) since there will be relatively few cases arising, almost all due to death and disability.

Actuarial Balance of Program in Past Years

ACTUARIAL BALANCE OF PROGRAM AFTER ENACTMENT OF 1967 ACT [1]

The changes made by the 1967 amendments involved an increased cost that was fully met by the accompanying changes in the financing provisions (namely, an increase in the contribution rates in 1973 and after and an increase in the earnings base). After an increase in the allocation to the disability insurance system, both that portion of the program and the old-age and survivors insurance portion were estimated to be in close actuarial balance.

In 1968 the cost estimates were completely revised, based on the availability of new operating data. The new estimates showed significantly lower costs. The actuarial balance of the old-age, survivors, and disability insurance program increased from +0.01 percent of taxable payroll to +0.53 percent of taxable payroll. The factors contributing to lower costs were as follows: (1) use of 1968 earnings assumption (instead of 1966 earnings) +0.33 percent; (2) use of 4¼ percent interest assumption (instead of 3¾ percent), +0.11 percent; (3) use of higher female labor force participation rates, +0.06 percent; and (4) other factors, +0.02 percent.

Then, in 1969, another complete revision of the actuarial cost estimates was made. The estimated cost of the program was again significantly reduced. The actuarial balance of the old-age, survivors, and disability insurance program was thereby increased from the figure of +0.53 percent of taxable payroll according to the 1968 estimate to +1.16 percent of taxable payroll. The factors contributing to lower costs were as follows: (1) use of 1969 earnings assumption (instead of 1968 earnings), +0.22 percent; (2) use of 4¾-percent interest assumption (instead of 4¼ percent), +0.11 percent; (3) use of higher labor force participation rates, for both men and women, +0.23 percent; and (4) other factors, +0.07 percent.

ACTUARIAL BALANCE OF PROGRAM AFTER ENACTMENT OF 1969 ACT

According to the cost estimates for the 1967 act made in 1969, there was a very favorable actuarial balance for the combined old-age, survivors, and disability insurance system, but that there was a deficit of 0.01 percent of taxable payroll for the disability insurance portion, and a favorable balance of 1.17 percent of taxable payroll for the old-age and survivors insurance portion.

Under the 1969 act, the benefit changes made were financed by utilizing the existing favorable actuarial balance, without any increases in the contribution rates and the earnings base. Accordingly, since the disability insurance system was in such close actuarial balance under the then-existing law, it was necessary to increase the portion of the combined contributions which were allocated to it, so as to finance the cost of the 15-percent benefit increase. Under the new allocation basis, both the old-age and survivors insurance system and the disability insurance system were in close actuarial balance.

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[1] For details of the actuarial balance of the program before the enactment of the 1967 act, see page 83, H. Rept. 544, 90th Cong.

ACTUARIAL BALANCE OF PROGRAM UNDER THE COMMITTEE BILL

Table I traces through the change in the actuarial balance of the system from its situation under present law, according to the latest estimate, to that under the committee bill, by type of major changes involved, determined as of January 1, 1970.

TABLE I—CHANGES IN ACTUARIAL BALANCE OF OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, EXPRESSED IN TERMS OF ESTIMATED LEVEL-COST AS PERCENTAGE OF TAXABLE PAYROLL, BY TYPE OF CHANGE, INTERMEDIATE-COST ESTIMATE, PRESENT LAW AND COMMITTEE BILL

[In percent]

Item	Old-age and survivors insurance	Disability insurance	Total system
Actuarial balance of present system	—0.08	0.00	—0.08
Effect of using 1970 earnings	+.25	+.03	+.28
Increase in earnings base	+.20	+.03	+.23
Age 62 computation point for men	—0.7	(1)	—.07
Earnings test changes	—.13	(1)	—.13
Widow's benefits 100 percent PIA at 65	—.20	(2)	—.20
Liberalized eligibility for blind	(2)	—.08	—.08
4-month disability waiting period	(2)	—.06	—.06
Family maximum for new beneficiaries	—.03	—.01	—.04
Miscellaneous changes[3]	—.01	(1)	—.01
10 percent benefit increase and $100 minimum	—1.11	—.13	—1.24
Revised contribution schedule	+1.04	+.21	+1.25
Total effect of changes in bill	—.06	—.01	—.07
Actuarial balance under bill	—.14	—.01	—.15

[1] Less than 0.005 percent.
[2] Not applicable to this program.
[3] Includes the following: child's benefits for children disabled at ages 18 to 21; disabled-child 7 years re-entitlement; reduced widower's benefits at age 60, and broaden definition of adopted child.

The changes made by the committee bill would maintain the sound actuarial position of the old-age, survivors, and disability insurance system. The estimated actuarial balance of −0.15 percent of taxable payroll is not quite inside the established limit within which the system is considered substantially in actuarial balance (i.e. −0.10 percent of taxable payroll), but—as pointed out earlier—the difference is small in light of rising earnings levels and should be made up when a new actuarial valuation is made in the latter part of 1971, when data on 1971 earnings become available.

It should be emphasized that in 1950 and in subsequent amendments, the Congress did not recommend that the system be financed by a high level tax rate in the future, but rather recommended an increasing schedule, which, of necessity, ultimately rises higher than such a level rate. Nonetheless, this graded tax schedule will produce a considerable excess of income over outgo for many years so that a sizable trust fund will develop, although not as large as would arise under an equivalent level tax rate. This fund will be invested in Government securities (just as is also the case for the funds of the civil service retirement, railroad retirement, national service life insurance, and U.S. Government life insurance systems). The resulting interest income will help to bear part of the higher benefit costs of the future.

Level-Cost of Benefit Payments, by Type

The level-cost of the old-age and survivors insurance benefit payments (without considering administrative expenses, the railroad retirement financial interchange, and the effect of interest earnings on the existing trust fund) under the 1969 act, according to the latest intermediate-cost estimate, is 8.90 percent of taxable payroll, and the corresponding figure for the program as it would be modified by the committee bill is 9.98 percent. The corresponding figures for the disability benefits are 1.10 percent for the 1969 act and 1.32 percent for the committee bill.

Table II presents the benefit costs for the old-age, survivors, and disability insurance system as it would be after enactment of the committee bill, separately for each of the various types of benefits.

TABLE II.—ESTIMATED LEVEL-COST OF BENEFIT PAYMENTS, ADMINISTRATIVE EXPENSES, AND INTEREST EARNINGS ON EXISTING TRUST FUND UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, AFTER ENACTMENT OF COMMITTEE BILL, AS PERCENTAGE OF TAXABLE PAYROLL,[1] BY TYPE OF BENEFIT, INTERMEDIATE-COST ESTIMATE

[In percent]

Item	Old-age and survivors insurance	Disability insurance
Primary benefits	6.80	1.09
Wife's and husband's benefits	.53	.07
Widow's and widower's benefits	1.62	(2)
Parent's benefits	.01	(2)
Child's benefits	.81	.16
Mother's benefits	.14	(2)
Lump-sum death payments	.07	(2)
Total benefits	9.98	1.32
Administrative expenses	.13	.04
Railroad retirement financial interchange	.09	.00
Interest on existing trust fund [3]	−.24	−.04
Net total level-cost	9.96	1.32

[1] Including adjustment to reflect the lower contribution rate on self-employment income and on tips, as compared with the combined employer-employee rate.
[2] This type of benefit is not payable under this program.
[3] This item includes reimbursement for additional cost of noncontributory credit for military service and is taken as an offset to the benefit and administrative expense costs.

Income and Outgo in Near Future

Under the committee bill, benefit disbursements under the old-age, survivors, and disability insurance program will increase, over present law, by about $6.7 billion in 1972, the first full calendar year of operation under the modified program. The contribution income for the old-age, survivors, and disability insurance program in 1972 is about $0.8 billion higher than under present law (table III). Although these estimates are on a level-cost basis, the idea underlying the estimates assumes that Congress will continue, as in the past, to legislate specific benefit increases which take into account changes in earnings and price levels. Therefore, these estimates, and the others in this section, assume no automatic increases in benefit rates under the cost-of-living provision.

Under the program as modified by the committee bill, the old-age and survivor's trust fund will increase slowly during 1971–74, rising from $32.3 billion at the end of 1970 to $37.3 billion at the

end of 1974. During this period the amount of annual increase will rise from about $0.2 billion in 1971 to about $2.6 billion in 1974. Then, in 1975, when the contribution rates increase (the combined employer-employee rate going from 8.8 percent to 10.0 percent), the trust fund increases by $9.3 billion; such large increases will also occur in the years immediately following 1975 (table IV). The trust fund balance at the end of each year during the period 1970–74 will amount to approximately 90 percent of the following year's outgo for benefit payments.

The disability insurance trust fund is estimated to increase by about $0.1 billion in 1971, and by somewhat larger amounts each year thereafter, through 1974, when the fund increases by about $0.4 billion. The increase in 1975 will be about $1.0 billion, reflecting the increase from 0.95 percent in 1974 to 1.05 percent in 1975, in the combined employer-employee contribution rate allocated to the fund. The balance in the disability insurance trust fund will increase from $5.6 billion at the end of 1970 to $6.5 billion at the end of 1974, and then to $7.5 billion at the end of 1975 (table V). The trust fund balance at the end of each year during the period 1970–74 will be approximately 1.3 times the amount of benefit payments in the following year.

TABLE III.—PROGRESS OF OLD-AGE AND SURVIVORS INSURANCE AND DISABILITY INSURANCE TRUST FUNDS, COMBINED, SHORT RANGE ESTIMATE

[In millions]

Calendar year	Income		Disbursements			Net increase in funds	Funds at end of year
	Contributions[1]	Interest on fund	Benefit payments[2]	Administrative expenses	Railroad retirement financial interchange		
Past experience:							
1960	$11,876	$569	$11,245	$240	$314	$647	$22,613
1961	12,323	614	12,749	303	337	−451	22,162
1962	13,105	594	14,461	322	372	−1,456	20,705
1963	15,640	587	15,426	348	442	10	20,715
1964	16,843	633	16,223	375	422	456	21,172
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
Estimated future experience under committee bill:							
1970[3]	34,987	1,821	31,894	623	589	3,702	37,884
1971	39,366	1,920	39,539	810	617	320	38,204
1972	42,202	1,985	41,797	812	778	800	39,004
1973	44,647	2,117	43,274	869	867	1,754	40,758
1974	47,206	2,303	44,779	885	840	3,005	43,763
1975	55,694	2,691	46,316	892	827	10,350	54,113

[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] Under present law.

Note: Estimates assume no automatic increases in benefit rates under the cost-of-living provision.

TABLE IV.—PROGRESS OF OLD-AGE AND SURVIVORS INSURANCE TRUST FUND, SHORT-RANGE ESTIMATE

[In millions]

Calendar year	Income		Disbursements			Net increase in funds	Funds at end of year
	Contributions[1]	Interest on fund	Benefit payments[2]	Administrative expenses	Railroad retirement financial interchange		
Past experience:							
1960	$10,866	$516	$10,677	$203	$318	$184	$20,324
1961	11,285	548	11,862	239	332	−599	19,725
1962	12,059	526	13,356	256	361	−1,388	18,337
1963	14,541	521	14,217	281	423	143	18,480
1964	15,689	569	14,914	296	403	645	19,125
1965	16,017	593	16,737	328	436	−890	18,235
1966	20,658	644	18,267	256	444	2,335	20,570
1967	23,216	818	19,468	406	508	3,652	24,222
1968	24,101	939	22,643	476	438	1,483	25,704
1969	28,389	1,165	24,210	474	491	4,378	30,082
Estimated future experience under committee bill:							
1970[3]	30,539	1,542	28,799	461	579	2,242	32,324
1971	35,272	1,598	35,452	572	605	241	32,565
1972	37,695	1,655	37,382	600	754	614	33,179
1973	39,849	1,770	38,656	646	832	1,485	34,664
1974	42,123	1,932	39,975	650	807	2,623	37,287
1975	49,837	2,281	41,332	649	794	9,343	46,630

[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] Under present law.

Note: Estimates assume no automatic increases in benefit rates under the cost-of-living provision.

TABLE V.—PROGRESS OF DISABILITY INSURANCE TRUST FUND, SHORT-RANGE ESTIMATE

[In millions]

Calendar year	Income		Disbursements			Net increase in funds	Funds at end of year
	Contributions[1]	Interest on fund	Benefit payments[2]	Administrative expenses	Railroad retirement financial interchange		
Past experinece:							
1960	$1,010	$53	$568	$36	−$5	$464	$2,289
1961	1,038	66	887	64	5	148	2,437
1962	1,046	68	1,105	66	11	−69	2,368
1963	1,099	66	1,210	68	20	−133	2,235
1964	1,154	64	1,309	79	19	−188	2,047
1965	1,188	59	1,573	90	24	−440	1,606
1966	2,022	58	1,784	137	25	133	1,739
1967	2,302	78	1,950	109	31	290	2,029
1968	3,348	106	2,311	127	20	996	3,025
1969	3,615	177	2,557	138	21	1,075	4,100
Estimated future experience under committee bill:							
1970[3]	4,448	279	3,095	162	10	1,460	5,560
1971	4,094	322	4,087	238	12	79	5,639
1972	4,507	330	4,415	212	24	186	5,825
1973	4,798	347	4,618	223	35	269	6,094
1974	5,083	371	4,804	235	33	382	6,476
1975	5,857	410	4,984	243	33	1,007	7,483

[1] Includes reimbursements from general fund of Treasury for cost of noncontributory credits for military service.
[2] Includes payments for vocational rehabilitation services.
[3] Under present law.

Note: Estimates assume no automatic increases in benefit rates under the cost-of-living provision.

Long-Range Operations of OASI Trust Fund

Table VI gives the estimated operations of the old-age and survivors insurance trust fund under the program as it would be changed by

the committee bill for the long-range future, based on the intermediate-cost estimate. It will, of course, be recognized that the figures for the next two or three decades are the most reliable (under the assumption of level-earnings trends in the future) since nearly all of the populations concerned—both covered workers and beneficiaries—are already born. As the estimates proceed further into the future, there is, of course, much more uncertainty.

In every year after 1969 for the next 25 years, contribution income under the system as it would be modified by the committee bill is estimated to exceed old-age and survivors insurance benefit disbursements. Even after the benefit-outgo curve rises ahead of the contribution-income curve, the trust fund will nonetheless continue to increase because of the effect of interest earnings (which more than meet the administrative expense disbursements and any financial interchanges with the railroad retirement program). As a result, this trust fund is estimated to grow steadily under the intermediate long-range cost estimate (with a level-earnings assumption), reaching $40 billion in 1980 and about $115 billion at the end of this century. The trust fund is shown as being exhausted in about 62 years, which results from the small lack of actuarial balance, as indicated previously.

TABLE VI.—ESTIMATED PROGRESS OF OLD-AGE AND SURVIVORS INSURANCE TRUST FUND UNDER SYSTEM AS MODIFIED BY COMMITTEE BILL, LONG-RANGE INTERMEDIATE-COST ESTIMATE

[In millions]

Calendar year	Contributions	Benefit payments [1]	Administrative expenses	Interest on fund	Balance in fund at end of year
1980	$50,481	$47,286	$714	$1,550	$40,505
1985	53,667	54,505	772	2,075	50,334
1990	63,564	61,888	830	3,018	73,106
1995	68,447	68,095	881	3,821	90,764
2000	73,942	71,885	920	4,870	115,118
2025	96,214	119,296	1,353	6,760	148,773
2040	110,534	138,606	1,558	(2)	(2)

[1] Includes effect of financial interchange with railroad retirement system.
[2] Fund exhausted in 2032.

Note: Contributions include reimbursement for additional cost of noncontributory credit for military service before 1957. No account is taken in this table of the outgo for the special benefits payable to certain noninsured persons aged 72 or over or for the additional benefits payable on the basis of noncontributory credit for military service after 1956—or of the corresponding reimbursement therefor, which is exactly counterbalancing from a long-range cost standpoint.
Estimates assume no automatic increases in benefit rates under the cost-of-living provision.

Long-Range Operations of DI Trust Fund

The disability insurance trust fund, under the program as it would be changed by the committee bill, grows after 1969, according to the intermediate long-range cost estimate, as shown by table VII. In 1980, it is shown as being $4 billion, while in 1990, the corresponding figure is $14 billion. There is a small excess of contribution income over benefit disbursements for every year after 1969 for the next 25 years, and then the fund declines and is exhausted by 2024.

TABLE VII.—ESTIMATED PROGRESS OF DISABILITY INSURANCE TRUST FUND UNDER SYSTEM AS MODIFIED BY COMMITTEE BILL, LONG-RANGE INTERMEDIATE-COST ESTIMATE

[In millions]

Calendar year	Contributions	Benefit payments [1]	Administrative expenses	Interest on fund	Balance in fund at end of year
1980	$7,129	$6,167	$226	$148	$4,277
1985	7,591	7,140	237	310	7,653
1990	8,674	7,904	250	608	14,455
1995	9,341	8,827	270	863	20,033
2000	10,098	10,084	306	1,078	24,634
2025	13,099	14,583	439	(2)	(2)
2040	15,044	17,117	516	(2)	(2)

[1] Includes effect of financial interchange provision with railroad retirement system.
[2] Fund exhausted in 2024.

Note: Contributions include reimbursement for additional cost of noncontributory credit for military service before 1957. No account is taken in this table of the outgo for the additional benefits payable on the basis of noncontributory credit for military service after 1956—or of the corresponding reimbursement therefor, which is exactly counterbalancing from a long-range cost standpoint.
Estimates assume no automatic increases in benefit rates under the cost-of-living provision.

Table VIII shows the estimated costs of the old-age and survivors insurance benefits and of the disability insurance benefits under the program as it would be changed by the committee bill as a percentage of taxable payroll for various future years, through the year 2040, and also the level-costs of the two programs.

TABLE VIII.—ESTIMATED COST OF BENEFIT PAYMENTS OF OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM AS PERCENT OF TAXABLE PAYROLL,[1] UNDER SYSTEM AS MODIFIED BY COMMITTEE BILL

Calendar year	Old-age and survivors insurance benefits	Disability insurance benefits	Total benefits
1980	8.91	1.17	10.08
1985	9.70	1.27	10.97
1990	10.40	1.33	11.73
1995	10.65	1.38	12.03
2000	10.43	1.46	11.89
2025	13.34	1.62	14.96
2040	13.50	1.65	15.15
Level-cost [2]	9.96	1.32	11.28

[1] Taking into account the lower contribution rate for self-employment income and tips, as compared with the combined employer-employee rate.
[2] Level contribution rate, at an interest rate of 4.75 percent benefits after 1969 taking into account interest on the trust fund on December 31, 1969, future administrative expenses, the railroad retirement financial interchange provisions, and the reimbursement of noncontributory military-wage-credits cost.

Note: Estimates assume no automatic increases in benefit rates under the cost-of-living provision.

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 estimated cost for benefit payments and administrative expenses that is in approximate long-range balance with contribution income. It is recognized that the preparation of cost estimates for hospitalization and related benefits is much more difficult and is much more subject to variation than cost estimates for the cash benefits of the old-age, survivors, and disability insurance system. This is so not only because the hospital insurance program has but a few years of operating

experience, but also because of the greater number of variable factors involved in a service-benefit program than in a cash-benefit one.

New long-range actuarial cost estimates for the hospital insurance system have recently been prepared. They show a significantly higher benefit cost than the previous estimates, which were used as the basis for the 1967 amendments.

These new cost estimates are based on revised assumptions as to the many factors involved in the hospital insurance program. Based on actual recent experience, the assumptions include higher unit costs in the future for hospital and other services covered by the program, an increasing trend in utilization of services, and somewhat higher increases in covered earnings that are subject to contributions. A detailed presentation of the new assumptions is contained in "Actuarial Study No. 71," issued by the Social Security Administration, Department of Health, Education, and Welfare, but some information on these matters is presented in the subsequent discussion here.

Financing Policy

FINANCING BASIS OF COMMITTEE BILL

The contribution schedule contained in the committee bill for the hospital insurance program, under a $9,000 taxable earnings base beginning in 1971, is as follows, as compared with that of present law:

[In percent]

Calendar year	Combined employer-employee rate			Self-employed rate		
	Present law	House-approved bill	Committee bill	Present law	House-approved bill	Committee bill
1970	1.2	1.2	1.2	0.60	0.6	0.6
1971–72	1.2	2.0	1.6	.60	1.0	.8
1973–74	1.3	2.0	1.8	.65	1.0	.9
1975	1.3	2.0	2.0	.65	1.0	1.0
1976–79	1.4	2.0	2.0	.70	1.0	1.0
1980–85	1.6	2.0	2.2	.80	1.0	1.1
1986	1.6	2.0	2.2	.80	1.0	1.1
1987 and after	1.8	2.0	2.2	.90	1.0	1.1

Only one provision of the committee bill would add to the cost of the hospital insurance program. This provision would authorize the Secretary of Health, Education, and Welfare to establish presumptive periods of coverage on the basis of a physician's certification for patients admitted to an extended care facility (ECF) or started on a home health plan. Unless disapproved in advance, coverage upon admission to an ECF would continue for the lesser of: (a) the initially certified period, (b) until notice of disapproval, or (c) 10 days. Administration of the home health benefit would follow essentially the same approach. It is believed that this provision might increase ECF admissions; however, some of the related hospital stays will be shortened. The net effect of this provision is estimated to be a level-cost of .03 percent of taxable payroll.

The bill contains a number of provisions which are intended to reduce the cost of the program. Among these provisions are the elimination of payments to certain providers of services who have abused

the program, the limitation of the payments to certain providers of services who furnish services which are determined to be unduly expensive, certain limitations on financial participation for supporting unnecessary capital expenditures, the possibility of increased economy under prospective-reimbursement experiments and demonstration projects, the limitation of reimbursement to customary charges in certain instances when these are less than reasonable cost, and the requirement of reasonable institutional planning. The actuaries have not found it possible to estimate the extent of these savings; accordingly, any savings resulting from these provisions represents a safety margin in the cost estimate.

Another provision is designed to establish at local levels professional standards review organizations (PSRO's) as primary professional quality and cost control mechanisms for all health care services provided under medicare (and medicaid). When PSRO's are fully operational, they will have the potential to reduce the program cost substantially. Although the effectiveness of such organizations has been demonstrated at various localities, there is no experience on a nationwide basis. Here, too, the actuaries have not found it possible to estimate the savings that will result from this provision ta this time; the reductions in cost (as well as any short-run increase in administrative expenses in setting up PSRO's) due to this provision are not taken into account in the actuarial cost estimates at this time. As the hospital insurance program experience affected by the PSRO's emerges, it is the committee's hope that they can be incorporated in the future actuarial cost estimates.

A provision designed to simplify medicare reimbursement requires the uniform use of the departmental method of cost apportionment for most larger institutions. The estimated level-cost savings to the program due to this provision is .02 percent of taxable payroll.

Another change made by the committee bill would permit individuals to obtain their medicare coverage (both hospital insurance and supplementary medical insurance) through a health maintenance organization (a group practice prepayment plan or other capitation plan). In such instances, the medicare program would pay for such coverage on a capitation basis. The capitation rate shall be determined by using established actuarial methods. It is the sum of the following three components: (1) An adjusted net premium which is determined by adjusting each HMO's net premium rate (actuarial benefit cost of providing the services) for enrollees under age 65 for differences between people age 65 and over and those under age 65 as to their utilization of services. Adjustments should also be made to reflect underwriting requirements, and other relevant factors. The adjusted net premium rate shall not exceed 95 percent of the benefit costs that, according to actuarial estimates (which would take into account such factors as age and sex of the enrollees, geographical location of the organization, the selection of risks, and the enrollment rules of the organization and other relevant factors determined by actuarial principles), would otherwise have been payable with respect to such persons if they had not been members of such organizations; (2) A risk charge (retention minus administrative expenses) which is the lesser of (a) the adjusted net premium times the ratio of the weighted gross premium rate of enrollees under age 65 over the corresponding actual

benefit costs per capita plus administrative expenses per capita, or (b) 150 percent of the average dollar amount of risk charges per capita that such organization structured in the premium rate for all enrollees under age 65; and (3) An administrative allowance which reasonably represents the actual administrative costs of such organization but not to exceed 95 percent of the national average per capita cost of administrative expenses incurred by intermediaries and carriers (excluding auditing expenses) for the same time period. The committee believes very strongly that the actuarial determinations shall be performed by qualified actuaries experienced in health insurance programs.

No valid experience under the medicare program is available for the purpose of making any cost estimates of the effect of the health maintenance organization provision. To the extent that adequate actuarial analysis can be made in the future as to the actual operation of those organizations, there could be a significant reduction in the long-run cost of the medicare program.

In the early years of operation, however, there might be increased program costs, because the relatively few organizations of this type now in existence are being reimbursed only their actual costs, whereas under the provisions of the committee bill, they could, in the future, be reimbursed somewhat more than costs. On the other hand, if such organizations can supply the covered services at a lower cost than what would otherwise prevail, then in the future, if more of these organizations are formed, there might be a significant net savings to the program. Acordingly, the actuarial cost estimates have not been increased to reflect the possible short-range cost aspects of this provision for a different reimbursement basis for health maintenance organizations since it is possible that in the long run the provision will result in savings.

The committee bill also contains a provision that would eliminate payments under the medicare program for services covered by the Federal employees health benefits plan, beginning in 1972, unless such plan is modified to make available coverage supplementary to that under the medicare program. For the purposes of the actuarial cost estimates, no account is taken of any possible reduction in benefit payments under the medicare program on this account, because of the likelihood that such modification will occur.

The committee bill provides an opportunity for persons who are not otherwise eligible under the hospital insurance program to enroll, on a voluntary basis, and then to pay the estimated full cost of the benefit protection thus made available. Such voluntary elective individual coverage can also be obtained by States and other organizations on a group basis for their retired employees aged 65 and over who are not otherwise protected under the hospital insurance program.

In this area also, the actuarial cost estimates presented in this report do not take into account the effect of this provision for voluntary coverage of otherwise ineligible persons, since it is not possible to estimate how many of the approximately 250,000 persons eligible to so elect will actually do so; of these 250,000 persons, about 145,000 are covered under the Federal Employees Health Benefits plan and so are unlikely to elect the voluntary hospital insurance under the bill. Thus, approximately 100,000 persons are really potentially eli-

gible to elect. Furthermore, if the premium rate, which has been actuarially estimated at $27 per month for the first year of operation, is adequate, there will be no net effect on the financial operations of the total program. In any event, whether or not such experience is favorable, there will be relatively little effect on the financial operations of the program, because of the small number of persons likely to be involved.

The hospital insurance program is completely separate from the old-age, survivors, and disability insurance system in several ways, although the earnings base has thus far been the same under both programs. First, the schedules of tax rates for old-age, survivors, and disability insurance and for hospital insurance are in separate subsections of the Internal Revenue Code (unlike the situation for old-age and survivors insurance as compared with disability insurance, where there is a single tax rate for both programs, but an allocation thereof into two portions). Second, the hospital insurance program has a separate trust fund (as is also the case for old-age and survivors insurance and for disability insurance) and, in addition, has a separate Board of Trustees from that of the old-age, survivors, and disability insurance system. Third, income tax withholding statements (forms W–2) show the proportion of the total contribution for old-age, survivors, and disability insurance and for hospital insurance that is with respect to the latter. Fourth, the hospital insurance program covers railroad employees directly in the same manner as other covered workers, and their benefit payments are paid directly from this trust fund (rather than directly or indirectly through the railroad retirement system), whereas these employees are not covered by old-age, survivors, and disability insurance (except indirectly through the financial interchange provisions). Fifth, the financing basis for the hospital insurance system is determined under a different approach than that used for the old-age, survivors, and disability insurance system, reflecting the different natures of the two programs (by assuming rising earnings levels and rising hospitalization costs in future years, instead of level-earnings assumptions and by making the estimates for a 25-year period rather than a 75-year one). Sixth, the contribution rate for self-employed persons is the same as for employees, whereas under old-age, survivors, and disability insurance, the self-employed pay 50 percent more at the present time.

SELF-SUPPORTING NATURE OF SYSTEM

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

ACTUARIAL SOUNDNESS OF SYSTEM

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

One major difference in this concept as it applies between the two different systems is that cost estimates for the hospital insurance program are made over a period of only 25 years in the future, rather than 75 years as in connection with the old-age, survivors, and disability insurance program. A shorter period for the hospital insurance program is necesary because of the greater difficulty in making forecast assumptions for a service benefit than for a cash benefit. Although there is reasonable likelihood that the number of beneficiaries aged 65 and over will tend to increase over the next 75 years when measured relative to covered population (so that a period of this length is both necessary and desirable for studying the cost of the cash benefits under the old-age, survivors, and disability insurance program), it is far more difficult to make reasonable assumptions as to the trends of medical care costs and practices for more than 25 years in the future. In fact, experience with the hospital insurance program has shown that it is difficult even to project 5 years into the future.

It seems desirable to the committee that the hospital insurance program should be in close actuarial balance. In order to accomplish this result, the committee has revised the contribution schedule to meet this requirement, according to the underlying cost estimates.

HOSPITALIZATION DATA AND ASSUMPTIONS

PAST INCREASES IN HOSPITAL COSTS AND IN EARNINGS

Table A presents a summary comparison of the annual increases in hospital costs and the corresponding increases in wages that have occurred since 1955 and up through 1969.

TABLE A.—COMPARISON OF ANNUAL INCREASES IN HOSPITAL COSTS AND IN EARNINGS

[Percent]

Calendar year	Increase over previous year	
	Average wages in covered employment[1]	Average daily hospitalization costs[2]
1956	5.7	4.5
1957	5.5	7.7
1958	3.3	8.6
1959	3.3	6.8
1960	4.3	6.8
1961	3.1	8.5
1962	4.2	5.3
1963	2.4	5.6
1964	3.1	6.9
1965	1.6	7.0
1966	4.4	8.3
1967	6.3	12.3
1968	7.0	13.5
1969	6.0	[3] 14.0
Average for 1956–65	3.6	6.8
Average for 1966–69	5.9	12.0

[1] Data are for calendar years (based on experience in 1st quarter of year).
[2] Data are for fiscal years ending in September of year shown. Data are from American Hospital Association, and "hospitalization costs" represents total hospital expense per patient day.
[3] Preliminary estimate made by Social Security Administration.

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

The annual increases in earnings fluctuated somewhat over the period up through 1965, although there were not very large deviations from the average annual rate of 3.6 percent; no upward or downward trend over the period is discernible. The annual increases in hospital costs likewise fluctuated from year to year during this period, around the average annual rate of 6.8 percent.

During the period 1956–65, hospital costs increased at a faster rate than earnings. The differential between these two rates of increase fluctuated widely, being as high as somewhat more than 5 percent in some years and as low as a negative differential of about 1 percent in 1956 (with the next lowest differential being a positive one of about 1 percent in 1962). Over the entire 10-year period, the differential between the average annual rate of increase in hospital costs over the average annual rate of increase in earnings was 3.2 percent.

Following 1965, however, both earnings and hospital costs have risen sharply, the former at a rate of about 6 percent per year and the latter at about 12 percent per year. Thus, the differential rate of increase of hospital costs as against earnings was about 6 percent per year during 1966–69, as compared with 3 percent in the preceding decade. Or, to put it another way, in the past 15 years, hospital costs have increased at double the rate that earnings in general have. No change in this relationship is evident currently, so that relatively high increases in hospital costs seem likely in at least the next few years.

The Deparment of Health, Education, and Welfare estimates that, in the future, after the next few years, earnings will increase at a rate of about 4 percent per year. It is much more difficult to predict what the corresponding increase in hospital costs will be.

EFFECT ON COST ESTIMATES OF RISING HOSPITAL COSTS

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

In connection with this latter factor, there are possible counterbalancing factors. The higher costs involved for more refined and exten-

sive treatments may be offset by the development of out-of-hospital facilities, shorter durations of hospitalization, and less expense for subsequent curative treatments as a result of preventive measures. Also, it is possible that at some time in the future, the productivity of hospital personnel will increase significantly as the result of changes in the organization of hospital services or for other reasons, so that, as in other fields of economic activity, the general wage level might increase more rapidly than hospitalization prices in the long run.

Perhaps the major consideration in making actuarial cost estimates for hospital benefits is that—unlike the situation in regard to cost estimates for monthly cash benefits, where the result is the opposite—an unfavorable cost result is shown when total earnings levels rise, unless the financing provisions of the system are kept up to date (insofar as the maximum taxable earnings base is concerned). The reason for this result is that hospital costs rise at least at the same rate over the long run as the total earnings level, whereas the contribution income rises less rapidly, unless the earnings base is kept up to date, than the total earnings level.

For these reasons, the cost estimates were previously based on the assumption that both hospital costs and the general level of earnings will increase in the future for the entire 25-year period considered, while at the same time the earnings base will not change. The present cost estimates no longer assume that the maximum taxable earnings base will not change, but rather that it will be increased in the future as in the past.

The committee is aware that such a modification represents a basic change from the way future financing of the hospital insurance program has previously been handled. However, there are a number of provisions in the committee bill which should result in savings but for which no savings have been reflected in the actuarial projections. It is the committee's hope that these provisions will offset any unanticipated further cost increases in the future.

The fact that the cost-sharing provisions (the initial hospital deductible and the coinsurance features) are on a dynamic basis which varies with hospital costs is taken into account as not requiring a higher cost estimate than would be needed if static conditions were assumed.

ASSUMPTIONS AS TO RELATIVE TRENDS OF HOSPITAL COSTS AND EARNINGS UNDERLYING COST ESTIMATE FOR COMMITTEE BILL

As indicated previously, the committee very strongly believes that the financing basis of the hospital insurance program should be developed on a conservative basis. Although the trend of beneficiaries aged 65 and over relative to the working population will undoubtedly move in an upward direction after 25 years from now, it seems impossible to predict what the trend of medical costs and what hospital-

utilization and medical-practice trends will be in the distant future.

The assumptions as to the short-term trend of hospital costs for the cost estimates presented here are shown in table B. As in the past, it is assumed that the greatest annual increases in hospital cost rates have already taken place.

TABLE B.—ASSUMPTIONS AS TO FUTURE RATES OF INCREASES IN HOSPITAL COSTS

Calendar year:	*Rate of increase (in percent)*
1969	15.0
1970	14.0
1971	13.0
1972	11.5
1973	10.0
1974	8.5
1975	7.0
1976	6.0
1977	5.0
1978 and after	4.0

ASSUMPTIONS AS TO HOSPITAL UTILIZATION RATES UNDERLYING COST ESTIMATES FOR COMMITTEE-APPROVED BILL

The hospital utilization assumptions for the cost estimates in this report are founded on the hypothesis that current practices in this field will not change even more in the future than past experience has indicated. In other words, no account is taken of the possibility that there will be a drastic change in philosophy as to the best medical practices, so as, for example, to utilize in-hospital care to a much greater extent than is now the case.

The hospital utilization rates used for the cost estimates for your committee's bill are based on the actual experience of the program in 1968, with assumed increases of 1 to 2 percent per year for the next decade.

ASSUMPTIONS AS TO HOSPITAL PER DIEM RATES UNDERLYING COST ESTIMATES FOR COMMITTEE-APPROVED BILL

The average daily hospital reimbursement rate by the program for 1968 (i.e. not including the cost-sharing payments made by the beneficiaries) was about $48. This was projected for future years in the manner described previously.

Results of Cost Estimates

SUMMARY OF COST ESTIMATE FOR COMMITTEE BILL

The level-cost of the benefits and administrative expenses under present law is estimated at 2.11 percent of taxable payroll under the

assumption that the earnings base will be increased in the future as in the past. Such level-cost would be 2.79 percent of taxable payroll if it were assumed that the earnings base would remain fixed at $7,800 over the entire 25-year valuation period—the assumption underlying previous actuarial evaluation of the program

Under the rising-earnings-base assumption, the level-equivalent of the graded contribution schedule under present law is 1.56 percent of taxable payroll and the level-equivalent value of the existing trust fund is 0.02 percent of taxable payroll, so that there is a lack of actuarial balance under present law, using the revised estimates of hospital cost trends and the other revised cost factors, amounting to 0.53 percent of taxable payroll. Under the assumption that the earnings base remains level in the future at the $7,800 amount specified in present law (the assumption which has heretofore been made in setting the contribution schedule), the level-equivalent of the contribution schedule is 1.52 percent of taxable payroll, and the level-equivalent of the existing trust fund is 0.03 percent of taxable payroll, so that then the actuarial balance would be −1.24 percent of taxable payroll.

Under the committee bill, there would be additional financing for the program, both through the increase in the earnings base to $9,000, effective in 1971, and through increasing the rates in the contribution schedule. Thus, the new contribution schedule (which has a level-equivalent value of 2.05 percent of taxable payroll) would, if the projected cost assumptions are valid, adequately finance the program, whose actuarial balance would then be −0.05 percent of taxable payroll.

Table C traces through the actuarial balance of the hospital insurance system from its situation under present law, according to the latest estimate, to that under the committee bill, determined as of January 1, 1970.

TABLE C.—CHANGES IN ACTUARIAL BALANCE OF HOSPITAL INSURANCE SYSTEM, EXPRESSED IN TERMS OF ESTIMATED LEVEL-COST AS PERCENTAGE OF TAXABLE PAYROLL, INTERMEDIATE-COST ESTIMATE, PRESENT LAW, HOUSE APPROVED BILL AND COMMITTEE BILL

[In percent]

Item	Level-cost or level-equivalent			
	Contributions	Benefit payments [1]	Existing trust fund	Actuarial balance
Present law, level $7,800 earnings base	1.52	2.79	0.03	−1.24
Present law, increasing earnings base [2]	1.56	2.11	.02	−.53
House approved bill, increaseing earnings base [3]	1.98	2.11	.02	−.11
Committee bill, increasing earnings base [3]	2.05	2.12	.02	−.05

[1] Including also the administrative expenses.
[2] The cost esitmate is made under the assumption that the maximum taxable earnings base will be increased after 1970, so that approximately the same proportion of the total payroll in covered employment will be taxable as was the case under the $7,800 base in 1968. This would produce a base of $9,000 in 1971–72 (as in the committee bill) and under the assumptions made as to future changes in earnings levels, $9,600 in 1973–74, $10,200 in 1975–76, $11,400 in1977–78, etc., to $21,000 in 1993–94.

The cost for the persons who are blanketed-in for the hospital and related benefits is met from the general fund of the Treasury (with the financial transactions involved passing through the hospital insurance trust fund). The costs so involved, along with the financial transactions, are not included in the preceding cost analysis, although

they are shown in the following discussion of the progress of the hospital insurance trust fund. A later portion of this section discusses these costs for the blanketed-in group.

FUTURE OPERATIONS OF HOSPITAL INSURANCE TRUST FUND

Table D shows the estimated operation of the hospital insurance trust fund under present law (assuming no change in the $7,800 earnings base), while table E gives similar figures for the committee bill (under the assumption that the $9,000 earnings base effective in 1971 will be increased as earnings levels rise in the future).

Under present law, outgo exceeds income for every year after 1969. As a result, the trust fund is shown as being exhausted in mid-1972. According to this estimate, under the committee bill the balance in the trust fund would grow steadily in the future, increasing from about $2.2 billion at the end of 1970 to $5.9 billion 5 years later; over the long range, the trust fund would build up steadily, reaching $22.4 billion in 1994, somewhat less than 1 year, ago.

TABLE D.—ESTIMATED PROGRESS OF HI TRUST FUND UNDER PRESENT FINANCING PROVISIONS, INCURRED BASIS

[In millions]

Calendar year	Contributions [1]	Government payment for uninsured [2]	Benefit payments	Administrative expenses	Interest on fund [3]	Net income	Fund at end of year
1970	$4,973	$618	$5,820	$140	$139	−$130	$2,183
1971	5,231	656	6,894	150	101	−1,056	1,127
1972	5,482	685	8,031	161	8	−2,017	(4)

[1] Includes payments from general fund for military service wage credits.
[2] Cost for benefit payments and accompanying administrative expenses for uninsured persons for each fiscal year is assumed to be paid to the trust fund in the middle of the fiscal year (i.e., at the end of the corresponding calendar year).
[3] Over the long range, a 5-percent rate is assumed, with a somewhat higher rate in the early years.
[4] Fund exhausted in 1972.

Note: Fund balance at beginning of 1970 is $2,413,000,000 on an incurred basis (as compared with $2,505,000,000 on a cash basis.)

TABLE E.—ESTIMATED PROGRESS OF THE HI TRUST FUND UNDER FINANCING PROVISIONS OF COMMITTEE BILL UNDER BASIS OF EARNINGS BASE BEING INCREASED IN THE FUTURE,[1] INCURRED BASIS

[In millions of dollars]

Calendar year	Contributions [2]	Payment from general fund for uninsured [3]	Benefit payments	Administrative expenses	Interest on fund [4]	Net income	Fund at end of year
1970	4,973	618	5,820	140	139	−230	2,183
1971	7,404	671	6,974	150	166	1,117	3,300
1972	7,784	700	8,111	161	208	420	3,720
1973	9,423	716	9,254	172	245	958	4,678
1974	9,853	716	10,433	183	275	228	4,906
1975	11,723	703	11,537	195	305	999	5,905
1976	12,211	680	13,592	207	311	−597	5,308
1977	13,326	646	12,615	219	329	1,467	6,775
1978	13,880	605	14,467	232	367	153	6,928
1979	14,763	558	15,322	246	368	121	7,049
1980	16,895	505	16,218	260	398	1,320	8,369
1985	22,238	292	21,472	345	718	1,431	15,431
1990	28,712	124	28,726	457	944	597	19,641
1994	35,732	48	35,670	560	1,077	627	22,395

[1] Maximum taxable earnings base would be $7,800 in 1970, $9,000 in 1971–72, $9,600 in 1973–74, $10,200 in 1975–76, $11,400 in 1977–78, increasing ultimately to $21,000 in 1993–94. Combined employer-employee contribution schedule would be 1.2 percent for 1970, 1.6 percent for 1971–72, 1.8 percent for 1973–74, 2.0 percent for 1975–79, and 2.2 percent for 1980 and after.
[2] Includes payment from general fund for military service wage credits.
[3] Cost for benefit payments and accompanying administrative expenses for uninsured persons for each fiscal year is assumed to be paid to the trust fund in the middle of the fiscal year (i.e., at the end of the corresponding calendar year).
[4] Over the long range, a 5-percent rate is assumed, with a somewhat higher rate in the early years.

COST ESTIMATE FOR HOSPITAL BENEFITS FOR NONINSURED PERSONS PAID FROM GENERAL FUNDS

Hospital and related benefits are provided not only for beneficiaries of the old-age, survivors, and disability insurance system and the railroad retirement system, but also on a "free" basis for most other persons who were aged 65 and over in 1966 (and for many of those attaining this age in the next few years) who are not insured under either of these two social insurance systems. The exceptions are noninsured persons who are active and retired Federal employees who are eligible (or had the opportunity of being eligible) for similar protection under the Federal Employees Health Benefits Act of 1959 or who are short-residence aliens.

Under present law, persons meeting such conditions who attain age 65 before 1968 qualify for the hospital benefits regardless of whether they have had any covered employment in the past, while those attaining age 65 after 1967 must have some such coverage to qualify—namely, 3 quarters of coverage (which can be acquired at any time after 1936) for each year elapsing after 1966 and before the year of attainment of age 65 (e.g., 3 quarters of coverage for attainment of age 65 in 1968, 6 quarters for 1969, etc.). This transitional provision "washes out" under present law for men attaining age 65 in 1975 and for women attaining age 65 in 1974, since the fully-insured-status requirement for monthly benefits for such categories is then no greater than the special-insured status requirement.

Under the committee bill, these requirements for noninsured men would "wash out" at the same time as for women (due to the "age-62 computation point for men" provision in the committee bill).

The benefits for the noninsured group who receive hospital insurance benefits on a "free" basis is to be paid from the hospital insurance trust fund, but with financial reimbursement therefor from the general fund of the Treasury on a current basis, or with appropriate interest adjustment. The estimated cost to the general fund of the Treasury for the hospital and related benefits for this noninsured group (including the applicable additional administrative expenses) for various future years is shown in Table E. The estimated cost to the general fund of the Treasury for the closed group involved increases slowly to a peak of about $716 million per year in 1973–74 and then decreases steadily thereafter. Offsetting, in large part, the decline in the number of eligibles blanketed-in are the factors, the increasing hospital utilization per capita as the average age of the group rises and the increasing hospital costs in future years.

The foregoing discussion and cost estimates do not include the noninsured persons who, under the provisions of the committee bill, can voluntarily buy into the hospital program on the basis of their paying the estimated full costs involved.

D. ACTUARIAL COST ESTIMATES FOR THE SUPPLEMENTARY MEDICAL INSURANCE SYSTEM

Summary of Actuarial Cost Estimates

The committee bill has broadened the benefit protection provided by the supplementary medical insurance program. Manual manipu-

lation of the spine by qualified chiropractors will be covered if the chiropractor meets certain minimum standards established by the Secretary of Health, Education, and Welfare.

The committee bill contains a number of provisions which will reduce the cost of the supplementary insurance program. Among these provisions is the establishment of limits on prevailing charges (using the 75th percentile upon enactment of the bill and adjusting the levels thereafter by means of an appropriate economic index) and the tightening up of the reimbursement provisions for teaching physicians who furnish services.

Also, the committee adopted certain provisions which have the potential of reducing the costs of the supplementary medical insurance program. Among these provisions are the limitation on the reimbursement of physical and other therapists, the establishment of professional standards review organizations, the establishment of the Office of Inspector General in the Department of Health, Education, and Welfare, the increased penalty for defrauding health care programs, the reasonable limitations on medicare allowances for routine follow-up visits, injections, and laboratory services, and the inclusion of Blue Shield payments in calculating reasonable charges. The actuaries have not been able to estimate the extent of the savings under these provisions; there could be a significant reduction in the long-run costs.

No account is taken in the actuarial cost estimates for the supplementary medical insurance program of the provisions of the committee bill that provide for medicare coverage to be obtained from health maintenance organizations or for medicare benefits to be withheld (after 1971) if benefits are payable to the individual under the Federal employees health benefits plan, unless such plan is coordinated with medicare.

The cost effects of these changes will be recognized by the Secretary of Health, Education, and Welfare in his determination of the standard premium rate for fiscal year 1972, which in accordance with the provisions of present law will be promulgated in December 1970.

Financing Policy

SELF-SUPPORTING NATURE OF SYSTEM

Coverage under supplementary medical insurance can be voluntarily elected, on an individual basis, by virtually all persons aged 65 and over in the United States. This program is intended to be completely self-supporting from the premiums of enrolled individuals and from the equal-matching contributions from the general fund of the Treasury. For the initial period, July 1966 through December 1967, the premium rate was established by law at $3 per month, so that the total income of the system per participant per month was $6. Persons who do not elect to come into the system at as early a time as possible generally have to pay a higher premium rate. The law requires that the standard monthly premium rate be adjusted annually by promulgation of the Secretary of Health, Education, and Welfare (using ap-

propriate actuarial methods), so as to reflect the expected experience on an incurred-cost basis, including an allowance for a margin for contingenices. All financial operations for this program are handled through a separate fund, the supplementary medical insurance trust fund.

ACTUARIAL SOUNDNESS OF SYSTEM

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

Results of Cost Estimates

Both the bill passed by the House of Representatives and the committee bill make changes which have a significant cost effect. These changes are summarized in the following table along with the cost per participant per month relative to the current $10.60 monthly premium rate (for participant and the Government combined):

[Premium rate per month]

Item	Cost	
	House-approved bill	Committee bill
Limited coverage of chiropractic services		+$0.22
Liberalized physical therapy benefits	+$0.03	
Lower limits on prevailing charge levels	−.20	−.20
Total [1]	−.17	+.02

[1] Savings effect of other provisions of the bill not estimated.

The total cost of $0.02 per month per capita is equivalent to an annual cost of $4.7 million with respect to 19.6 million participants.

E. ACTUARIAL COST ESTIMATES FOR THE CATASTROPHIC HEALTH INSURANCE SYSTEM

Introduction

This section of the report presents the actuarial cost estimates for the catastrophic health insurance program established by the Social Security Amendments of 1970 approved by the committee. A summary

of the benefit, coverage, and financing provisions of the system is contained in previous sections.

Summary of Actuarial Cost Estimates

The catastrophic health insurance program established by the committee bill has an estimated cost for benefit payments and administrative expenses that is in long-range balance with contribution income. It is recognized that the preparation of the cost estimates for hospital and physicians' services and related benefits is much more difficult and much more subject to variation than cost estimates for the old-age, survivors, and disability insurance system. It is also recognized that future experience can be different from the projections. This is not only because the catastrophic health insurance program will be newly established, with no past operating experience, but also because of the great number of variable factors in the underlying cost elements of covered medical services. It is essential as stated in the committee report, that the operations of this new program should be carefully studied as they occur in the future, so that the Congress and the executive branch can be kept well informed and on a timely basis. Under these circumstances, the committee has agreed with the practice which has been established with the title XVIII programs that there should be a small continuing actuarial sample (of perhaps 1 percent of all eligible individuals), so that the emerging experience can be analyzed promptly and thoroughly. In this connection, it will be essential for carriers and intermediaries involved in the processing and payment of claims to supply the necessary actuarial information promptly and in an adequate fashion for the actuarial analysis to be made.

Financing Policy

FINANCING BASIS OF BILL

The contribution schedule contained in the committee-approved bill for the catastrophic health insurance program, on a maximum earnings base of $9,000 in 1971 and assuming earnings base increases thereafter, is as follows:

Calendar year	Employer-employee rate (percent)	Self-employed rate (percent)
1972–74	0.6	0.3
1975–79	.7	.35
1980 and after	.8	.4

Although the taxable earnings base is the same for the catastrophic health insurance program as for the hospital insurance program, the financial operations of the two programs are completely separate. First, the catastrophic health insurance program will have a completely separate trust fund, as well as a separate Board of Trustees from that of the old-age, survivors, and disability insurance system and the hospital insurance and supplementary medical insurance systems. Secondly, the schedule of tax rates for the catastrophic health insurance program is in a separate subsection of the Internal Revenue Code.

SELF-SUPPORTING NATURE OF SYSTEM

The old-age, survivors, and disability and health insurance system has always been of a self-supporting nature. The committee has carefully considered the cost aspect in the proposed catastrophic health insurance program, and believes that this program should also be completely self-supporting from the contributions of covered individuals and employers. Accordingly, the committee very strongly believes the program should be financed on an actuarial sound basis. The tax schedule in the committee bill should make the catastrophic health insurance program self-supporting over the next 25 years.

Actuarial Soundness of System

The concept of actuarial soundness as it applies to the catastrophic health insurance program is the same as it applies to the hospital insurance program.

The cost estimates for the catastrophic health insurance program are made over a period of 25 years in the future. Although it is difficult to predict the future trends of medical care costs and the change in medical technology for the next 25 years, it is feasible to make reasonable assumptions as to these factors. Another consideration is that changes in the population can be predicted with a higher degree of accuracy. The future costs of the program and financing thereof are in large part affected by population changes.

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

Results of Cost Estimates

LEVEL-COST OF CATASTROPHIC HEALTH INSURANCE BENEFITS

The level-cost of the catastrophic health insurance benefits (including administrative expenses) that was adopted by the committee is estimated to be 0.80 percent of taxable payroll. Under the assumption that the maximum taxable earnings base will be $9,000 in 1971 and increased in the future as in the past. The valuation period used in determining the level-cost is a 25-year period (1972–96), as explained previously.

The level equivalent of the contribution schedule in the bill over the same 25-year period, is 0.76 percent. Accordingly, these estimates indicate that the catastrophic health insurance program has an actuarial balance of −.04 percent of taxable payroll.

ASSUMPTIONS USED IN THE COST ESTIMATE

The benefit coverages provided by the catastrophic health insurance program are the same benefits as those currently provided under parts A and B of medicare except that there will be no limitations on hospital days. extended care facility days, or home health visits. However, the limitations on the psychiatric coverage remains unchanged (limited to 190 days of hospitalization in psychiatric hospitals during

a lifetime, also limited to $312.50 of psychiatric medical expenses per calendar year). The program would not cover the first 60 days of hospital care in a calendar year (with a provision which allows the carryover of hospital days from the last quarter of the previous year). Other medical expenses are subject to a $2,000 deductible in each calendar year, which is kept on a dynamic basis. The program adopted by the committee would pay 80 percent of the reasonable cost of covered services above the deductibles.

There is only a relatively small amount of data available in regard to the insurance experience with respect to a catastrophic insurance plan as adopted by the committee. The data used in determining the actuarial cost estimate include information obtained from the national health survey, private health insurance experiences, and data from the national health expenditures series. The experience under the supplementary medical insurance program was also used.

Past increases in hospital costs

Table 1 presents a summary comparison of increases in hospital costs and the corresponding increases in wages that have occurred since 1955.

TABLE 1.—COMPARISON OF ANNUAL INCREASE IN HOSPITAL COSTS AND IN WAGES

[In percent]

Year	Increase over previous year	
	Average wages in covered employment [1]	Average daily hospitalization costs [2]
1956	5.7	4.5
1957	5.5	7.7
1958	3.3	8.6
1959	3.3	6.8
1960	4.3	6.8
1961	3.1	8.5
1962	4.2	5.3
1963	2.4	5.6
1964	3.1	6.9
1965	1.6	7.0
Average for 1956–65	3.6	6.8
1966	4.4	8.3
1967	6.3	12.3
1968	7.0	13.5
1969	6.0	[3] 14.0
Average for 1960–69	4.2	8.8

[1] Data are for calendar years (based on experience in 1st quarter of year).
[2] Data are for fiscal years ending in September of year shown. Data are from American Hospital Association, and "hospitalization costs" represents total hospital expense per patient day.
[3] Preliminary estimate made by Scoial Security Administration.

The annual increase of earnings are based on the covered employment under the old-age, survivors, and disability insurance system as indicated by the first quarter taxable wages, which by and large are not affected by the maximum taxable earnings base. The increases in hospitalization costs are mostly based on a series of average daily costs published by the American Hospital Association. However, the series published by the AHA is only related to the short-term hospitals.

The annual increase in hospital costs have fluctuated around an average rate of 6.8 percent between 1956 to 1965, while the annual rate of increase in average wages in covered employment was 3.6 percent during the same period. On the other hand, since 1965, the annual rate of increase in daily hospitalization costs has been rising more rapidly. The actuarial cost estimate for the catastrophic health in-

surance program used the assumptions as shown in table 2. For the earlier years, it reflects the most recent trends, with the series generally decreasing to the long-term historical experiences.

In the past, the hospital utilization rates have been increasing. This phenomenon is caused by numerous factors including the change in medical technology, higher income per capita, and greater insurance coverage. The long-term trend used in this actuarial cost estimate assumes that the historical trend will continue in the future.

TABLE 2.—ASSUMPTIONS AS TO FUTURE INCREASES IN INPATIENT HOSPITAL COST ELEMENTS

[In percent]

	Inpatient hospital	
	Average daily cost	Utilization rate
Calendar year:		
1973	14.0	2.0
1974	14.0	2.0
1975	13.0	2.0
1976	11.0	2.0
1977	9.5	1.5
1978	8.5	1.5
1979	8.5	1.5
1980	7.0	1.0
1981 and after	6.0	1.0

Physician services

Table 3 summarizes the past trend of physician charges as reported by the Consumer Price Index. The annual increase in physicians' fees, as measured by the Consumer Price Index, have fluctuated around the average rate of 3.1 percent between 1956 to 1965, while the average annual rate of increase in average wages in covered employment was 3.6 percent during the same period. On the other hand, since 1965, the annual rate of increase in physicians' fees have been rising more rapidly.

The assumptions used for future years appear in table 4. As in the past, it is assumed that the largest annual fee increases have already occurred. For the early years, the recent increasing trend in the physician charges is used. The series gradually decreases thereafter to the long-term historical trend.

TABLE 3.—AVERAGE ANNUAL INCREASE IN PHYSICIANS' FEES AND IN WAGES

[In percent]

Calendar year	Physicians' fees[1]	Average wages in covered employment[2]
1956	3.0	5.7
1957	4.3	5.5
1958	3.4	3.3
1959	3.4	3.3
1960	2.5	4.3
1961	2.5	3.1
1962	2.9	4.2
1963	2.2	2.4
1964	2.5	3.1
1965	3.4	1.6
Average, 1956-65	3.1	3.6
1966	5.8	4.4
1967	7.1	6.3
1968	5.6	7.0
1969	7.0	6.0
Average, 1960-69	4.7	4.2

[1] As measured by the Consumer Price Index of physician fees.
[2] Data are for calendar years (based on experience in 1st quarter of year).

There is a long-term trend in the United States in the increasing use of physician services per capita. This amounts to an annual rate of 1 to 2 percent increase. This phenomenon is taken into account in the cost estimate.

TABLE 4.—ASSUMPTIONS AS TO COST ELEMENTS OF PHYSICIANS' SERVICES

[In percent]

Calendar year	Increase over previous year	
	Physician fees	Utilization rate
1972	6.0	2.5
1973	5.5	2.2
1974	5.0	2.2
1975	4.5	2.0
1976 and after	4.0	2.0

NUMBER OF PERSONS PROTECTED ON JANUARY 1, 1972

All wage earners under age 65 who are fully or currently insured under the social security program, their spouse and minor children and persons under age 65 receiving disability benefits will be eligible for the catastrophic health insurance protection. This constitutes about 95 percent of all persons under age 65. It is estimated that in 1972 approximately 180 million people in the United States will be protected by this program.

Persons age 65 and over will not be covered under the catastrophic health insurance program because these persons are protected under the medicare program. The largest noncovered group under age 65 will be those Federal employees who are not fully or currently insured under social security. However, these employees are eligible for both basic and catastrophic health insurance protection under the Federal Employee Health Benefit Act.

There are a small number of other citizens who are still not covered by social security. The majority of these are domestic or agricultural workers who have not met the necessary coverage requirements.

ADMINISTRATIVE EXPENSES

The administrative expenses in connection with the catastrophic health insurance program, including those of fiscal intermediaries, are calculated on the assumption that they will represent 5 percent of the benefit cost. This total amount is projected to increase in the future at the same rate of increase as general wages.

INTEREST RATE

An interest rate of 5 percent is used in determining the level costs of the benefit payments and administrative expenses and the level equivalent of the contributions. However, in developing the progress

of the trust fund, higher rates are used in the first few years—namely, 6 percent in 1972, gradually declining to a level of 5 percent by 1982 and thereafter.

ASSUMPTIONS AS TO FUTURE INCREASES IN EARNINGS IN COVERED EMPLOYMENT

The increase in average earnings in covered employment has been about 6–7 percent per year since 1967. It is assumed that the annual rate of increase will decline gradually in the future, to an ultimate rate of 4 percent by 1976.

Under the committee's bill, the maximum taxable earnings base is $9,000 in 1971. For estimating the actuarial costs, it was assumed the earnings base will be increased in the future as in the past. With this assumption, the taxable payroll will rise in close relationship to the increase in general earnings. Table 5 shows the assumptions used in future increases in the average total earnings.

Table 5.—Projection of wage increases in covered employment

Calendar year:	*Average earnings (percent)*
1972	5.0
1973	4.6
1974	4.3
1975	4.1
1976 and after	4.0

FUTURE OPERATIONS OF THE CATASTROPHIC HEALTH INSURANCE TRUST FUND

Table 6 shows the estimated operation of the catastrophic health insurance trust fund under the bill adopted by the committee. According to this estimate, the balance in the trust fund would grow steadily in the intermediate future, increasing from about $400 million at the end of 1972 to $2.5 billion 5 years later. The trust fund is estimated to reach $6.9 billion in 1995.

TABLE 6.—ESTIMATED PROGRESS OF THE CATASTROPHIC INSURANCE TRUST FUND UNDER FINANCING PROVISIONS OF COMMITTEE BILL UNDER BASIS OF EARNINGS BASE BEING INCREASED IN THE FUTURE,[1] INCURRED BASIS

	Contributions	Benefit payments	Administrative expenses	Interest	Net income	Fund at end of year
Calendar year:						
1972	$2,915	$2,380	$120	$13	$428	$428
1973	3,137	2,692	126	35	354	782
1974	3,281	3,037	132	49	161	943
1975	4,099	3,404	137	71	629	1,572
1976	4,270	3,790	143	99	436	2,008
1977	4,660	4,180	149	122	453	2,461
1978	4,854	4,575	155	139	263	2,724
1979	5,163	4,963	161	148	187	2,911
1980	6,140	5,371	167	170	772	3,683
1985	8,082	7,576	204	353	655	7,557
1990	10,437	10,626	248	455	18	9,343
1995	14,029	14,904	301	357	−819	6,900
1996	14,562	15,947	314	302	−1,397	5,503

[1] Maximum taxable earnings base would be $9,000 in 1972, $9,600 in 1973–74, $10,200 in 1975–76, $11,400 in 1977–78, increasing to $21,000 in 1993–94. Combined employer-employee contribution schedule would be 0.6 percent for 1972–74, 0.7 percent for 1975–79, 0.8 percent for 1980 and after.

VII. TRADE ACT OF 1970

Trade Act of 1970

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VII. TRADE ACT OF 1970

A. BACKGROUND

The committee trade amendment accomplishes many needed reforms in our tariff and trade laws which are long overdue. The last time the Congress had an opportunity to pass extensive trade legislation was in 1962 in the so-called Trade Expansion Act. That Act provided authority for the President to enter into trade negotiations, popularly known as the "Kennedy Round."

Since July 1, 1967, the President has been without negotiating authority. Moreover, since the end of the "Kennedy Round," many United States industries and their employees have been subject to sharply increasing import competition, which, in many cases, has resulted in shutdowns of plant and equipment and loss of American jobs.

The Committee on Finance has been very concerned about the impact of rapidly rising imports on the American economy. It has examined this question in depth on a number of occasions since 1967. Shortly after the end of the Kennedy Round, in October 1967, the committee held hearings on proposed import quota legislation. At that time, the committee heard from many witnesses expressing various points of view on import problems. The hearing record covered 1,218 pages. Thereafter in February 1968 the committee published a compendium of papers dealing with foreign trade issues. Again, a broad range of views was presented which dealt with very specific issues in our foreign trade relations. The executive branch participated in both the 1967 hearings and the 1968 compendium of papers. Moreover, the committee initiated a study of the effect of steel imports on our economy, and also examined unfair trade practice statutes in its consideration of the International Antidumping Code.

On two occasions, the Senate itself expressed its concern over outstanding import problems. On March 27, 1968, the Senate approved a floor amendment to a major tax bill by a vote of 55 to 31 which would have imposed import quotas on textile and apparel products. The members of the House of Representatives participating in the conference at that time were unwilling to accept the Senate amendment. On December 10, 1969, the Senate again passed an amendment to another major tax bill, expressing its concern over foreign nontariff barriers and the need to protect American industries and jobs. Once again, the Members of the House of Representatives choose not to accept the Senate amendment.

In the meantime, the Committee on Ways and Means held extensive hearings on trade legislation in the past two years. In 1968, the House committee held a series of hearings on the then administration's trade bill which covered 10 volumes and 5,099 pages. This year, 1970, that committee again held hearings on essentially the same proposal submitted by the new administration which comprised 16 volumes and

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4,691 pages. Both hearing records have been made available to the Committee on Finance and its staff for study.

Thus, the basic issues raised by the committee's trade amendment to the Social Security Act are matters which the committee has studied since 1967.

Earlier this year, in executive session the committee members determined that it would be wise and useful to hold a public hearing on the trade matter with as many administration and other witnesses as could be heard in the time available to the committee. These hearings were held on October 9 and 12. While the committee did not have as long a time as it normally might have wished for a major piece of legislation, it did get a fuller understanding of what was in the House-proposed bill and how the administration felt about it, as a result of these hearings. In addition, it heard from some major groups and organizations which were opposed to the legislation as well as from some who favored it. Subsequent to the hearings the committee approved, in executive session, the basic provisions of the House-passed trade bill, as an amendment to the Social Security bill (H.R. 17550).

B. REASONS FOR THE AMENDMENT

There have been significant structural changes in the world economy since the end of World War II. The preponderance of the economic strength of the United States in the early post-World War II period permitted this country to give freely of its economic resources to assist other countries in the free world in rebuilding and developing their war-torn economies. An important part of the foreign economic policy of the United States in that period was the leadership it was able to exert toward a liberalized and expanded system of world commerce.

In the mid-50's, as some of the countries in Europe were considering moving toward economic integration, the United States took further measures to liberalize trade in order that Japan might become a full partner among the trading nations of the world. In the late 50's and early 60's, as some of the countries in Europe took major steps toward economic integration, Congress recognized the need to keep countries looking outward in their trade relations by approving the Trade Expansion Act of 1962.

While successful in terms of completing agreement on significant reductions in tariffs among many of the industrialized countries, the Kennedy Round of trade negotiations had little success in dealing with the problems of barriers to trade other than tariffs. The remaining task of economic integration in Europe and the development of regional trade blocks in other areas of the world blunted the thrust of the Kennedy Round toward further progress in trade liberalization.

During the 1960's, there has been a tremendous growth in productive capacity abroad. What has come to be recognized as an economic miracle in Japan has made that country the third largest industrial nation in the world. Not far behind in economic growth has been the development in Europe and in particular West Germany. Indeed, many of the development goals toward which the United States strived in the early post-World War II period are being realized. While the economies of the developing countries have not kept pace with the progress of the industrialized nations, many of these countries, particularly in the Far East, have developed new and modern in-

dustries. These industries, usually involving mass production techniques imposed on a low-wage base, in some instances an extremely low-wage base, have enabled some of the developing countries to assume a formidable competitive position in world markets.

At the same time as productive and therefore export capacities abroad have been expanding, the United States has continued to experience deficits in its balance of payments. In more recent years, due to a variety of factors, the balance of trade of the United States has also moved to a far less favorable position. One of the developments that has affected the efforts to improve the balance-of-payments position, and has worked to erode the traditional export surplus of the United States has been the pervasive influence of domestic inflation experienced by the United States, particularly since the mid-1960's.

A major factor in the trends in U.S. exports and imports over the past 5 years has been the long-term upward trend in prices, both at the wholesale and at the retail level. Between 1960 and 1969, the U.S. export prices in terms of unit values of manufactured exports increased by 18 percent, a rate of increase greater than that experienced by any other major industrialized country. In comparison, the unit value of manufactured exports from Japan experienced an overall decline during the decade.

Inflation in the United States has not only affected the competitive position of U.S. exporters; it has increased significantly the competitive impact of imports on domestic producers. Other countries facing similar problems have either devalued their currencies (thus making their goods more competitive in world markets) or imposed import restrictions, or a combination of both. The United States has neither devalued its currency nor imposed import restrictions to improve its competitive position or balance of payments. The combination of increased productive capacity abroad and inflation in the United States has resulted in greatly increased imports. The rate of increase in imports in some product areas, if allowed to continue, would call for economic adjustments in the domestic economy which would be as undesirable as they are unacceptable.

The committee believes that the U.S. economy, and the world economy in general, have been well served by the leadership exerted by the United States in expanding world trade. The preponderance of the economic strength of the United States afforded this country the opportunity to exert such leadership in the anticipation that other countries would follow. However, the hope that other countries would move toward allowing greater access to their own markets has not been realized. Certain major trading countries continue to maintain unjustifiable and unreasonable restriction on imports and investment even though they are enjoying strong domestic economies and balance of payment surpluses. To date, there has been precious little evidence that would indicate that these foreign countries are willing to share the burdens of improving the international adjustment process by removing or ameliorating their barriers against U.S. imports.

The stake that this country has in expanded world trade is, of course, still important. But, the time has come for other countries to realize that the United States alone can not accept all of the surplus production stemming from increased productivity abroad. Other industrialized countries must move much more rapidly to open their markets,

not only to competitive products of other industrialized countries, but also to the exports of developing countries.

The United States remains the largest and most accessible market in the world. Despite the claims of our trade partners, U.S. duties, subject to continued reductions under the trade agreements program, are at the lowest average level of any major industrialized country. Aside from the agricultural area, in which some restrictions are necessary as a corollary of domestic agricultural policy, the U.S. quantitative restrictions on imports are few. In some cases, such as coffee and sugar, the quantitative restrictions for the most part serve the interests of developing countries in contributing to the stability of their export earnings.

This is in contrast to many other countries which have moved much more slowly in opening their markets. Situations have already arisen which make necessary extraordinary measures by the United States to protect its own producers when foreign markets are closed. The Meat Import Act of 1964 was made necessary primarily because other markets in Europe suddenly closed to the major beef producers in the South West Pacific and caused trade diversion to the United States. Restraints maintained by virtually all the European countries on imports of textiles and apparel from countries in the Far East have added to the great increase in competitive pressures which have been borne by the U.S. textile industry since the late 1950's. Over 50 percent of Japan's apparel exports are destined for the United States, compared with only 5 percent to Europe. The Secretary of Commerce presented the committee with a voluminous list of such restrictions, which are published in the hearings record. It is unfortunate that since the Trade Expansion Act of 1962, foreign nontariff barriers have grown, not diminished, particularly in the agricultural field, and in border tax adjustments. Moreover, soon after the Kennedy Round was completed many foreign countries devalued their currencies or took other measures which in effect, vitiated all or part of their tariff concessions granted during the Kennedy Round.

Trade policy requires continuing adjustments as economic conditions change. However, as expanding world trade calls for economic adjustments in a nation's economy, dynamic developments in the world economy sometimes necessitate temporary measures to avoid uneconomic and unwarranted adjustments. Also, the nontariff import barriers and export subsidies of other nations have added to the competitive difficulties of U.S. firms.

Since the end of the Kennedy Round, it has become obvious that the remedial provisions in domestic trade law have not afforded domestic producers adequate opportunity to adjust to competitive forces, particularly during an inflationary period. For these reasons, the committee has provided measures that will afford domestic producers the time and opportunity to adjust to new competitive situations. The committee's amendment also strengthens the unfair trade practice statutes to enable domestic industries, firms, and workers to obtain prompt relief against unwarranted and unjustifiable foreign trade practices.

The changes made in the tariff adjustment and adjustment assistance provisions recognize the adjustment process which must be followed if the United States is to continue an overall policy of liberal trade. Insofar as textiles and footwear are concerned, the

committee believes that the temporary measures for providing quantitative limitations on imports of these articles are absolutely necessary and to ensure the viability of these basic industries, the existence of the companies in those industries, and the livelihood of over 2½ million workers those industries represent. The record is replete with detailed evidence of foreign restrictions in the field of textiles and footwear trade which has served to channel low-cost imports into the U.S. market. The European countries and Japan have import quotas and other restrictions on imports of textile, apparel, and footwear products.

In the past 5 years the ratio of imports of footwear to domestic consumption has increased from 13 to 26 percent and in the first 4 months of 1970, imports were accounting for one-third of the domestic consumption of footwear. If these trends were to continue, imports of footwear would constitute close to 70 percent of U.S. consumption of shoes by 1975. Stated in different terms, in the past 5 years imports of footwear more than doubled from 96 million pairs in 1965 to 202 million pairs in 1969. Imports thus far in 1970 were running at an annual rate of 282 million, three times the volume of imports in 1965.

Domestic production of footwear declined from 642 million pairs in 1968 to 581 million pairs in 1969. The annual rate of production thus far in 1970 is about the same as for 1969.

The rapidity of and the magnitude of increases in imports of footwear in recent years cannot be sustained if this country is to have a viable footwear industry. Unless and until firm measures are taken to arrest the sharp decline in the share of the domestic market available to domestic producers, there will continue to be a contraction in domestic production.

Job losses have been experienced in this industry for a number of years. The workers in the industry, and the communities throughout the Nation, who are dependent upon the shoe industry for their economic support, can ill-afford to suffer further economic dislocation, and what is worse the threat of ever greater loss of sales to imports. The temporary measures provided in the bill to limit the volume of injurious imports, either through quotas or agreements is essential. Such import restraint will remove a serious threat and permit time to adjust. Moreover, the various programs recently proposed by the President for firms producing footwear and their employees can help to revitalize the industry and hasten the removal of the extraordinary relief provided in the bill.

The imports of textiles have constituted a difficult trade problem for a number of years. The potentials of exporting textiles and apparel to the United States and the relative accessibility of this market resulted in the international arrangement for trade in cotton textiles in the early 1960's. As productive capacity developed abroad, exports shifted from cotton textiles, to exports of manmade fiber textiles. Between 1965 and 1969, U.S. imports of textiles of manmade fiber increased from 79 million pounds to 257 million pounds, over a threefold increase. U.S. imports of wearing apparel of manmade fiber increased from 31 million pounds (raw-fiber equivalent) in 1965 to 144 million pounds (raw-fiber equivalent) in 1969. The rate of increase in many product lines has been much more rapid.

For example, imports of sweaters of manmade fibers in 1965 were 501,000 dozen. By 1969 imports of such sweaters had increased to 6,974,000 dozen.

Such increases in imports, year after year, particularly in certain products where imports are gaining a greater and greater share of the domestic market have had a serious impact on textile and apparel firms. The ability of foreign producers to shift product lines and to produce at short notice, large volumes of stylized merchandise at extremely low delivered cost, is beginning to result in an increase in plant closings. Thus, as a result, employment in both textile mills and apparel factories declined by 69,000 in the first 6 months of 1970, the first such decline in a number of years.

Given the great growth in plant capacity abroad, and taking into account plans for even greater production levels in a number of foreign countries the threat to the textile and apparel industry is extremely serious.

The lack of success in gaining the cooperation of textile exporting nations to restrain their exports to the United States of textiles of wool and of manmade fiber at reasonable levels is a cause of great concern to the committee. The problem of world trade in textiles is recognized by all concerned. Unfortunately, the ease of access to the U.S. markets, compared with the restraints on exports of textiles to other developed countries have placed the burden of action on the United States. For example, the United States imports over 50 percent of Japanese apparel exports; the European Community imports only 5 percent.

The importance of the textile and apparel industry and its over 2 million workers to the economy of this country is too great to permit further stalemate or further erosion of the industry's base. In this connection, it should be noted that the industry is playing a vital social role as a growing employer of Negroes, with over 14 percent of the total textile work force being Negro, a higher percentage than for manufacturing industry as a whole. A considerable number of other employees in the textile and apparel industries, particularly in large urban cities are from other minority groups. The threat of import increases in some product lines spreading to all product lines makes industrywide action essential if these jobs are to be saved. Here, too, it is hoped that the measures provided in the bill will prove to be needed only temporarily.

There has been a tendency in the past to administer the Antidumping Act or countervailing duty provision as another facet of the trade agreements program under which proposed actions by the United States are negotiable. These provisions of law need to be enforced if domestic producers are to be assured that they may compete with imports on the same basis and subject to the same requirements which domestic producers must meet under provisions of law covering business operations in this country. To this end, the committee believes that many of the changes made both in the trade agreement provisions and other domestic laws are necessary to restore confidence on the part of the U.S. business, that it can expect effective action by the U.S. government in order to protect its interests and the interests of the country as a whole in carrying out the laws as intended by the Congress.

The committee is concerned with developments that erode the productive base of our economy. There are a number of reasons why American firms have established plants abroad among them being the lower wage costs associated with foreign production. It is necessary to face up frankly to the fact that unit wage-cost differentials can and do

bear more heavily on U.S. producers and their workers than ever before due to the economic development abroad in particular industries. With international mob lity of capital, management skills, and technological know how, large U.S. industries can move abroad to establish plants, but U.S. labor often cannot, and therefore must bear the brunt of dislocation. As indicated above, the United States cannot accept increases in imports that result in economic adjustments, the costs of which are greater than the benefits derived from increased trade.

U.S. Balance of Trade and Balance of Payments

In the 10-year period 1960 through 1969, our balance of payments has been in deficit in all but 1 year on a liquidity basis and in seven out of the 10 years on an official settlements basis.[1]

The cumulative deficits on a liquidity basis of measurement over th's period have totaled $27.2 billion. The deficits generally decreased somewhat in the period 1960 through 1966. For example, as is shown in table 1 over these years on a liquidity basis, the deficit shrank from $3.9 billion to $1.4 billion, while on an official settlements basis, a $3.4 billion deficit was converted to a $266 million surplus. Since 1966, however, the balance of payments on a liquidity basis has deteriorated markedly, and in 1969, the deficit on this basis exceeded $7.2 billion. For the first half of 1970, the seasonally adjusted deficit in the balance of payments, including receipts of special drawing rights, was running at an annual rate of $5.6 billion on a liquidity basis and $9.2 billion on an official settlements basis.

Our balance-of-payments position would have deteriorated much more rapidly in the past few years than it did were it not for the fact that high domestic interest rates and a shortage of investment funds in the United States attracted a high inflow of short-term money from abroad. Unfortunately, these "tight money" policies have also contributed to the economic slowdown and increased unemployment. Foreign capital inflow in 1960, for example, amounted to $419 million. By 1966, these inflows had grown to almost $3 billion and by 1967 to $3.4 billion. In 1968 they reached the unprecedented level of $9 billion. By 1969, they still amounted to $4.1 billion. This influx of foreign funds, however, cannot be expected to continue indefinitely. In fact, in 1970, there has already been some reversal of this pattern and withdrawal of capital funds from this country. This has contributed to the sizable deficit in our external accounts in the early months of this year. This country needs a real surplus on current account—mainly trade—of between $5 and $8 billion if it is to offset its capital expenditures for foreign aid, military expenditures abroad and foreign investment.

The United States officially published foreign trade statistics consistently overstate this country's real competitive position. Traditionally, our exports have been tabulated to include U.S. Government concessional sales and outright grants to foreign countries under AID and P.L. 480 programs. This practice overstates our export income since for the great majority of these exports the United States does not earn any hard currencies. The committee feels strongly that

[1] The liquidity balance reflects changes in U.S. reserves and in all foreign holdings (both official and nonofficial) of liquid dollar liabilities which mature in 1 year or less. The official settlements basis reflects changes in U.S. reserves and in foreign official holdings of both liquid and nonliquid dollar liabilities.

TABLE 1.—U.S. BALANCE OF PAYMENTS, 1960–69

[In millions of dollars]

	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969
Merchandise trade [1]	4,906	5,588	4,561	5,241	6,831	4,951	3,926	3,860	624	638
Exports	19,650	20,107	20,779	22,252	25,478	26,447	29,389	30,681	33,588	36,473
Imports	−14,744	−14,519	−16,218	−17,011	−18,647	−21,496	−25,463	−26,821	−32,954	−35,835
Travel (including fares)	−1,238	−1,235	−1,444	−1,596	−1,499	−1,613	−1,627	−2,144	−1,872	−2,092
Receipts	1,025	1,057	1,070	1,133	1,357	1,545	1,785	1,881	2,035	2,363
Payments	−2,263	−2,292	−2,514	−2,729	−2,856	−3,158	−3,412	−4,025	−3,907	−4,445
Military	−2,752	−2,596	−2,449	−2,304	−2,133	−2,122	−2,935	−3,138	−3,140	−3,355
Receipts	335	402	656	657	747	830	829	1,240	1,395	1,515
Payments	−3,087	−2,998	−3,105	−2,961	−2,880	−2,952	−3,764	−4,378	−4,535	−4,850
Dividends and interest	2,689	3,398	3,889	3,984	4,686	5,088	5,140	5,646	6,000	5,744
Receipts	3,752	4,405	4,999	5,309	6,142	6,817	7,282	8,008	8,933	10,207
Payments	−1,063	−1,007	−1,110	−1,325	−1,456	−1,729	−2,142	−2,362	−2,933	−4,463
Other services and transfers, including Government grants	−1,730	−2,020	−2,023	−2,058	−2,003	−1,941	−2,011	−1,981	−1,947	−1,841
Current account total [2]	1,873	3,136	2,536	3,269	5,883	4,364	2,492	2,243	−336	−885
Direct investment	−1,674	−1,598	−1,654	−1,976	−2,328	−3,468	−3,631	−3,137	−3,209	−3,070
Bank claims	−1,148	−1,261	−450	−1,536	−2,465	93	253	−475	253	−541
Nonbank claims	−394	−558	−354	158	−1,108	340	−443	−760	−1,202	−269
U.S. transactions in foreign securities	−662	−762	−969	−1,105	−677	−759	−481	−1,266	−1,254	−1,494
U.S. Government capital, net excluding unscheduled repayments)	−1,158	−1,621	−1,774	−1,987	−1,799	−1,819	−1,963	−2,427	2,537	−2,097
Foreign capital	419	1,398	1,707	1,016	812	492	2,961	3,366	8,970	4,060
Errors and omissions	−1,156	−1,103	−1,246	−509	−1,118	−576	−514	−1,088	−514	−2,924
Balance on liquidity basis	−3,901	−2,371	−2,204	−2,670	−2,800	−1,335	−1,357	−3,544	171	−7,221
Balance on official reserve transactions basis	−3,403	−1,347	−2,702	−2,011	−1,564	−1,289	266	−3,418	1,641	2,708

[1] Balance-of-payments basis.
[2] Including unilateral transfers.

Source: Treasury Department.

concessional exports should be excluded from regular government publications on exports and shown in our balance of payments accounts as part of government foreign assistance programs. Similarly, our imports are understated since they are generally valued f.o.b. at the foreign dock. The practice recommended by the United Nations and the International Monetary Fund and adopted by virtually all of our major trading partners and by over 100 countries is to tabulate import statistics on a c.i.f. basis; that is, to include the costs of insurance and freight. For comparability if nothing else this fact would suggest that the United States should tabulate its import statistics to include the cost of insurance and freight. But the committee feels that in addition to the comparability factor the importer must pay the cost of insurance and freight and those costs are often just as important to a domestic manufacturer who must compete with the foreign import as any other factor with the exception of wage rate differentials.

If our balance of trade figures were tabulated in this fashion, then instead of having a $15.5 billion cumulative surplus for the years 1965–1969, the United States would have had a $10.6 billion cumulative deficit. (See table 3.)

In short, the committee is convinced that the U.S. trade position is not as favorable as officially published figures now indicate.

Examination of the decline in the merchandise surplus discloses that while exports have increased moderately over the period 1961–69, they have not nearly kept pace with the rapid growth in imports. This can be seen from table 2 which shows the percentage change in merchandise exports, imports, and balance in the period 1961–69. The most striking point shown in the table is the rapid increase in imports beginning in 1965. In that year they increased 15 percent over the prior year and in 1968, they increased 23 percent over the prior year, which resulted in a decline of nearly 84 percent in the balance. In 1969, the rate of increase in imports slowed down appreciably but still kept pace with the increase in exports occurring in that year.

In 1970, based upon experience in the first half, imports are increasing at a rate of somewhat over 9 percent while exports are increasing by over 14 percent. This, however, in no small part is due to the fact that the export level in 1969 was below what otherwise might have been expected because of the dock strikes in that year. Moreover, as a share of world exports, U.S. exports in the first quarter showed a continuation of the long term decline.

Table 2.—Percentage change in merchandise exports, imports, and balance, 1961–69 [1]

Percentage change in—	1961	1962	1963	1964	1965	1966	1967	1968	1969
Exports	2.3	3.3	7.1	14.5	3.8	11.1	4.4	9.5	8.6
Imports	−1.5	11.7	4.9	9.6	15.3	18.5	5.3	22.9	8.6
Balance	13.9	−18.4	14.9	30.3	−27.5	−20.7	−1.7	−83.8	10.2

[1] From table 1. Percentage change from previous year.

Table 3.—U.S. trade balance, 1960–69

[In billions of dollars]

	Total exports, f.o.b. (A)	Total imports, f.o.b. (B)	Trade balance (C=A−B)	AID and Public Law 480, Government-financed exports (D)	Total exports less AID and Public Law 480, financed exports (E=A−D)	Total imports, c.i.f.[1] (F)	Merchandise trade balance (G=E−F)
1969	37.3	36.1	+1.2	[2] 2.0	[2] 35.3	39.7	−4.4
1968	34.1	33.2	+.9	2.2	31.8	36.5	−4.7
1967	31.0	26.9	+4.1	2.5	28.5	29.6	−1.1
1966	29.5	25.6	+3.9	2.5	27.0	28.2	−1.2
1965	26.8	21.4	+5.4	2.5	24.3	23.5	+.8
1964	25.8	18.7	+7.1	2.7	23.1	20.6	+2.5
1963	22.5	17.2	+5.3	2.6	19.9	18.9	+1.0
1962	21.0	16.5	+4.5	2.3	18.7	18.2	+.5
1961	20.2	14.8	+5.4	1.9	18.3	16.3	+2.0
1960	19.6	15.1	+4.5	1.7	17.9	16.6	+1.3

[1] C.i.f. imports are assumed to be 10 percent higher in value than f.o.b. imports in accordance with Tariff Commission study.
[2] Estimated by Department of Commerce.

Source: U.S. Department of Commerce.

The continuing balance-of-payments deficit has been of major concern to this committee, with regard to trade legislation and also with regard to other legislation with which the committee must deal and in particular, tax legislation which affects the competitive position of domestic producers, both in this market and abroad.

The committee is very much aware that the United States holds a unique position in the field of international financial and monetary policy. The responsibility that this country has in the world at large makes it essential that it have flexibility with regard to its international payments position. The dependence of other countries on a healthy U.S. economy and balance of payments, should motivate them to remove restrictions and end policies which tend to perpetuate their balance-of-payments surpluses.

Since the end of World War II, many countries have found it necessary to resort to quantitative limitations on their imports, or more recently import surcharges, as a means of dealing with particularly serious balance-of-payments difficulties. With one major exception, such trade restrictions imposed for balance-of-payments reasons have been eliminated by the major trading countries. But they have substituted other restrictive measures such as variable import fees and border taxes which are often more trade restrictive than import quotas.

Despite its persistent balance-of-payments difficulties, the United States has chosen not to impose restrictions on imports as a means of relieving pressures stemming from the deficits in the international balance of payments. However, the only provision in the GATT dealing with balance of payments safeguards specifically sanctions the use of quotas. Other countries have used quotas and other import-discouraging devices. The trade problems faced by the United States at this time call for the same degree of international understanding and cooperation by other nations, as the United States manifested

toward them in the period when they had balance of payments difficulties.

Among those actions taken by the European Economic Community which have affected U.S. trade interest is the border tax system and the integration of the value added tax system among the member countries. These adjustments have to some degree negated the concessions granted to their countries in the Kennedy Round. As a result, various proposals have been made aimed at offsetting or reducing the impact of the border tax system. There has been no apparent progress toward a solution of this problem. The basic provisions of the GATT dealing with export subsidies, border taxes and balance of payments must be revised to allow for more flexible remedies for countries suffering from serious balance-of-payments difficulties.

Over the years, the GATT, which was established in the very early postwar years, has dealt primarily with the effects of tariffs on trade. Moreover, as originally drafted, the instrument was oriented toward the conditions of trade as they existed at that time. In the ensuing two decades, the conditions of trade, relative tariffs, the structure of world economies and industries changed markedly and rapidly. Accordingly, the basic provisions of the GATT dealing with non-tariff and other factors affecting world trade (such as the effects of subsidies, border taxes, variable levies, the multinational corporations, disparate labor conditions, market disruption) should—indeed must—be reexamined with a view toward the development of a viable instrumentality to deal with trade problems in the context of the complex conditions of trade as they exist today and promise to confront us in the decade of the 1970s.

The United States, which took a strong initiative in the establishment of the GATT at the end of World War II, should again provide leadership in developing an international accord establishing fair ground rules for governing trade problems.

C. GENERAL DESCRIPTION OF BILL (INCLUDING SPECIFIC LEGISLATIVE INTENT)

Trade Agreement Authority

BASIC AUTHORITY TO MODIFY TARIFF AND OTHER IMPORT RESTRICTIONS

(Sec. 301 of the bill)

The authority of the President to enter into trade agreements with foreign countries or instrumentalities thereof would be extended until July 1, 1975 for purposes of compensation only. The President's trade agreement authority expired on July 1, 1967, and would be, reinstated, in a limited way, on the enactment of this amendment.

The President did not request trade agreement authority in order to enter into major trade negotiations. The Executive has not presented any proposals to the Congress or the committee with respect to negotiating with foreign countries on trade barriers with foreign countries which would require a grant of authority by the Congress. It was the expressed intent of the President's Special Trade Representative to use this authority mainly for the payment of compensation in situations in which the United States increased a

duty or imposed a new restriction on a product which was the subject of a tariff concession. Consequently, the committee limited the tariff cutting authority requested by the President to those situations in which compensation is required under international obligations. In addition, it determined that the authority should be granted until July 1, 1975, in order not to jeopardize the granting of tariff adjustment relief to injured industries because of the lack of Presidential authority to reduce tariffs.

Under the bill he is authorized to reduce by 20 percent or by 2 percentage points, the rates of duty which will exist when the final stage of the Kennedy Round reductions is to be made effective on January 1, 1972. This authority is limited to those cases in which the President is required under the tariff adjustment provisions or otherwise to proclaim increased import restrictions on an article covered by concessions granted by the United States in trade agreements.

The committee feels that the Executive may not have exercised its rights under international agreements to demand and receive "compensation" from other countries that have imposed higher tariffs or other import restrictions which are in violation of trade agreement concessions. Consequently, the committee feels that whenever a question of "compensation" arises because of an increase in U.S. duties or other import restrictions, the Executive should study carefully its rights with respect to the affected countries' restrictions, and the degree to which "compensation" has been paid to the United States for these restrictions.

The committee did not renew or extend any of the other authorities to modify tariffs provided in section 202, 211, 212, or 213 of the Trade Expansion Act of 1962.

STAGING REQUIREMENTS

(Sec. 302 of the bill)

This section of the bill is directed to the need to implement in two stages, tariff reductions to be made pursuant to trade agreements. The bill provides that the tariff concessions agreed to under this new authority shall be staged in at least two installments with one year intervening. It also provides that tariff reductions agreed to under the new authority may be combined with any remaining stages of earlier proclamations made pursuant to the Kennedy Round of trade negotiations.

The committee agreed to this arrangement recognizing that Kennedy Round tariff reductions will not be fully implemented until January 1, 1972. In practical effect, the last stage of those concessions is the only one which might be pending at the time of negotiations and implementation of new concessions which may be under the authority of this bill. Further, the committee assumes that the President would not stage any new concession concurrently unless he had previously determined that this could be done without detriment to the U.S. industry producing the article or articles affected by the tariff reduction.

Other Presidential Authority

FOREIGN IMPORT RESTRICTIONS AND DISCRIMINATORY ACTS

(Sec. 303 of the bill)

The bill would amend section 252 of the Trade Expansion Act of 1962 and provide new authority and direction to the President to act against import restrictions or other acts of foreign countries which unjustifiably or unreasonably burden, or discriminate against U.S. commerce.

The bill would amend section 252(a) by removing the word "agricultural" so that the President is directed to take such action as he deems necessary and appropriate when a foreign country unjustifiably restricts "any" U.S. product. Such action under existing provisions of the law might include the imposition of duties or other import restrictions on products of the foreign country imported into the United States.

The committee also proposes to amend section 252(b) of the Trade Expansion Act to direct that the President shall take certain actions whenever a foreign country whose products benefit from U.S. trade agreement concessions provides subsidies or other incentives to its exported products to other foreign markets so that U.S. sales of competitive products to those other markets are unfairly affected thereby. This amendment was recommended by the executive branch and approved by the committee as necessary to protect U.S. commercial interests. The committee believes that the executive branch will use this new authority to fully offset any foreign practices which adversely affects U.S. commerce.

In addition, the committee increased the authority of the President under section 252(b) of the Trade Expansion Act by enabling him to impose duties and other import restrictions whenever such a foreign country is maintaining nontariff restrictions substantially burdening U.S. commerce, engaging in discriminatory acts which unjustifiably restrict U.S. commerce or providing such subsidies or other incentives for its exports.

Section 252(c) would be amended by directing and authorizing the President to take action whenever a foreign country whose products benefit from U.S. trade agreement concessions maintains unreasonable import restrictions which substantially burden U.S. commerce. The President is authorized and directed to impose duties or other import restrictions on the products of such foreign country in such instances as well as suspending or withdrawing trade agreement concessions or refraining from proclaiming benefits to carry out trade agreements with such foreign countries.

The committee determined that since subsections (a) and (b) of section 252 are both directed toward foreign import restrictions and discriminatory acts which are illegal, that the scope of Presidential authority to act to prevent the establishment or obtain the removal of such foreign import restrictions ought to be the same in both subsections. Consequently, a new subparagraph (C) to the latter subsection provides powers equal to that provided in existing (a)(3). Similarly it was deemed desirable that subsection (c)(1) be amended to give the President power to impose duties or other import restric-

tions against the unreasonable, though legal, foreign government practices to which that subsection is directed. Finally, the committee deemed it desirable that the obligatory word "shall" used in both of the two first subsections, with regard to the President's action, should also be used in the third subsection in place of the existing "may."

The committee also provided a clear complaint procedure in section 252 similar, in principle, to the procedures used under some other unfair trade practice statutes, such as antidumping and countervailing duty, and to the statutory procedures under the national security provision. Under the committee amendment an interested party could file a complaint with the Secretary of Commerce concerning a foreign import barrier or export subsidy which he feels is unreasonably and unjustifiably restricting U.S. exports. In accordance with the criteria already spelled out in the statute, the Secretary would then investigate to determine whether or not a foreign barrier or export subsidy is unjustifiably and unreasonably restricting U.S. commerce. The Secretary would have a 3-month time limit within which he must reach a finding. If he reaches an affirmative finding, he would inform the President and publish such finding (and the reasons therefor) in the Federal Register. The reasons for a negative finding would also be published in the Federal Register. Under an affirmative finding the President would have an additional 3 months to work out a solution to the problem through negotiation with the foreign government. If the President failed to obtain a satisfactory negotiated solution, then he would take the retaliatory action called for by section 252.

These amendments provide important new direction and authority to the President to act to protect the interest of United States commerce in the face of unjustifiable import restrictions and other unreasonable import restrictions, including discriminatory acts which substantially burden U.S. commerce or unfairly restrict or affect market access for U.S. products. The committee feels that not only should the President respond to this additional direction by the Congress to protect U.S. commercial interests, it is also incumbent on such domestic producing interests to use the new provisions in section 252(d) to fully and accurately inform the Secretary when action is taken or contemplated by foreign countries in order that the President and those to whom he has delegated this responsibility may act promptly and effectively.

It must be recognized that over the years, the United States has granted increased market access to foreign produced goods in order to gain greater access in foreign markets for goods produced in the United States. It is incumbent on both the government and United States producing interests to cooperate in the maintenance of access to foreign markets on a fair and reasonable basis for goods produced in the United States.

National Security Provision

(Sec. 304 of the bill)

The committee amendment to section 232 of the Trade Expansion Act of 1962, the "national security provision," would provide that any adjustment of imports under that section shall not be accomplished by the imposition or increase of any duty, or of any fee or

charge having the effect of a duty. The committee has reviewed the legislative history of section 232 of the Trade Expansion Act and its predecessor provisions in the trade agreements legislat on, and concludes that the delegation of authority to the President to adjust imports should be limited to the use of quantitative limitations.

The amendment to section 232 is not intended in any way to foreclose the President from adjusting imports to such levels as he deems necessary to prevent impairment to the national security. Nor does it affect the flexibility of the President to modify import limitations already imposed under section 232 to meet increased demands for raw materials or other emergency requirements which may arise from time to time. If, under particular circumstances, not foreseen by your committee, the President believed that duties or tariffs would be a more appropriate remedy in a case he would be free to request such authority from the Congress.

The bill would also amend section 232 with respect to the time within which the Director of the Office of Emergency Preparedness is to make a determination with respect to applications for action under the national security provision. The committee's attention was called to the delays that often ensue in reaching determinations under this section. It therefore has provided that a determination on new applications shall be reached within one year after the date on which the investigation is requested. Determinations on active pending cases are to be made within 60 days of the date of enactment of this Act.

The committee was informed by the Director of Emergency Preparedness that imposition of a tariff in the case of oil imports in lieu of a quota would tend to increase consumer prices on petroleum and petroleum products. Moreover, the committee believes that there are serious practical problems in substituting a tariff for a quota in the regulation of oil imports. The volatility of freight rates, the geographic distribution of the world's oil reserves, and various pricing and taxing policies by foreign governments are important factors which would make the substitution of tariffs to regulate oil imports very costly and inefficient. No tariff can be so scientifically set as to reasonably regulate the level of imports in accordance with the needs of national security. The committee felt that whenever a national security matter is concerned, importations of the commodity involved should be set at a level so as to provide a reasonable degree of certainty that they will not impair the national security. This cannot be done effectively by a tariff or duty scheme.

The committee also considered the fact that four U.S. Presidents, two from each major political party (Presidents Eisenhower, Kennedy, Johnson, and Nixon), after careful study of all the military, security, and economic facts available to them, have determined that quantitative controls over oil imports were in the national security interest. The need for establishing a reasonably specific and predictable level of imports was particularly manifest to President Kennedy who issued the Presidential proclamations which established a regional formula for regulating such imports.

TARIFF ADJUSTMENT AND ADJUSTMENT ASSISTANCE

(Subpart 2 of Part A of Title III)

GENERAL

Subpart 2 of part A of title III of the bill would amend the provisions of title III of the Trade Expansion Act of 1962 (TEA) relating to tariff adjustment for industries, and adjustment assistance for firms and workers. The primary purpose of the amendments is to liberalize the criteria that must be met before such relief may be afforded. Subpart 2 would also make certain other changes in related provisions of sections 311, 317, 323, 326, 351, and 352 of title III of the TEA.

Since the liberalization of criteria and the investigative procedures differ with respect to industry relief as distinguished from firm or worker relief, the two categories will be discussed separately.

TARIFF ADJUSTMENT [1]

Sections 301, 302, 351, and 352 of the TEA set forth the current authority and procedures for an industry to obtain assistance in the form of proclaimed increases in the duty or other import restrictions applicable to articles on which concessions have been granted in trade agreements. Provision is also made therein (section 302) for such industry relief to be provided in combination with adjustment assistance to firms and workers, the terms of which are discussed in the next section of this report relating to adjustment assistance.

The amendment would not change the status of petitioners for tariff adjustment. In other words, section 301(a)(1) would still permit petitions to be filed with the Tariff Commission by any trade association, firm, certified or recognized union, or other representative of industry so long as petitioner's authority is drawn from firms or groups of workers embracing a substantial part of the industry involved.

AUTHORITY FOR TARIFF ADJUSTMENT

(Sec. 311 of the bill)

Section 311 of the amendment would amend section 301(b) of the TEA in a number of significant ways, viz.: (1) By liberalizing existing criteria for tariff adjustment; (2) by adding an additional determination as to the nature of the injury; (3) by including a definition of the term "domestic industry producing articles like or directly competitive with the imported article"; and (4) by directing the Tariff Commission also to investigate factors which in its judgment may be contributing to increased imports of the article under investigataion, and (5) by changing the voting requirements of the Commission in regard to its determinations with respect to tariff adjustment remedies.

Relaxed criteria. The amendment would accomplish liberalization of present tariff adjustment criteria basically by (a) significantly modifying the present causal connection between increased imports and trade-agreement concessions, and (b) by substituting for the present concept of "the major factor" (in existing paragraph (3)) the concept

[1] The term "tariff adjustment", as used in the TEA, refers not only to tariff rate increases but also to other import restrictions.

of increased imports contributing substantially toward causing serious injury which was embodied in section 7 of the Trade Agreements Extension Act of 1951, as amended.

The committee relaxed the causal relationship that exists in the Trade Expansion Act between increased imports and trade concessions. Under present law the Tariff Commission must determine "whether as a result *in major part* of concessions granted under trade agreements, an article is being imported into the United States in such increased quantities as to cause, or threaten to cause, serious injury to the domestic industry producing an article which is like or directly competitive with the imported article."

The committee agreed that this "major part" test is too rigid, and adopted the same causal relationship between increased imports and tariff concessions which existed between 1951 and 1962 under section 7 of the Trade Agreements Extension Act, as amended, which in pertinent part, reads as follows:

> The Tariff Commission shall . . . determine whether any product upon which a concession has been granted under a trade agreement is, as a result, in whole or in part, of the duty or other customs treatment reflecting such concession, being imported into the United States in such increased quantities, either actual or relative, as to cause or threaten serious injury to the domestic industry producing like or directly competitive products."

The committee determined that restoration of this causal relaionship should not impede any industry from receiving relief if it is seriously injured by imports. Restoration of the causal relationship was considered necessary for two basic reasons:

(1) Without any relationship between increased imports and a tariff concession, the articles imported from Communist countries (which have never received a U.S. tariff concession) would have to be subject to "escape clause" proceedings along with the articles from column 1 or non-Communist countries; and

(2) Without any causal relationship between increased imports and tariff concessions the United States could be in violation of trade agreement obligations which could give foreign countries a reason for arguing that any action by the United States under tariff adjustment provisions of this act was, *ipso facto*, in violation of such obligations.

With respect to the products of Communist countries, it is entirely conceivable that certain imported products from these countries could be of sufficient magnitude to "tip the scales" in the judgment of the Tariff Commission to decide a case in favor of an affirmative finding. Thus higher duties could be imposed on the articles of free-world countries, because of importations from Communist countries.

The committee felt that the causal relationship between increased imports and tariff concessions embodied in section 7 of the Trade Agreements Act of 1951, as amended, which was in effect for 11 years, was not only fully compatible with U.S. obligations, but did not serve as a hindrance for seriously injured domestic industries from receiving an affirmative determination from the Tariff Commission, on the question of serious injury.

The words "in whole or in part, of the duty or other customs treatment reflecting such concessions" which the committee adopted have not in the past been construed by the Tariff Commission as a reason not to proceed to determine whether increased imports have "contributed substantially" toward causing or threatening serious injury to an industry. The committee strongly believes that the Tariff Commission will not close out any case on an article subject to a tariff concession, because of the causal link between increased imports and a tariff concession, which the committee feels is an integral part of our trade agreement program.

Even in cases in which there is a zero rate of duty on an article which has been bound by a tariff concession, the "binding" itself is a significant concession, without which, high duties could be imposed consistent with international obligations which would assuage the growth of imports and thereby relieve a domestic industry. In Tariff Commission Report to the President on escape clause investigation No. 7–90, under section 7 of the 1951 Act relating to binder and baler twines which had been historically free of duty, the Commission said: (p. 52).

> *By enacting the escape-clause provisions, of which the language here in question is a part, the Congress was in effect declaring that American industry should be protected against serious injury from an increase in imports following the granting of trade-agreement concessions. The possibility that such injury may occur arises from the fact that a concession, whether it be a "modification" or a "binding" of customs treatment, is conceptually merely an undertaking not to impose a more restrictive customs treatment than that specified for the product involved during the life of the trade agreement. Such an undertaking represents a distinct commercial advantage to any country which receives the benefit of the concession, and constitutes a stimulus to exports of the product from these countries. Thus, the escape-clause legislation is, in the final analysis, calculated to remove or mitigate the stimulus to an injurious volume of imports which may result from the customs treatment of the product in question,[1] an objective which can be effectively served only if remedial action is taken with respect to the customs treatment of such imports from all countries which receive the benefit of the undertaking represented by the concession. Accordingly, if a country received the benefit of a trade-agreement concession, its exports of the product involved must be within the reach of the escape-clause remedy.*

Thus, in such situations the committee understands and intends that the "binding" itself would satisfy the causal relationship.

Moreover, the words "in part" mean *any* part, *not* the major part, a significant part or any other qualification on the degree of relationship between increased imports and a tariff concession.

It will be observed that under the relaxed criteria it is sufficient that increased imports, which have resulted in whole or in part from trade-agreement concessions, "contribute substantially" (whether or not such increased imports are the major factor or primary factor) toward

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[1] This is implicit in the language of the statute itself, which does not purport to be addressed to the concession *per se* but rather to the "duty or other customs treatment reflecting such concession."

causing or threatening to cause injury. The parenthetical language was inserted to contrast the proposed criteria with the existing concept of "the major factor" and the concept of "the primary factor" proposed by the administration, and to show that these latter concepts were not in any sense controlling in the interpretation of the concept adopted by the committee. The committee's acceptance of the criteria of section 7 of the 1951 Extension Act was also based upon the fact that such criteria had previously been determined by the President to be compatible with our international obligations.

The term "like or directly competitive", used in the bill to describe the products of domestic producers that may be adversely affected by imports, was used in the same context in section 7 of the 1951 Extension Act and in section 301 of the Trade Expansion Act. The term was derived from the escape-clause provisions in trade agreements, such as article XIX of the GATT. The words "like" and "directly competitive", as used previously and in this bill, are not to be regarded as synonymous or explanatory of each other, but rather to distinguish between "like" articles and articles which, although not "like", are nevertheless "directly competitive". In such context, "like" articles are those which are substantially identical in inherent or intrinsic characteristics (i.e., materials from which made, appearance, quality, texture, etc.), and "directly competitive" articles are those which, although not substantially identical in their inherent or intrinsic characteristics, are substantially equivalent for commercial purposes, that is, are adapted to the same uses and are essentially interchangeable therefor.

With respect to question of *threat* of injury the committee believes the factual situation necessary to support a finding that an article is being imported in such increased quantities as to "threaten" serious injury to a domestic industry cannot differ greatly from the factual situation necessary to support a finding that the product is being imported in such increased quantities as to "cause" serious injury. Since both a finding of present serious injury and a finding of threatened serious injury must be related to currently increased imports, it necessarily follows that a finding of threatened serious injury must be based upon facts which, applied to the statutory criteria, show that serious injury is about to occur. In other words, the serious injury must be imminent.

Additional determination as to the nature of injury. There are some situations in which injury to industry would be so serious as to be acute or severe, indicating an especially urgent need for *immediate* remedial relief. Furthermore, in such acute or severe injury cases the relief should be adequate to the nature and extent of the injury. Consequently, the committee provided that in situations in which the Tariff Commission finds that the injury to the domestic industry is acute or severe or that imports threaten to acutely or severely injure such industry, the Tariff Commission would so report to the President. In this case, the President shall impose whatever restrictions the Tariff Commission recommends to remedy the severe or acute injury or threat thereof, unless he determines it is not in the national interest.

The committee intends that acute or severe injury is to be construed as a high level of injury well above the threshold of serious injury required for an affirmative injury determination under paragraph (1)

of section 301(b). However, under this criteria an industry would not have to be on its death bed for the injury to be deemed acute or severe. The word "acute" is taken generally to mean "seriously demanding urgent attention," "intensification of need," "sharp" or "pointed," "constituting a crisis." Similarly, the word "severe" means "sharp," "extreme," or "grievous." Analogously, the committee would consider a broken bone in the body to be a serious injury, and if the broken bone were a compound fracture this would be a severe or acute injury. The body as a whole can be relatively healthy even though one of its members is acutely or severely injured. But if no relief is immediately forthcoming to remedy the acute or severe injury, or threat thereof, the body itself will suffer irreparable damage. Thus, it is the committee's intention that in cases where the injury is acute or severe, the remedy is more urgent than in cases where only serious injury has been found, although in the latter cases, it is expected that the President will also weigh heavily the Tariff Commission's recommendation for relief in his decision to impose whatever restrictive action he deems necessary to provide relief.

The committee rejected the arithmetic approach in H.R. 18970 to the question of severe or acute injury because it involved a number of highly complex and untried criteria which not only would have sharply increased the workload of the Tariff Commission but would not have assured any improvement in the qualitative determinations of the degree of injury involved in any particular case. Moreover, this arithmetic test in H.R. 18970 involved computations which were often difficult, if not impossible, to compute. For example, the arithmetic test would have required that the imported articles be sold at prices "substantially below" those prevailing for like and competitive products produced in the United States, and that the unit labor cost attributable to producing the imported article are "substantially below" those attributable to producing like or competitive articles in the United States. The committee was informed that unit labor costs information is not available to the degree envisioned by this legislation, and believes that the question of whether imported prices were "substantially below" those prevailing in the United States is not essential to the question of severe injury. An article could be sold in the United States only slightly below the domestic price but in such volume and in such concentration that the domestic industry, operating on a very slim profit margin, would not be able to compete.

Moreover, the arithmetic determination would have required the Tariff Commission to determine whether domestic production of the like or directly competitive product is declining or is likely to decline so as to substantially affect the ability of domestic producers to continue to produce the like or directly competitive product "at a level of reasonable profit." The committee was informed that it is extremely difficult to determine what "a reasonable level of profit" constitutes in any one particular product line in a multiproduct industry. Current accounting practices do not usually segregate out profitability on a product by product basis. Moreover, profits tend to vary industry by industry in accordance with the degree of competition in the marketplace and the supply and demand relationships for the goods involved as well as with the general state of the economy.

In opting for the qualitative approach to the question of acute or severe injury, the Committee is placing great faith and expectation in

the sound judgment of the members of the Tariff Commission to reach, after consideration of all relevant factors, a degree of consensus on the question of injury consistent with the intention of this Act and with the exercise of such sound judgment. In this connection, the Committee has noted the generally increasing tendency of Commissioners to resort to the use of separate statements of their views when there are no significant differences between them or when the differences, if any, are not apparent. The committee feels that the Commissioners should strive to eliminate this practice. Commissioners should make reasonable efforts to reach a consensus on the main questions of injury and remedy, and, when this is not possible, should present clear majority and minority viewpoints on these principal questions, with any significant differences clearly drawn and explained.

Definition of domestic industry. This definition of domestic industry, which appeared in former section 7 of the 1951 Extension Act, is the so-called segmentation concept. By virtue of this definition, the domestic industry will include the operations of those establishments in which the domestic article in question (i.e., the article which is "like," or "directly competitive with," the imported article, as the case may be) is produced. Where a corporate entity has several establishments (e.g., divisions or plants) in some of which the domestic article in question is not produced, the establishments in which the domestic article is not produced would not be included in the industry. The concern of the Tariff Commission would be with the question of serious injury to the productive resources (e.g., employees, physical facilities, and capital) employed in the establishments in which the article in question is produced. In the case of multiproduct establishments in which productive resources are devoted to producing products A, B, C, and D, of which only product A is suffering from import competition, it is only necessary that the Commission find that the resources engaged in the production product A have been injured. However, the Tariff Commission should take into account other relevant factors including whether there has been a transfer of productive resources from A to B, C, or D for reasons other than the impact of imports. The extent to which the products of a multiproduct establishment can be so separately considered is necessarily affected by the accounting procedures that prevail in a given case and the practicability of distinguishing or separating the operations for each product line.

A reinstatement of the "segmentation principle" in the definition of industry is made more important now because of the growth and proliferation of mergers and conglomerate type industrial enterprises. One or several of these large integrated firms with many lines of production can take a considerable market share in any one article of production. There may be scores of smaller, nonintegrated firms producing like or competitive products and if the economic condition of the whole large, integrated, multiproduct firm had to be weighed on the scale of injury alongside that of the small, nonintegrated firm, the balance would inevitably be tipped against the small producer.

Factors causing increased imports. Subsection (b)(6) will require the Tariff Commission, in the course of any proceeding initiated under paragraph (1), to investigate any factors which may be contributing to

increased imports of the article under investigation. Such factors would include the effect of tariff concessions, foreign wage rates, and also possible dumping, subsidization, or other forms of unfair competition. If the Tariff Commission has reason to believe that increased imports are attributable in part to circumstances which come within the purview of the Antidumping Act, 1921, section 303 or 337 of the Tariff Act of 1930, or other remedial provisions of law, it is directed to promptly notify the appropriate agency and to take such other action as it deems appropriate in connection therewith. There is no intention in this amendment to transfer to the Tariff Commission action responsibility for the implementation of statutory language falling within the purview of other agencies.

This provision is designed to assure that the United States will not needlessly invoke the escape-clause [article XIX of the GATT] and will not become involved in granting compensatory concessions or inviting retaliation in situations where the appropriate remedy may be action under one or more U.S. laws against unfair competition for which action no compensation or retaliation is in order.

Commission voting requirements. In accordance with subsection (b)(4) the remedy determination of a majority of the Commissioners voting for the affirmative injury determination shall be treated as the remedy determination of the Commission.

Ninety-day transition period. The committee provided the Tariff Commission with a period of 90 days after enactment, within which the Commission, acting as expeditiously as possible, will issue new rules and regulations on handling all petitions under its jurisdiction. The committee intends that the Commission will issue these rules and regulations as soon as possible, but no later than 90 days after the enactment of this Act. During that period, no petition may be filed under section 301(a) of the Trade Expansion Act of 1962.

PRESIDENTIAL ACTION WITH RESPECT TO TARIFF ADJUSTMENT

(Sec. 313 of the bill)

The bill would amend section 351 of the TEA to provide that the President shall, upon receipt of an affirmative injury determination, proclaim such import restrictions as he determines to be necessary to prevent or remedy serious injury, unless he determines that it would not be in the national interest.

When the Tariff Commission makes an injury determination and makes the aforementioned additional determination provided for in section 301(b)(5), the President is directed to implement the remedy determination of the Commission unless he determines that such action would not be in the national interest. In situations in which the President rejects the Tariff Commission's remedy under the national interest provision he would be free to provide whatever relief he deems necessary, which is consistent with this Act and the national interest.

The amendment would make no change in the existing provisions for congressional review which applies to those cases where the President does not carry out the remedy determination of the Commission.

REVIEW OF ADJUSTMENT ACTION

The review procedures on outstanding tariff adjustment actions are amended to provide that the Tariff Commission, in its reports on conditions in the industry concerned with the tariff adjustment, will include information on the steps taken by the firms in the industry to compete more effectively with imports.

The reporting requirements regarding such reviews of tariff adjustment actions are also amended to provide that the Tariff Commission will make findings similar to those in an original tariff adjustment investigation if it should determine in an investigation reviewing an outstanding tariff adjustment action that the existing restrictions on imports are insufficient to prevent or remedy serious injury to the domestic industry. Such finding would be in addition to that presently required with regard to the effect of a reduction or elimination of a tariff adjustment action.

ORDERLY MARKETING AGREEMENTS

(Sec. 314 of the bill)

Section 352 of the Trade Expansion Act is amended to provide that the President may negotiate orderly marketing agreements at any time after an affirmative injury determination. Further, the amendment provides that such agreements may replace in whole or in part tariff adjustment actions. Under existing law, the negotiating authority under section 352 is to be used at the conclusion of the Tariff Commission investigation and the agreements are to be a substitute for tariff adjustment action. This provision may serve as a means for the President to avoid imposing mandatory quotas, if a suitable voluntary agreement is reached.

ADJUSTMENT ASSISTANCE

(Sec. 315 of the bill)

Adjustment assistance for firms and workers injured by increased imports is made more readily available under this amendment. The committee believes that the criteria for determination of eligibility of firms and workers to apply for adjustment assistance contained in the Trade Expansion Act of 1962 are too strict. The committee amendment therefore liberalizes these criteria. The amendment also provides that the President, instead of the Tariff Commission, will make the substantive determinations of eligibility.

Under the amendment, firms or workers may petition directly to the President rather than to the Tariff Commission as at present; also, firms and workers may apply directly to the Secretaries of Commerce or Labor, respectively, after Presidential action providing for such requests following a Tariff Commission finding of injury to an entire industry.

The basic formula for the weekly trade readjustment allowance payable to an adversely affected worker is increased in the bill from 65 percent to 75 percent of his average weekly wage or to 75 percent of the average weekly manufacturing wage, whichever is less, reduced by 50 percent of the amount of his remuneration for services performed during the week. The existing provisions affording training

and other reemployment assistance to adversely affected workers is expanded to include supportive and other services provided for under any Federal law.

The changes in the bill will serve to make adjustment assistance more effective and more readily available to help individual firms or groups of workers cope with the impact of increased import competition.

Direct Petitions. The Trade Expansion Act of 1962 presently provides that petitions for a determination of eligibility to apply for adjustment assistance may be filed with the Tariff Commission by or on behalf of a firm or group of workers. These are petitions for determinations under section 301(c). The committee amendment changes this procedure by requiring that the petitions be filed with the President rather than the Tariff Commission. It is intended that a group of three or more workers in a firm may qualify as a petitioner for adjustment assistance.

The committee believes that affected workers have a responsibility to endeavor to give prompt notice of difficulties by applying for assistance as soon as they become unemployed or are threatened with unemployment. Section 301(a)(2) of the Trade Expansion Act has been amended to provide that petitions filed by or on behalf of a group of workers shall apply only with respect to individuals who are, or who have been within one year before the date of filing of such petition, employed regularly in the firm involved. Individuals who become unemployed or underemployed after the date of the filing of the petition may be eligible to apply under any certification issued if they are members of the group described therein.

The committee has amended the provisions of the existing act with respect to the criteria to be applied in a determination of eligibility to apply for adjustment assistance by a firm or group of workers. It has provided that the President shall determine whether an article like or directly competitive with an article produced by the firm or an appropriate subdivision thereof is being imported in such increased quantities, either actual or relative, so as to contribute substantially toward causing or threatening to cause serious injury to such firm or subdivision or unemployment or underemployment of a significant number or proportion of the workers of a firm or appropriate subdivision thereof.

This amendment eliminates completely the former causal link between the increased imports and a trade agreement concession insofar as adjustment assistance cases are concerned. These cases are substantially different from the tariff adjustment (industry-wide escape clause) cases in that adjustment assistance involves no potential alteration of trade agreement concessions and therefore should not be related at all to such concessions. No obligations exist with respect to Article XIX of GATT with respect to adjustment assistance cases; they do exist with respect to tariff adjustment cases. The Senate amendment also changes the relationship between the increased imports and the injury or unemployment from "the major factor" to "contribute substantially (whether or not such increased imports are the major factor or the primary factor)."

It is intended that an "appropriate subdivision" of a firm shall be that establishment in a multi-establishment firm which produces the domestic article in question. Where the article is produced in a dis-

tinct part or section of an establishment (whether the firm has one or more establishments), such part or section may be considered an appropriate subdivision. In the Trade Expansion Act, this concept was confined to groups of workers. This bill would extend the concept to firms as well.

Section 301(c) of the Trade Expansion Act as amended by the committee provides for reports from the Tariff Commission to assist the President in making determinations with respect to petitions filed by firms or groups of workers. The President is to transmit promptly to the Tariff Commission a copy of each petition filed with him by a firm or group of workers and not later than five days thereafter to request the Tariff Commission to conduct an investigation relating to questions of fact relevant to the President's determinations and to make a report of the facts disclosed by such investigation. In his request, the President may specify the particular kinds of data which he deems appropriate. This is not intended, however, to preclude the Tariff Commission from making an investigation of, and including in its report, such additional data as it considers relevant. Upon receipt of the President's request, it is required that the Tariff Commission promptly initiate the investigation and promptly publish notice thereof in the Federal Register.

It is intended that the President, and not the Tariff Commission, shall make the determinations under section 301 (c)(1) and (c)(2) with respect to firms and groups of workers. Accordingly, the Tariff Commission is not to include in its report conclusions, opinions, or judgments which are tantamount to the determinations. Instead, it is to present the facts and in a manner which will render the report useful to the President. It is recognized that the Tariff Commission will have to reach conclusions with respect to suc subsidiary questions as what constitutes the firm or an appropriate subdivision thereof, what product is like or directly competitive, and what is the appropriate base period, in order to gather the relevant facts. In any case, however, the President has the final authority to make a decision with respect to any element which enters into the determinations under section 301 (c)(1) and (c)(2), and section 302 (c), (d), and (e).

In the course of any such investigation, the Tariff Commission shall hold a public hearing if requested by the petitioner or any other interested person. However, such a request must be made not later than 10 days after the date of the publication of its notice of the investigation. It is understood that a public hearing may be held in any case on the Tariff Commission's own motion. The report of the Tariff Commission of the facts disclosed by its investigation with respect to a firm or group of workers is to be made at the earliest practicable time, but not later than 60 days after the date on which it receives the request of the President.

After receiving the Commission's report, the President has a maximum of 30 days in which to make his determination as to whether the firm or group of workers is eligible to apply for adjustment assistance. However, within this period he does have the authority to request additional factual information from the Tariff Commission. The Commission is then to furnish the additional information in a supplemental report within 25 days and the President is to make his final determination not later than 15 days after he receives such supplemental report (section 302(c)).

The President is required to publish in the Federal Register a summary of each determination made with respect to a petition for adjustment assistance filed by any firm or group of workers.

For transitional purposes, investigations relating to adjustment assistance under existing section 301(c) in progress immediately before the date of enactment of H.R. 18970 are to be continued as if the investigation had been instituted under the amended section 301(c) and the petition treated as filed as of the date of enactment. Tariff Commission determinations pending before the President on date of enactment are also to be subject to the amended criteria and procedures.

If the President makes an affirmative determination on a petition for adjustment assistance with respect to any firm or group of workers, he shall promptly certify that such firm or group of workers is eligible to apply for adjustment assistance. This certification permits the firm to apply to the Secretary of Commerce and individual workers to apply to the Secretary of Labor to seek the types and amounts of adjustment assistance provided for in Chapters 2 and 3 respectively of Title III of the Trade Expansion Act of 1962. Certifications of groups of workers specify the workers' firm or appropriate subdivision and, under section 302(d) of the Trade Expansion Act, the date on which the unemployment or underemployment began or threatens to begin.

Section 302(e) of the Trade Expansion Act provides that the President shall terminate the effect of any certification of eligibility of a group of workers whenever he determines that separations from the firm or subdivision thereof are no longer attributable to the conditions specified in section 301(c)(2) or section 302(b)(2). Such termination applies only with respect to separations occurring after the termination date specified by the President.

The committee amendment specifically authorizes the President to delegate any of his functions with regard to determinations and certifications of eligibility to apply for adjustment assistance. Authority to issue rules and regulations related to these delegated functions is provided for under section 401(2) of the Trade Expansion Act.

PRESIDENTIAL ACTION WITH RESPECT TO ADJUSTMENT ASSISTANCE

(Sec. 312 of the bill)

Under the current law (Sec. 302(a)), whenever the Tariff Commission reports to the President a finding of serious injury or threat thereof to an industry, the President may take any of several courses of action. He may provide: (a) tariff adjustment on the imported product involved in the investigation; or (b) that the firms in the industry may request the Secretary of Commerce for certifications of eligibility to apply for adjustment assistance; or (c) that the workers in the industry may request the Secretary of Labor for certifications of eligibility to apply for adjustment assistance; or (d) he may take any combination of such actions. No order of priority among these various courses open to the President is established nor is there a requirement that the President must take some action.

We are persuaded that provision for adjustment assistance should not be continued as a discretionary alternative action for the President in place of tariff adjustment action where the Tariff Commission has made an affirmative injury and remedy determination after an

industry investigation. The committee has amended section 302(a) to deal with Presidential actions after receiving a Tariff Commission report containing an affirmative injury determination for an industry. If the President provides tariff adjustment for an industry, he may also provide that its firms or workers (or both) may request the Secretaries of Commerce and Labor, respectively, for certifications of eligibility to apply for adjustment assistance. If the President does not provide tariff adjustment for the industry, he shall provide that both firms and workers may request the respective Secretaries for certifications. Notice must be published in the Federal Register of each such action taken by the President. As amended, section (302(a)) also requires that any request for such a certification must be made to the Secretary concerned within the one-year period (or such longer period as may be specified by the President) after the date on which the notice is published.

There currently are, and may be, outstanding escape clause actions with respect to a few industries under which the President has acted to authorize firms and workers to request certifications of eligibility to apply for adjustment assistance from the Secretary of Commerce or the Secretary of Labor. It is the committee's intention that the provisions of section 302(b) as amended should also apply to requests from individual firms or groups of workers in those few industries which may be pending on date of enactment of this bill or submitted thereafter.

Under section 302(a) a firm or group of workers is not automatically certified as eligible to apply for adjustment assistance. Following Presidential action upon request by a firm in the industry found to be seriously injured or threatened with such injury, the Secretary of Commerce, in effect, must conclude whether the increased imports found by the Tariff Commission to have caused or threatened serious injury to the industry as a whole have also caused serious injury to the individual firm in question. Similarly, upon request by a group of workers in a firm in such industry, the Secretary of Labor must conclude whether the increased imports have caused or threatened unemployment or underemployment to a significant number or proportion of the workers of the firm or an appropriate subdivision thereof. In both situations, under existing provisions of 302(b), the increased imports must have been the major factor in causing or threatening to cause injury or unemployment. Your committee has amended these provisions to conform to the liberalized criteria in amended section 301(c).

This function given to the Secretaries of Commerce and Labor reflects the intention that adjustment assistance is not to be extended to a firm or group of workers which has not satisfied the conditions of eligibility. Under this procedure, these firms and workers are not required to wait upon a Tariff Commission investigation. It is expected that the Secretaries of Commerce and Labor will continue to make full use of Tariff Commission information derived from its investigation of the industry concerned. It is also expected, however, that where relief is warranted it will be given as quickly and as expeditiously as is practicable and that the Secretaries of Commerce and Labor will issue such rules and regulations that will assure prompt and effective relief.

The committee has required with respect to certifications made by the Secretary of Labor under section 302(b) that such certifications shall only apply with respect to individuals who are or who have been employed regularly in the firm involved within one year before the date of the institution of the Tariff Commission investigation relating to the industry. This refers to industry investigations instituted by the Commission whether by petition on behalf of the industry or by request, resolution, or motion, as the case may be, as provided in section 301(b). It is not intended that these certifications be limited to those individuals who are or who have been employed in the firm involved within the one-year period antedating the institution of the Tariff Commission investigation. Individuals who became or will become unemployed or underemployed (or threatened therewith) after the date of the institution of the investigation or after the date of the filing of the request with the Secretary of Labor may be eligible to apply under the certification if they are members of the group described therein.

Assistance for Individual Workers. The committee concurs with the House in making several changes in the adjustment assistance program for workers directed at helping adversely affected workers adjust to the loss of employment and reenter the labor force as rapidly and efficiently as possible. When the worker assistance provisions of the Trade Expansion Act were enacted in 1962, the Congress recognized that the adversely affected workers would frequently need retraining in a new skill. Section 326 of the Act, therefore, now expressly provides that workers are to be afforded, where appropriate, testing, counseling, training, and placement services available under any Federal law. The committee believes that upgrading the skills and educational opportunities of workers displaced by imports should be encouraged by the various agencies of Government having responsibility in this area.

The provisions were enacted at approximately the same time that the Federal Government was launching the first Manpower training programs under the Manpower Development and Training Act. Since that time it has been demonstrated that workers frequently need other services to prepare them effectively for full employment. The Congress recognized this by providing that workers enrolled in various Manpower programs, such as under the Manpower Development and Training Act and the Economic Opportunity Act, could be given what have come to be called "supportive services." (See Manpower Development and Training Act section 202 (j) and (k) and Economic Opportunity Act section 123(a)(6)).

The committee's amendment adds to the second sentence of section 326(a) of the Trade Expansion Act the phrase "supportive and other services." This phrase includes, to the extent provided in Federal law, services such as work orientation, basic education, communication skills, employment skills, minor health services, and other services which are necessary to prepare a worker who is eligible for assistance under the act for full employment in accordance with his capabilities and prospective employment opportunities. It is the committee's intention that the minor health services furnished under this section be limited to those which are necessary to correct a condition that would otherwise prevent a worker from being able to accept a training or employment opportunity.

We also wish to make it clear that the language of section 337 of the existing Trade Expansion Act authorizing appropriations to the Secretary of Labor to enable him to carry out his functions under the act includes the authority to expend the funds appropriated thereunder for all programs that are provided to adversely affected workers under the act, including training and supportive services, and that use of the funds is not limited to payment of the financial allowances to the eligible workers.

The committee also considered the basic formula for the level of weekly trade readjustment allowances as provided in section 323(a)—65 percent of the worker's average weekly wage or 65 percent of the average weekly manufacturing wage, whichever is less, reduced by 50 percent of the amount of his remuneration for services performed during the week.

We believe that this level of benefits is now inadequate and has increased it to a basic formula level of 75 percent of the worker's average weekly wage or 75 percent of the average weekly manufacturing wage, whichever is less, reduced by 50 percent of the amount of his remuneration for services performed during the week. If this provision had been in effect in the summer of 1970, the maximum payment would have been $98 per week.

This increase is based on the policy inherent in the Trade Expansion Act of 1962 that readjustment allowances are intended to do more for adversely affected workers than the compensation provided by unemployment insurance. The level of benefits available under state unemployment insurance has increased appreciably since 1962, and some states now provide unemployment compensation higher than the readjustment allowances established in the Trade Expansion Act of 1962. The President has also recommended that the States take action to assure that unemployment insurance be increased to a maximum representing not less than 66⅔ percent of the average weekly wage in covered employment.

The increase in trade readjustment allowances recommended by the committee will serve to maintain the general 1962 relationship where such allowances were higher than unemployment compensation. We believe that this relationship is appropriate in view of the fact that the finding that the unemployment was caused by increased imports implies that a lower level of imports would have resulted in full job maintenance. Worker assistance is, therefore, in the nature of adjustment to conditions resulting from actions taken for the benefit of the nation as a whole.

The basic amended formula for the level of trade readjustment allowances will apply for weeks of unemployment beginning on or after the date of enactment of the bill. The amended formula will thus also apply to workers who became eligible through a certification issued before enactment of H.R. 18970.

The committee has maintained the standards of eligibility of the individual to receive adjustment assistance benefits which were established in the Trade Expansion Act of 1962. These standards are stricter than those under State law for eligibility for unemployment insurance or those under the Manpower Development and Training Act. In order to be eligible for assistance the individual worker must be a member of the group specified in the certification and must have been separated from adversely affected employment due to lack of

work. That is, he must have been separated from a firm or subdivision for which a certification of worker eligibility has been issued. The worker must also have had a substantial employment history: he must have been gainfully employed (at weekly wage of $15 or more) for at least half of the weeks of the three years preceding his separation from adversely affected employment and in the 52 weeks immediately preceding his separation he must have had at least 26 weeks of employment in a firm or firms, the workers of which have been found adversely affected by imports. The committee believes that these stricter standards of individual eligibility are justified by the scale of trade adjustment assistance compared with that available under other programs.

Quotas on Textiles and Footwear

(Part B of Title III)

Part B of title III provides temporary measures to restrict imports and avoid the threat of serious injury to the textile and footwear industries and further deterioration in the domestic market for textiles and apparel and nonrubber footwear.

This is to be accomplished by—

(*a*) The establishment of annual quotas, based on imports during 1967–69, by category and by foreign country of production for all categories of textile articles and footwear articles which may be imported during each calendar year beginning after December 31, 1970;

(*b*) Authorizing exemptions from such quotas when the President determines that exemption will not disrupt the domestic market or that exemption is in the national interest; and

(*c*) Authorizing negotiation of agreements with foreign countries which would result in the regulation of imports into the United States of textile articles or footwear articles or both and would supersede the statutory quotas for the articles covered by the agreements.

Within this general framework, part B of title III authorizes increased imports where the supply of articles subject to limitation is inadequate to meet domestic demand at reasonable prices; provides for certain exclusions with respect to noncommercial entries and to articles already subject to international agreement; and establishes the applicability of the rulemaking provisions of the Administrative Procedure Act to various actions under part B of title III of the bill. Part B of title III terminates at the close of July 1, 1976, unless extended in whole or in part by the President following his determination that such extension is in the national interest.

These provisions are designed to provide a mechanism for establishing a reasonable and effective limitation on U.S. imports of textile products and of nonrubber footwear products for the broad purpose of remedying market disruption in those cases in which it now exists, and of preventing the spread of market disruption to other categories of articles. It is intended that, insofar as may be possible, the limitation of these imports will be accomplished through the negotiation of voluntary agreements provided for under section 322 and that the quota provisions of section 321 will assist in the negotiation of such agreements as well as to provide protection for the domestic market and workers in cases where such agreements are not concluded.

The quota, exemption, and agreement provisions of part B of title III are intended to assure that all textile articles and all footwear articles, as defined, come within the scope of such provisions and may, at any point in time, be subject to quota or agreement if they are not at such time exempted.

The committee in its deliberations of import controls for textiles gave careful consideration to the relationship of the thousands of textile articles and the devastating effect which results when one textile article is controlled and imports shift to one not under restraints. The committee firmly believes that the only way to effectively control textile imports by means of negotiated agreements is to provide for comprehensive coverage of the textile articles described and defined in part B of Title III. We expect this title to be administered so as to carry out this basic and necessary concept.

ANNUAL QUOTAS

(Sec. 321 of the bill)

Annual quotas are established by statute on the total quantity of each category of textile articles (defined in sec. 326), and of footwear articles (defined in sec. 326), produced in any foreign country which may be imported during 1971 and in each subsequent year. The limit for 1971 for each category of articles produced in each country is the average annual quantity of such articles from such country which was imported during the years 1967, 1968 and 1969.

1. Selection of Base Level

Textiles.—The average of imports from all countries of the principal textile articles not at present subject to import limitation (or to voluntary export restraint to the United States), i.e., principally wool and man-made fiber textile articles, amounted to an annual average of 1,390 million square yards equivalent in the 1967–1969 base period for man-mades, and 184.5 million square yards for wool textile products. (These figures include tops, yarns, fabrics, apparel, and made-up and miscellaneous textile products.) In 1969, imports were 1,782.6 million square yards equivalent for man-mades and 191.1 million for wool textiles. As of June 1970 imports are running at an annual and all time record rate of 2.4 billion square yards for man-made fiber textiles. However, wool textile imports are expected to total 150 million square yards.

At the same time, cotton textile imports, which are subject to the terms of the Long Term Arrangement Regarding International Trade in Cotton Textiles, are continuing at a high rate. They are expected to again reach more than 1.6 billion square yards in 1970.

Apparel, the most labor intensive sector of the textile-apparel industry is experiencing a continuing sharp increase in imports. At present rates, 1970 apparel imports will rise to 1.6 billion square yards equivalent, of which more than 1 billion yards will be manufactured from man-made fibers, 500 million will be cotton apparel and 50 million will be wool apparel.

These imports pose a threat to the future of a strong textile-apparel "industry" in the United States and its over 2 million employees unless import growth is more closely brought into balance with growth in the domestic market and in domestic production.

Nonrubber Footwear.—U.S. imports of footwear (non-rubber) have also surged in recent years, from a 1961 level of 40 million pairs to a 1969 level of 202 million pairs. Each recent year has seen a sharp and substantial rise in these imports, from 133 million pairs in 1967, to 181 million in 1968 and to more than 200 million in 1969. 1970 imports are expected to exceed 260 million pairs. At the same time, U.S. production is declining in a number of key lines of products. The decline of employment opportunities for American shoe workers, the closing of shoe factories, and the serious damage done to this industry justify the legislative quotas in the committee amendment.

Accordingly, to relieve the market disruption and the dislocation to firms and workers in these industries, and to restore to them the possibilities for full and equitable participation in future market growth, the 1967–1969 average annual level base formula has been adopted as the base for the statutory quotas.

2. Growth in Base Level Quotas

The quantities provided for under the base level (1967–1969) formula may be increased annually beginning January 1, 1972 by not more than 5 percent of the amount authorized for the preceding calendar year if the President determines that an increase is consistent with the purposes of section 321 (section 321 (b)(1) and (b)(2)(A)). Any percentage increase granted for a category of articles is to be the same for such category from all countries.

Section 321 also provides (subsection (b)(2)) that a yearly determination be made of the quotas which would apply for each category of articles from each country throughout the life of this title III, part B, notwithstanding that such limitations may not, in fact, be in effect as a result of the operation of other provisions of this title (e.g. the exemption authority (sec. 321(d) or the agreements negotiated (sec. 322)). This requirement will assure that a continuing reference point is maintained enabling the comparison of statutory quotas with negotiated agreements and with actual trade which has been permitted to occur as a result of use of the exemption authority by the President.

Section 321(b)(3) provides that when a quota under this section begins or resumes after a period in which the article produced in a foreign country was exempted from quota as a result of a Presidential decision, or an agreement under section 322, and the President determines that imports of such article from such country during the 1967–69 period were insignificant, a more recent base period shall be used with respect to such article from such country if he finds that use of such more recent base period is consistent with the purpose of this section. In that event, the quota for such articles shall be an amount equal to the average annual imports of such article from such country during the three calendar years preceding the year in which the quota goes into effect. Under this provision the President will have flexibility in a case in which a given country's base period trade (i.e., U.S. imports from that country in the 1967–1969 period) was insignificant and the article has been the subject of an exemption by the President under section 321(d) or was exempted under an agreement provided for in section 322 or 324(b).

Section 321(c) further provides for the spacing of allowable annual quotas over the course of a calendar year as appropriate to carry out the purposes of section 321. Such spacing, taking seasonal factors

in trade and production into account, would enable the President to avoid a heavy influx of quota goods in a short period of time at the beginning of a year, an influx which could disrupt the domestic market under some circumstances. Also, by requiring a re-opening of a divided annual quota, importers of smaller volumes of articles would be given several opportunities to participate in the entry of available quota articles. Section 321(c)(2) provides for the pro-rata adjustment of any annual quota which comes into effect after the beginning of a calendar year as the result of the termination of an exemption or other actions authorized by part B of title III. At such time, in addition to the amounts actually entered during the calendar year up to the date the quota resumes, an additional quantity equal to the statutory quota adjusted pro rata according the number of full months remaining in the calendar year after the date of such quota resumption is authorized to be imported.

EXEMPTION OF ARTICLES FROM QUOTAS

(Sec. 321 of the bill)

The bill provides three mechanisms through which textile or footwear articles may be exempted from the quotas imposed under subsections 321 (a), (b), and (c), in the absence of an international agreement concluded under section 322 (or the arrangement or agreement referred to in subsection 324(b)).

1. Non-Disruptive Imports

The President is authorized by section 321(d)(1) to exempt articles produced in any foreign country if he determines that imports of such article produced in such country are not contributing to, causing, or threatening to cause market disruption in the United States. These exemptions, which may be made for an initial one year period, and which may be extended for additional periods not to exceed one year each, and may be terminated by the President at any time upon his finding that the article in question is contributing to, causing, or threatening to cause market disruption in the United States.

In making the determinations under section 321(d)(1) and in making similar determinations under other provisions of part B of title III, the President should consider market conditions in the United States for articles similar to the imported articles in question, taking particular account of the relevant market disruption standards set forth in Annex C of the Long Term Arrangement Regarding International Trade in Cotton Textiles (the arrangement referred to in section 204(b)). These market disruption standards are as follows: "these situations (market disruption) generally contain the following elements in combination:

> (i) a sharp and substantial increase or potential increase of imports of particular products from particular sources;
>
> (ii) these products are offered at prices which are substantially below those prevailing for similar goods of comparable quality in the market of the importing country;
>
> (iii) there is serious damage to domestic producers or threat thereof; . . ."

In applying market standards under part B of title III, the President would be expected to consider factors affecting the level of employ-

ment, in the domestic industry, including the number of hours worked per week.

In many instances it is the cumulative effect on the market of articles produced in a number of countries which causes market disruption, although the committee recognizes that in some cases the market for a particular article may be disrupted by imports from one country alone.

The committee understands that disruptive conditions in the market for any product cannot in all cases be precisely measured. Thus, while the above quoted conditions are generally found in a circumstance of market disruption, it is not always the case and in other situations different elements may be considered in determining the state of the domestic market for the articles concerned.

The term "articles" in this provision can be as narrowly defined as the President deems necessary and is not meant to be restricted to the "category" of articles as described in the Tariff Schedules of the United States. This would enable the President to exclude individual "articles" within "categories" of articles from the quota provisions if he found that they were not disrupting the domestic market.

It was brought to the committee's attention that certain articles of athletic footwear imports are selected by athletes because they feel that the design of the shoes, including a close fit and light weight, are particularly suited to their needs as a professional or amateur performer. The shoe is selected by the athlete for its suitability for the particular athletic event involved, and the price is generally higher than that charged for domestically produced athletic shoes of the same type. It is expected that the President would exercise his authority in this kind of a situation.

2. The National Interest

Part B of title III also provides that the President may exempt articles from the quotas when he determines that such action would be "in the national interest" (Sec. 321(d)(2)).

The committee intends that the President have freedom in this regard and understands that he is not expected to indicate what particular reasons may have motivated his determination to act on the basis of the national interest criteria.

3. Supply at Reasonable Prices

The President is also authorized to provide for additional imports in excess of established quotas or in addition to the limitations provided in agreements whenever he finds that the total supply from domestic and foreign sources, of textile articles or footwear articles similar to those subject to limitations under such quotas or agreements will be inadequate to meet demands at reasonable prices. This standard is set forth in Section 323.

The committee believes that in view of the broad flexibility afforded the President to exclude individual articles from the quota provisions, specific legislative exemptions were unwarranted. Consequently, the committee deleted a provision in the House version of the Trade Act of 1970 which would have exempted from the quota provisions on textile articles certain woven fabrics for use only in the manufacture of neckties.

NEGOTIATION OF AGREEMENTS

(Sec. 322 of the bill)

Section 322 provides an alternative to the statutory quota provision of section 321. It authorizes the negotiation of voluntary agreements with the countries exporting textile articles, footwear articles, or both. These agreements would provide for the quantitative limitation by category of the textile articles and/or the footwear articles which these countries may export to the United States during each year of the agreement. Such agreements may be administered on the base of either import controls by the United States or export controls by the country concerned or a combination thereof. Whenever such agreements are in effect, the articles which are included under them are exempted from the quota provision of section 321. Both multilateral agreements and bilateral agreements and arrangements are provided for under section 322 and the President is authorized to issue regulations necessary to carry out such agreements.

Section 322(b) authorizes the President to issue regulations limiting the quantity of articles which may be imported from countries not participating in a multilateral agreement whenever such an agreement is in effect among countries, including the United States, accounting for a significant part of world trade in the article concerned, and such agreement contemplates the establishment of limitations on trade in such articles which are produced in countries which are not participating in such agreement. It is intended in this context that a "significant part of world trade" would be in excess of 50 percent of such world trade in the article concerned. The regulations issued by the President under section 322(b) may not provide for lesser quantities from such countries than would be applicable if the quota provision of section 321 applied to such articles.

A multilateral agreement or arrangement covering wool and/or man-made fiber textile products or footwear products could be implemented under this section with respect to imports from countries which did not participate in such an arrangement. The authority provided in section 322(b) is patterned after that provided under section 204 of the Agricultural Act of 1956, as amended in 1962. Any agreement, whether bilateral or multilateral, would be concluded under the authority of section 322(a); section 322(b) authorizes only the issuance of regulations governing imports from countries not participating in multilateral agreements. Section 322(a) authorizes the issuance of regulations covering imports of articles from countries participating in bilateral or multilateral agreements concluded thereunder.

In determining which articles are exempted from quotas as a result of the conclusion of an agreement under section 322, any article falling under the purview of such agreement, whether or not a specific ceiling or limitation has been established for such article in that agreement, is to be exempted from the quota provision provided that under the agreement a mechanism is established whereby the entry of such article into the United States can be limited. This applies with respect to multilateral as well as bilateral agreements or arrangements. In many U.S. bilateral agreements on cotton textiles, some articles are subject to specific limitation while others are subject to consultation provisions. These latter articles (in a similarly structured agreement

pursuant to which limitation can be established) could be exempted from section 321 quotas.

Section 322(a) refers to agreements "regulating by category the quantities of * * * articles * * * which may be exported to the United States or entered. * * *" Thus, the basic thrust of the agreement must be to provide for a limitation of quantities of goods entering the domestic market, recognizing, however, that not all categories of goods from all countries are causing or threatening disruption of the domestic market, and recognizing that the pattern of such disruptive trade changes. In the case of a multilateral agreement implemented under section 322(b), the regulation of imports will also apply to articles from countries which are not party to such an agreement when the agreement provides a basis upon which imports of such articles from such countries can be controlled.

The amendment provides that negotiated agreements with foreign countries will supersede the quotas that otherwise would be imposed. The existing multilateral cotton textile agreement is specifically given this same treatment by the exclusion of articles subject to it for such time as the United States remains a party to that agreement.

The committee recognizes that substantial administrative discretion is required in order to make possible a negotiation of voluntary agreements among a number of supplying countries. For that reason, the bill does not establish any limitation on the quantities of articles that may be exempted from quotas by reason of their inclusion in a bilateral or multilateral agreement. The direction to the President in this respect is contained in Section 322 which requires that in negotiation of agreements, the President take into account conditions in the U.S. market, the need to avoid disruption of that market, and such other factors as he deems appropriate in the national interest.

ADMINISTRATIVE PROVISIONS

(Sec. 325 of the bill)

Section 325 provides generally for the administration of part B of title III. It incorporates by reference the rulemaking provisions of the Administrative Procedure Act (which has been codified in title 5 of the United States Code) with respect to all actions taken under certain specified provisions. Actions brought under these rulemaking procedures concern increases in the quotas, use of the more recent base quotas for countries whose exports were insignificant during the 1967–1969 base, exemptions and terminations of exemptions on the grounds of market disruption or the lack thereof in accordance with section 321(d)(1), the issuance of regulations affecting trade of non-participating countries (sec. 322(b)), and increases in imports authorized under section 323. Also subject to such rulemaking provisions are the issuance of regulations by the Secretary of Commerce, with respect to the exclusion of certain non-commercial articles, the issuance of determinations by the Secretary of Commerce that certain articles should be included in the definition of textile articles under section 326 notwithstanding that they have been classified elsewhere in the Tariff Schedules, and the determination by the Secretary of Commerce of the category systems for textile articles or footwear articles to be established for the purpose of the administration of part B of title III.

Application of the rulemaking procedures to these actions is intended to provide assurance of opportunity for public comment and notice of actions intended to be taken as well as of those which have been taken, and to provide for public hearings where that is deemed appropriate under the circumstances in accordance with that act (subchapter II of chapter 5 of title 5 U.S.C.).

In addition, the bill requires that all quantitative limitations established under part B of title III whether by statute or by agreement, all exemptions and terminations of exemptions, and all regulations issued to carry out title III be published in the Federal Register. Furthermore, to assure an additional comprehensive source of information regarding the state of quota limitations, exemptions, and limitations established under agreements, all of such information is to be included on a continuing basis as a part of the appendix to the Tariff Schedules of the United States. This publication will also include actions taken pursuant to the Long Term Cotton Textile Arrangement.

The committee believes that the use of these rulemaking and notice procedures will provide a sound basis for the development of an effective public information program regarding the operation of this part B of title III. The committee expects that public hearings will be held in connection with the establishment of the administrative machinery for the quota provisions of part B of title III.

With respect to the appropriate administration of quotas on textiles and footwear products, the committee concurred with the House that the President should be given full flexibility and latitude to develop regulations providing for efficient and fair administration of the quotas. The committee expects that the President will, consistent with efficient administration and to the extent practical, use this authority to provide for administration of these provisions to insure against inequitable sharing of imports by a relatively small number of the larger importers. Additionally, if on the basis of the experience with administering these provisions, it is determined that additional legislative authority is required to provide for an efficient and fair administration, it is expected that legislative recommendations will be promptly made to the Congress.

EXCLUSIONS

Section 324 excludes from the import restrictions established in part B of title III certain articles which would be covered by the definitions but which are imported under circumstances which the committee believes should not be subject to quota limitations. The provisions referred to in section 324(a) relate to such circumstances as the importation of personal belongings of persons who have lived overseas, articles brought back to the United States by returning tourists, and similar situations.

The Secretary of Commerce is authorized to issue regulations prescribing the circumstances under which articles imported in noncommercial quantities for noncommercial purposes may be entered free of quota restrictions (sec. 324(a)). In this regard care shall be taken not to exclude from the quotas samples shipments of which are in the nature of commercial sales. The committee intends that such regulations may provide for quota free imports of samples which are not for sale or for use other than as samples, and of other articles imported in very small quantities for personal use. Section

324(b) excludes from Part B of title III all articles subject to the Long Term Cotton Textiles Arrangement so long as the United States is a party thereto. In addition, certain cordage which is subject to a quantitative limitation in the bilateral agreement with the Philippines (the Laurel-Langley Agreement) is exempted for such time as that agreement remains in effect.

Section 324(c) provides that section 22 of the Agricultural Adjustment Act, as amended, is not affected by part B of title III.

DEFINITIONS

(Sec. 326 of the bill)

Section 326 of the bill defines the terms "textile article" and "footwear article" by reference to the applicable provisions of the TSUS.

Except as indicated below, the term "textile article" is limited to any article classified in schedule 3 of the TSUS, if such article is wholly or in part of cotton, wool or other animal hair, human hair, man-made fiber, or any combination or blend thereof, or cordage of hard (leaf) fibers. Specifically excepted from the term, are: raw cotton, cotton wastes and advanced wastes, and cotton processed but not spun; raw wool or hair, wastes and advanced wastes of wool or hair; wastes and advanced wastes of man-made fiber; and scrap cordage and rags. In addition to articles classified under schedule 3, the term includes certain headwear and gloves provided for in schedule 7, parts 1B and 1C of the TSUS, if wholly or in substantial part of cotton, wool, or man-made fiber.

In addition, the Secretary of Commerce is authorized to control under part B of title III of the bill an article which would have been classified under one of the provisions of the Tariff Schedules referred to in section 326(1) but for the inclusion of some substance or because of processing which caused it to be classified elsewhere, in a provision of the Tariff Schedules designed to embrace nontextile articles. The committee intends that this provision be used to prevent or remedy the abuse of the quotas or agreements by avoidance practices which, because of the requirements of Customs laws and interpretations, result in the article being classified as other than a textile article even though it is fundamentally a textile article in use, purpose and design. The committee understands that a possible current example of such avoidance involves the inclusion of a small quantity of asbestos fiber in a fabric made in chief weight of reused or reprocessed wool. It is claimed by importers that this wool should be classified as an article in chief value of asbestos under item 518.21 of the Tariff Schedules. Such a classification, if sustained, would remove the article from the specified coverage of part B of title III as defined in section 321. In such a situation, if the Secretary of Commerce determined that the article is, in a practical commercial sense, a wool textile fabric used interchangeably with articles classified as such by the Bureau of Customs, he could control the article under part B of title III. Prior to making this determination, the Secretary must receive the advice of the Secretary of the Treasury with regard to such classification.

Any article included in the definition, "textile article" which is admitted under item 807.00 of the Tariff Schedules or under the appendix to the Tariff Schedules is also included. Thus, an article

which, if wholly manufactured in a foreign country of foreign materials would be under quota, but which has been manufactured or assembled in part of American fabricated components and which is admitted under item 807.00 is covered by part B of title III. The committee understands that cotton textile articles entered under item 807.00 are currently subject to the LTA and to U.S. bilateral agreements thereunder.

The term category is defined as a group of textile articles or of footwear articles as defined by the Secretary of Commerce using the applicable 5- and 7-digit item numbers of the Tariff Schedules of the United States, Annotated. The committee understands that with respect to textile articles, a category system is in use at the present time as the basis for the compilation of textile trade statistics by the Department of Commerce. The committee understands that this system will be proposed for public comment and that various changes in it may be developed as a result thereof. It is recognized that the development of such a category system can affect trade levels provided for in this title and it is intended by the committee that any changes in such a system will be carefully considered and that the public will have an opportunity to comment on them prior to their adoption. Under this definition, the Secretary of Commerce may revise the category system adopted initially for purposes of part B of title III. The committee intends, however, that such revisions should be made as infrequently as practicable in light of trade conditions, recognizing the value of a continuing and consistent system. The committee notes that the category system used by the United States in its implementation of the Long Term Cotton Textile Arrangement has been revised only once since its original promulgation in 1961.

The term "produced" is defined to mean produced or manufactured, and as such incorporates the standard used in determining the country of origin of an imported article for U.S. customs purposes. Thus, in setting base levels, exemptions, or other controls "by country," part B of title III relies on the existing U.S. customs determinations of country of origin of the articles in question.

TERMINATION

(Sec. 331 of the bill)

Subpart 2 of part B provides that the title will expire at the close of July 1, 1976, unless the President extends it in whole or in part prior to such time.

The President is authorized to make such an extension for additional periods not to exceed more than 5 years at any one time if he determines that such extension is in the national interest. In making such determination, the President shall seek the advice of the Tariff Commission and of the Secretary of Commerce and the Secretary of Labor in addition to such other advice as he may wish to seek. The President is required to report to the Congress with respect to any action taken by him under this provision. Section 331(d) provides that arrangements of agreements included prior to the termination of part B of title III shall remain in effect beyond such termination date if their terms so provide, and that any regulations issued under section 322 in connection with such agreements would similarly remain in effect.

D. ANTIDUMPING AND COUNTERVAILING DUTY PROVISIONS

(Subpart 1 of Part C of Title III)

ANTIDUMPING PROCEDURES

(Sec. 341 of the bill)

Section 341 of the bill would amend procedures under the Antidumping Act to require the Secretary of the Treasury to decide, within four months after a question of dumping is properly raised by or presented to him, whether withholding of appraisement of affected merchandise should be ordered. In exceptional circumstances the Secretary may have an additional period of 90 days if he publishes the reasons for this extra time within 60 days after receiving a complaint. It is intended that this "extra" time would be used by the Secretary only in extraordinary circumstances in which the case is so complex that it would be impossible to make a reasonable determination within only 4 months. The significance of withholding of appraisement is that, if there is later a finding of dumping, the assessment of dumping duties is effective as of the date of withholding. If the Secretary's decision is affirmative, it will be published in the Federal Register and the withholding of appraisement made effective to affected merchandise entered, or withdrawn from warehouse, for consumption on or after the date of publication of that notice in the Federal Register.

If the Secretary's decision is negative, it too will be published in the Federal Register. A negative decision in this respect will be accomplished by a tentative determination that the merchandise is not being or likely to be sold below its fair value. The bill provides that, within a period of up to three months after the tentative negative determination is published, the Treasury Department may order the withholding of appraisement if it has reason to believe or suspect that sales below fair value are taking place. Alternatively, the Treasury Department will publish a final negative determination of sales at less than fair value. Under the Treasury's present practice and that contemplated in the future, interested persons are given an opportunity to request an informal hearing on the merits of a withholding of appraisement or a tentative negative determination.

The committee is informed that the Treasury regulations will be amended to provide that the Commissioner of Customs will decide, within 30 days after the information is first received, whether or not a formal investigation regarding alleged dumping should be opened. If he decides that a formal investigation should be opened, he will publish a notice to that effect in the Federal Register. The date of publication will constitute the date on which the question of dumping is raised or presented and trigger the commencement of the four-month period within which the Secretary must decide in the first instance whether or not to order the withholding of appraisement.

The foregoing changes will impose specific time limitations on the Treasury Department within which it must make a decision regarding sales below fair value. This is in sharp contrast with present procedures where such decisions sometimes take two years or even longer.

The committee recognizes that substantial Customs manpower will be needed to carry out the provisions of the committee's amend-

ments. Present preliminary estimates by Treasury call for about 40 more expert technicians, plus additional supporting personnel and the funding required for necessary office space, equipment, allowances for foreign and domestic travel and similar incidental administrative expenses. Moreover, extensive planning will be necessary to permit an orderly implementation of these amendments. For these reasons, your committee has determined that the amendments made by section 341(a) should not be effective until 180 days after the date of enactment of the bill.

The committee feels that these new abbreviated procedures are essential to effectively protect American industry from dumping. Under the current Treasury procedures which make possible long, drawn-out dumping investigations, the affected U.S. industry may be irreparably damaged before the dumping is halted. The committee, therefore, considers it imperative that the time taken by the Treasury in connection with its antidumping investigations be reduced.

At the same time the committee considers it important that procedures not be abbreviated to such a degree that would prevent the Treasury Department from reaching a sound and well-based decision. Deadlines for furnishing information, and rebutting information furnished, whether by American producers, foreign manufacturers or American importers will in many instances create hardships, but nevertheless will have to be adhered to strictly. If the Treasury fails to receive requested information within the prescribed time limits, it will be compelled to act on the basis of the best information available to it. The committee recognizes this as a price that will have to be paid for the changes in antidumping investigation procedures called for in the present bill. It is the opinion of the committee that the abbreviated procedures provided for in the bill represent a reasonable compromise of the interests involved.

Section 341(b) would adopt in the law the substance of the existing Treasury Department practice, as reflected in section 153.3(b) of the Treasury regulations (19 CFR 153.5(b)), under which decisions regarding dumping are made with respect to merchandise from State-controlled economy countries. From time to time, a case arises in which the information indicates that the economy of the country, from which the merchandise is exported, is controlled to an extent that determinations cannot be made in accordance with the usual technical rules. The amendment would confirm the Treasury practice under which the Secretary makes the necessary dumping determinations with respect to State-controlled economy countries based on prices at which such or similar merchandise of a non-State-controlled economy country is sold either for consumption in its home market or to other countries, or based on the constructed value of such or similar merchandise in a non-State-controlled economy country.

The committee also amended section 210 of the Antidumping Act to provide domestic producers with the same rights to judicial review in the Customs Courts that are afforded to importers under existing law.

Importers involved in antidumping proceedings have the right under section 210 to judicial review, in the Customs Court and the Court of Customs and Patent Appeals, of both dumping determinations by the Treasury Department and injury determinations by the Tariff Commission. This right of review has been frequently used by

importers, and in fact the Customs Courts have accepted jurisdiction in a number of cases for review of Treasury Department and Tariff Commission antidumping determinations.

On the other hand, the domestic industries involved in antidumping cases do not have such a clear right to judicial review in the Customs Courts. The law appears to limit such review to importers. Further, the Federal Courts have concluded that they lack jurisdiction to review an antidumping determination by the Secretary of Treasury. *North American Cement Corp.* v. *Anderson*, 284 F.2d 591 (D.C. Cir. 1960).

In hearings on the International Antidumping Code before the Senate Finance Committee in June 1968, the General Counsel of the Treasury Department and the General Counsel of the Office of the Special Trade Representative suggested that judicial review might be available to domestic industries under the existing law, although this was not clear. In a memorandum submitted by the Executive Branch in connection with the hearings, it was stated that:

> It cannot be stated categorically that the Customs Courts would or would not have jurisdiction over actions brought by domestic producers to challenge the consistency of the Code with the Act. As far as we are able to determine, no domestic producer has ever attempted to invoke the jurisdiction of the Customs Court under 19 U.S.C. 1516 in a dumping proceeding. The court, therefore, has never had occasion to pass on the question of jurisdiction.
>
> Absent a decision by the Customs Courts on the issue, however, there is no apparent reason to doubt that the court does have such jurisdiction, bearing in mind the issue of consistency of the Code with the statute would raise questions relating to whether the administrative action was taken within the framework of the statute. Section 210 of the Antidumping Act, 1921, itself appears to provide that the Customs Courts shall have the same jurisdiction, powers, and duties in connection with appeals and protests relating to dumping duties as those courts have in the case of appeals protests relating to customs duties under existing law. And section 516 of the Tariff Act of 1930 (19 U.S.C. 1516) gives domestic producers the right to contest in the Customs Courts administrative decisions relating to appraised value and classification of imported merchandise. (Hearings page 191.)

In any event, it is considered desirable by the committee to clarify that judicial review is available to a domestic industry in an antidumping proceeding. Judicial review is provided to both parties in practically every other statute involving an administrative determination and administrative relief.

Countervailing Duty Procedures

(Sec. 342 of the bill)

Section 342 of the bill would amend section 303 of the Tariff Act of 1930 in a number of important respects. Section 303 is the statute under which the Secretary of the Treasury determines whether imported foreign articles receive a "bounty or grant." The Secretary is

required to ascertain and determine, or estimate the net amount of any bounty or grant, and is required to declare the net amounts so determined and order the imposition of countervailing duties.

Although the present statute is mandatory in terms, it does not compel the Secretary to act within any specified period of time. The committee's amendment to the existing law would impose on the Secretary of the Treasury the responsibility to make his determinations as to whether a bounty or grant exists within twelve months after the question is presented to him.

Existing Treasury regulations call for certain types of information to be presented by a person who alleges that an imported article is receiving a bounty or grant. The regulations provide that such communications should include a full statement of the reasons for the belief that a bounty or grant is being paid or bestowed, a detailed description or sample of the merchandise and all pertinent facts obtainable as to any bounty or grant alleged to be paid or bestowed with respect to the merchandise. The regulations go on to provide, among other things, that the Commissioner of Customs will review the information submitted, and if he determines that it is patently in error, he will so advise the person who submitted it and close the case: otherwise he will proceed with an investigation.

The committee is advised by the Treasury Department that its regulations will be amended to require the Commissioner of Customs to determine, within 30 days after the information is first received, whether the information submitted is adequate under the regulations to enable Customs to proceed with the matter. The new regulations will also provide that the person submitting the information will be advised in writing within the 30 days whether or not Customs will proceed with the inquiry. If the information submitted is inadequate, Customs' advice to the person furnishing it will include a statement of the reasons why. The date of affirmative advice would be "the date on which the question is presented" for purposes of triggering the commencement of the 12-month period within which the amendment would require the Secretary to act.

The 12-month limitation would be applicable only with respect to questions presented on and after the date of enactment of the bill. Any inquiries relating to the application of countervailing duties which are already pending in the Treasury Department on the date of the enactment of the bill will not be affected by the 12-month limitation for action. However, the Treasury Department has agreed to make all reasonable efforts to proceed with such inquiries as promptly as possible.

The present statute is mandatory, in that the Secretary is required to apply countervailing duties to *dutiable* merchandise which benefits from a bounty or grant. Section 302(a) would extend the provisions of the statute to nondutiable items. However, in the case of nondutiable items, there will be an additional requirement of a determination by the Tariff Commission that an industry in the United States is being, or is likely to be, injured, or is prevented from being established, as a result of the importations benefiting from the bounty or grant. The Tariff Commission is required under the bill to make an injury determination with respect to nondutiable imports within three months after the initial determination by the Secretary of the Treasury that a bounty or grant is being paid or bestowed. This language con-

ferring jurisdiction on the Tariff Commission was derived verbatim from the Antidumping Act, 1921, and is intended to have the same meaning.

There is no requirement in the existing statute that a U.S. industry be injured as a result of imported foreign merchandise benefiting from a bounty or grant before countervailing duties are to be imposed. The committee determined that there should continue to be no such requirement at this time with respect to *dutiable* imports.

The bill also provides for suspension of liquidation in the event the Secretary of the Treasury determines a bounty or grant exists with respect to nondutiable imports. The suspension would take effect with respect to merchandise entered, or withdrawn from warehouse for consumption, on or after the 30th day after publication in the Federal Register of the Secretary's determination of the existence of a bounty or grant. The significance of this suspension is that if there is later a determination of injury by the Tariff Commission, the subsequent countervailing duty order, requiring the assessment of duties equivalent to the amount of the bounty or grant, issued by the Secretary of the Treasury following the Tariff Commission's determination of injury, would be effective as of the date of suspension of liquidation.

Section 342 of the bill also provides that all determinations by the Secretary with respect to the existence of a bounty or grant and all determinations by the Tariff Commission with respect to injury will be published in the Federal Register. Under the current Treasury practice, countervailing duty orders become effective 30 days after publication in the Customs Bulletin. Accordingly, this new provision will advance by two or three weeks the date orders become effective by avoiding present printing lead time lags in publication of the Customs Bulletin.

As under existing practice countervailing duty orders issued by the Secretary of the Treasury with respect to dutiable items will apply to items entered or withdrawn on or after the 30th day after publication of the Secretary's affirmative determination of the existence of a bounty or grant. Such orders will so apply in the case of nondutiable items if an affirmative determination is made with respect to such items by the Tariff Commission under new section 303(b).

The committee amendment to the existing law would also add a new subsection (d) to section 303 of the Tariff Act having the effect of giving the Secretary of the Treasury some discretion in applying the countervailing duty law to an article which is subject to quota restrictions or to an article whose exportation to the United States is limited by an arrangement or agreement entered by the Government of the United States. The bill provides that no countervailing duty shall be imposed on such an article unless the Secretary determines, after seeking information and advice from such agencies as he may deem appropriate, that such quantitative limitation is not an adequate substitute for the imposition of the countervailing duty.

For purposes of the discretionary authority under the new subsection (d), the Secretary of the Treasury will make his determinations on an article-by-article basis, and not on the basis of overall class. For example, if dairy products as a class are subsidized by a particular country but all products in such class are not subject to U.S. quota restrictions, the discretionary authority under subsection

(d) would be applicable only with respect to the dairy products described in the U.S. quota provisions of part 3 of the appendix to the TSUS. Thus, in the case of a quantitative limitation on a subsidized article which applies only if the price of the article does not exceed a stipulated value, the discretionary authority of the Secretary would not be applicable to imports of such article in cases where the price exceeds the stipulated value.

The committee recognizes that applicability of the countervailing duty law on a mandatory basis to foreign articles benefiting from the payment or bestowal of a bounty or grant by developing countries may present a special problem requiring further consideration. It plans to examine this question at a later date in connection with a general review of problems affecting the developing countries.

The committee is also aware of the Supreme Court cases, and a recent Customs Court case which has interpreted the words "bounty" or "grant" to apply to virtually all subsidies, including the rebate of indirect taxes. The committee has requested in section 361 of this title, a thorough study of the border tax—export rebate system of the European Economic Community with particular reference to U.S. countervailing duty laws.

The committee's amendments preserve the authority of the Secretary to meet situations where the net amount of a bounty or grant changes from time to time. As under present law the Secretary, having once determined that a bounty or grant exists and having declared the net amount of the bounty or grant, will continue to be authorized to order appropriate changes in the net amount, making the changes effective as the facts of the particular case dictate. For example, under present law there is no requirement that changed amounts of bounties or grants be made effective only after a 30-day delay. To the contrary, the changed net amount, whether an increase or decrease, would become effective as of the time the change occurred.

Similarly, in a situation where the Secretary has determined that nondutiable merchandise benefits from a bounty or grant and the Tariff Commission has made an affirmative determination of injury in the case, and countervailing duties are being assessed, if subsequently the amount of the bounty, and therefore the amount of the countervailing duty changes, the Secretary is not required to refer the matter again to the Tariff Commission for a further injury determination. Instead, the countervailing duties may be assessed and collected at the new rate.

The committee has determined that the effective date of the provisions of the bill amending the countervailing duty procedures should be the date of enactment of the bill.

E. TARIFF COMMISSION

(Sec. 351 of the bill)

The Tariff Commission, which was established in 1916, is a permanent independent nonpartisan body whose principal function is to provide technical and fact-finding assistance to the Congress and the President upon the basis of which trade policies may be determined. The committee strongly believes in the need to prevent the Commission from being transformed into a partisan body. For this reason

the committee preserved the present membership of the Commission at six, no more than three of whom can be of any one political party. The committee emphasizes that the Commission and its staff must be selected on the basis of merit. In this connection, the committee calls attention to the provision in section 330(a) that—

> No person shall be eligible for appointment as a commissioner unless he is a citizen of the United States and, in the judgment of the President, is possessed of qualifications requisite for developing expert knowledge of tariff problems and efficiency in administering the provisions of Part II of this title.

In addition, the committee finds that it is imperative that measures be taken at once to strengthen the Commission not only in the interest of assuring adequate staff and facilities to handle its current work load which is increasing considerably, but also to prevent its inevitably being overwhelmed by the additional responsibilities imposed upon it by this bill. From testimony received in the public hearings, from discussions in executive session, as well as from other evidence, it is manifestly clear to the committee that, in making policy determinations respecting trade, the Congress and the Executive are far too often severely handicapped by the lack of the requisite relevant background information.

As indicated, the Tariff Commission was created by the Congress, for the very purpose of assisting the Congress and the Executive in their determinations with respect to foreign trade policy. The broad jurisdiction of the Commission in regard to the international trade of the United States is shown by section 332(b), Tariff Act of 1930, which provides—

> The Commission shall have power to investigate the tariff relations between the United States and foreign countries, commercial treaties, preferential provisions, economic alliances, the effect of export bounties and preferential transportation rates, the volume of importations compared with domestic production and consumption, and conditions, causes, and effects relating to competition of foreign industries with those of the United States, including dumping and cost of production.

Due to budgetary restrictions over a period of years, the Commission is not adequately staffed or equipped to exercise even in a modest way its statutory investigative powers. The committee notes with concern, for example, that, notwithstanding the fact that trade and trade problems are at a historic high point with resulting increased demands upon the Commission, its staff has been undergoing a systematic attrition by 28 percent since 1966 (from 278 to 200). This staffing contrasts with an average of 315 in the five-year period 1931–35 when imports under the Tariff Act of 1930 were at their lowest point. The consequences of this strict budgetary policy has been low staff morale, loss of staff by resignations and transfers, and extreme difficulties in recruiting. Consequently, the committee amendment identifies the Tariff Commission more closely as a Federal agency independent from the executive departments thus placing its budget authority directly under control of Congress, and removing the possi-

bility of its being reorganized by Executive action. Under the committee amendment there would be no change in the President's authority to appoint Commissioners, by and with the advice and consent of the Senate, in the duties or functions of the Tariff Commission, or in the right of the executive branch or the Congress to call upon the Commission for special studies or investigations. Nor would there be any change in the application of other existing provisions of law, including section 331(b) of the Tariff Act of 1930, which relates to the status of Commission employees under the civil service law.

The committee strongly believes that the only way to preserve the strict "independence" of the Commission from unwarranted interference or influence by the executive branch is to place its budget directly under the control of the Congress. In this regard, the committee had asked the General Accounting Office to study the Tariff Commission. The GAO report indicated that at the very time when its workload was increasing sharply, the Bureau of the Budget was severely cutting back on the Commission's requests to Congress. At the same time, the executive was adding tremendously to the workload of the Commission by requesting long and complex studies. It would appear that the executive branch has placed a low premium on the value of the Tariff Commission in its budget request, but a high premium on the Commission's ability to make the thorough studies and investigations in the face of a cutback in personnel. This appears contradictory.

In the interests of establishing a career-type service for professional employees of the Commission and to enable the Commission to be competitive with other agencies in hiring its staff, the committee is of the view that the Commission should be allocated a reasonable number of super grade positions and should be provided with sufficient funds to the end that the Commission will have adequate staff, grade, structure, and facilities to carry out its assigned duties.

The enactment of the Trade Act of 1970 would add considerably to the Commission's workload. The relaxation of the criteria for tariff adjustment and for adjustment assistance for firms and workers will undoubtedly lead to numerous petitions being filed for investigations by the Tariff Commission. This legislation is expected to greatly increase the Commission's investigative workload and many of its investigations must be performed within strict time deadlines.

The intelligent formulation of trade policy by the executive and the legislative branches is impossible without the development of the factual data on which these policies are based. The Tariff Commission is the agency primarily charged with this responsibility, and with staff expertise and continuity of personnel is ideally suited to do so. Additionally, the Tariff Commission, through its hearing procedures, adjudicates cases of utmost importance to the parties concerned as well as the Nation. Performance of these responsibilities in accordance with the highest professional standards is absolutely essential. The committee therefore strongly emphasizes the need to provide the Tariff Commission with the adequate staff and facilities to meet this high standard.

In connection with its oversight review of U.S. foreign trade policies, the committee's bill directs the Tariff Commission to undertake studies on certain important issues relating to U.S. trade policy. (See Section 362.)

F. STUDIES OF UNITED STATES TRADE POLICIES

Comprehensive Study by the President

(Section 361)

There is no statutory recognition of GATT. The Executive never submitted the GATT to the Congress either for its advice and consent or for implementing legislation. United States participation is through the signing in 1947 of the "Protocol of Provisional Application." In trade agreement authorizations the Congress has often put a disclaimer regarding GATT; e.g., "The enactment of this Act shall not be construed to determine or indicate the approval or disapproval by the Congress of Executive Agreement known as the General Agreement on Tariffs and Trade". The United States share of GATT expenses currently comes through the contingency fund of the Department of State.

The committee strongly believes that a direct appropriation for the United States share of GATT expenses sought by the Executive would be a direct recognition of the GATT agreement, including the possible interpretation that in such a recognition, Congress is expressing its approval of GATT provisions and interpretations. Consequently, the Committee deleted a provision from the House version of the Trade Act of 1970 which would have authorized the United States share of GATT expenses.

There are a number of outstanding problems in the field of international trade which require intensive study.

The presently constituted GATT Agreement contains certain provisions that were written in 1947 when the United States had an overwhelmingly dominant position in world trade. Some of these provisions were designed to put dollars into the hands of the then war-torn European countries. In 1947 we had a $10 billion trade surplus, and $25 billion in gold with only $7.6 billion in liquid foreign claims against that gold; in 1970 our trade surplus has virtually disappeared, our gold stock has been reduced to about $11 billion, and foreigners have $42 billion in liquid claims against our remaining gold stock. In the light of the changed international economic conditions since 1947 the committee questions whether these provisions offer the United States full reciprocity in international trade. For example, the GATT permission to rebate "indirect" taxes on exports and to apply border taxes on imports in the case of "indirect" taxes, but to deny comparable treatment for "direct" taxes (such as the U.S. income tax) is an example of lack of balance and reciprocity in the agreement.

In addition, the GATT appears to allow European countries to enter into special commercial arrangements with other countries in violation of the most-favored-nation principle. The GATT fails to adequately deal with the question of agricultural trade.

Studies on GATT.—Therefore, the committee requests the Executiye to do a thorough study of all GATT provisions by December 31, 1971. Such a study would include, but not be limited to—

(1) The most-favored-nation (MFN) principle and the exceptions thereto; their effect of MFN exceptions on intra-regional and extra-regional trade where common markets and free trade areas are concerned;

(2) The GATT provisions and interpretations on export subsidies and border taxes, the rationale underlying the differing treatment of "direct" and "indirect" taxes insofar as border tax adjustments are concerned, and the U.S. negotiating position on border tax adjustments;

(3) The adequacy of GATT provisions dealing with agriculture;

(4) The adequacy of the balance of payments exceptions in Article XII of GATT;

(5) The GATT provisions on unfair trade practices, fair international labor standards, and relief from injurious imports;

(6) The GATT provisions on "compensation" and "retaliation".

Other Important Trade Issues.—In addition to the above study of GATT provisions the Committee requests a detailed study by the Executive by December 31, 1971, of its plans for negotiating the elimination (or reduction) of foreign nontariff barriers including:

(1) The quantitive restrictions that remain in effect in many countries such as Japan;

(2) The common agricultural policy of the EEC;

(3) The border tax-export rebate system of the EEC, and the reasons why indirect tax rebates on exports are not considered "bounties or grants" within the meaning of the countervailing duty statute as interpreted by Supreme Court cases.[2]

(4) Discriminatory government procurement policies;

(5) The probable effects of British entry into the Common Market on U.S. trade and balance of payments;

(6) The effect of foreign exchange-rate changes on United States trade and tariff concessions; and

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[2] The case of Nicholas and Co., v. U.S. (G. S. Nichols & Co. v. United States 249 U.S. 34 (1919) represent a landmark decision in the area of countervailing duties. The question in the Nicholas case was whether a certain sum of money paid by the British government to its exporters on the exportation of certain British alcoholic spirits amounted to a direct or indirect bounty or grant under the terms of paragraph E of § 4, Tariff Act of 1913.

"The statute was addressed to a condition, and its words must be considered as intending to define it, and all of them—'grant' as well as 'bounty'—must be given effect. If the word 'bounty' has a limited sense, the word 'grant' has not. A word of broader significance than 'grant' could not have been used. Like its synonyms 'give' and 'bestow,' it expresses a concession—the conferring of something by one person upon another. And, if the 'something' be conferred by a country 'upon the exportation of any article or merchandise,' a countervailing duty is reqnired by paragraph E of Section IV of the Tariff Act of 1913]."

"We have the fact of spirits able to be sold cheaper in the United States than in the place of their production, and this the result of an act of government because of the destination of the sporits being a foreign market. For that situation Paragraph E was intended to provide." (At pages 39-40.)

In the decision of the Court of Customs Appeals in the same case (*Nicholas & Co.*, v. *United States*, 7 Ct. Cust. Appls. 97), that court, after commenting upon the clarity of the language and purpose of the statute said:

"There is nothing obscure, abstruse, mystic, or even ambiguous about this language, which has been as to the particular words, a part of all our tariff acts from 1897 to and including the present act. Section 5, tariff of 1897 (30 Stat. L., 151), section 6, tariff act of 1909 (36 Stat. L., 11), paragraph E of section 4, tariff act of 1913 (38 Stat. L., 114). Its plain, explicit, and unequivocal purpose is: Whenever a foreign power or dependency or any political subdivision of a government shall give *any aid or advantage* to exporters of goods imported into this country therefrom *whereby they may be sold for less in competition with our domestic goods*, to that extent by this paragraph the duties fixed in the schedule of the act are increased. It was a *result* Congress was seeking to equalize regardless of whatever name or in whatever manner or form or for whatever purpose it was done. The statute interprets itself as a member of an act calculated to maintain an accorded protection. incidental or otherwise, as against payments or grants of any kind by foreign powers, *resulting* in an equalization thereof to any extent directly or indirectly. Wherefore, in obedience to that obvious purpose, the court does not feel at liberty to adopt any constrained or technical definitions of the words 'bounty' or 'grant' suggested, but to vouchsafe the paragraph a meaning, well within its lanaguage, that will best effectuate the unquestioned congressional purpose." (at page 106).

Other Supreme Court decisions have spoken with equal clearness on the subject. The *Downs* case involved a bounty paid upon the exportation of sugar by the Russian government. The court cited examples of what may constitute a bounty within the meaning of the countervailing duty statute:

"A bounty may be direct, as where a certain amount is paid upon the production or exportation of particular articles, of which the Act of Congress of 1980, allowing a bounty upon the production of sugar, and Rev. Stat. sections 3014-3027, allowing a draw-back upon certain articles exported, are examples; or *indirect, by the remission of taxes upon the exportation of articles which are subjected to a tax when sold or consumed in the country of their production, of which our laws, permitting distillers of spirits to export the same without payment of an internal revenue tax or other burden, is an example.*"

Further:

"When a tax is imposed on all sugar produced, but is remitted upon all sugar exported, then, by whatever process, or in whatever manner, or under whatever name it is disguised, it is a bounty upon exportation."

(7) An analysis of whether or not greater flexibility in foreign exchange rates would serve in the interests of United States and world trade;

(8) The nature and extent to which other countries subsidize their exports, directly or indirectly;

(9) A comparative analysis of various proposals to extend tariff preferences to the products of less developed countries with particular emphasis on the effects on U.S. trade and investment patterns and on U.S. labor.

(10) The various agency responsibilities within the executive branch for handling all U.S. foreign trade matters, and the means by which policy coordination is achieved.

Tariff Commission Studies

(Sec. 362 of the bill)

Section 362 of part C of title III requests certain studies by the Tariff Commission by December 31, 1971. These include:

(1) The tariff and nontariff barriers among principal trading nations in the industrialized countries, including an analysis of the disparities in tariff treatment of similar articles of commerce by different countries and the reasons for the disparities;

(2) The nature and extent of the tariff concessions granted in trade agreements and other international agreements to which the United States is a party by the principal trading nations in the industrialized countries;

(3) The customs valuation procedures of foreign countries and those of the United States with a view to developing and suggesting uniform standards of custom valuation which would operate fairly among all classes of shippers in international trade, and the economic effects which would follow if the United States were to adopt such standards of valuation, based on rates of duty which will become effective on January 1, 1972; and

(4) The implications of multinational firms on the patterns of world trade and investment and on United States trade and labor.

G. MISCELLANEOUS AMENDMENTS

(Subpart 4 of Part C of Title III)

Amendments to the Automotive Products Trade Act of 1965

(Section 371)

The committee has also amended the special adjustment assistance provisions of section 302 of the Automotive Products Trade Act of 1965. The time for filing petitions under these provisions expired at the close of June 30, 1968. The amendment, in effect, restores, without a specific termination date, the authority for filing petitions by firms and groups of workers for a determination of eligibility to apply for adjustment assistance. These determinations are related to dislocations resulting from the operation of the U.S.-Canadian Automotive Products Agreement.

Special assistance provisions were established in the Automotive Products Trade Act because of the unique characteristics of the U.S.-Canadian Agreement. The agreement required immediate elimination of duties on new vehicles and original equipment parts imported into the United States. It was recognized that dislocations would result not only from increased imports but also from decreased exports, and from shifts in production and supply sources both within each country and between the two countries.

Since the act was passed, trade in automotive equipment has increased markedly and steadily indicating that the process of rationalization of the North American industry was of major magnitude. Adverse employment effects in the United States which may have been attributable to development under the agreement in the first years were largely masked by the general increase in employment in the U.S. automotive products industry, although there were a number of cases where assistance was provided to groups of workers under the transitional adjustment assistance. The authority to petition for such assistance under the act terminated on July 1, 1968. Problems of worker dislocation may continue to arise. On the strength of more than four years of experience during the existence of the U.S.-Canadian Agreement the committee believes that it would be prudent to provide the means of responding to such dislocation.

The committee has also changed the existing standard of "the primary factor" as the required causal link between dislocation and the operation of the agreement to conform to the more liberal standard contained in the Trade Expansion Act as amended by H.R. 18970. The committee has substituted "a substantial factor" in place of "the primary factor" in sections 302 (c), (d), and (g) of the Automotive Products Trade Act of 1965. This new standard will apply to all petitions filed after the date of enactment of this Act including petitions with respect to dislocations which began after June 30, 1968. The committee, however, included a requirement that petitions with respect to dislocations which began after June 30, 1968, and before July 1, 1970, must be filed on or before the 90th day after the date of enactment of this act.

U.S.-Canadian automotive agreement. The committee expects that urgent attention will be given by our Government to the attainment of the agreement's objectives. While our automotive exports to Canada have multiplied, imports have grown even more rapidly, and our bilateral surplus in this sector has disappeared.

The committee has noted that no steps have been taken which will assure attainment of the objective of the agreement of allowing market forces to determine the most economic pattern of investment, production, and trade. For example, although the retail price differential between automobiles in the United States and Canada has been reduced, prices remain higher in Canada. The failure to eliminate the price differential is a consequence of the fact that under terms of the agreement market forces have not yet been allowed to operate freely. In this regard, the committee notes with concern that nearly six years after the agreement was signed the Canadian duty remains virtually unchanged and Canadian citizens still cannot import automobiles duty-free from the United States, although there is no such restriction on imports from Canada. This Canadian restriction and other conditions frustrate the achievement of the free-trade objectives of the

agreement. They artificially permit the continuation of a price differential and interfere with commercial decisions in an industry in which it has been agreed that market forces would be allowed to operate freely.

The Committee noted that in the latest annual report of the President on the operation of the Automotive Products Trade Act of 1965, the President stated:

"Complete realization of the objectives of the Agreement has been impeded by the continued existence of the restrictions to the free flow of trade set forth in Annex A. (This Annex specifies the Canadian duties and other restrictions.) As stated in the Third Annual Report, developments in the trade in automotive products between the two countries indicate these restrictions have served their purpose. Accordingly in 1969 the United States initiated discussions with Canada for the purpose of eliminating the restrictive measures. . . . To date the two governments have been unable to agree on the specific conditions under which the transitional restrictions in Annex A would be eliminated."

The Committee also noted that the U.S. trade balance in automobiles and parts with Canada has deteriorated from a surplus position of $658 million in 1965 to a deficit of $686 million in 1969, a deterioration of over $1 billion since the Agreement was signed nearly six years ago.

Consequently, the committee has added an amendment to the Automotive Products Trade Act of 1965 which provides that the President shall endeavor to secure elimination by the Government of of Canada of its duties and other import restrictions on automobiles produced in the United States. If the elimination of such duties and import restrictions has not been secured before January 1, 1973, the President shall consider the failure to secure such elimination grounds (1) for terminating U.S. participation in the agreement and (2) for exercising the authority conferred on him by section 204 of the Automotive Products Trade Act of 1965 to terminate proclamations issued under such act.

Rates of Duty on Mink Furskins; Repeal of Embargo on Certain Furs

(Sec. 372 of the bill)

Section 372 of the bill establishes separate provisions under which a tariff-rate quota system is imposed on furskins of mink whether or not dressed.

The mink growers have been adversely affected by imports of mink furskins principally from Scandinavia and Canada. At the present time, the demand for mink has declined and domestic production and imports are declining. The number of domestic ranchers is also declining. One of the largest auction houses, that provided substantial assistance to mink ranchers, has recently gone out of business. The serious decline in the domestic industry is a cause for real concern.

Under the Senate amendment the aggregated annual quota quantity is established at 3.6 million skins. This quota quantity is, approximately equal to the volume of skins imported in 1969. The amendment is designed to assist domestic producers in their efforts to rebuild the market for mink.

Imports of mink furskins within the tariff-rate quota quantity will continue to be dutiable at existing rates of duty (a zero rate of duty applies today to raw skins) except that such skins raw or undressed the product of Communist countries will become dutiable at the rate of 30% ad valorem under the Senate amendment. Under the provisions of the House-passed bill, in determining the number of skins and pieces of skins for quota purposes, each of the individual pieces assembled into a plate, mat, lining, strip, cross, or similar form would be counted. The committee found that this would be too restrictive with respect to certain of these plates, etc., made wholly from trimming scrap pieces of mink furskins, and therefore excluded from the tariff-rate quota provisions, trimming scrap pieces of mink, and plates, mats, linings, strip, cross, etc., made from such trimming scrap.

In each calendar quarter when the quota has been filled, mink furskins would become dutiable for the rest of that calendar year at the rate of 25 percent ad valorem if imported from non-Communist countries and at the rate of 40 percent if imported from Communist countries. The bill would make the current rates of duty on certain wearing apparel of mink in schedule 7, part 13, subpart B, of the TSUS permanent rates of duty. Thus, the rates of duty on dressed mink furskins (dyed and not dyed) and on wearing apparel of mink, scheduled to be further reduced during the next two years under the Kennedy Round trade agreement, would be frozen at their present levels.

In agreeing with the House-passed provision which would repeal the existing embargo on certain furs from Russia and China (ermine, fox, Kolinsky, marten, muskrat and weasel), the committee's bill would apply a rate of 30 percent ad valorem to these six furs, when raw and undressed, the product of designated Communist countries. As previously indicated, mink fur skins from such countries would also be dutiable at 30 percent ad valorem as well as being subject to the tariff-rate quota provisions.

Rate of Duty on Glycine and Certain Related Products

(Sec. 373 of the bill)

Section 373 of the bill establishes separate provisions under which a tariff-rate quota system would be imposed on aminoacetic acid (glycine) and salts thereof and certain mixtures of such acid or its salts.

This provision is designed to give special relief to an industry which is adversely affected by persistent dumping practices engaged in by foreign competitors. By reason of such practices, imports increased their penetration of the U.S. market from 25 to 70 percent during the period 1964–67, inclusive. Two of the three domestic producers have stopped production. The cessation of dumping by virtue of action taken under the Antidumping Act, 1921, has provided no relief for the damage already done to domestic producers.

Under the tariff-rate quota system, importers would still be allowed to import at the existing level with no increase in the current rate of duty. Imports in excess of this quantity, however, would be subject to an additional duty of 25 cents per pound. It is expected that this provision would allow domestic producers to recover from the damage

caused by the dumped imports because of the advantage it would give them in producing to meet the increasing demand in the United States for this product.

The rates of duty on both the imports which are within the quota and those which are over-quota would become permanent statutory rates. Thus, they would not be subject to further reductions under the Kennedy Round trade agreement.

Parts of Ski Bindings

(Sec. 374 of the bill)

Section 374 of the Committee's bill would reduce the statutory duty on parts of ski bindings (TSUS item 734.97) from 11 percent ad valorem to 3 percent ad valorem. This amendment is intended to preserve the competitive position of domestic ski manufacturers who import foreign made parts of ski bindings.

Invoice Information

(Sec. 375 of the bill)

The committee is concerned that the official data collected and published with respect to U.S. imports, production, and exports are not adequate to meet the current and expanding needs of U.S. foreign trade policy. Basic to the problem is the fact that the various classification systems under which imports, production, and exports are collected are not generally concordant. These trade data are collected and published by a number of Federal agencies such as the Bureau of the Census, Business and Defense Services Administration, Bureau of International Commerce, Department of Agriculture, Bureau of Mines, Fish and Wildlife Service, Bureau of Customs, and the Tariff Commission.

The committee believes that it is important that the aforementioned trade data be collected and published regularly on a current basis and that they be accurate and in such detail as to be reasonably compatible with their anticipated uses in trade analysis and policy making. With a view to achieving this end, the committee urges each of the responsible government agencies to undertake promptly a review of its statistical programs and to institute at the earliest practicable time, under the coordination and guidance of the Office of Management and Budget, methods specifically for the purpose of establishing compatible classification systems for U.S. imports, production, and exports. It is recognized that the Bureau of the Census, which has primary responsibility for collection and publication of these statistics has for some years been issuing a report on U.S. exports and imports as related to output. This annual publication, however, is far from complete because of lack of comparability of import, production, and export data. Moreover, the publication is not current because of the lag in the availability of production data.

It is understood that methods of improving trade statistics can be developed and implemented without new legislation, except with respect to import statistics which are collected by the Bureau of Customs and reported to the Bureau of the Census for compilation and publication in accordance with the 7-digit statistical import classi-

fications of the Tariff Schedules of the United States Annotated (TSUSA). These 7-digit classifications are established by the Departments of Commerce and Treasury and the Tariff Commission under authority of section 484(e) of the Tariff Act of 1930.

The customs entry form and its supporting invoice, which are filed by the importer or his broker with customs officers at the port of entry, are the basis for all import data collected at the time of entry. Customs officers have traditionally regarded their primary responsibility as being the enforcement of customs laws and the protection of the customs revenue. With the increasing workload and limited staff, the collection of trade data has become a secondary function. As a result import statistics do not receive proper attention from customs officers, foreign exporters, importers, and brokers.

The committee believes that the enforcement of the statistical requirements for imports, as set forth in the statistical headnotes and 7-digit classifications of the TSUSA, is a primary responsibility of customs officers and should be given attention by them accordingly. Such enforcement would be facilitated by the enactment of section 345 of the bill which would amend section 481(a) of the Tariff Act of 1930 to require invoices to provide a product description which would enable customs officers to classify imports for statistical as well as for duty purposes.

The committee recognizes that the provisions of title III of H.R. 17550 will have a significant impact upon the Bureau of Customs, and that substantial additional staffing in customs will be necessary to assure the collection of accurate import trade data.

This new statistical requirement is in no way intended to be an impediment to trade. Rather, it is intended to provide necessary information as to trade that is taking place, to the long run interest of foreign exporting and domestic business, both importer and producer.

It is recognized that the information not previously required will entail some burden on those in the trade, at least initially. In this regard, the importer community can do much to mitigate the initial burden by informing their suppliers abroad of the types of information necessary for the purpose at hand, i.e., information sufficient to classify products according to the TSUSA.

Foreign Trade Statistics

(Sec. 376 of the bill)

Current trade statistics tend to distort and mislead the general public and foreign nations as to the true state of the U.S. international economic competitive position. U.S. export data include nonremunerative foreign aid and P.L. 480 sales, and to this extent they overstate our competitive position in world markets. Also, U.S. import data, *unlike* those of over 100 other countries, are tabulated on the basis of their value at the foreign port (free on board or f.o.b.)

The United Nations and the International Monetary Fund recommend that import data for all countries be compiled to include the cost of insurance and freight (cost, insurance and freight or c.i.f. system).

The committee amendment requires the Secretary of Commerce to publish all trade statistics to show with respect to imports: (1) The

value of imported articles in terms of their dutiable value at the foreign port (f.o.b.); and (2) the c.i.f. of such value of imports, including the costs of insurance and freight and all other handling and other costs involved in shipping and importing an article into the customs territory of the United States.

With respect to exports, the Secretary of Commerce shall state separately from the total value of all exports: (1) The value of agricultural commodities under the Agricultural Trade Development and Assistance Act of 1954 as amended; (2) The total amount of all export subsidies paid to exporters by the United States under such Act for the exportation of such commodities; and (3) the value of goods exported under the Foreign Assistance Act of 1961.

Under the Committee amendment, the Secretary of the Treasury would be responsible for collecting all information concerning shipping, insurance and other costs, and forwarding that information on a monthly basis to the Secretary of Commerce, along with the regular f.o.b. value information. The Secretaries of State and Agriculture will also collect export information relating to A.I.D. and P.L. 480 transactions, and will send those data on a monthly basis to the Secretary of Commerce. The Secretary of Commerce will be responsible for the tabulation and publication of those data which would show, with respect to all import data, c.i.f. values along with f.o.b. values, and with respect to export totals, all those exports *not* financed by A.I.D. and P.L. 480 funds and other Government grant programs.

These changes in the method of tabulating U.S. trade statistics will make U.S. trade statistics more comparable with those of foreign countries and will give a more accurate picture of the competitive position of the United States in world trade.

The committee would expect the Secretary of Treasury to fully cooperate with the Secretary of Commerce in gathering the necessary data and making it available to the Department of Commerce.

Meat Import Quotas

(Sec. 377 of the bill)

Section 377 of title III of the bill amends the meat quota provision in Public Law 88-482 to: (1) provide for a quarterly allocation of meat imports and (2) close a loophole in the present law relating to certain "prepared" beef and veal of a fresh, chilled or frozen state.

Quarterly quotas will help avoid the sharp fluctuations in imported meats which, in the past, have disrupted the United States market. These sharp fluctuations have not only disrupted domestic market conditions, but also have worked severe hardship on cattle producers in the major exporting countries. In 1968, 1969, and 1970 heavy meat imports into this country in the early part of the year caused cutbacks in exports by those nations in the latter months of those years. In 1970 the heavy imports of meat into the United States during the early months of the year threatened to exhaust the quota early in the year and served to "trigger" the more restrictive quotas under P.L. 88-482. The quotas were suspended by the President under authority granted to him by P.L. 88-482, and a voluntary restraint system was substituted. The Committee felt that quarterly quotas would have a stabilizing influence on the domestic beef cattle industry as well as on foreign cattle producers who will be able to plan their marketing on an orderly basis.

The committee also included item 107.6020 in the meat import quota provisions. This involves certain "prepared" fresh, chilled or frozen beef and veal, the imports of which during the base period (1959–1963) averaged 1.3 million pounds. It was brought to the committee's attention that earlier in 1970 certain countries began to "prepare" fresh, chilled or frozen beef, by cutting or slicing this meat into pieces, in order to avoid counting these meats against their quota allocations. This avoidance practice threatened to grow to the point where by simple manipulation of meat, an exporting country could have avoided the quotas altogether, unless the practice was stopped.

Trade With Foreign Countries Permitting Uncontrolled Production of or Trafficking in Certain Drugs

(Sec. 378 of the bill)

Under section 378 the President would be authorized to impose an embargo or suspension of trade with a nation which permits uncontrolled or unregulated production or trafficking in opium, heroin, or other poppy derivatives in a manner to permit these drug items to fall into illicit commerce for ultimate disposition and use in this country.

The committee is greatly concerned that certain countries which commercially produce poppies for pharmaceutical uses, have not adequately controlled, regulated or otherwise policed surplus poppy crops which eventually have fallen into illicit commerce in a derivative form for ultimate disposition and use in the United States.

The language in this provision is designed to give the President the authority to restrain trade with any nation which does not exhibit a willingness to control illegal production or trafficking in opium or heroin. The testimony of John E. Ingersoll, Director, Bureau of Narcotics and Dangerous Drugs, Department of Justice, established that the great preponderance of illicit heroin entering the U.S. results from diversion of Turkish produced opium and its processing into heroin in southern Europe and elsewhere in the Middle East.

We are pleased that on its own initiative, Turkey has set in train a series of actions aimed at minimizing, or eliminating, the harmful effects of Turkish opium in the world. The committee has been advised that by 1971 Turkey will have reduced to four (from 21 in 1967) the number of provinces where farmers may grow opium poppies, and that production will be limited to a more easily controlled area. The committee has also been advised that Turkey is making intensive efforts to keep its opium out of illicit channels, that the amounts should be substantially reduced this year, and that it is in the process of enacting legislation providing for better control.

It is noted that the French Government is also cooperating to bring a halt to the illicit processing and merchandizing of heroin on French territory which eventually finds its way into the United States, creating a drug-abuse problem which is controllable with this kind of cooperation from abroad. The best place to control the critical drug problem in the United States is at the source of supply.

H. PROVISIONS OF HOUSE-PASSED TRADE ACT OF 1970 NOT INCLUDED IN SENATE AMENDMENT

Certain Classification by the Secretary of Agriculture

Section 342 of the House version of the Trade Act of 1970 would have provided that the Secretary of Agriculture rather than the Secretary of the Treasury shall have the final administrative responsibility for classifying certain articles subject to import restrictions under Section 22 of the Agricultural Adjustment Act, as amended.

The committee felt that classification of imported materials was properly a function of the Bureau of Customs under the Secretary of the Treasury. Furthermore, the committee was concerned that transferring the jurisdiction for classification of certain agricultural products to the Secretary of Agriculture could lead to demands to transfer jurisdiction for classification of certain industrial products which are under import restrictions to the Secretary of Commerce. The agency administering quotas could be under severe pressure to continually change the import classification system, which could have a deleterious effect on foreign trade.

Repeal of the American Selling Price (ASP) System of Valuing Certain Imported Articles

The House version of the Trade Act of 1970 would have authorized the President to proclaim certain modifications in the Tariff Schedules of the United States resulting from two agreements concluded during the Kennedy Round relating to the application of ASP to certain chemicals, canned clams, and wool-knit gloves. Rubber-soled footwear, which is also subject to the ASP system of valuation, would not have been affected by the House provisions.

During the Kennedy Round, the Committee on Finance and the full Senate, concerned that U.S. trade negotiators would exceed the authority granted them by the Trade Expansion Act of 1962, approved a resolution which, in effect, expressed the intent that the U.S. trade negotiators should not exceed the authority granted to the President by the Trade Expansion Act of 1962. Unfortunately, the President's Special Trade Representative did not heed the advice of the Senate with respect to ASP and the International Antidumping Code. The Congress has acted to make those provisions of the International Antidumping Code which conflict with U.S. law, null and void. The committee did not feel that the Senate would be consistent if it approved an ASP agreement which it told the U.S. negotiators not to negotiate in the first place.

Moreover, the committee did not believe that the United States received reciprocity in the ASP negotiation or that the loss of jobs in the benzenoid sector of the chemical industry which would have resulted from the elimination of ASP, would have been offset by gains in employment in other sectors of the chemical industry.

Domestic International Sales Corporations

The House-passed Trade bill (H.R. 18970) contains in title IV provisions relating to a domestic international sales corporation

(DISC) designed to provide United States income tax treatment for export transactions similar to that applicable to profits derived from overseas manufacture.

The basic objective of the provision, as stated by the Administration and in the House Committee report was to eliminate the present disadvantage under Federal income tax law that exists for manufacturing in the United States for export and favors manufacturing abroad. The use of a domestic corporation as a sales subsidiary instead of a foreign corporation was said to simplify administration both for taxpayers and for the Internal Revenue Service, since it would permit books and records to be maintained in the United States in English under our own corporate laws and accounting principles.

Your committee is concerned with the income tax status of American exports as contrasted with that of goods produced abroad by foreign companies, whether or not controlled by Americans. It is also concerned with tax practices in foreign countries giving advantages to their exporters. Your committee is not satisfied, however, that the DISC proposal is the best method of dealing with any imbalance that now exists, and believes that further consideration should be given to the matter at an early date. Your committee is concerned among other matters, with the validity of the present GATT distinction in treatment of direct and indirect taxes on export and imports, and in particular with the present failure to allow any rebates on exports for corporate income taxes paid on export sales profits. The time available since the trade bill was referred to your committee has not permitted the thorough review that it considers essential to a resolution of the issues involved.

Accordingly, your committee has not included in the present bill the DISC provisions of H.R. 18970, but has deferred the subject matter for further consideration early in the next Congress. At that time the Administration and the committee staff will be asked to present studies of various alternative proposals for dealing with the subject and further comments from public witnesses will be solicited.

I. OTHER TRADE MATTERS

There are a number of trade issues on which the committee has no legislative proposal at this time, but on which the committee does have certain views.

U.S. Agricultural Exports

For some time the committee has been seriously distrubed by the agricultural policies of some of our trading partners. These policies are hurting U.S. farm product exports in two major ways. First, variable levies of the EEC countries are the most protective device ever devised, except for an embargo. They effectively shield the European market from outside competition and, when coupled with high domestic price supports, cause serious disruption of third country markets as well. U.S. exports of agricultural commodities to the European Common Market subject to the variable levy, have declined by 47 percent since 1966. And, surpluses stimulated by high prices in the protected countries are being moved into world trade channels through use of heavy subsidies.

The failure of others to mitigate the impact their agricultural policies are having on the world is a matter of deep concern. U.S. imports of competitive agricultural products over the same period have increased by 15 percent. European Community grain policies have resulted in a drop in European Community net imports from 12 million tons to less than 2 million tons over the last 3 years. This has had significant repercussions on world trade. Moves by the United Kingdom toward increased agricultural protectionism and the prospect of increased reliance on a variable levy system have also contributed to growing world agricultural isolationism. We cannot hope for a better climate until the current trends in agricultural policy are arrested. Specifically, the price of grains in Europe needs to be significantly reduced and subsidies need to be limited. The further extension of restrictionist policies to other products would be very damaging. Any impediment to access for soybeans and soybean products would be of great concern. The committee would expect the President to use every power granted to him by this and other acts, including retaliatory power of section 252 of the Trade Expansion Act to negotiate the reduction and discrimination in the variable levy system.

Voluntary Steel Arrangement

Among those industry situations reviewed by the committee in terms of rapidly increasing imports and rising proportion of domestic market accounted for by imports is the position of the domestic steel industry. The attention of the committee has been called to the fact that the voluntary arrangements entered into by the European Coal and Steel Community and Japanese steel producers are to remain in effect until the end of 1971. It is understood that these arrangements provide for annual increases in exports to the United States and involve a commitment to maintain both product and geographic distribution patterns based on trade prior to the undertaking by the foreign steel producers. We believe, based on an extensive staff study of the steel import problem, that this arrangement was necessary to forestall a serious deterioration in the domestic steel market insofar as domestic steel producers are concerned. Accordingly, it is the sentiment of the committee that the administration should endeavor to have these voluntary undertakings extended and improved in order to assure a stable domestic steel industry and an adequate supply of steel for the American economy in the future. It is hoped that the problems of international marketing of steel as recognized by the voluntary arrangement, would also be recognized by the steel industries in countries not party to the agreement, particularly those which export substantial quantities of carbon and specialty steel products to the United States. It is the Committee's view that specialty steels should be included within the terms of these voluntary agreements.

International Labor Standards

The committee is very much aware of the employment problems that can result from economic adjustments created by present trends both in imports into the United States and foreign investment decisions involving shifts of productive capacity abroad.

The huge differentials which exist between U.S. wage costs and those of many other countries pose extremely difficult competitive problems for some domestic industries, as the committee has recognized in the temporary measures provided for in title II with regard to textile and footwear. With widespread availability of technology and capital large differences in labor costs cannot easily be offset by productivity differentials.

The committee has in its amendments of the tariff adjustment provisions also provided means whereby serious injury stemming from such wage differentials can be dealt with on a temporary basis giving time for the adjustment process. For the long run, however, the committee feels that it is in the interest of trade liberalization and expansion that the trade agreements program include formal procedures under which unfair labor conditions can be dealt with.

The committee concurs with the House in the belief that the President as soon as practicable should take steps with respect to trade agreements which would lead to the elimination of unfair labor conditions which substantially disrupt international trade. Machinery should be set up in trade agreements to which the United States is a party which would include: (1) the recognition of principles with respect to earnings, hours, and conditions of employment of workers; (2) the development of a complaint procedure under which situations of unfair labor conditions affecting international trade could be brought before the parties to the agreement for appropriate remedial action; and (3) the establishment of a system of periodic reports by all parties to the agreements on earnings, hours, and conditions of employment for the workers in the exporting industries of the countries involved.

Tariff Disparities

Tariff rates vary widely from country to country on the same article of commerce. For example, the duty on automobiles in Japan and Canada is 17.5 percent ad valorem; in the European Community, it is 22 percent ad valorem and in the United Kingdom it is about 15 percent ad valorem. The U.S. duty on automobiles is only 4 percent ad valorem.

In many instances, nontariff barriers such as road taxes, border taxes, "uplift" taxes and safety standards clearly add further discrimination against American commerce. The committee has directed the Tariff Commission to do a thorough study on the tariff disparity issue, which would also investigate the tariff and nontariff barriers in each category of articles. The committee feels that the results of this study could lead to negotiating proposals which would aim at greater equality in tariff levels on a product-by-product basis for principal trading nations.

Articles Assembled Abroad With U.S. Components

The committee received a great deal of material with respect to the repeal of item 807.00 of the tariff schedules. During the period 1966 through 1969, the total value of imports under item 807.00 and 806.30, a similar provision which provides for a partial exemption from duty for U.S. articles of metal exported for processing and reimported for further processing, rose from $953 million to $1.8 billion. Such a

growth in the use of these tariff provisions is an indication of the economic force at work, particularly with regard to labor costs in labor intensive operations.

The committee recognizes that in some United States firms the provisions, which have the effect of providing a tariff preference for products containing U.S. materials, improve the competitive position of the U.S. firms vis-a-vis products of wholly foreign origin. In some respects the competitive position of the domestic firms can be improved to the extent of providing an encouragement to United States exports. On the other hand, the committee is seriously concerned that the duty advantage may have the effect of encouraging the exports of job opportunities from the United States, particularly in those operations which are labor intensive.

The President requested last year that the U.S. Tariff Commission make a study of these two provisions, and the results of that study were sent to the President on September 30, 1970. The Tariff Commission study recognized that the provision creates opportunities in both directions—increased assembly operations abroad and increased U.S. exports and employment opportunities in cases where the whole manufacturing plant would have moved abroad to take advantage of lower labor costs. As a result, the committee has determined not to propose any changes in the existing provisions. At the same time, the committee would urge that those appropriate agencies in the executive branch promptly review the Tariff Commission report and submit to the Congress recommendations as may be needed to assure that the use of these provisions will not endanger the overall job opportunities of U.S. workers, or encourage working conditions abroad inconsistent with the improvement of labor standards in the United States and in other countries.

Other Barriers to Trade

Further trade liberalization is dependent upon the dismantling of the many unjustifiable and uneconomic burdens on world commerce. The failure to deal with non-tariff barriers is threatening the basic foundation of reciprocity and what the United States believed to be a mutually beneficial exchange of tariff concessions in past negotiations. Despite continued efforts in the General Agreement on Tariffs and Trade and other internationl forums, including the OECD, and in bilateral discussions, insufficient progress is being made in reducing or eliminating such barriers to international trade. The committee has recognized this growing problem in its amendments to section 252 of the Trade Expansion Act.

There is much that can and should be done in lifting the burdens from U.S. exports, and the administration should vigorously pursue this goal in discussions with our trading partners. One of the difficulties is that the administration does not appear either to have a clear negotiating position on many of the outstanding non-tariff barriers of our trading partners, or to have a shopping list of priorities and a method of negotiating to deal with these problems.

Unlike tariffs, prior Congressional delegation of authority to the President to reduce barriers to trade, other than tariffs, is difficult to embody in legislation because these restrictions often have their roots in purely domestic concerns that are only indirectly related to

foreign trade and are imbedded in domestic laws and practices. Many such barriers would require legislative action to accomplish their removal. To some degree, the nature of such actions might not finally be clear until negotiations had shown what is possible.

In view of these difficulties, the committee does not consider it appropriate or feasible to consider legislation regarding the international negotiations on barriers to trade other than tariffs until the specific details of such legislation are clear. In this respect, representatives of the executive branch should consult with this committee and such other committees of the Congress, as may be appropriate, in the examination of possible changes in domestic law which might be called for as a result of international negotiations in order to benefit from Congressional views on the future development of acceptable standards of conduct in international trade practices. Subject to such consultation and in consideration of the subsequent enactment of any necessary implementing legislation, the President should continue to discuss with other countries the means by which barriers to trade, other than tariffs, can be reduced or eliminated.

In addition, the committee believes that the international harmonization of standards for industrial and agricultural products and the adoption of common quality assurance and certification schemes merit immediate consideration. Decisions being made oday with respect to international harmonization of product standards are extremely important to the future growth of U.S. exports. Producers, for example, can manufacture a single model that will meet the requirements of many countries instead of having to manufacture several models to meet varying national standards requirements. And mutual recognition of quality testing saves producers the expense and time involved in undergoing tests in each market. But if these arrangements are exclusive, they become trade barriers by discriminating against the product of third countries. The "Tripartite" agreement among European electrical producers appears to be such a discriminatory device. To prevent such discrimination and to fully enjoy their benefits countries willing and able to assume the responsibilities of membership should be free to join in these undertakings.

In order for the United States to effectively participate in international harmonization and certification schemes there must be full cooperation and coordination between government and industry in standard matters.

Both government and industry should now take whatever steps are necessary to ensure that U.S. exports are not denied the opportunities offered by international efforts directed toward standards harmonization and certification. In particular, this will require adequate funding of U.S. participation in international standards writing and insuring that the United States possesses the institutional facilities necessary to take part in testing and certification arrangements. The Department of Commerce is the logical agency within the U.S. Government to initiate and coordinate these efforts as they relate to industrial products.

Study of Meat Imports

With respect to the meat import situation, there appear to be some controversy as to whether there is a change in the composition of beef imports. The Tariff Commission is presently working on a

survey of markets for imported beef. Since information will be available to the Department of Agriculture from the Commission, and other sources, the committee requests that the Department of Agriculture provide it with a study on imported meat.

J. TECHNICAL EXPLANATION OF THE AMENDMENT

Section 1. Short title

Section 1 of the bill provides that the bill when enacted may be cited as the "Trade Act of 1970"

PART A—AMENDMENTS TO THE TRADE EXPANSION ACT OF 1962

SUBPART 1—TRADE AGREEMENTS

Section 301. Basic Authority for Trade Agreements

Section 301(a) of the bill amends section 201(a)(1) of the Trade Expansion Act of 1962 (hereinafter in this explanation referred to as "1962 Act") so as to extend until the close of June 30, 1975, the period during which the President may enter into trade agreements with foreign countries and instrumentalities under the 1962 Act.

Section 301(b) of the bill amends section 201(b)(1) of the 1962 Act to provide that no proclamation made by the President to carry out any trade agreement entered into during the period July 1, 1967, through June 30, 1975, may decrease any rate of duty to a rate below the lower of (1) the rate 20 percent below the rate existing on July 1, 1967 (as defined in section 301(d) of the bill); or (2) the rate 2 percent ad valorem (or ad valorem equivalent) below the rate existing on July 1, 1967.

Section 301(c) amends section 201 of the 1962 Act to provide that no proclamation pursuant to subsection (a) shall be made in order to carry out a trade agreement entered into after June 30, 1967, and before July 1, 1975, except to proclaim (1) increased or additional import restrictions or (2) such modifications as may be necessary to fulfill concessions granted as compensation for import restrictions imposed by the United States.

Section 301(d) amends sections 202, 211 (a) and (e), 212, 213(a), and 221 of the 1962 Act. These sections provided that the limits on the authority contained in section 201(b)(1) of the 1962 Act were not to apply in specified cases (so that the rate of duty could have been reduced to zero). The specified cases were articles having a 1962 rate of duty of 5 percent ad valorem or less, articles in any category for which the United States and the European Economic Community accounted for 80 percent or more of the aggregated world export value of all such articles, and certain agricultural, tropical agricultural, and forestry commodities. These amendments make it clear that these exceptions waiving the limitations on the decreases in duty will not apply to the new authority granted by the bill.

Section 301(e) of the bill amends section 256 of the 1962 Act to provide that the rate of duty "existing on July 1, 1967" which may be reduced for the purposes of carrying out a trade agreement entered into on or after such date is the lowest nonpreferential rate of duty (however, established, and even though temporarily suspended by Act of Congress or otherwise) existing on such date or (if lower) the

lowest nonpreferential rate to which the United States was committed on July 1, 1967, and with respect to which a proclamation was in effect on July 1, 1970.

Section 302. Staging Requirements

Subsections (a) and (b) of section 302 of the bill amend subsections (a) and (c) of section 253 of the 1962 Act so as to apply the staging requirements therein only to rate reductions made pursuant to trade agreements entered into under such Act before July 1, 1967.

Section 302(c) of the bill redesignates subsection (d) of such section 253 as subsection (e) and adds a new subsection (d) which provides that any rate reduction made pursuant to a trade agreement entered into under the amendment made by section 301(a) of the bill cannot take effect more rapidly than if it took effect in two equal installments with 1 year intervening between the installments. New section 253(d) also provides that in applying such staging requirements, any reductions with respect to an article made under a trade agreement entered into before July 1, 1967, and which have not taken effect on the date of the first proclamation under a new agreement are to be included within the aggregate duty reduction made with respect to such article under the new agreement.

Section 302(d) of the bill makes technical amendments to section 253(e) (as redesignated by section 302(c) of the bill).

Section 303. Foreign Import Restrictions and Discriminatory Acts

Section 252(a)(3) of the 1962 Act is amended by section 303(a) of the bill to strike out the word "agricultural" each place it appears in the phrase "United States agricultural products". The effect of this change is to provide that the President may, without regard to any provision of a trade agreement, impose duties or other import restrictions on the products of a foreign country in order to obtain the removal, or prevent the establishment, of unjustifiable import restrictions imposed by such country against any type of United States product (whether or not agricultural) and to provide access for any such product to the markets of such country on an equitable basis.

Section 303(b) of the bill amends section 252(b) of the 1962 Act to provide that the action provided for in such section 252(b) (that is, the suspension, withdrawal, or prevention of the application of the benefits of trade agreement concessions; the refraining from proclaiming the benefits of such concessions; or the imposition of duties or other import restrictions under the amendment made by section 103(c) of the bill) is to apply in the case of any foreign country the products of which receive the benefits of trade agreement concessions, if such country provides subsidies (or other incentives having the effect of subsidies) on its exports of one or more products to other foreign markets which unfairly affect the sales of the competitive United States product or products to those other foreign markets.

Section 303(c) of the bill further amends such section 252(b) to include within the action of the President covered by section 252(b) the imposition of duties or other import restrictions on the products of any foreign country or instrumentality which (1) maintains nontariff trade restrictions, (2) engages in discriminatory acts or policies which substantially or unjustifiably burden United States commerce, or

(3) provides subsidies of the type discussed in the preceding paragraph of this explanation, when the President deems such duties and other import restrictions to be necessary and appropriate to prevent the establishment, or obtain the removal, of such restrictions, acts, policies, or subsidies and to provide access for United States products to foreign markets on an equitable basis.

Section 303(d) of the bill amends section 252(c) of the 1962 Act to require (rather than to permit, as is the case under existing section 252(c)) the President to take action (to the extent that such action is consistent with the purposes of section 102 of the 1962 Act) under section 252(c) if a foreign country maintains unreasonable import restrictions which directly or indirectly substantially burden United States commerce.

The amendment by section 303(e) of the bill to such section 252(c) makes the imposition of duties or other import restrictions on the products of the foreign country concerned a third alternative course of action which the President may choose to use in the case of such country. The two alternative courses available under present law are (1) to suspend, withdraw, or prevent the application of benefits of trade agreement concessions to products of such country, or (2) to refrain from proclaiming benefits of trade agreement concessions to carry out a trade agreement with such country.

Section 303(f) amends section 252(d) of the 1962 Act to provide that the Secretary of Commerce upon the request of any interested party shall make an investigation to determine whether any specified restriction established or maintained by, act engaged in, or subsidy provided by a foreign country constitutes (1) a foreign import restriction referred to in subsection (a), (2) a non-tariff trade restriction, discriminatory or other act, or subsidy or the incentive referred to in subsection (b) or (3) an unreasonable import referred to subsection (c), and publish the findings from his investigation within three months after the complaint was filed. If the Secretary makes an affirmative determination, he shall so report to the President, and, after negotiating with the foreign government, the President shall report to the Congress, within three months after receiving the Secretary's report, any actions taken by him under subsections (a), (b), or (c) of the 1962 Act as amended.

Section 303(g) amends the heading for such section 252 to read "Foreign Import Restrictions and Discriminatory Acts".

Section 304. Determinations and Import Adjustments for Safeguarding National Security

Section 304(a) of the bill amends section 232(b) of the 1962 Act to provide that any adjustment of imports under section 232 of such Act is not to be accomplished by the imposition or increase of any duty, or of any fee or charge having the effect of a duty.

Section 304(b) of the bill requires the Director of the Office of Emergency Preparedness to make a determination as to whether an article is being imported in such quantities or under such circumstances as to threaten to impair the national security within 1 year after receiving a request or application for such a determination.

Section 304(c) applies the 1-year limitation discussed in the preceding paragraph to requests or applications received by the Director of the Office of Emergency Preparedness on or after January 1, 1968;

except that a determination with respect to a request or application received after that date and more than 1 year before the date of the enactment of this bill must be made by the Director not later than 60 days after such date of enactment.

SUBPART 2—TARIFF ADJUSTMENT AND ADJUSTMENT ASSISTANCE

Section 311. Petitions and Determinations

Section 311(a) of the bill amends section 301 of the 1962 Act in its entirety.

Section 301(a)(1) of the 1962 Act, as amended by the bill, is the same as existing section 301(a)(1) which provides that a petition for tariff adjustment under section 351 of the Act of 1962 may be filed with the Tariff Commission by a trade association, firm, certified or recognized union, or other industry representative.

Section 301(a)(2) of such Act, as amended by the bill, provides that petitions for determination of eligibility to apply for adjustment assistance under chapter 2 (firm assistance) or chapter 3 (worker assistance) of title III of the 1962 Act may be filed with the President. Under existing law, such petitions are filed with the Tariff Commission. Section 301(a)(2) as amended by the bill also provides that a petition filed by or on behalf of a group of workers shall apply only with respect to individuals who are, or who have been within 1 year before the date on which such petition is filed, employed regularly in the firm involved as full-time or part-time employees.

Subsection (b)(1) of section 301, as amended by the bill, provides that upon the request of the President, upon resolution of either the Committee on Finance of the Senate or the Committee on Ways and Means of the House of Representatives, upon its own motion, or upon the filing of a petition under section 301(a)(1), the Tariff Commission is to promptly make an investigation to determine whether an article upon which a concession has been granted under a trade agreement is, as a result, in whole or in part, of the duty or other customs treatment reflecting such concession, being imported into the United States in such increased quantities, either actual or relative, as to contribute substantially (whether or not such increased imports are the major factor or the primary factor) toward causing or threatening to cause serious injury to the domestic industry producing articles like or directly competitive with the imported article.

The criterion in subsection (b)(1), as amended, for determining whether a domestic industry is being injured by imports differs from that in existing law in that the Tariff Commission presently must determine whether as a result in major part of concessions granted under trade agreements, the article in question is being imported into the United States in such increased quantities as to cause, or threaten to cause, serious injury to the domestic industry producing an article which is like or directly competitive with such imported article. Paragraph (3) of existing section 301(b) provides that for purposes of existing paragraph (1) increased imports are to be considered to cause (or threaten to cause) serious injury when the Tariff Commission finds that such increased imports have been the major factor in causing (or threatening to cause) such injury.

Section 301(b)(2), as amended by the bill, provides that in making an injury determination under section 301(b)(1), the Tariff Commission, without excluding other factors, is to take into consideration a downward trend of production, prices, profits, or wages in the domestic industry concerned, a decline in sales, an increase in unemployment or underemployment, an increase in imports, either actual or relative to domestic production, a higher or growing inventory, and a decline in the proportion of the domestic market supplied by domestic producers.

Section 301(b)(3) sets forth a definition of "domestic industry producing articles like or directly competitive with the imported article" for purposes of applying subsection (b)(1). For purposes of applying the definition, the Tariff Commission is required (insofar as practicable) to distinguish or separate the operations of producing organizations involving like or directly competitive articles from the operations of such organizations involving other articles.

Section 301(b)(4), as amended by the bill, provides that if a majority of the Commissioners of the Tariff Commission who are present and voting on the issue of injury under section 301(b)(1) make an affirmative injury determination, then the Commissioners making such affirmative injury determination are also required to determine under section 301(b)(5) whether the injury to the industry is acute or severe, or threatens to be acute or severe after the Commission make the determinations relating to serious injury and, if affirmative, to acute or severe injury.

Section 301(b)(4) also provides that those Commissioners making an affirmative determination or injury, whether serious, severe or acute shall also determine the amount of the increase in, or imposition of, any duty or other import restriction on such article which is necessary to prevent or remedy the injury to the industry. Any such remedy determination by a majority of the Commissioners making the affirmative injury determination is treated as the remedy determination of the Tariff Commission for the purposes of title III of the 1962 Act (principally for purposes of any tariff adjustment action taken under section 351).

Section 301(b)(5), as amended by the bill, sets forth procedures whereby if an affirmative injury determination is made by the Tariff Commission under section 301(b)(1), the Commissioners voting for such determination are required to make an additional determination. In making this additional determination, such Commissioners look to see if imports are increasing to the point where they are (1) acutely or severely injuring a domestic industry or (2) threatening to acutely or severely injure a domestic industry.

Section 301(b)(6), as amended by the bill, provides that if the Tariff Commission, in the course of any 301(b) investigation, has reason to believe that the increased imports are attributable in part to circumstances which come within the purview of the Antidumping Act, 1921, section 303 or 337 of the Tariff Act of 1930, or other remedial provisions of law, it shall promptly notify the appropriate agency and take such other action as it deems appropriate.

Sections 301(b) (7), (8), and (9) under the bill are the procedural and reporting requirements pertaining to section 301(b)(1) investigations and determinations. They replace similar requirements contained in existing section 301(d)(1), the first sentence of section 301(f)(1), and section 301(f)(2).

Section 301(b)(10) provides that no investigation under section 301(b) may be undertaken by the Tariff Commission, on the basis of any petition filed under section 301(a)(1) of the 1962 Act, with respect to any subject matter which has previously been investigated by it under section 301(b) unless at least 1 year has elapsed since the Commission reported the results of such previous investigation to the President.

Section 301(c)(1) of the 1962 Act, as amended by the bill, provides that in the case of a petition by a firm for a determination of eligibility to apply for adjustment assistance, the President is to determine whether an article like or directly competitive with an article produced by the firm, or an appropriate subdivision thereof, is being imported into the United States in such increased quantities, either actual or relative, as to contribute substantially (whether or not such increased imports are the major factor or the primary factor) toward causing or threatening to cause serious injury to such firm or subdivision.

The President, in making such a determination with respect to a firm, is required to take into account all economic factors which he considers relevant, including idling of productive facilities, inability to operate at a level of reasonable profit, and unemployment or underemployment.

Section 301(c)(2) states that the President is to determine, in the case of a petition by a group of workers for a determination of eligibility to apply for adjustment assistance, whether an article like or directly competitive with an article produced by such workers' firm, or an appropriate subdivision thereof, is being imported into the United States in such increased quantities, either actual or relative, as to contribute substantially (whether or not such increased imports are the major factor or the primary factor) toward causing or threatening to cause unemployment or underemployment of a significant number or proportion of the workers of such firm or subdivision.

The President is required under section 301(c)(3) as amended by the bill to transmit promptly to the Tariff Commission a copy of each firm or worker petition filed under section 301(a)(2) and to request the Commission, not later than 5 days after the date of filing of the petition, to make an investigation of facts relevant to the determinations involved. The Commission must promptly institute, and publish notice in the Federal Register of, an investigation with respect to the petition.

Section 301(c)(4) provides that in the course of any firm or worker petition investigation, the Tariff Commission shall, after reasonable notice, hold a public hearing, if such hearing is requested (which request must be made not later than 10 days after the date of the publication of notice under section 301(c)(3)) by the petitioner or any other interested person, and shall afford interested persons an opportunity to be present, to produce evdience, and to be heard at such hearing.

Section 301(c)(5) requires that the report of the Tariff Commission of the facts disclosed by its investigation under section 301(c)(3) with respect to a firm or group of workers is to be made at the earliest practicable time, but not later than 60 days after the date on which it receives the request of the President for such investigation.

Section 311(b)(1) of the bill provides that the report of any industry injury investigation by the Tariff Commission under section 301(b)(1) of the 1962 Act during the 1-year period ending on the date of the enactment of the bill is to be treated as made more than 1 year before such date for purposes of the requirement of a 1-year interval between investigations of the same matter contained in section 301(b)(10).

Section 311(b)(2) of the bill provides that any industry, firm, or worker investigation under existing section 301 (b) or (c) which is pending before the Tariff Commission immediately before the date of enactment of the bill will be continued as an investigation instituted under section 301 (b) or (c), as amended by the bill, and for purposes of the time periods within which reports by the Tariff Commission with respect to such investigations must be filed, petitions therefor shall be deemed to have been filed on the date of enactment of the bill.

Section 311(b)(3) of the bill provides that any report of an affirmative determination by the Tariff Commission with respect to a firm or worker petition under existing section 301(c) (1) or (2) of the 1962 Act on which the President has not acted by the date of the enactment of the bill is to be treated by him as a report received under section 301(c)(5), as amended by the bill, on such date of enactment.

Section 311(b)(4) of the bill provides that no petition may be filed under section 301(a) of the 1962 Act during the period beginning on the date of enactment and ending on the 90th day after such date, or, if earlier, on the 10th day after the date of publication of the related rules of the Tariff Commission.

Section 312. Presidential Action With Respect to Adjustment Assistance

Section 312(a) of the bill amends section 302(a) of the 1962 Act to provide, under subsection (a)(1) thereof, that the President, if he provides tariff adjustment under section 351 or 352 after receiving an affirmative injury determination under section 301(b), may provide, with respect to such industry, that its firms may request the Secretary of Commerce for certification of eligibility to apply for firm adjustment assistance, that its workers may request the Secretary of Labor for certification of eligibility to apply for worker adjustment assistance, or that both the firms and workers may request such certifications.

Under paragraph (2) of such section 302(a), if the President does not provide tariff adjustment for an industry under section 351 or 352 after receiving an affirmative injury determination under section 301(b), he shall promptly provide that both firms and workers of such industry may request certifications of eligibility for adjustment assistance.

Paragraph (3) of such section 302(a) provides that notice of each action taken by the President under section 302(a) must be published in the Federal Register, and that any request by a firm or group of workers for certification must be made to the Secretary of Commerce or Labor, as the case may be, within the 1-year period after the date on which notice is so published (unless the President specifies a longer period).

Section 312(b) of the bill makes certain conforming amendments to section 302(b) of the 1962 Act to reflect the amendments made to section 302(a) by section 312(a) of the bill. Section 312(b) also amends paragraph (2) of section 302(b) to provide that a certification of eligibility by the Secretary of Labor shall apply only to workers who are, or who have been, employed regularly (on a full-time or part-time

basis) in the firm involved within 1 year before the date of the institution of the applicable Tariff Commission investigation under section 301(b).

Section 312(c) of the bill amends section 302(c) of the 1962 Act to provide under paragraph (1) thereof that after receiving a report of the Tariff Commission of the facts disclosed by its investigation under section 301(c)(3) with respect to any firm or group of workers, the President is to make his determination (with respect to the eligibility of such firm or group to apply for adjustment assistance) not later than 30 days after the date on which he receives such report, unless, within such period, the President requests additional factual information from the Tariff Commission. In that event, the Tariff Commission must, not later than 25 days after the date on which it receives the President's request, furnish such additional factual information in a supplemental report, and the President must make his determination not later than 15 days after the date on which he receives such supplemental report.

Under paragraph (2) of section 302(c), the President is required to publish promptly in the Federal Register a summary of each determination under section 301(c) with respect to any firm or group of workers.

Under paragraph (3) of section 302(c), the President is required to certify promptly that a firm or group of workers is eligible to apply for adjustment assistance if he makes an affirmative determination under section 301(c) with respect to the firm or group.

Paragraph (4) of such section authorizes the President to delegate to any agency or other instrumentality of the United States any of his functions with respect to determinations and certifications of eligibility of firms or workers to apply for adjustment assistance under sections 301 and 302.

Section 312(d) amends the heading of section 302 to read "Presidential Action with Respect to Adjustment Assistance."

Section 313. Tariff Adjustment

Section 313(a) of the bill amends paragraph (1) of section 351(a) of the 1962 Act to provide, under subparagraph (A) thereof, that after receiving an affirmative injury determination of the Tariff Commission under section 301(b)(1), which is not combined with an additional affirmative determination of the Commission under section 301(b)(5), the President is to proclaim such increase in, or imposition of, any duty or other import restriction on the article concerned as he determines to be necessary to prevent or remedy serious injury to the industry, unless he determines that such action would not be in the national interest.

Under paragraph (1)(B) of such section 351(a), as amended by the bill, if the President receives an affirmative injury determination of the Tariff Commission under section 301(b)(1) which is combined with an affirmative additional determination of the Commission under section 301(b)(5), he shall proclaim the increase in, or imposition of, any duty or other import restriction on the article concerned determined and reported by the Commission pursuant to section 301(b), unless he determines that such action would not be in the national interest.

Section 313(a) of the bill also makes certain conforming amendments to paragraph (2) of section 351(a). Paragraph (2) sets forth procedures whereby, if the President does not proclaim the increase in, or imposition of, any duty or other import restriction on the article

concerned determined and reported by the Tariff Commission under section 301(b), the Congress can (by the adoption of a concurrent resolution) cause such increase or imposition to take effect. Such paragraph (2) is also amended to provide that if the President does not proclaim the remedy determined by the Tariff Commission because of considerations of national interest, he is not required to state the considerations on which his decision was based.

Subsections (b) and (c) of such section 113 make certain conforming amendments to paragraphs (3) and (4) of section 351(a).

Section 313(d) of the bill makes certain amendments to section 351(d)(1) which provides that the Tariff Commission must keep under review developments with respect to the industry concerned after tariff adjustment for such industry is proclaimed. One amendment requires that the Commission, in making such review, take into account the specific steps taken by firms in the industry to enable them to compete more effectively with imports. Another amendment requires the Commission to take such steps into account when, at the request of the President, it advises him under section 351(d)(2) of the probable economic effect on the industry concerned of the reduction or termination of the increase in, or imposition of, any duty or other import restriction previously proclaimed under section 351. Such section 351(d) is further amended by the addition of a new paragraph (6) which provides that the Tariff Commission, in making any investigation initiated under paragraph (2) or (3) of section 351(d), shall also determine and report to the President if the termination of the proclaimed increase or imposition threatens to cause serious injury to the industry concerned, and if such determination is affirmative, (1) the limit to which such increase or imposition may be reduced without threatening to cause serious injury to the industry concerned, and (2) whether, in lieu of such termination, additional increases or impositions of duties and other import restrictions are required to prevent or remedy serious injury to the industry concerned.

Section 314. Orderly Marketing Agreements

Section 314 of the bill amends section 352(a) to provide that the President may at any time after receiving an affirmative injury determination of the Tariff Commission with respect to an industry negotiate international agreements with foreign countries to limit the export to, and import into, the United States of the article causing or threatening to cause serious injury to such industry. Any such agreement may replace in whole or part any tariff adjustment action taken by the President under section 351, but any such agreement entered into before such time as the Congress takes action under section 351(a)(2) which has the result of placing the Tariff Commission remedy in effect must terminate on the date the President proclaims such remedy pursuant to section 351(a)(3).

Section 315. Increased Assistance for Workers

Section 315(a) amends section 323(a) of the 1962 Act to provide that the trade readjustment allowance payable under such section 323(a) to workers found eligible for adjustment assistance is an amount equal to 75 percent of his average weekly wage or to 75 percent of the average weekly manufacturing wage, whichever is less, reduced by 50 percent of the amount of his remuneration for services performed during such week. Under existing law the applicable percentage of his weekly wage or the weekly manufacturing wage is 65 percent.

Section 315(b) of the bill amends section 326(a) of the 1962 Act so as to make it clear that "supportive and other services" provided for under any Federal law are among the services which can be afforded to adversely affected workers in order to prepare them for full employment.

Under section 315(c) of the bill, the increased trade readjustment allowances provided for under the amendment made by section 515(a) applies with respect to weeks of unemployment beginning on or after the date of enactment of the bill.

Section 316. Conforming Amendments

Section 316 of the bill makes conforming amendments to sections 242(b)(2), 302(b), 311(b)(2), and 317(a)(2) of the 1962 Act.

PART B—QUOTAS ON CERTAIN TEXTILE AND FOOTWEAR ARTICLES

Subpart 1—Textile and Footwear Articles

Section 321. Annual Quotas

Section 321(a) of the bill establishes a statutory quota for calendar year 1971 under which the total quantity of each category of textile articles, and the total quantity of each category of footwear articles, produced in any foreign country which may be entered for consumption in the United States during such year may not exceed the average annual quantity of such category produced in such country and entered during 1967, 1968, and 1969.

Paragraph (1) of section 321(b) of the bill provides that the statutory quota applicable to each category of textile articles and to each category of footwear articles produced in any foreign country which may be entered in the United States during 1972 and any calendar year thereafter may not exceed the total quantity determined for such category for such country under section 321(a), as increased by the President for any calendar year after 1971 and before the current calendar year under paragraph (2)(A) of section 321(b), plus any further increase in such quantity for the current calendar year which may be provided for by the President under such paragraph (2)(A).

Paragraph (2)(A) of section 321(b) provides that the President may increase the total quantity of each category of textile articles, and the total quantity of each category of footwear articles, produced in any foreign country which may be entered during any calendar year after 1971 by such percentage (but not exceeding 5% of the total quantity determined for such category for such country under section 321(a) or section 321(b) for the immediately preceding calendar year) as he determines to be consistent with the purposes of section 321.

Paragraph (2)(B) provides that any annual increase in any category authorized by the President under paragraph (2)(A) for any calendar year must be the same percentage for all foreign countries.

Paragraph (2)(C) requires that a determination of the total quantity of each category of articles for each foreign country be made under section 321 (a) and (b) for each calendar year after 1971 notwithstanding the fact that the statutory quota provided for therein may not apply during the whole or part of such year by reason of the application of other provisions of Subpart B of title III of the bill or the provisions

of the Arrangement or the Agreement referred to in section 324(b) of the bill. Where any category of articles for a foreign country is affected by the nonapplication of the statutory quota to one or more articles falling within such category, for purposes of subsections (a) and (b) of section 201 the remaining articles in such category shall, for purposes of that country and for the period of such nonapplication of the statutory quota, be treated as having constituted a separate category for such country for all years after 1966. The application of the preceding sentence would yield, of course, to a change in the category or categories concerned effected under paragraph (3) of section 326 of the bill after compliance with section 205(a) of the bill (relating to rulemaking procedures).

Paragraph (3) of section 321(b) provides that if (1) the statutory quota does not apply (for any of the reasons mentioned in the preceding paragraph of this explanation) with respect to any textile article or footwear article produced in a foreign country, but (2) at any time after 1971 a statutory quota begins to apply to, or resumes in application to, such article produced in such country, and (3) the President determines (A) that the average annual quantity of the article, produced in such country, and entered in the United States during 1967, 1968, and 1969 was insignificant, and (B) that the application of section 321(b)(3) to the category which includes such article for such country is consistent with the purposes of section 321, then for the calendar year in which such termination occurs, the statutory quota applicable with respect to the quantity of the category including such article, produced in such country, shall be deemed to be the annual average quantity (of such category) which was entered during the 3 calendar years immediately preceding such calendar year of termination (rather than during the 1967–69 base period provided for in section 521(a)) plus any applicable yearly increases for periods after 1971.

Section 321(c)(1) of the bill provides that any annual quantitative limitation under section 321(a) or (b) shall be applied on a calendar quarter or other intra-annual basis if the President determines that such application is necessary or appropriate to carry out the purposes of section 321.

Paragraph (2) of section 321(c) of the bill provides that if the application of section 321 (a) or (b) to any category for any foreign country begins or resumes after the first day of any calendar year, then the amount of the quota for such category for such country for the remainder of such calendar year shall be the annual amount determined under section 321 (a) or (b), adjusted pro rata according to the number of full months remaining in the calendar year after the date of such beginning or such resumption.

Under section 321(d)(1) of the bill the President may exempt from the statutory quota determined under section 321 (a) and (b) for an initial period of not to exceed 1 year any textile article or footwear article produced in any foreign country if he determines that imports of such article produced in such country are not contributing to, causing, or threatening to cause market disruption in the United States. Any such exemption may be extended by the President for one or more additional periods of not in excess of 1 year each if he makes a new determination (before each such extension) that imports of such article produced in such country are not contributing to,

causing, or threatening to cause market disruption in the United States.

The President may terminate an exemption made under paragraph (1) of section 321(d) of the bill at any time upon his finding that the article covered by such exemption is contributing to, causing, or threatening to cause market disruption in the United States.

Paragraph (2) of section 321(d) provides that the President may exempt from section 321 (a) and (b) any textile article or footwear article produced in any foreign country whenever he determines that such an exemption is in the national interest, and the President may terminate any such exemption whenever he determines that such termination is in the national interest.

Paragraph (3) of section 321(d) provides that no exemption, extension of an exemption, or termination of an exemption under section 321(d) (1) or (2) may take effect sooner than the 30th day after the day on which notice of such exemption, extension, or termination is published in the Federal Register.

Under paragraph 321(e) of the bill, the Secretary of Commerce is required to compute quantities under the statutory quotas provided for in section 321 (a) and (b) of the bill.

Section 322. Arrangement or Agreements Regulating Imports

Section 322(a) of the bill authorizes the President to conclude bilateral or multilateral arrangements or agreements with the governments of foreign countries for the purpose of regulating, by category, the quantities of textile articles or footwear articles, or both, produced in those countries which may be exported to, or entered for consumption in, the United States. The President is authorized to issue regulations necessary to carry out the terms of such arrangements or agreements. The President is required, in concluding any such arrangement or agreement, to take into account conditions in the United States market, the need to avoid disruption of that market, and such other factors as he deems appropriate in the national interest.

Section 322(b) of the bill provides that whenever a multilateral arrangement or agreement concluded under section 322(a) is in effect among the countries, including the United States, which account for a significant part of world trade in the article concerned and such arrangement or agreement contemplates the establishment of limitations on the trade in the article produced in countries not parties to such arrangement or agreement, the President may by regulation establish the total quantity of the article produced in each country not a party to such arrangement or agreement which may be entered for consumption in the United States. Section 322(b) provides, however, that such regulations may not have the effect of reducing the total quantity for any category for any country for any calendar year to an amount less than the total quantity which would be permitted to be entered if section 321 (a) and (b) (the statutory quota) applied to such category for such country for such year.

Section 322(c) of the bill states that neither the statutory quota nor exemption provisions of section 321 of the bill are to apply to imported articles which are subject to an arrangement or agreement entered into under section 322(a) or to regulations issued under section 202(b).

Section 323. Increased Imports Where Supply Is Inadequate To Meet Domestic Demand at Reasonable Prices

Section 323 of the bill permits the President, in carrying out sections 321 and 322, to authorize increased exports to the United States or increased entries in the United States of textile articles or footwear articles of any category if he determines that the supply of textile articles or footwear articles similar to those subject to limitation under such sections will be inadequate to meet domestic demand at reasonable prices.

Section 324. Exclusions

Section 324(a) of the bill exempts from the import restrictions provided for in part B of title III of the bill any article exempted from duty under part 2 of schedule 8 of the Tariff Schedules of the United States (personal exemptions) and any article the entry of which is regulated pursuant to paragraph (4), (5), (6), or (7) of section 498(a) of the Tariff Act of 1930 (relating to household effects, gifts from abroad, tools of trade, and certain other personal articles). Section 204(a) also provides that, to the extent provided in regulations prescribed by the Secretary of Commerce, the import restrictions provided for in part B of title III of the bill will not apply to other articles imported in noncommercial quantities for noncommercial purposes. Such regulations may include provision for the nonapplication of quotas to commercial samples, not for sale or use other than as samples, under safeguards which will ensure that such provision will not be used to weaken the effectiveness of part B of title III of the bill.

Section 324(b) exempts from the application of part B of title III (1) articles subject to the Long-Term Arrangement Regarding International Trade in Cotton Textiles, so long as the United States is a party thereto, and (2) articles produced in the Philippines provided for in item B (cordage) in the schedule to paragraph 1 of article II of the 1955 Agreement With the Philippines Concerning Trade and Related Matters, so long as such Agreement remains in effect.

Section 324(c) of the bill provides that nothing in title III affects the authority provided for under section 22 of the Agricultural Adjustment Act of 1933, as amended.

Section 325. Administration

Section 325(a) of the bill applies the rulemaking provisions of subchapter II of chapter 5 of title 5, United States Code, to section 321(b)(2) (yearly increases in statutory quota amounts); 321(b)(3) (application of special statutory quota base in the case of countries providing insignificant imports during 1967–69); 321(d)(1) (exemptions from statutory quota for articles not causing market disruption); 322(b) (regulations limiting imports from countries not party to certain multilateral arrangements or agreements entered into under section 202(a)); 203 (increased imports in cases where supply is inadequate to meet domestic demand at reasonable prices); 324(a) (regulatory determination of articles excluded from quota if imported in noncommercial quantities for noncommercial purposes); and 326 (article and category definitions).

Section 325(b) of the bill requires that all quantitative limitations established under part B of title III of the bill or pursuant to any arrangement or agreement entered into under such title, all exemptions established under such title and all extensions or terminations

thereof, and all regulations promulgated to carry out such title be published in the Federal Register.

Under section 325(b), the Secretary of Commerce is required to certify to the Secretary of the Treasury for each period the total quantity of each textile article and footwear article produced in each foreign country the entry of which is affected by any such quantitative limitation on importation; and the Secretary of the Treasury is directed to take such action as may be necessary to ensure that the total quantity so entered during such period does not exceed the total quantity so certified.

Section 325(c) requires that all quantitative limitations and exemptions established under part B of title III or pursuant to any arrangement or agreement entered into under such title and all quantitative limitations established pursuant to the Long-Term Arrangement Regarding International Trade in Cotton Textiles be promulgated as a part of the appendix to the Tariff Schedules of the United States, Annotated.

Section 326. Definitions

Section 326 of the bill contains six definitions which are applicable for purposes of part B of title III of the bill.

Section 326(1) of the bill defines "textile article" to include—

(1) any article if wholly or in part of cotton, wool or other animal hair, human hair, man-made fiber, or any combination or blend thereof, or cordage of hard (leaf) fibers, classified under schedule 3 of the Tariff Schedules of the United States;

(2) any article classified under subpart B or C of part 1 of schedule 7 of such schedules if wholly or in substantial part of cotton, wool, or man-made fiber;

(3) any other article specified by the Secretary of Commerce which he has been advised by the Secretary of the Treasury would be classified under any of the provisions of the schedules referred to in paragraph (1) or (2) above but for the inclusion of some substance, material, or other component, or because of its processing, which causes the article to be classified elsewhere; and

(4) any article provided for under paragraph (1), (2), or (3) above if entered under item 807.00 of such schedules (relating to articles assembled abroad in whole or in part of certain components fabricated in the United States), or under the appendix to such schedules.

Such section 326(1) does not include within the term "textile article" any article classified under any of items 300.10 through 300.50, 306.00 through 307.40, 309.60 through 309.75, and 390.10 through 390.60, inclusive, of the Tariff Schedules.

Section 326(2) defines the term "footwear article" to include footwear provided for in any of items 700.05 through 700.45, inclusive, item 700.55, items 700.66 through 700.80, inclusive, and item 700.85 of the Tariff Schedules of the United States.

Section 326(3) defines the term "category" to mean a grouping of textile articles, or a grouping of footwear articles, as the case may be, as determined by the Secretary of Commerce, for the purposes of part B of title III of the bill, using the five-digit and seven-digit item numbers applied to such articles in the Tariff Schedules of the United States, Annotated.

Section 326(4) defines the term "entered" as meaning entered, or withdrawn from warehouse, for consumption in the customs territory of the United States.

Section 326(5) defines the term "produced" to mean manufactured or produced.

Section 326(6) defines the term "foreign country" to include a foreign instrumentality. For this purpose the term "country" is used in an all inclusive sense; a dependency or colony which is not treated as part of another country is to be treated as a separate country.

SUBPART 2—EFFECTIVE PERIOD

Section 331. Termination of Title, Extension Under Certain Conditions

Section 331(a) of the bill provides that title III of the bill which establishes quotas on certain textile and footwear articles is to terminate at the close of July 1, 1976, unless extended under section 331(b).

Section 331(b) provides that the effective period of part B of title III of the bill may be extended in whole or in part by the President after July 1, 1976, for such periods (not to exceed 5 years at any one time) as he may designate if after seeking advice of the Tariff Commission and of the Secretary of Commerce and of the Secretary of Labor, the President determines that such extension is in the national interest.

Under section 331(c) the President is required to report promptly to Congress with respect to any action taken by him to extend the effective period of part B of title III.

Section 331(d) states that nothing in section 331 affects the validity of any arrangement or agreement entered into under section 322(a) before the termination of part B of title III or of any regulations issued under subsection (a) or (b) of section 322 in connection with any arrangement or agreement entered into under section 322(a) before such termination.

PART C—OTHER TARIFF AND TRADE PROVISIONS

SUBPART 1—AMENDMENTS TO THE ANTIDUMPING AND COUNTERVAILING DUTY LAWS

Section 341. Antidumping Act, 1921

Section 341(a) of the bill amends section 201(b) of the Antidumping Act, 1921, to provide that the Secretary of the Treasury or his delegate must, within 4 months after a question of dumping is raised by or presented to him, make the determination required under present law as to whether there is reason to believe or suspect that the purchase price of imported merchandise is less, or the exporter's sales price is less or likely to be less, than the foreign market or constructed value of the merchandise. If the Secretary's determination is in the affirmative, then under paragraph (2) of such section 201(b), as amended by the bill, he must publish notice thereof in the Federal Register and require the withholding of appraisement of any such merchandise entered on or after such date of publication. Such paragraph (2) also retains the present provision in the Antidumping Act which authorizes the Secretary to order that such withholding be made effective with respect to merchandise entered on or after an earlier date, but in no

case may the effective date of withholding be earlier than the 120th day before the question of dumping was raised by or presented to him.

Paragraph (3) of such section 201(b) provides that if the Secretary's determination is negative, notice thereof must be published in the Federal Register, but the Secretary may within 3 months thereafter order the withholding of appraisement if he then has reason to believe or suspect that dumping is involved; an order of withholding of appraisement in that case is treated in the same manner as is a withholding under paragraph (2) of section 201(b). Such section 201(b) as amended by the bill also provides that the question of dumping is deemed to have been raised by or presented to the Secretary on the date on which a notice is published in the Federal Register that information relating to dumping has been received in accordance with regulations prescribed by him.

Section 341(b)(3) also provides that if the Secretary determines within 2 months after the question of dumping was raised that the circumstances are such that a determination cannot reasonably be made within 4 months, he shall publish notice to that effect, and in such cases, may take up to 7 months after the question of dumping was raised to reach a determination.

Section 341(b) of the bill adds a new subsection (b) to section 205 of the Antidumping Act, 1921, which provides that if available information indicates to the Secretary of the Treasury that the economy of the country from which merchandise is exported is state-controlled to an extent that sales of such or similar merchandise in that country or to countries other than the United States do not permit a determination of foreign market value under section 205(a) of such Act, he shall determine the foreign market value of the merchandise on the basis of the normal costs, expenses, and profits as reflected by either (1) the prices at which such or similar merchandise of a non-state-controlled-economy country is sold either for consumption in the home market of that country, or to other countries, including the United States; or (2) the constructed value of such or similar merchandise in a non-state-controlled-economy country as determined under section 206 of the Antidumping Act, 1921.

Section 341(c) of the bill makes the amendment made by section 341(a) of the bill effective on the 180th day after the date of enactment of the bill.

Section 341(c) of this title amends section 210 of the Antidumping Act to make it clear that the right of protest referred to in section 210 includes the right of an American manufacturer, producer or wholesaler of merchandise of the same class or kind as foreign merchandise which is the subject of a determination by the Secretary under section 201(c). This section 341(c) also amends section 516 of the Tariff Act of 1930 to add a new subsection (d) which would provide the procedure for the U.S. manufacturer, producer or wholesaler of merchandise to protest a negative dumping decision by the Secretary of Treasury.

Section 342. Countervailing Duties

Section 342(a) of the bill amends section 303 of the Tariff Act of 1930 in its entirety, although retaining many of the provisions of existing section 303. Subsection (a)(1) of the amended section 303 pro-

vides that whenever any country or other governmental entity or private entity, pays or bestows any bounty or grant upon the manufacture, production, or export of any article or merchandise manufactured or produced in such country or subdivision thereof, then upon the importation of such article or merchandise into the United States, whether imported directly from the country of production or otherwise, and whether such article or merchandise is imported in the same condition as when exported or has been changed in condition by remanufacture or otherwise, there is to be levied and paid with respect to such article or merchandise, in addition to any duties otherwise imposed, a duty equal to the net amount of such bounty or grant. The bill adds the requirement that the Secretary of the Treasury must determine, within 12 months after the date on which the question is presented to him, whether any bounty or grant is being paid or bestowed.

Section 303(a)(2) as added by the bill requires that in the case of any imported article or merchandise which is free of duty, duties may be imposed under section 303 only if there is an affirmative determination by the Tariff Commission under section 303(b)(1).

Section 303(a)(3) retains the requirement in existing section 303 that the Secretary from time to time must ascertain and determine, or estimate, the net amount of each such bounty or grant, and declare the net amount so determined or estimated.

Under section 303(a)(4) the Secretary is required to make all regulations he may deem necessary for the identification of articles and merchandise covered by section 303 and for the assessment and collection of the duties thereunder. Such paragraph (4) also provides that all determinations by the Secretary under section 303(a), and all determinations by the Tariff Commission under section 303(b)(1), whether affirmative or negative, are to be published in the Federal Register.

Under section 303(b)(1), as added by the bill, the Secretary of the Treasury must, whenever he determines that a bounty or grant is being paid with respect to duty-free merchandise, advise the Tariff Commission which shall determine within 3 months thereafter, and after such investigation as it deems necessary, whether an industry in the United States is being or is likely to be injured, or is prevented from being established, by reason of the importation of such article or merchandise into the United States and notify the Secretary of that determination. The Secretary is further required, under such regulations as he may prescribe, to suspend liquidation of any such article or merchandise which is entered, or withdrawn from warehouse, for consumption, on or after the 30th day after the date of the publication in the Federal Register of his determination under section 301(a)(1), and such suspension will continue until further order of the Secretary.

New section 303(b)(2) provides that if the determination of the Tariff Commission under section 303(b)(1) is affirmative, the Secretary is to make public an order directing the assessment and collection of duties in the amount of such bounty or grant as is from time to time ascertained and determined, or estimated, under section 303(a).

Subsection (c) of the amended section 303 provides, that an affirmative determination by the Secretary of the Treasury under section 303(a)(1) with respect to any imported article or merchandise which (1) is dutiable, or (2) is free of duty but with respect to which the

Tariff Commission has made an affirmative determination under section 303(b)(1), applies with respect to articles entered, or withdrawn from warehouse, for consumption on or after the 30th day after the date of the publication in the Federal Register of such determination by the Secretary.

Section 303(d) as added by the bill provides that no countervailing duty is to be imposed with respect to any article which is subject to a quantitative limitation imposed by the United States on its importation, or subject to a quantitative limitation on its exportation to or importation into the United States imposed under an agreement to which the United States is a party, unless the Secretary of the Treasury determines, after seeking information and advice from such agencies as he deems appropriate, that such quantitative limitation is not an adequate substitute for the imposition of a countervailing duty. This determination is to be made on an article-by-article basis. Furthermore, in the case of a quantitative limitation with respect to an article which applies only if the article does not exceed a stated value, the determination shall be made as if the article, when valued below the stated amount, constituted a separate article.

Section 342(b) of the bill provides that the amendment made by section 342(a) takes effect on the date of the enactment of the bill, except that the last sentence of section 303(a)(1) of the Tariff Act of 1930 (requiring that bounty determinations be made within 12 months after presented) applies only with respect to questions regarding bounties presented on or after such date of enactment.

Subpart 2—Tariff Commission

Section 351. Independent Status of the Tariff Commission

Section 351 of this title amends section 330 of the Tariff Act of 1930 to provide that except as otherwise specifically provided by law, the Tariff Commission shall be independent of the Executive.

Subpart 3.—The General Agreement on Tariffs and Trade

Section 361 of this title would direct the Executive Branch to study and submit to the Congress reports on important issues involved in international trade.

Section 361(a) would involve all presently existing provisions and interpretations of the GATT. It would include but not be limited to:

(1) The most favored nation principle, the special exceptions thereto, the effect of these exceptions on U.S. trade and investment patterns;

(2) The provisions on export subsidies and border taxes and the rationale underlying the different treatment of direct and indirect taxes insofar as border tax adjustments are concerned;

(3) The adequacy of provisions on agricultural trade;

(4) The adequacy of provisions dealing with balance of payments matters;

(5) The provisions on unfair trade practices and relief from injurious imports; and

(6) The provisions on "compensation" and "retaliation."

Section 361(b) would direct the Executive Branch to study a number of specific problems including:

(1) A United States negotiating position with respect to the quantitative restrictions that remain in effect in many countries;

(2) The border tax—export rebate system of the European Community with particular reference to U.S. countervailing duty laws;

(3) The common agricultural policies of the European Community;

(4) Discriminatory government procurement policies;

(5) The probable effects of British entry into the Common Market on United States trade and balance of payments;

(6) The effect of foreign exchange-rate changes on U.S. trade and tariff concessions;

(7) An analysis of whether or not greater flexibility in foreign exchange rates would serve in the interests of United States and world trade;

(8) The nature and extent to which other countries subsidize their exports directly or indirectly;

(9) A comparative analysis of various proposals to extend "tariff preferences" to the products of less developed countries with particular emphasis on the effects on U.S. trade and investment patterns and on U.S. labor; and

(10) The various agency responsibilities within the Executive Branch for handling all U.S. foreign trade matters, and the means by which policy coordination is achieved.

Section 361(c) of this title provides that the Executive shall complete these studies by December 31, 1971.

Section 362 of this title directs the Tariff Commission to conduct studies and submit reports on them to the Committee on Finance not later than December 31, 1971, on the following subjects:

(1) The tariff and nontariff barriers among the principal trading nations in the industrialized countries, including an analysis of the disparity in tariff treatment of similar articles of commerce by different countries. This analysis is to explore the reasons for the disparities;

(2) The nature and extent of the tariff concessions granted in the GATT by the principal trading nations in the industrialized countries;

(3)(a) The foreign customs valuation procedures and those of the United States with a view to developing and suggesting uniform standards of custom valuation which would operate fairly among all classes of shippers in international trade and (b) the economic effects which follow if the United States adopts such standards of valuation, based on rates of duty which will become effective on January 1, 1972; and

(4) The implications of multinational firms on the patterns of world trade and investment and on U.S. trade and labor.

It is the committee's expectation that these studies will lead to constructive proposals for international principles for insuring free and fair competition in world markets and which would guarantee *reciprocity* for U S. trade and investment. Only on the basis of the full facts can the committee and the Congress exercise its Constitutional prerogative and responsibilities in the field of international trade.

SUBPART 4—MISCELLANEOUS PROVISIONS

Section 371. Amendments to Automotive Products Trade Act of 1965

Section 371(a) of the bill amends section 302(a) of the Automotive Products Trade Act of 1965 to authorize the filing of petitions by firms or groups of workers with the President for certifications of eligibility to apply for adjustment assistance under title III of the 1962 Act. Under existing law, the last day on which such petitions could be filed was June 30, 1968.

Section 371(b) amends the side heading of section 302 of such Act of 1965 to read "Special Authority".

Section 371(c) amends subsections (c) and (d) of such section 302 to provide that in determining whether groups of workers or firms are eligible to apply for adjustment assistance, the President is to consider whether or not the operation of the Agreement Concerning Automotive Products Between the Government of the United States of America and the Government of Canada has been a substantial factor (rather than the primary factor, as under existing law) in causing or threatening to cause dislocation of the firm or group of workers. Section 371(c) also makes a conforming change in section 302(g)(2) of such act of 1965.

Section 371(d) provides that the amendments made by section 341 apply with respect to petitions for certification of eligibility filed after the date of the enactment of the bill, except that such amendments will apply only with respect to dislocations which began after June 30, 1968. Where such a dislocation began after June 30, 1968, and before July 1, 1970, such amendments will apply only if the petition concerned is filed on or before the 90th day after such date of the enactment.

Section 371(e) directs the President to secure elimination by the Government of Canada of its duties and other import restrictions on automobiles produced in the United States. If this is not achieved before January 1, 1973, the amendment directs the President to exercise the authority conferred on him by section 204 of the Automotive Products Act of 1965 to terminate in whole or in part proclamations issued under such Act.

Section 372. Rates of Duty on Mink Furskins; Repeal of Embargo on Certain Furs

Section 372(a)(1) of the bill adds new items to schedule 1, part 5, subpart B of the Tariff Schedules to establish a tariff rate quota on mink furskins. A quota of 3,600,000 skins is established for each calendar year and is allocated on a quarterly basis. Raw or not dressed skins entered within the quota are duty free (as at present) if the column 1 rate applies and dutiable at 30% ad valorem if the column 2 rate (rate applied if the article is the product of a designated Communist country) applies. Dressed furskins entered within the quota, if in the form of plates, mats, linings, strips, crosses, or similar forms, are dutiable at 12% ad valorem if not dyed (35% ad valorem if the column 2 rate applies) and at 14% ad valorem if dyed (40% ad valorem under column 2). Other dressed furskins entered within quota if not dyed are dutiable at 3.5% ad valorem (25% ad valorem under column 2) and if dyed are dutiable at 5.5% ad valorem (30% ad valorem under column 2). Any furskin, whether or not dressed and whether dyed or

not dyed, which is entered in a calendar year after the quota for that year is filled is dutiable at 25% ad valorem under column 1 and 40% ad valorem under column 2.

Section 372(a)(2) adds a new item 791.12 to schedule 7, part 13, subpart B of the Tariff Schedules making garments of mink dutiable at 14% ad valorem under column 1 and at 50% ad valorem under column 2.

Section 372(b) repeals the existing embargo in headnote 4 to schedule 1, part 5, subpart B of the Tariff Schedules on ermine, fox, kolinsky, marten, mink, muskrat, and weasel furskins, raw or not dressed or dressed, which are the product of the Soviet Union or Communist China and applies a duty of 30% ad valorem on these articles, raw or not dressed.

Section 372(c) makes the amendments and the repeal effected by section 372 of the bill applicable with respect to articles entered, or withdrawn from warehouse, for consumption on or after January 1, 1971.

Section 373. Rate of Duty on Glycine and Certain Related Products

Section 373(a) of title III of the bill amends schedule 7, part 13, subpart B of the Tariff Schedules to provide a tariff rate quota on glycine (aminoacetic acid) and salts thereof, and certain mixtures of glycine or its salts. Under the quota, the first 1,500,000 pounds of the articles entered during any calendar year, and the first 375,000 pounds entered during any calendar quarter are dutiable at 8.5% ad valorem if the column 1 rate applies and at 25% ad valorem if the column 2 rate applies. Glycine, salts, and mixtures entered after the annual quota is filled in a calendar year or the quarterly quota is filled in a calendar quarter are dutiable at 8.5% ad valorem plus 25 cents per pound under column 1 and at 25% ad valorem plus 25 cents per pound under column 2.

Section 373(b) makes the tariff rate quota established in section 344(a) effective with respect to articles entered on or after January 1, 1971.

Section 374. Ski Bindings

Section 374 of the bill amends schedule 7, part 5, subpart D of the Tariff Schedules to provide a new rate on parts of ski bindings (TSUS 734.97) of 3% ad valorem on January 1, 1971.

Section 375. Invoice Information

Section 375 of title III of the bill amends section 481(a) of the Tariff Act of 1930 (relating to information required on invoices of imported merchandise) to require that such invoices contain such information as to product description as is required to be made a part of the entry by provisions of the Tariff Schedules of the United States, Annotated.

Section 376. Reports of Imports and Exports

Section 376 of title III of this bill amends section 301 of title 13 of the United States Code to require the Secretary of Commerce in compiling and publishing any information:

(1) With respect to imports to state:
  (A) The dutiable value of the imported article; and
  (B) The c.i.f. value of the imported article; and

(2) With respect to exports to state separately from the total value of all exports:

(A) (i) the value of agriculture commodities exported under the Agricultural Trade Development and Assistance Act of 1954, as amended; and

(ii) the total amount of all export subsidies paid to exporters by the United States under such Act for the exportation of such commodities; and

(B) the value of goods exported under the Foreign Assistance Act of 1961.

Section 377. Certain Meat and Meat Products

Section 377 of title III of the bill amends Public Law 88–482 to include "prepared" fresh, chilled and frozen beef and veal in the basic meat import quota provisions of that Act and to allocate the annual total quantities of all meats subject to import limitations on a quarterly basis.

Section 378. Trade With Foreign Countries Permitting Uncontrolled Production of or Trafficking in Certain Drugs

Section 378 of title III of the bill authorizes the President of the United States to impose an embargo or suspension of trade with a nation which permits the uncontrolled or unregulated production of or trafficking in opium, heroin, or other poppy derivatives in a manner to permit these drug items to fall into illicit commerce for ultimate disposition and use in the United States.

VIII. AMENDMENTS TO PUBLIC ASSISTANCE PROGRAMS AND WORK INCENTIVE PROGRAM

Amendments to Public Assistance Programs and Work Incentive Program

CONTENTS

VIII. AMENDMENTS TO PUBLIC ASSISTANCE PROGRAMS AND WORK INCENTIVE PROGRAM

A. AID TO THE AGED, BLIND, AND DISABLED

The committee has a continuing deep concern for those of our citizens who are in financial need because of old age or because of blindness or other crippling disabilities. Accordingly, the committee bill adds provisions to the House bill which significantly improve welfare benefits for such individuals. At the same time, recognizing the already heavy burden of welfare expenditures faced by the States, the committee has included in the bill provisions which will not only assure no increase in State costs because of the improvements in welfare for the aged, blind, and disabled, but will also actually reduce State budgets for these programs.

National Minimum Income Standard for the Needy Aged, Blind, and Disabled

(Sec. 501 of the bill)

Under present law, each State determines the level of assistance which it will provide to needy persons under the Federally-matched programs of aid to the aged, blind, and disabled. The committee recognizes that this arrangement is basically sound in that it allows each State to design its program in accord with its resources and with the level of costs prevailing within the States. However, the committee also feels that it is both possible and appropriate to establish by Federal law a minimum level of income support applicable on a nationwide basis to all needy persons who are aged, blind, or disabled. Accordingly, the committee bill would require States to provide a level of assistance sufficient to assure persons in these categories a total monthly income from all sources of at least $130 for a single individual and at least $200 for a couple. Each State would, of course, remain free to continue or establish a higher standard.

Old-age assistance: State needs standards and payment levels

	Single person		Couple	
	Standard of need	Payment to person with no other income	Standard of need	Payment to couple with no other income
Alabama	$140	$97	$235	$194
Alaska	211	211	273	273
Arizona	118	85	164	164
Arkansas	135	94	224	188
California	171	171	306	306

Old-age assistance: State needs standards and payment levels—Continued

	Single person		Couple	
	Standard of need	Payment to person with no other income	Standard of need	Payment to couple with no other income
Colorado	132	132	264	264
Connecticut	136	136	184	184
Delaware	130	100	184	184
District of Columbia	132	112	181	153
Florida	114	85	170	170
Georgia	93	84	151	151
Guam	120	120	161	161
Hawaii	122	122	191	191
Idaho	153	153	190	190
Illinois	176	176	221	221
Indiana	128	80	183	160
Iowa	122	113	186	172
Kansas	128	128	173	173
Kentucky	94	94	156	156
Louisiana	137	89	210	166
Maine	130	115	205	205
Maryland	91	91	124	124
Massachusetts	169	169	243	243
Michigan	156	156	198	198
Minnesota	143	143	196	196
Mississippi	120	65	184	130
Missouri	166	91	242	182
Montana	110	110	172	172
Nebraska	182	182	235	235
Nevada	165	165	264	264
New Hampshire	160	115	196	196
New Jersey	157	157	232	232
New Mexico	116	116	159	159
New York	162	162	234	234
North Carolina	108	108	132	132
North Dakota	147	140	190	180
Ohio	119	119	199	199
Oklahoma	122	122	206	206
Oregon	141	113	200	160
Pennsylvania	128	128	193	193
Puerto Rico	54	18	88	29
Rhode Island	163	163	211	211
South Carolina	87	80	121	121
South Dakota	145	138	189	189
Tennessee	102	97	142	142
Texas	115	115	184	184
Utah	76	76	122	122
Vermont	137	137	200	200
Virgin Islands	59	59	102	102
Virginia	138	138	179	179
Washington	192	192	247	247
West Virginia	146	76	186	97
Wisconsin	103	103	164	164
Wyoming	138	104	182	178

For aged single individuals who have no other income, this provision would result in increased assistance in about 31 States where monthly payments to such persons now range from $65 to $128. Aged couples would receive increased assistance payments in about 36 States.

Concurrently with establishing national minimum standards for assistance to the aged, blind, and disabled, the committee bill would also make persons receiving assistance under these programs ineligible to participate in the food stamp program. In effect, the committee bill would give needy persons more cash in lieu of food stamps.

Effective date—April 1, 1971.

PASS-ALONG OF SOCIAL SECURITY INCREASES TO WELFARE RECIPIENTS

(Sec. 502 of the bill)

Under the committee bill, social security benefits would be increased by 10 percent, with the minimum basic social security benefit increased to $100 from its present $64 level. If no modification were made in the present welfare law, however, many needy aged, blind, and disabled persons would get no benefit from these substantial increases in social security since offsetting reductions would be made in their welfare grants. For example, a needy aged individual in the State of Colorado is now eligible for a public assistance grant which will assure him a total monthly income of $132. If he now gets the minimum social security benefit of $64, his assistance grant would be $68. If his social security benefit is raised to $100, his welfare grant would be reduced to $32 leaving him with the same total monthly income of $132 and no net benefit from his social security increase. To assure that such individuals would enjoy at least some benefit from the social security increases, the committee bill requires States to raise their standards of need for those in the aged, blind, and disabled categories by $10 per month for a single individual and $15 per month for a couple. As a result of this provision, recipients of aid to the aged, blind, or disabled who are also social security beneficiaries would enjoy an increase in total monthly income of at least $10 ($15 in the case of a couple). Thus, in the above example, the needy aged individual in Colorado would have his welfare grant reduced by $10 less than the increase he receives in social security. This would leave him with a total monthly income of $142 as compared with his total income under present law of $132.

Under the committee bill, all social security beneficiaries also receiving aid to the aged, blind, or disabled would be guaranteed an increase in total income of at least $10 ($15 for a couple). The social security pass-along provision would affect needy aged, blind, and disabled persons in States which now have standards of need in excess of $120 for single individuals or $185 for couples. Recipients in States with lower standards would receive an increase in total monthly income of at least $10 ($15 for a couple) as a result of the provision establishing national minimum standards of $130 for aged, blind, or disabled individuals and $200 for couples.

Effective date—April 1, 1971.

Definitions of Blindness and Disability

(Secs. 503 and 504 of the bill)

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. The committee believes that the definition of these basic eligibility factors is a proper area for the establishment of nationally uniform standards. Accordingly, the committee bill makes applicable to these programs the definitions of blindness and disability which are used in the disability insurance program established under Title II of the Social Security Act.

The term "disability" would be defined by the committee bill 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).) This same test would apply in determining eligibility for welfare.

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 would be the particular sight limitation which is referred to as "tunnel vision."

The committee bill would permit States to continue assistance to disabled or blind individuals who are now on the rolls under the existing State definition, but who would not meet the Federal definition of blindness or disability.

Effective date—April 1, 1971.

Aid to the Blind—Prohibition of Liens

(Sec. 505 of the bill)

Under present law, States may at their discretion impose liens against the property of recipients of cash public assistance grants. The committee feels that it is inappropriate to require a blind individual to agree to a lien against his property in order to be eligible to receive welfare assistance. Accordingly, the committee bill would prohibit the imposition of such liens against the property of blind individuals as a condition of eligibility for aid to the blind.

Effective date—April 1, 1971.

Fiscal Relief for the States

(Sec. 506 of the bill)

The committee is aware that the rapid growth of welfare expenditures in recent years has severely strained the fiscal capacities of the States, and feels that the States should not be made to bear the additional costs resulting from the improvements which the committee bill makes in the welfare programs for the aged, blind, and disabled. In particular, the committee notes that some of the States which are already among those making the greatest fiscal effort in these programs relative to per capita income would also be among the States required by this bill to make the largest increases in their levels of assistance. While a certain amount of fiscal relief will accrue to the States to the extent that welfare grants are reduced because of the increases which the bill provides in social security benefits, this relief is not necessarily distributed in a way which reflects the relative welfare burdens of the States under present law or under the additional requirements imposed by the bill.

The committee bill accordingly contains a provision to assure that with respect to aid for the aged, blind, and disabled all the additional expenditures required by the bill will be met without increasing State costs, and, furthermore, that the present State liabilities under these programs will be reduced. The bill provides that States in future years will not be required to spend more for assistance to the aged, blind, and disabled than 90 percent of their expenditures for this purpose in calendar year 1970. The 10 percent savings would be paid from Federal funds as would the full amount of any increased expenditures resulting from mandatory provisions of the bill (such as the $10 pass-along of social security increases and the $130 national minimum standard for assistance to the aged, blind, and disabled). Increases in caseloads resulting from normal program growth (for example, as a result of population increases) would also be fully paid for with Federal funds, but increased expenditures resulting from liberalizations in State welfare programs not required by Federal law would not be covered by the 90 percent limitation. The costs of any such non-mandatory program liberalizations would be shared by the Federal and State Governments in accordance with the regular matching provisions.

How this provision could work is illustrated in the following table.

Illustration of how committee bill could affect expenditures for aid to the aged, blind, and disabled in a hypothetical State

[In millions of dollars]

	Total	Federal		State	
		Present matching	Committee bill	Present matching	Committee bill
1970 costs	$100	$60	(1)	$40	(1)
Costs in a future year:					
(a) Continuing present level	100	60		40	
(b) Normal program growth	10	6		4	
(c) $130 minimum; $10 pass-along; other requirements of committee bill	20	12	94	8	36
Total	130	78	94	52	36
(d) Growth from optional State program changes	10	6	6	4	4
Total	140	84	100	56	40

[1] Not applicable.

In the hypothetical State described in the above table, total Federal-State expenditures for calendar year 1970 are $100 million with the State now paying 40 percent ($40 million) and the Federal Government paying 60 percent ($60 million). In a future year, the costs of the program based on the continuation of present program levels could be $100 million to which might be added a cost of $10 million resulting from population increase and other normal program-growth factors, and a cost of $20 million resulting from the social security pass-along, the national minimum standard of $130 and other mandatory requirements of the committee bill. This would bring program costs for the year in question to a total of $130 million. Under present matching provisions as applicable to this State, the Federal Government would pay 60 percent ($78 million) and the State would pay 40 percent ($52 million). The committee bill, however, would limit the State's share of these expenditures to $36 million—90 percent of its 1970 expenditures of $40 million. Thus, under the committee bill, the total program costs of $130 million would be shared as follows: Federal share of $94 million (72%); State share of $36 million (28%). If, in the following year, total expenditures rose to $150 million, the State's share would remain at $36 million. (On a percentage basis, its share would drop to 24%).

If, however, a State raised its standards to more than the amount required by the $10 social security pass-along provision or the $130 national minimum, or if it made other program liberalizations not required by the committee bill, it would have to bear its full share of the extra costs resulting from such actions according to the regular Federal-State matching provisions. Thus, in the above example, if there were $10 million of additional costs from optional State liberalizations, the State would be responsible for 40 percent of these costs—

$4 million—which would be added to its $36 million share of other program costs.

Effective date—April 1, 1971.

B. FEDERAL CHILD CARE CORPORATION

(Sec. 510 of the bill)

At the present time the lack of adequate child care represents perhaps the single greatest impediment to the efforts of poor families, especially those headed by a mother, to achieve economic independence.

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 of 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.

A new emphasis began with the Public Welfare Amendments of 1962, in which the committee placed increased stress on child care services through a specific earmarking of child welfare funds for the provision of child care for working mothers. 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 the legislative hopes have not been met, and much less child care has been provided than was anticipated, it is a fact that child care provided 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, 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 includes provision for the creation of a Federal Child Care Corporation, with the basic goal of making child care services available throughout the Nation to the extent they are needed. 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.

Need for Child Care Services

The need for child care resources is great and is growing, and it 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. There are, at the present time, approximately 13 million women with children under age 18 who are in the labor force. More than four million of these women have children under age 6.

Furthermore, the number of women workers is expected to grow rapidly in the years to come, and in fact is expected to increase faster

than the number of men workers. It is estimated that by 1980, the labor force will include more than 5 million mothers between the ages of 20 and 44 who have children under age 5. This would represent an increase of more than 40 percent in the number of such mothers just over the next decade.

We know that at the present time there are many mothers who would be working if they could arrange adequate care for their children. This is as true of mothers in low-income families as it is of middle-class mothers. A recent study of welfare mothers in New York City showed that seven out of 10 would prefer to work if they could find care for their children. Similarly, studies and statistics relating to the Work Incentive Program (WIN) for recipients of aid to families with dependent children have shown that lack of child care is a major impediment preventing mothers from participating in employment and training programs.

A recent study by the Department of Health, Education, and Welfare on the Aid to Families with Dependent Children program points out that in the 1960's the proportion of AFDC women with high employment potential increased from 25.3 percent in 1961 to 44.5 percent in 1968. The researcher, Perry Levinson, stated that "as the AFDC caseload grew ever larger between 1961 and 1968, recipients were more and more women who had stronger educational and occupational backgrounds, that is, high employment potential." However, over 80 percent of the women reportedly could not take jobs because they had children under 8 at home, while more than 50 percent lacked day-care facilities.

The facts and figures document the very great demand by parents at all economic levels for child care resources. Unfortunately, we can also document the very poor supply of resources available to meet this demand.

Recent statistics indicate that licensed child care facilities today can accommodate only between 600,000 and 700,000 children. That is, of course, only a fraction of the children who now need child care services. Many "latchkey children" are left with no supervision whatsoever; other children are placed in child care programs which do not even provide custodial care of adequate quality, much less the kind of care which would meet the child's individual needs for healthy development.

The committee is concerned that in spite of greatly increased willingness to pay for child care services by both governmental institutions and by private individuals, the supply of child care services is not increasing rapidly. In 1967, when the Congress established the Work Incentive Program, unlimited Federal matching funds were authorized for child care for mothers in work and training. Despite a Federal appropriation of $25 million in fiscal year 1969, only $4 million was actually used to purchase child care. In fiscal year 1970, $52 million was appropriated but only $18 million was used. The Department of Health, Education, and Welfare showed itself unable to utilize funds appropriated by the Congress to expand the availability of child care.

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 matching funds to the States and hoping that child care will become available is not working. It is not resulting in the necessary increase in supply.

The States themselves have had very limited resources to devote to child care, and for many of them child care services have been given a low priority. A number of State governments are 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.

In very few instances is there strong State initiative in promoting the development of child care resources. Private voluntary organizations by their own efforts alone are not capable of meeting the magnitude of need for child care services, however admirable a job they are able to do in individual instances. Local governments have shown themselves generally to be incapable of providing leadership in this area, and in many cases unnecessarily restrictive and complex local ordinances make it difficult for any group to establish a licensed child care facility.

Private enterprise has begun to move into the gap, and in some areas is doing an excellent job in providing needed child care. On its own, however, we cannot expect private enterprise to do the whole job of organizing and providing a wide range of child care services wherever they are needed in the Nation.

It is the committee's view that we need a new mechanism in facing this problem, a single organization which has both the responsibility and the capability of meeting this Nation's child care needs. It must be an organization which has the welfare of families and children at the forefront, an organization which, though national in scope, will be able to respond to individual needs and desires on the local level. It must be an organization which will be able both to make use of the child care resources which now exist and to promote the creation of new resources. It must be able to utilize the efforts of governmental agencies, private voluntary organizations, and private enterprise.

The new Federal Child Care Corporation, which would be created under the committee bill, is intended to be such an organization.

Establishment of Federal Child Care Corporation

The basic goal of the Corporation would be to arrange for making child care services available throughout the Nation to the extent they are needed. As its first priority, the Corporation must provide services to present, past, and potential welfare recipients who need child care in order to undertake or continue employment or training.

To provide the Corporation with initial working capital, the Secretary of the Treasury would be required to lend the Corporation $50 million as working capital, to be placed in a revolving fund. With these funds the Corporation would begin arranging for day care services. Initially, the Corporation would contract with existing public, nonprofit private, or proprietary facilities providing child care services. The Corporation would also provide technical assistance and ad-

vice to groups and organizations interested in setting up day care facilities under contractual relationship with the Corporation. The committee bill would in addition authorize the Corporation to provide child care services directly in its own facilities. It would be expected that services would be provided directly only where they are not otherwise available or where the quality of existing services is unacceptably low.

Financing Child Care Provided by the Corporation

The Corporation would have three sources of funds with which to operate:

1. A $50 million loan from the Treasury to initiate a revolving fund;
2. Revenue bonds which could be sold to finance construction of facilities (this is discussed in more detail below), and
3. Fees paid for child care services.

Of the three, fees represent by far the most important source of funds.

The Corporation would charge fees for all child care services provided or arranged for; these fees would go into the 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 to fully cover the Corporation's costs in arranging for the care.

It should be emphasized that the Federal Child Care Corporation which would be created under the committee bill would provide a mechanism for expanding the availability of child care services, but it would not itself provide funds for the subsidization of child care provided the children of low income working mothers. These costs would be met, as under present law, through the welfare programs, although the Federal share for child care costs would be raised from 75 percent to 90 percent (in certain cases, 100 percent). It would be expected that the Corporation would derive a major source of its funding from fees charged for child care provided the children of mothers on welfare.

In view of the past history, the committee anticipates that in most cases, welfare agencies will find it convenient to utilize the Corporation for the provision of child care services. However, the committee bill would not require them to do so.

If after its first 2 years the Corporation felt it needed funds for capital investment in the construction of new child care facilities or the remodeling of old ones, it would be authorized to issue 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 Corporation's establishment, with an overall limit of $250 million on bonds outstanding.

The committee bill is carefully designed so that the Corporation's operations and capital expenditures over the long run would not cost the taxpayers a penny. The Corporation would pay interest on the initial $50 million loan from the Treasury, interest which each year would match the average interest paid by the Treasury on its borrowings. The Corporation would further be required to amortize the loan

over a 25-year period by paying back principal at the rate of $2 million annually. Finally, the Corporation's capital bonds would be sold directly to the public and would not be guaranteed by the Government, but only by the future revenues of the Corporation.

Kinds of Child Care Offered

From the standpoint of parents, the Corporation would provide a convenient source of all kinds of child care services, at reasonable fees. Like the Social Security Administration, the Corporation eventually would maintain offices in all larger communities of the Nation, where parents desiring child care services would be able to obtain them through the Corporation either directly in Corporation facilities or in facilities under contract with the Corporation. In either case, the parents could be confident that the child care services were under the supervision of the Corporation and met the standards set forth in the bill.

The bill would require the Corporation to make available a wide variety of child care services, some already well known and some unavailable in most places today. For example:

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 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 wishing to have their preschool-age child 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 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, in a center or under trained adult supervision in a home.

Parents seeking child care during the summer vacation would be able to send their children to day camps or summer camps.

The Corporation 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 otherwise engaged.

The Corporation would be required to arrange for at-home child care, or 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 them to night care facilities, primarily designed to care for the child during sleeping hours. Nurses, maintenance

staff, and persons in other nighttime jobs now find it almost impossible to arrange for child care services while they work.

Parents requiring care for their children 24 hours a day for less than a month would be able to arrange for the care at a boarding facility. This kind of facility, which could be a summer camp, would provide care if the parents planned to be away for a weekend or for a vacation. If a welfare agency were purchasing care on the child's behalf, provision could be made for a disadvantaged child in a city to be sent to summer camp.

Establishing New Child Care Facilities

The Corporation will depend for its success in expanding the availability of child care services on the efforts of 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 organizations will be stimulated to establish child care facilities. 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 Corporation for the provision of child care services. If the Corporation 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 Corporation will replace the present time-consuming approvals required from various agencies at the local level.

If the Corporation is in particular need of child care facilities in an area and facilities exist but are of low quality, the Corporation might contract with the understanding that the facility will be improved. If the promised improvement does not take place, the Corporation would be expected to provide child care services directly in the future rather than to continue to contract for services of unacceptable 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. Groups interested in promoting parent involvement should find it possible to establish child care facilities through the Corporation where they are unable to do so today.

Training of Child Care Personnel

The committee regrets that lack of trained personnel has hampered efforts to expand child care services in the past. It is clear that the purpose of establishing the Federal Child Care Corporation will be frustrated if this situation is not changed. Authority already exists under section 426 of the Social Security Act for the training of personnel in the child care field. It is the committee's intention that sufficient funding be sought under this authority to greatly expand child care personnel.

In addition, the committee feels that many mothers receiving Aid to Families with Dependent Children have both the inclination and the ability to provide child care for other children. It is the committee's intention that welfare mothers and other women in low-income neighborhoods where the need for child care services is greatest be

given the highest possible priority in training additional child care personnel. It is with this goal in mind that the committee bill would direct the Secretary of Labor to utilize the Work Incentive Program to the maximum extent in providing training for welfare recipients to become proficient in child care.

In addition, the Corporation is authorized to conduct (either directly or by contract) in-service training programs to prepare individuals in the child care field. It is the committee's hope that these provisions will enable the Corporation to accomplish two aims at once—ending the dependency of some welfare recipients by providing opportunities in child care, and expanding child care services so that other mothers on welfare may have an opportunity for employment.

Construction of Child Care Facilities

It is the committee's view that 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 frequently 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 Corporation to issue revenue bonds for capital construction costs, but it is the committee's intention that construction be resorted to only when child care services may not otherwise be provided. With the provisions of the bill discussed below, enabling facilities arranged for through the Corporation 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

As has been noted, of the millions of children who are not cared for by their parents during the day, well under 1 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 Corporation's auspices meet national child care quality standards which are set forth in the bill.

When Dr. Edward Zigler, the head of the Office of Child Development in the Department of Health, Education, and Welfare, was before the Committee for hearings on his confirmation, he was asked if he agreed that it was unnecessarily difficult to set up a licensed child care facility in a large city. Dr. Zigler replied:

> I think it is probably true that there have been so many demands placed on both profit and non-profit groups that in certain instances it is becoming ridiculous because there is overlapping responsibility on the part of local people, State people, and so forth: I think if we are serious about setting up a worthwhile social institution such as day care for working mothers we may have to develop guidelines at a national level which would have some nationwide application. It would be a standard process because now it is too difficult and it is too rigid, and I am very much afraid the professionals have overdone themselves here.

They have bent so far backwards in protecting the physical welfare at the expense of psychological wellbeing that I do not find myself in great sympathy with some of the statutes.

As Dr. Zigler points out, overly rigid licensing requirements in general have relegated children to unsupervised and unlicensed care, if indeed any care, while their parents work.

The problem is highlighted in a recent report entitled "Day Care Centers—The Case for Prompt Expansion," which explains why day care facilities and programs in New York City have lagged greatly behind the demand for them:

The City's Health Code governs all aspects of day care center operations and activities. Few sections of the Code are more detailed and complex than those which set forth standards for day care centers. The applicable sections are extremely detailed, contain over 7,000 words of text and an equal volume of footnotes, and stretch over two articles and twenty printed pages.

The provisions of the City's Health Code that apply to day care center facilities constitute the greatest single obstacle to development of new day care center facilities. The highly detailed, and sometimes very difficult-to-meet, specifications for day care facilities inhibit the development of new facilities. Obviously there must be certain minimum fire, health, and safety standards for the protection of children in day care centers. The provisions of the Health Code go far beyond this point. Indeed, some sections of the Code are a welter of complex detail that encourages inflexibility in interpretation and discourages compliance.

Section 45.11(i) of the Health Code, for example, reads: "Toilets shall be provided convenient to playrooms, classrooms and dormitories and the number of such toilets shall be prescribed by section 47.13 for a day care service, 49.07 for a school, or 51.09 for a children's institution. In a lavatory for boys six years of age and over, urinals may be substituted for not more than one-third of the number of toilets required. When such substitution is made, one urinal shall replace one toilet so that the total number of toilets and urinals shall in no case be less than the number of required toilets. Toilets and urinals shall be of such height and size as to be usable by the children without assistance."

Subsection 6 of Section 45.11 of the Health Code is another example. It prescribes lighting standards for day care centers, as follows:

(1) Fifty foot candles of light in drafting, typing, or sewing rooms and in all classrooms used for partially sighted children;

(2) Thirty foot candles of light in all other classrooms, study halls or libraries;

(3) Twenty foot candles of light in recreation rooms;

(4) Ten foot candles of light in auditoriums, cafeterias, locker rooms, washrooms, corridors containing lockers; and

(5) Five foot candles of light in open corridors and store rooms.

Legally, only those centers that conform to the Health Code may be licensed. Faced with Health Code requirements of such detail, personnel of the Divisions concerned in the Department of Health and in the Department of Social Services have had to choose between considering the regulations as prerequisites to

the licensing of new day care centers or merely as goals toward which to work.

In general, the choice is made in favor of strict interpretation notwithstanding the fact that this severely handicaps the efforts of groups attempting to form centers in substandard areas.

The 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 Corporation the maximum amount of discretion in evaluating the suitability of an individual facility. The Corporation 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 assure the physical safety of children, the bill requires that facilities must meet the Life Safety Code of the National Fire Protection Association. This will provide protection for those many children today who are being cared for in unlicensed facilities, the safety of which is unknown.

Any facility in which child care was provided by the Corporation, 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. This provision would make it possible for many groups and organizations to establish child care facilities under contract with the Corporation 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 Corporation; 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 Corporation.

Reporting Requirement

The bill requires the Corporation to submit a report to each Congress on the activities of the Corporation, including data and information necessary to apprise the Congress of the actions taken to improve the quality of child care services and plans for future improvement.

Board of Directors

The Corporation would be headed by a Board of Directors consisting of three members, to be appointed by the President with the consent of the Senate. The members of the Board would hold office for a term of three years.

National Advisory Council

A National Advisory Council on Child Care would be established to provide advice and recommendations to the Board on matters of

general policy and with respect to improvements in the administration of the Corporation. 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 12 individuals (nine of them representative of consumers of child care), appointed by the Board.

Increase in Federal Matching for Child Care Services

Under present law, child care for the children of working mothers who receive public assistance may be paid for in one of two ways:

1. The child care may be arranged by the welfare agency, which would pay for the care and receive 75 percent Federal matching; or
2. A mother may arrange for child care herself and in effect be reimbursed by adding the cost of child care to her welfare payment as a work expense.

According to the Auerbach Corporation, an organization that studied the Work Incentive Program, the latter method has by far been the more common:

> Our own findings raise even more doubts about the extent to which WIN mothers may be benefiting themselves and their families through WIN. In the cities selected for the child care studies, slightly over two hundred mothers were interviewed to determine their need for child care, what they were told about child care, and how it was obtained. Our results show that not only did the overwhelming majority (eighty-eight percent) arrange their own plans, independent of welfare, but that most (eighty percent) were informed by their caseworkers that it was their responsibility to do so. Even more discouraging is that the majority of mothers (eighty-three percent) who were informed about child care by their caseworkers were left with the impression that they could make use of any service they wanted; approved services were not required.

This situation is reflected in the inability in the Department of Health, Education, and Welfare to use all the funds appropriated by the Congress for child care under the Work Incentive Program.

The committee bill would increase the Federal matching percentage for child care services under the AFDC program from 75 percent to 90 percent, with the Secretary of Health, Education, and Welfare authorized to waive the requirement of 10 percent non-Federal funds for a limited period of time when this is necessary in order for any child care services to be available. States would be required to maintain their present level of expenditures for child care services so that the additional Federal funds would not simply replace State funds.

Under present law, Federal matching is provided for all individuals who need child care services in order to participate in employment or training under the Work Incentive Program, and States are required to make such services available. States may, at their option, provide services for other past, present, or potential recipients of welfare. The committee bill retains these provisions, and 90 percent Federal matching would be available to provide services in all of these circumstances.

C. IMPROVEMENTS IN THE WORK INCENTIVE PROGRAM

(Sec. 520 of the bill)

The Work Incentive Program was created by the Congress as a part of the Social Security Amendments of 1967. It represents an attempt to cope with the problem of rapidly growing dependency on welfare by providing recipients with the training and job opportunities needed to help them become economically independent.

The Committee on Finance was a principal architect of the WIN program and was responsible for the basic decision that the Department of Labor would administer the manpower training program. However, the committee has been greatly disappointed in the administrative implementation of WIN. The Auerbach Corporation, the Labor Department's prime evaluator of WIN, succinctly sums up the situation:

"Despite the program's timeliness and general conceptual soundness, it has not lived up to expectations."

The points of emphasis the committee thought were abundantly clear in the 1967 amendments have been paid lip service or have been totally ignored. A meaningful program of on-the-job training continues to be an unfulfilled Labor Department promise. The legally required program of special work projects (public service employment) is a reality in only one State. Lack of Labor Department and Health, Education, and Welfare cooperation and that of their counterparts at the local level has been a major problem in the referral process and in the provision of necessary supportive services for recipients in work and training. The main thrust of the WIN program as it exists today remains in the direction of basic education and classroom training, which our experience with manpower training over the last decade shows not to result in the placement of people in jobs, but rather in a growing skepticism of both welfare recipients and the public as to the worth of such endeavors.

The committee's amendments to the Work Incentive Program are designed to make even clearer and more effective what it intended in 1967, and to add certain tax credit mechanisms which will effectively link manpower training with the actual provision of jobs.

Status of the Work Incentive Program

It has been characteristic of the Work Incentive Program that stated expectations and actual results have diverged widely. The Department of Labor estimates to the House-Senate conferees in 1967 included a projection that in fiscal year 1970, the first full year of the WIN program, there would be 150,000 trainees. In 1969, the estimate to the Appropriations Committee of the number of trainees in 1970 was cut approximately in half—to a total of 77,000 trainees. The actual average number of trainees in 1970 was 42,000—less than one-third of the projection given the Congress when the program was established.

The Department of Labor spokesman told the Appropriations Committee in the fall of 1969 that there would be 150,000 enrollees actually in the program by July 1970. Later in the fiscal year they told the Committee on Ways and Means and this committee that 100,000

enrollees would be in the program by July 1970. Actually, by this date there were only 89,689 enrollees and by the first of October 1970, this figure had only increased to 97,238. What is more significant, however, is that almost 30,000 of these enrollees are either waiting for training to begin, waiting between training components, or have completed their training but have not been placed in jobs. This latter category has nearly doubled between July and October of this year, and there are now 4,500 WIN participants who have completed training but are waiting for jobs. Of the approximately 68,000 WIN participants actually involved in training on October 1, almost 50,000 of them are either in orientation, basic education, or classroom vocational training—training with little relationship to actual work experience.

On-the-Job Training and Public Service Employment

A major criticism of the present Work Incentive Program has been the lack of development of on-the-job training and public service employment (special work projects). These components offer the best opportunity for the employment of welfare recipients because they provide training in actual job situations. Unfortunately, only about 1.8 percent of the welfare recipients enrolled in WIN are participating in on-the-job training and public service employment.

The Auerbach Corporation, in its report on the WIN program, made the following comment on OJT:

> The majority of training courses for WIN are institutional. Though these have been supplemented by individual contracts, a pressing need exists for on-the-job training. In most areas, including some of the largest programs visited, no OJT courses for WIN enrollees have been procured. For example, the largest program evaluated has staff dedicated to the development of OJT slots. After seven months no results have been produced. The main reason for this is the competition for the limited number of OJT slots among many agencies and programs. In some areas, the private sector has been saturated. The Work Incentive Program finds itself further limited since its contracting provisions are not competitive with National Alliance of Businessmen (NAB) OJT under the MA-4 Contracting provisions. The MA-4 contracts, moreover, are usually unavailable to WIN applicants since the Concentrated Employment Program (CEP) is the prime deliverer of manpower to NAB and can fill the slots from its own applicants.
>
> In many respects, OJT is the most desirable of all training options, since it screens for a job at the beginning rather than at the end of training. The applicants are aware when they are placed in OJT that this is already a job and that they have a position if they can hold it. Unlike Institutional Training, which does not guarantee a placement (and many applicants express the fear that they will not get a job), OJT has the incentive of employment built in.

Although these observations as to the development of OJT were made during a period of a higher level of employment and economic activity than exists today, the committee believes that with increased

efforts of Federal and State personnel and the use of the tax credit mechanism discussed in the next section, OJT can become an important part of WIN. The committee also believes that the Department of Labor and the local manpower agencies should give the highest priority to obtaining OJT slots for WIN participants.

The need for a substantial program of public service employment was clearly recognized and made mandatory by this committee in 1967. The legislation put an obligation on the Secretary of Labor to establish as part of each WIN program a program of special work projects for individuals for whom a job in the regular economy cannot be found. Since that time the need for this type of program has become increasingly apparent but this fact has only belatedly been recognized in principle by the Executive Branch.

To remedy this lack of emphasis in the WIN Program, the committee's amendment would require that at least 40 percent of the funds spent for the Work Incentive Program be used for on-the-job training and public service employment (which replaces the special work projects of the current WIN program). Moreover, the committee's bill would simplify the financing and increase the Federal share of the cost of public service employment by providing 100 percent Federal funding for the first year, and 90 percent Federal sharing of the cost in subsequent years. If the project was in effect less than three years, Federal sharing for the first year would be cut back to 90 percent. The safeguards on special work projects under existing law relating to health, safety, and other working conditions are continued for public service employment, as well as the provision that no wages "shall be lower than the applicable minimum wage for the particular work concerned."

As under the special work projects of existing law, the persons under public service employment will be reviewed every 6 months for possible placement in private employment.

Effective date—July 1, 1971.

Tax Incentive for Hiring WIN Participants

As an incentive for employers in the private sector to hire individuals placed in on-the-job training or employment through the Work Incentive Program, the committee amendment would provide a tax credit equal to 20 percent of the wages and salaries of these individuals. The credit would only apply to wages paid to these employees during their first 12 months of employment, and it would be recaptured if the employer terminated employment of an individual during the first 12 months of his employment or before the end of the following 12 months. This recapture provision would not apply if the employee became disabled or left work voluntarily. This provision will constitute an important link between training and jobs.

The tax credit is described more fully in Part X of this report.

Lack of Relation Between Training Program and Local Labor Market Needs

The Auerbach Corporation stated in its report:

> Much more needs to be known about the actual availability of jobs for WIN "graduates" in areas where the program

functions. Analysis should be made, on a site-by-site basis, and should include both job opportunities which are extant and those which are expected to be developed. A particular area of inquiry is the relative potential of the public and private sectors of the economy to supply jobs. WIN operates in many areas on the assumption that large numbers of jobs can be readily secured in the private sector; this assumption may not be borne out by investigation.

Once the potential job market for WIN enrollees is defined, the program should be planned around that market, in terms of both slot allocation and provision of components. The size of WIN projects is presently determined by the size of the local AFDC population: it would make more sense to let project size be governed by actual job availability. Labor market analysis would also ensure that training programs were suitable for existing jobs.

To meet the existing unmet need for labor market analysis, the committee bill would require the Secretary of Labor to establish local labor market advisory councils whose function would be to identify present and future local labor market needs. The bill provides that if there is already an appropriate body in an area, the Secretary of Labor may designate it as the advisory council. The findings of this council would have to serve as the basis for local training plans under the Work Incentive Program to assure that training was related to actual labor market demands.

Effective date—July 1, 1971.

Registration of Welfare Recipients and Referral for Work and Training

Under present law, all "appropriate" welfare recipients must be referred by the welfare agency to the Labor Department for participation in the Work Incentive Program. Certain categories of persons are statutorily considered inappropriate. Persons may volunteer to participate in the Work Incentive Program even if the State welfare agency finds them inappropriate for mandatory referral.

A major criticism of the program has been that the State application of those standards of "appropriateness" for the program have resulted in widely differing rates of referrals and program participation. The committee's bill would eliminate this situation with a series of amendments. First, it would require welfare recipients to register with the Labor Department as a condition of welfare eligibility unless they fit within one of the following categories:

1. Children who are under age 16 or attending school;
2. Persons who are ill, incapacitated or of advanced age;
3. Persons so remote from a WIN project that their effective participation is precluded;
4. Persons whose presence in the home is required because of illness or incapacity of another member of the household; and
5. Mothers with children of preschool age.

At least 15 percent of the registrants in each State would be required to be prepared by the welfare agency for training and referred to the Work Incentive Program each year. States failing to meet this per-

centage would be subject to a decrease in Federal matching funds for aid to families with dependent children. Under the bill the Federal matching percentage for AFDC assistance payments would be reduced by one percentage point for each percentage point the State fell below the 15 percent requirement for referral of registrants. The committee emphasizes the point that the only referrals of welfare recipients which meet the 15 percent requirement are those made after adequate assessment of training and employment potential together with the provision of the day care, social and medical services which are necessary for their effective participation in WIN. "Paper referrals" by the welfare agencies in some States have been one of the problems of WIN and such referrals would not meet the requirement of this provision.

The committee bill would also establish clear statutory direction in determining which individuals would receive employment or training by generally requiring the Departments of Labor and Health, Education, and Welfare to accord priority in the following order, taking into account employability potential:

1. Unemployed fathers;
2. Dependent children and relatives age 16 or over who are not in school, working or in training;
3. Mothers who volunteer for participation; and
4. All other persons.

Thus, under the amendment, mothers would not be required to participate until every person who volunteered was first placed.

Effective date—July 1, 1971.

Allowances for Transportation and Other Expenses Necessary to Training

Another of the problems of the WIN program has been reimbursement for training expenses which, under existing law, must come from the welfare side of the program. This has often resulted in delayed payments, multiple checks and general inconvenience to the trainee which have had an adverse effect on his attitude toward the program. Under the committee's bill the local manpower agency could reimburse the trainee for necessary expenses directly related to his participation in training, such as transportation, lunches, special clothes, and supplies needed for the training.

Effective date—January 1, 1971.

Program Coordination on the Federal Level

The successful administration of the entire referral process requires the careful coordination of efforts by both the Labor Department and HEW and their agencies at all levels of Government. This requirement has not always been met in the operation of the current WIN program. The Auerbach report observes:

> Though the success of WIN depends on a coordinated activity, it has been largely carried out as two separate programs. Separate guidelines—not always in agreement—have been issued by Departments of Labor and Health, Education and Welfare, and few joint procedures or training packages

> have been promulgated. The result has been a misunderstanding between local welfare and manpower agencies since there has been little interagency liaison and little information in either agency about the other's responsibility or activities. In particular, caseworkers—who are responsible for many of the WIN services—often know little about the WIN responsibilities of the welfare agency, much less about those for the Employment Service.

The committee bill meets this problem by mandating coordination between the Departments of Labor and Health, Education, and Welfare on the national, regional, and local levels. It requires that all regulations on the Work Incentive Program be issued jointly by both Federal agencies within six months of enactment. It also requires that a joint Health, Education, and Welfare-Labor Committee be set up to assure that forms, reports, and other matters are handled consistently between the two departments. The Auerbach report cited as imperative the need that the Work Incentive Program be operated under one set of guidelines, policies, and administrative procedures—a situation found not to be the case today.

Program Coordination at the Local Level

Under present law, the welfare agency is supposed to prepare an employability plan for each appropriate welfare recipient and make referrals to the Department of Labor. The Department of Labor is then to prepare an employability plan and place the individual in employment, on-the-job training, institutional training, or public service employment (special work projects).

Problems have arisen in this process. In some cases, the welfare agency has not referred sufficient numbers of persons, while in other cases they have referred far too many persons, without first arranging for the supportive services (such as child care or remedial medical services) needed in order to enable the welfare recipient to participate in the Work Incentive Program. The large number of persons who are enrolled in the WIN program but are forced merely to wait for training or placement, attest to the lack of planning and coordination in the present process.

The more dynamic WIN jurisdictions have established separate administrative units in their welfare agencies, with the sole responsibility of seeing that WIN trainees are afforded the medical, social, and vocational rehabilitation services necessary to their effective participation in the program. The committee bill would require that all States set up such separate units. To help implement this provision, expenditures related directly to the services provided by these units will generally be matched by the Federal Government at the 90 percent level under the committee bill. Under present law, the Federal matching for these services is generally at 75 percent (but may be as low as 50%) and must compete with other social and medical services not related to the employment program. Furthermore, the bill would require that the welfare agency and the Labor Department on the local level enter into a joint agreement on an operational plan—that is, a

plan setting forth the kinds of training they would arrange for, the kinds of job development the Labor Department would undertake, and the kinds of job opportunities for which both agencies would need to prepare persons during the period covered by the plan. In addition, both agencies would jointly develop employability plans for individuals, consistent with the overall operational plans, to assure that individuals receive the necessary supportive services and preparation for employment without unnecessary waiting. Recipients may be consulted during the development of their employability plans, but they will not be allowed to veto a plan which is developed for them.

Effective date—July 1, 1971.

WIN Staffing Problem

Relying on the report of the Auerbach Corporation, the Department of Labor notes the problem that the application of State civil service laws has had on the effective staffing of WIN projects. The Labor Department WIN report transmitted to the Congress in July 1970 states.

> Staffing WIN projects was hampered by civil service procedures in many States. Seniority provisions in State merit systems often required that persons in the employment service agencies with seniority be given preference for positions needed to staff the new programs, even though they might be poorly suited to work with welfare recipients. This problem was particularly acute at the management supervisory levels.
>
> Existing job descriptions, lists, and qualifications indices did not facilitate recruitment of the kind of staff who could work with disadvantaged persons. Where the selection criteria were not changed, the new employees were not what the program really needed. For example, qualifications for counselor positions in most States require a college degree with credits in a behavioral science. Such academic background, however, does not insure that the graduate will be able to handle vocational problems, work with disadvantaged minority group applicants, and understand the lifestyle and outlook of the poor. In addition, turnover is encouraged by low salary levels, particularly among counselors with a few years' experience who can find more lucrative positions elsewhere.

The committee notes that inasmuch as responsibility for administering WIN is delegated in the statute specifically to the Secretary of Labor, he currently has authority to overcome these impediments to effective WIN administration.

Allocation of Federal Funds and Increased Federal Matching

Under existing law, there is no method of allotment of Federal funds to the States for WIN programs. The committee bill would provide that funds for the program be allocated among the States on the basis of the number of registrants for work and training. This would give

States some advance knowledge of their entitlement for training slots under the Work Incentive Program.

One of the reasons stated by the Department of Labor for the slow implementation of WIN in some States is the current Federal matching share for training expenditures of 80%. The committee bill endorses the Administration's proposal to raise the Federal matching share to 90%. This should go far in removing any financial impediment to State participation in WIN.

Effective date—July 1, 1971.

Coordination With Other Manpower Programs

The committee bill would require that the Secretary of Labor utilize other existing manpower programs to the maximum extent feasible, to avoid unnecessary duplication of programs. This continues a similar provision of existing law. Under this provision, as under existing law, the committee expects that WIN participants will be placed in programs—such as JOBS—established under other statutes. WIN funds are available for these costs, and the committee does not wish separate programs established for WIN participants where these people can be served by already-established manpower programs. The committee expects that WIN participants will be given the priority appropriate to their situation as being the most disadvantaged citizens of our nation.

Technical Assistance

Under existing law there appears to be a question of whether the Secretary of Labor is authorized to provide technical assistance to local manpower agencies in establishing and carrying on WIN projects. The committee's bill includes a provision giving the Secretary this specific authority, thus clarifying the matter.

Effective date—January 1, 1971.

Information on WIN

The committee bill would require the Secretary of Labor to collect significant statistical information on the Work Incentive Program so that progress under the program can be better evaluated.

Specifically, as part of his overall information gathering responsibilities, the Secretary of Labor shall publish monthly the following information on WIN participants, by age group and sex:

1. The number of individuals registered with the Labor Department, the number of individuals receiving each particular type of work training services, and the number of individuals receiving no such services;
2. The number of individuals placed in jobs by the Secretary under the program, and the average wages of the individuals so placed;
3. The number of individuals who begin with but fail to complete training, and the reasons for the failure of such individuals to complete training; and the number of individuals who register voluntarily but do not receive training or placement;

4. The number of individuals who obtain employment following the completion of training, and the number of such individuals whose employment is in fields related to the particular type of training received;

5. Of the individuals who obtain employment following the completion of training, the average wages of such individuals, the number retaining such employment 3 months, 6 months, and 12 months following the date of completion of such training;

6. The number of individuals in public service employment, by type of employment, and the average wages of such individuals; and

7. The amount of savings, realized by reason of the operation of each of the programs established pursuant to this part.

Effective date—July 1, 1971.

Earned Income Disregard

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.

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 those who are able to move into full time jobs.

Effective date—July 1, 1971, except that States may adopt this change earlier at their option.

Conclusion

The task of training welfare recipients for jobs and actually placing them in employment on a permanent basis is admittedly one of the most difficult tasks facing government. The committee believes that the changes it is proposing for WIN are important, albeit some of these could have been made without changes in the statute. But the committee is also aware that regardless of what the Congress does in this area the ultimate success of the program will, in large measure, be dependent on the dedication of administrators at the Federal, State,

and local level and the resources they are allocated. The committee believes it is incumbent upon the Department of Labor to show its commitment to WIN and to provide sufficient staffing at the Federal level commensurate with its responsibilities as the primary administrator of the program. The WIN program must receive the kind of implementation its importance deserves.

D. FAMILY PLANNING SERVICES

(Sec. 520(a)(9) of the bill)

The committee bill provides for a major advance in enabling the poor to obtain free family planning services by authorizing 100 percent Federal funding for State family planning programs for present and potential welfare recipients, including both information and the provision of medical services.

As under present law, States would be required to offer family planning services to all appropriate recipients of Aid to Families with Dependent Children. The committee's amendment would also allow the States to receive 100 percent Federal funding for programs for both former recipients and those who are likely to become recipients of welfare. Acceptance of services, as under present law, would be voluntary with the recipient.

The committee believes that its amendments will give great impetus to the development of family planning services by the States. A beginning has been made as the result of congressional action in 1967, when provisions were included in the Social Security Amendments which required that family planning services be offered all appropriate AFDC recipients, and authorized 75 percent Federal matching funds for this purpose. The same matching was also 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. . . .

Testimony presented during the hearings has persuaded the committee 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 committee. By providing 100 percent Federal funding, the committee bill will remove any existing financial barrier.

The committee believes its amendment is consistent with the aims of the Administration, as expressed by the President in a speech in July 1969:

> Most of an estimated five million low income women of childbearing age in this country do not have adequate access to family planning assistance, even though their wishes concerning family size are usually the same as those of parents of higher income groups.
>
> It is my view that no American woman should be denied access to family planning assistance because of her economic condition. I believe, therefore, that we should establish as a national goal the provision of adequate family planning services within the next five years to all those who want them but cannot afford them. This we have the capacity to do.

The committee shares the goal of the President. It notes that, according to testimony of Planned Parenthood Federation, full family planning services can be provided for about $60 per woman per year. This seems a small price to pay for the personal, social and economic benefits which can be achieved as the result of an effective nationwide family planning program.

Effective date—January 1, 1971.

E. EMERGENCY ASSISTANCE FOR MIGRANT FAMILIES WITH CHILDREN

(Sec. 530 of the bill)

Under existing law, emergency assistance may, at the option of the States, be provided to needy migrant families and be provided either Statewide or in part 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. Therefore, the committee bill amends existing law (1) to require all States to provide such a program; (2) to require that it be Statewide in application; and (3) to provide Federal matching of its cost at the 75 percent level.

Under existing law, the emergency assistance program, which has been adopted in about 25 jurisdictions, is matched by the Federal Government at the 50 percent level. The regular emergency assistance program will continue to be optional, and its rate of Federal matching will remain at 50 percent.

The same feature of existing law as to the nature of the emergency and the mode of assistance in the regular emergency program would be applicable to the new migrant program: Assistance would 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, or other payments as the State agency may specify with respect to, or medical care or any other type of remedial care in behalf of, the child or other member of the household in which the child is living, and other services as may be specified by the Secretary.

Effective date July 1, 1971.

F. OBLIGATION OF A DESERTING FATHER

(Sec. 540 of the bill)

Families may receive Aid to Families with Dependent Children if the father is dead, incapacitated, unemployed, or absent from the home. Absence from the home constitutes by far the major reason for dependency among children. In 1969, three out of four families receiving AFDC were eligible because of the father's absence from the home.

One out of six families is on welfare because of the father's desertion. With about 9 million AFDC recipients, this means that about 1,500,000 mothers and children are receiving welfare today because the father of the family has deserted.

An illustration of the impact of desertion on a city's AFDC rolls is included in the findings of a special review of AFDC in New York City by the Department of Health, Education, and Welfare and the New York State Department of Social Services.

According to this review, the number of AFDC women whose husbands had deserted them rose from 12,138 cases in 1961 to 52,855 cases in 1967, a 335.4 percent increase, as compared with a total caseload increase of 159.7 percent between 1961 and 1967. The number of cases of deserted wives and wives separated without court decree was 15,457 in 1961; 63,185 in 1967; and 79,147 in 1968. Thus, between 1961 and 1968 the cases of deserted or informally separated wives grew by 412 percent, as compared with a total caseload increase of 234.7 percent.

Nationally, the largest single cause of dependency among children is illegitimacy. In 28 percent of the families receiving AFDC, the mother is not married to the father of the child.

The Congress has attempted to deal with this aspect of the dependency problem in the past. Present law requires that the State welfare agency 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 Internal Revenue Service records in locating deserting parents.

These measures, however, have failed to stem the explosive growth of the welfare rolls in the past 3 years, a growth largely consisting of families in which there either never was a father or in which the father has deserted the family or is otherwise separated from the mother.

Officials from Milwaukee, Wis., in testimony before the committee urged that it be made a Federal offense for a father to leave a State to abandon his family.

During the hearing on the welfare bill, Secretary Richardson was asked his opinion about direct Federal action in desertion cases. He replied:

> We would support legislation which made it a Federal crime to cross State lines for the purpose of evading parental responsibility. The only real problems that arise here—and I cannot speak to these—involve the responsibility that would thereby be put on the Justice Department and U.S. attorney's offices.
>
> Generally speaking, Federal law enforcement officials, I think, have felt that this ought to be a State responsibility. This system is, in effect, an interstate compact designed to enable the States to work together and to trace and get money payments from fathers. From the standpoint of our Department to make this a Federal crime would help to reduce the problem, we think, and to that extent we would be for it. (P. 690 of hearings.)

The committee considers the provisions of present law useful and feels they should be retained. However, it is clear that further action is necessary to permit more extensive involvement of the Federal Government in cases where the father is able to avoid his parental responsibilities by crossing State lines.

First, the committee bill would make it a Federal misdemeanor for a father to cross State lines in order to avoid his family responsibilities. The penalty under this new amendment would be imprisonment for up to one year.

Second, the committee bill would provide that an individual who has deserted or abandoned his spouse, child, or children shall owe a monetary obligation to the United States equal to the Federal share of any welfare payments made to the spouse or child during the period of desertion or abandonment. In those cases where a court has issued an order for the support and maintenance of the deserted spouse or children, the obligations of the deserting parent would be limited to the amount specified by the court order.

Present law requires the State to seek to obtain a court order requiring the deserting parent to support his family. The committee feels it is desirable to continue to provide an incentive for the States to do this. Therefore, under the committee bill, if the State has obtained a court order, the Federal Government would attempt to recover both the Federal and non-Federal share of welfare payments to the deserting father's family. If the State has not obtained a court order, the Federal Government would only attempt to recover the Federal share of the welfare payments. The deserting parent's obligation could be collected in the same manner as any other obligation against the United States.

The bill also provides that information regarding the whereabouts of the deserting individual would be furnished, on request, by the Federal Government to the deserted spouse, or to the guardian or custodian of the child or children deserted, or their counsel, where a judgment for support has been obtained.

In an article entitled "The Crises in Welfare" written two years ago Daniel P. Moynihan stated:

> While minority group spokesmen are increasingly protesting the oppressive features of the welfare system and liberal scholars are actively developing the concept of the constitutional rights of welfare recipients with respect to such matters as man in the house searches, it is nonetheless the fact that the poor of the United States today enjoy a quite unprecedented de facto freedom to abandon their children in the certain knowledge that society will care for them, and what is more, in a State such as New York, to care for them by quite decent standards. Through most of history a man who deserted his family pretty much assured that they would starve or near to it if he was not brought back, and that he would be horsewhipped if he were. Much attention is paid the fact that the number of able-bodied men receiving benefits under the AFDC program is so small. In February 1966, Robert H. Mugge of the Bureau of Family Services of HEW reported that of the 1,081,000 AFDC parents there were about 56,000 unemployed, but employable fathers. But in addition to the 110,000 incapacitated fathers, there were some 900,000 mothers of whom by far the greatest number had been divorced or deserted by their presumably able-bodied husbands.
>
> Now, a working-class or middle-class American who chooses to leave his family is normally required first to go through elaborate legal proceedings and thereafter to devote much of his income to supporting them. Normally speaking, society gives him nothing. The fathers of AFDC families, however, simply disappear. Only a person invincibly prejudiced on behalf of the poor would deny that there are attractions in such freedom of movement.

It is the committee's hope that the measures contained in the committee bill will equate the responsibilities of a father of AFDC children with those of the father of a working-class or middle-class family.

Effective date—Immediate.

G. THE SUPREME COURT AND WELFARE CASES

Court decisions have played a major role in the phenomenal growth of the welfare rolls in the last three years. One of the most important of these cases—the so-called "man-in-the-house" decision—is based solely on a statutory interpretation. Other cases, such as the decision prohibiting the duration of residence requirements, are based on statutory interpretation with Constitutional implications. Still other cases apparently are predicated on the judicial finding that welfare is a property "right" rather than the traditional view that it is a "gratuity" granted as a privilege by the Congress and subject to such eligibility conditions as it decides to impose.

It should be remembered that welfare is a statutory right, and like any other statutory right, is subject to the establishment by Congress of specific conditions and limitations which may be altered or repealed by subsequent congressional 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." Under Secretary Veneman testified before the committee (p. 216 of the hearings), and Secretary Richardson agreed (p. 469 of the hearings) that there is no Constitutional right for a person to draw welfare. The following colloquy took place between Senator Long and Under Secretary Veneman at the hearings:

> The CHAIRMAN. Do you believe that there is any constitutional right for a person to draw welfare money?
>
> Mr. VENEMAN. No, sir.
>
> The CHAIRMAN. I do not, either. I am glad we agree on that point.
>
> Mr. VENEMAN. There is a statutory provision, sir, that allows certain people to draw welfare payments.

The "right to welfare" implies no vested, inherent or inalienable right to benfits. 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 (or of a State legislature). 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.

DENIAL OF ELIGIBILITY FOR AID TO FAMILIES WITH DEPENDENT CHILDREN WHERE THERE IS A CONTINUING PARENT-CHILD RELATIONSHIP

(Sec. 541 of the bill)

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.

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 states: "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. 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. The committee believes that the determination of 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 between an adult individual and a child 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." (Emphasis added.)

It should be further pointed out that the use of this provision would be optional with the States. If a State does affirmatively exercise its option, however, it must comply with this statutory method in determining the child-father relationship. The committee believes that this will provide coherent and uniform standards governing this delicate area of the law and provide a clear statement of statutory intent.

Effective date—January 1, 1971.

Duration of Residence Requirement

(Sec. 542 of the bill)

Under present Federal law the Secretary of Health, Education, and Welfare is required to approve all State plans for Aid to Families with Dependent Children which meet the requirements specified in section 402(a) unless the plan includes a duration of residence requirement denying aid to children who have resided in the State for one year preceding the date of application for aid (or to children born during that year and living with a parent or relative who has resided there for a year). In the programs of cash assistance for the aged, blind, and disabled, present law 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 of last year, 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 could have the effect of influencing States against any liberalization of their welfare programs for fear of attracting large numbers of needy persons from nearby States with less liberal programs. 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 threshhold of the current discussions regarding the 'federalizing' of these aspects of welfare relief."

The committee's amendment eliminates the constitutional question raised by the Supreme Court by making it an affirmative requirement of Federal law that State plans for cash public assistance under the Social Security Act include a requirement of one year's residence in the State as a condition of eligibility. (The committee's amendments would, however, not deny Federal matching to States which by virtue of State law do not in fact impose a duration of residency requirement.) Thus under the amendment, one year's duration of residence in a State would, in effect, be a nationally uniform condition of eligibility for assistance imposed by Federal law. Accordingly, the question of State violation of the equal protection clause of the 14th Amendment would be eliminated.

The committee recognizes that the one-year duration of residence requirement can impose a severe hardship on some families and could, in fact, discourage them from moving to a new State for even such admirable motives as seeking better employment opportunities. Accordingly, the committee added to that requirement a further requirement that the State which a recipient leaves must continue assistance payments to him, as long as he continues to be eligible for assistance, for a period of one year unless the new State of residence assumes this responsibility before the end of that 12-month period.

Taken together, the committee amendments to establish a residence requirement and to require the State of origin to continue payments for a year after the recipient moves, represent a significant improvement in the Federal-State welfare programs from the point of view of both the States and individuals involved. States which have found duration of residence requirements useful will be able to reinstitute them and be able to make improvements in their welfare programs without fear of creating substantial incentives to in-migration. Welfare recipients would, on the whole, be neither advantaged nor disadvantaged by the combined provisions. At least on a short-term basis, the level of welfare assistance provided in a given State would be made a neutral factor in the recipient's decision of whether to move there. In fact, it appears quite probable that the overall effect of the committee's amendments would be to facilitate the interstate movement of welfare recipients to seek employment or for other motives. A recipient contemplating such a move would generally know what he could expect in the way of assistance for the first year and would not face the prospect of a period with no assistance whatever while he was trying to establish his eligibility under the program of the new State.

Effective date—July 1, 1971.

Limitation on Duration of Appeals Process

(Sec. 543 of the bill)

The committee's bill requires 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 also requires the repayment to the

agency of amounts which a recipient receives during the period of the appeal if it is determined that he was not entitled to them. Any amounts not repaid are to be considered an obligation of the recipient to be withheld from any future assistance payments to which the individual may be entitled.

The committee's action is designed to assure that the appeals procedure will be handled expeditiously by the States, and also to assure that appeals will not be made frivolously. It is the view of the committee that these amendments to existing law are necessary in view of the recent Supreme Court decision that assistance payments cannot be terminated before a recipient is afforded an evidentiary hearing.

Effective date—July 1, 1971.

State Permitted To Seek To Establish Name of Putative Father

(Sec. 544 of the bill)

Of all families receiving Aid to Families with Dependent Children, those in which the father is not married to the mother constitute the single largest category (28 percent of all families). It is also the category that has been showing the most rapid growth. The Congress has clearly established in legislation its belief in the importance of making every reasonable effort to establish the paternity of a child born out of wedlock, both for the sake of the child and the family, and as a matter of good social policy. It is for this reason that a provision was written into the Social Security Act (sec. 402(a)(17)(A)) 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. . . ."

Despite this clear legislative history, a U.S. District Court in August 1969 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 in the case clearly sets forth the Congressional intent:

> The focal statutory provision which has application here is § 602(a)(7) [Sec. 402(a)(7) of the Social Security Act]; it reads in part:
>
> > (A State plan for aid and services to needy families with children must) . . . 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.

It is fundamental in this statutory scheme, that the sources of all family income be disclosed as a prerequisite to an applicant's qualifying for eligibility benefits. Thus the mother's disclosure of the known identity of a legally liable putative father is certainly an essential element in correctly evaluating the applicant-mother's support capabilities, as stated on the application in behalf of herself and her dependent children. Her limited disclosure of actual current income is incomplete, if any of the available sources remain unrevealed.

She is the actual party plaintiff in this action; it is to her that the government welfare benefits are directly paid. It is through her, that the family unit is sought to be preserved, as an essential unit of our society. She is the actual recipient of these moneys as head of the household. It is the plan and expectation, that her maternal interest as natural parent and guardian will assure to the dependent child the full benefits of the government allotment.

Unless the principle of personal parental responsibility is to be abandoned, as an obsolete cornerstone for gaging 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 cooperativenss 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 requires 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?

Clearly, the answer is no. Under the committee bill, the intent of the Congress that States must attempt to establish the paternity of a child born out of wedlock is reaffirmed by providing that the requirement that welfare be furnished "promptly" may not preclude a State from seeking the aid of a mother in identifying the father of the child.

Effective date—Immediate.

Home Visits as a Condition of Welfare

(Sec. 545 of the bill)

The committee bill permits the States, at their option, to require as a condition of welfare eligibility that recipients allow a caseworker

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, such as those under the public assistance titles of the Social Security Act, 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.

Effective date—January 1, 1971.

H. USE OF FEDERAL FUNDS TO UNDERMINE FEDERAL PROGRAMS

(Sec. 546 of the bill)

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 Hearing on July 20, 1970.)

In carrying out this broad, highly subjective, and basically legislative function, the committee notes that certain Legal Services activities have been aimed directly at undermining the welfare programs—which are, of course, established by duly enacted Federal laws and properly prescribed Federal regulations.

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.

Recently 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 in a Federal district court.

In response to a question by the Chairman of the committee when the Office of Economic Opportunity appeared before the committee during the 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, prohibiting denial of welfare

for refusal to allow a case-worker in the home, and prohibiting denial of welfare for refusal to name the putative father (the reply appears in pt. 2 of hearings, pp. 969–970).

The success of the program's aims was asserted in OEO's Narrative Justification at the House Appropriations hearings for the fiscal year 1970:

> Several landmark decisions were won by Legal Services attorneys during FY 1969. Of major importance was a U.S. Supreme Court decision ruling that residency requirements for the receipt of welfare benefits were unconstitutional. Also, the court ruled that the welfare "substitute father" regulation was illegal. . . .

The committee is unwilling to accept the implication of these activities: that the Legal Services lawyers are better qualified than the Congress to, in effect, determine national policy regarding the poor. The committee draws a distinction between 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—and the type of advocacy that aims at undermining established institutions that were consciously created through acts of Congress. If the welfare statutes are inadequate, and there is little disagreement on this point, then the proper forum for improving them is the legislative branch of our Government, not the judicial.

Accordingly, the committee's amendment 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.

Effective date—Immediate.

I. REGULATIONS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

The committee is concerned at the extent to which the Department of Health, Education, and Welfare has imposed requirements on the States which go far beyond the statute itself and in some cases bear no relationship to the law.

Section 1102 of the Social Security Act authorizes 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" he is charged with under the Act. (Emphasis added.) Under this broad authority, the Secretary has attempted through regulation to make substantial legislative changes in the welfare provisions of the Social Security Act.

Governor Warren E. Hearnes of Missouri, testifying on behalf of the National Governors' Conference, told the committee in hearings:

> . . . We have had a great deal of problems fiscally with laws passed by the Congress in the welfare field, but we have many, many times over problems created by regulations from HEW . . . .
>
> . . . It is almost every session that we are required to enact new laws to conform with their regulations.

> . . . These things are very exasperating for the Governors and the legislatures to try to stay not only within the intent of Congress but with what Congress has evidently done and given to HEW so much power to promulgate regulations. (pp. 1974, 2061 of hearings on the Family Assistance Plan)

The Congress did not intend that the regulatory authority in section 1102 be employed by the Department of Health, Education, and Welfare as a substitute for an act of Congress. Several provisions of the committee bill will make clear the Congressional intention to curb the use of this authority in regulatory lawmaking.

"Declaration Method" of Determining Eligibility

(Sec. 550 of the bill)

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 (six months in the case of Aid to Families with Dependent Children), 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 possible 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 stated that a three percent level of ineligibility would be considered "acceptable."

In May of this year, Secretary Finch announced that the results of the testing were so conclusive that he was requiring the States, through regulation, to use the simplified declaration method in welfare programs for the aged, blind, and disabled beginning July 1, 1970.

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 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 might not be indicative of the manner in which the simplified method will operate; and

3. The sample size under the testing was so small that there is a substantial probability that the ineligibility level exceeded Health, Education, and Welfare's arbitrary 3-percent "acceptable" level.

In view of the inconsistency ofthe test findings, the committee feels that use of the declaration method should remain optional with the States rather than mandatory. The committee bill accordingly specifies that the Secretary may not require use of the declaration method by regulation.

Effective date—Immediate.

Definition of Unemployment

(Sec. 551 of the bill)

Under present law Aid to Families with Dependent Children may be provided to needy families in which the children are dependent because of the death, incapacity, or absence of a parent—and, at the State's option, if the father is unemployed. Twenty-three States currently provide assistance to needy families in which the father is unemployed. Before the Social Security Amendments of 1967, each State used its own definition of "unemployment." The committee felt that a uniform national definition was desirable, and authorized the Secretary of Health, Education, and Welfare to define unemployment. Unfortunately, the Department of Health, Education, and Welfare issued regulations defining unemployment which go far beyond anything contemplated by the committee in 1967. Under the regulations, unemployment is defined in a way that requires States with unemployed father programs under AFDC to include "any father who is employed less than 30 hours a week" and the State may include "any father who is employed less than 35 hours a week."

During hearings on the Family Assistance Plan, Secretary Richardson agreed that an individual working regularly 34 hours a week could not be considered "unemployed." At that time he stated his intention to change the definition:

> Senator Talmadge. Mr. Secretary, reverting to another matter, in our previous hearings on this bill, several members of the committee noted that regulations of the Department permitted States to consider an individual working less than 35 hours as being unemployed. Secretary Finch agreed that he had difficulty conceiving of a man working regularly at 34 hours a week as being unemployed. Yet, to the best of my knowledge, there has been no change in this regulation.
>
> If I read correctly, the electrical workers in New York City recently negotiated contracts for a 20-hour week. Why should not the system have a more realistic definition of unemployment?
>
> Secretary Richardson. We should have a more realistic definition, Senator. I would again emphasize that if our recommendations are all adopted, that problem will disappear with the declining rolls of the unemployed father category.
>
> Senator Talmadge. Is it not a problem now that ought to be corrected by regulation now, rather than waiting on Congress?
>
> Secretary Richardson. I think it should, and I shall follow that up.

To date, the regulations of the Department of Health, Education, and Welfare have not been changed. Accordingly, the committee bill includes an amendment defining a father as unemployed for purposes of AFDC eligibility if he has worked less than 10 hours in the last week or less than 80 hours in the last 30 days.

Effective date—July 1, 1971.

Veto of WIN Child Care Services

(Sec. 520(a)(7) of the bill)

Department of Health, Education, and Welfare regulations state that "child care services, including in-home and out-of-home services, must be available or provided to all persons referred to and enrolled in the work incentive program and to other persons for whom the agency has required training or employment. Such care must be suitable for the individual child, and the parents must be involved and agree to the type of care to be provided."

This apparent absolute veto power over child care by the mother is not in accord with Congressional intent. The committee bill provides that if child care services are necessary to permit participation of a mother in the Work Incentive Program, she should be given a choice of type of child care if more than one type is available, but she may not avoid participation in work and training by refusal to accept child care.

Effective date—Immediate.

Advisory Committees on Welfare

(Sec. 552 of the bill)

Regulations issued by the Department of Health, Education, and Welfare 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 has no objection to the establishment of such advisory committees where the State wishes to do so, but finds that there is no statutory basis for requiring their establishment. Accordingly, the committee bill would make the setting up of welfare advisory committees and the nature of such committees a matter of State discretion.

Effective date—Immediate.

J. USE OF SOCIAL SECURITY NUMBERS

(Sec. 560 of the bill)

The committee bill requires applicants for public assistance 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 already in widespread use by governmental agencies and others. In fact, the committee understands that a number of States have, on their own initiative, undertaken to use social security numbers in administering their welfare programs. The committee believes that this practice should be made a nationally uniform requirement of Federal law with a view to improving the administration of welfare programs, aiding in the detection and prevention of fraudulent practices and facilitating the collection and analysis of welfare statistics on both the State and National levels.

Effective date—January 1, 1972.

K. TESTING OF ALTERNATIVES TO AFDC

(Secs. 561 and 562 of the bill)

Over the years, the Congress has enacted a wide range of social welfare programs designed to assure that all Americans, including the needy and the unfortunate, will have the opportunity to obtain at least the basic necessities for a life of decency and dignity. Some of these programs have proven successful. Too often, however, such programs have been enacted on the basis of estimates which later proved to be far too low with respect to costs and far too high with respect to effectiveness.

The committee feels that, in the light of this sad experience, this is not the time to adopt a major new welfare program which has the potential of costing the American taxpayer vast sums of money until such a program and alternative approaches have been thoroughly examined on an experimental basis. Accordingly, while the committee agrees with the generally accepted sentiment that the problems of the present program of aid to families with dependent children are reaching overwhelming proportions, it cannot agree that the present system is so bad that any untested alternative would be preferable merely because it is new or different. The committee bill takes the more responsible approach of adopting a number of changes in the present welfare system designed to correct its worst and most obvious defects, while at the same time providing for the testing of possible alternatives to the present system.

The committee bill provides for the Secretary of Health, Education, and Welfare to conduct up to four tests of possible alternatives to the AFDC program. One or two of these tests would test a "family assistance" type proposal for welfare, and one or two of the tests would test a "workfare" type proposal. In addition, the bill provides for a test in which a program of rehabilitation of welfare recipients would be administered by vocational rehabilitation personnel.

The committee expects that these tests will provide a sound basis for rational legislative action in the welfare area.

It is hoped that each test will produce data from which there can be estimated for the various types of programs the cost, extent of participation, and effectiveness in reducing dependency on welfare which could be expected if such programs were adopted as a substitute for AFDC. These tests should also provide valuable administra-

tive experience which would facilitate the implementation of any of the tested proposals which might eventually be enacted.

General Requirements Applicable to Tests of AFDC Alternatives

In drawing up its proposals for the testing of alternatives to the present welfare system, the committee has profited from the experience of the relatively small-scale income maintenance experiment being conducted with OEO funds in the States of New Jersey and Pennsylvania. A General Accounting Office evaluation of that project requested by the committee revealed a number of pitfalls which the committee bill is designed to avoid. For example, the GAO report found that an attempt was made to draw conclusions from the New Jersey experiment before it had run long enough to provide a reliable data base to support such conclusions. The committee bill requires, therefore, that all tests be conducted for a minimum of two years unless Congress authorized earlier termination. It is anticipated that such authorization would be requested and granted only if it became obvious that a test in progress was a total failure and would yield no useful results. Other problems tending to lessen the value of the OEO experiment were the limited size of the sample population and the availability to those in the experiment of alternative benefits under existing welfare programs. These difficulties are avoided by provisions of the committee bill which require that all eligible families in the test area be permitted to participate in it and that no families in that area may, during the period of the test, receive aid or assistance under AFDC.

The committee feels that the Department of Health, Education, and Welfare should have considerable flexibility in choosing the areas in which these tests are to be conducted. Accordingly, the bill permits a given test to be conducted either throughout an entire State or only within certain areas of a State. The committee wants to make clear, however, its intention that the areas which the Department does choose for each test should be broadly representative of the country as a whole so that the data from the tests may serve as a reliable basis for future Congressional action.

The committee also desires to assure that the tests will be conducted in such a way that valid comparisons among the various alternatives can be made. The bill, therefore, requires that the Department conduct the same number of "workfare" tests as "family assistance" tests—either one or two of each. In each pair of tests (one "workfare" and one "family assistance") the beginning and ending dates of the two tests must be the same, the number of participants must be approximately the same, and the areas in which the two tests are conducted must be comparable as to population, per capita income, unemployment level, and other relevant factors.

The committee bill also provides that the tests are to be conducted with State cooperation and with State sharing in the costs of the tests. The State share of costs, however, could not exceed its share of the costs under AFDC (as determined by its costs for the test area in the 12 months before the test begins).

To assure that the tests are so designed as to fulfill their objective of providing Congress with the necessary data on which to base further welfare legislation, the bill requires the Secretary of Health, Education, and Welfare to give a complete and detailed description of the test plans before they are implemented to this committee and to the Committee on Ways and Means of the House of Representatives. The Secretary would also be required to give consideration to any comments and suggestions of the committees and to report to Congress at least annually on the operations of the test programs.

In addition, the Secretary would be required in planning the tests and in preparing reports on the tests to consult with the General Accounting Office which also would have full access to the books and records concerning the tests and would itself annually or more often conduct audits of the test programs and make reports to Congress concerning them. At the conclusion of the tests, complete reports with recommendations would be submitted to Congress by both the Secretary of Health, Education, and Welfare and the Comptroller General.

Tests of "Family Assistance" Programs

The committee bill provides for the Department of Health, Education, and Welfare to conduct one or two tests of "family assistance" programs. Essentially, "family assistance" programs would be similar to the present welfare program of Aid to Families with Dependent Children except that eligibility would not be restricted to families in which children are deprived of parental support because of the death, incapacity, or absence from the home of a parent or because of the father's unemployment. In addition to such AFDC-type families, a "family assistance" program would also cover low income families in which both parents are present and nondisabled and in which the father is working full time, but is not earning a sufficient amount to meet the family's needs as determined by an income standard related to family size.

The "family assistance" tests would provide money payments to families with incomes below certain minimum levels. Non-disabled adults (with certain exceptions) could not refuse to accept employment or training; and placement, employment training, and supportive services would be provided. In determining eligibility and the amount of assistance, a portion of earnings would be disregarded in order to provide a monetary incentive for work.

Tests of "Workfare" Programs

The committee bill provides for one or two "workfare" tests to be conducted at the same time as the "family assistance" tests. A "workfare" program, under the provisions of the bill, would in large part cover the same persons eligible for "family assistance"—but while the "family assistance" tests would follow the traditional welfare approach, this proposal would stress "workfare" as a basis of entitlement for those able to work. A sharp distinction would be made between welfare and "workfare." In effect, a presumption would be made that certain groups (the aged, blind, disabled, and families with preschool age children where the father is dead, absent, or dis-

abled) are not employable. These persons would be eligible for cash welfare payments amounting to a guaranteed minimum income. For all other groups, however, there would be no guaranteed minimum income but only a guaranteed work opportunity, with training and other preparation for employment where necessary.

Thus, the "workfare" proposal would restrict the types of families eligible to receive welfare, and other families with incomes below the specified standards would be expected to participate in the "workfare" program. Participants in the "workfare" program would have their wages supplemented if they are below the minimum wage. Allowances would also be paid to those in training. The policy incorporated in the "workfare" test proposals is that it should always be more profitable for a mother with no children of preschool age heading a family to work than to remain at home and receive welfare payments; and mothers who head families with children of preschool age should be given a choice. In order for this policy to be carried out, large-scale day care and job development programs must be initiated, and the "workfare" test provisions of the bill provide for such programs, including programs of subsidized public service employment.

One possible way in which the "workfare" test provisions could be carried out would be through an employment corporation created to administer the proposal. It would be the corporation's job to secure employment in the community at least at the minimum wage for persons registering for the workfare program. If jobs could not be found at the minimum wage, the registrant could become an employee of the corporation, which would contract out for his services on a temporary or regular basis. If the corporation charged the employer less than the minimum wage, the employee could receive a wage perhaps half-way between the charge to the employer and the minimum wage. For example, if the employer paid $1.00 per hour, the Corporation could pay the employee $1.30 per hour (half way between $1.00 and $1.60). If after evaluating an employee's improved productivity the corporation decided to charge $1.20 per hour for his services, the employee would receive $1.40 per hour. Once his wages had reached the minimum wage, he would no longer be an employee of the corporation.

An employee of the corporation might be paid $1.00 per hour while in full-time training, or if he is willing to work but there is no job available.

Whether through such a corporation or through some other method of wage subsidization, each "workfare" test proposal would consist of at least these elements:

—Welfare payments to those unable to work (the aged, blind, and disabled, and families with preschool age children where the father is dead, absent, or disabled);

—A workfare program of guaranteed work opportunities for families headed by a person able to work;

—Day care for children of low-income working mothers; and

—Other appropriate supportive services.

Pilot Propect To Test the Administration of Welfare Programs by Vocational Rehabilitation Personnel

In recent years, analogies have frequently been drawn between those who suffer from physical disabilities and those whose lack of cultural or educational background places them at a substantial disadvantage in competing for jobs in the labor market. The committee agrees that these analogies have a certain validity in that both groups are in a very real sense handicapped.

Further, the committee is impressed with the extent to which personnel engaged in the profession of fostering vocational rehabilitation have been able to motivate the physically disabled with the desire to overcome their handicaps and have been able through such motivation and through training to restore disabled individuals to useful, productive, and independent lives. Unfortunately, public assistance and manpower agencies have often not had similar success in rehabilitating welfare recipients. The committee is not sure that the welfare group will be as susceptible to rehabilitation techniques as the less socially deprived segments of the population which have generally constituted caseloads of vocational rehabilitation agencies. The committee bill, therefore, authorizes a pilot project designed to find out whether the methods and attitudes of those who have been successful in rehabilitating the physically disabled can be applied with equal success to welfare recipients.

Under the provisions of the bill, this project would be run concurrently with the first "family assistance" and "workfare" tests and in a comparable area. AFDC payments would be suspended in the area for the duration of the test, but equivalent benefits would be provided to those who would otherwise have been eligible for AFDC. In administering the project, the Secretary of Health, Education, and Welfare is directed to use the personnel and facilities of the Rehabilitation Services Administration. The objective of the project is to encourage and assist adult individuals with a potential for work to prepare for and obtain employment. Necessary counseling, rehabilitative, and other services would be provided together with appropriate job training.

The "workfare" and "family assistance" test provisions relating to reports to Congress and requiring consultation between the Department and the committees and the Department and the General Accounting Office are also applicable to this pilot project.

IX. VETERANS' PENSION INCREASES

Veterans' Pension Increases

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TABLES

IX. VETERANS' PENSION INCREASES

(Sec. 607 of the bill)

Nature of Pension Benefits

Since our Nation's independence was declared, some 40 million persons have served in its Armed Forces. After each major conflict in which the United States has been involved, benefits have been provided for veterans of the conflict. A major distinction is made between *service-connected benefits* for veterans who are disabled as a result of their military service or for the dependents of veterans who die as a result of service, and *non-service-connected benefits* which have been enacted not because of needs arising directly from military service, but on the ground that the Government owes a special obligation to those who were in military service during time of war but who are now in need.

Pensions are the major type of non-service-connected benefit. Non-service-connected pension benefits date back to the Revolutionary War, although they did not appear until 1818, 35 years after the Revolution ended. Such benefits have also been provided for veterans of every one of the major conflicts in which the United States has engaged. In the 19th century, pension laws were enacted many years after the conflict to which they pertained. Today, the same permanent pension laws apply to the veterans of World War I, World War II, the Korean conflict, and the Vietnam era. Under the current law, a veteran may be eligible for pension benefits if:

He served in the Armed Forces at least 90 days, including at least one day of service during wartime;

His income does not exceed limits specified in the law (currently $2,000 if the veteran is single, $3,200 if he has dependents);

He is permanently and totally disabled (for purposes of the pension law all veterans 65 or older are defined as permanently and totally disabled); and

His net worth does not exceed a limitation determined by the Veterans' Administration.

Widows and minor children of wartime veterans are also eligible for pension benefits if they are needy.

Before 1960, pensions for veterans of World War I, World War II, and the Korean Conflict were provided on the basis of a flat amount (generally $78.75 per month) if the veteran's income did not exceed a specified figure—regardless whether his annual income was $100 or $1,000, and whether he was single or married. Legislation was enacted effective July 1, 1960, taking a first step in relating benefits more closely to need. Under the new law, married veterans were eligible for higher benefits than single veterans, and veterans with less income were eli-

gible for higher pensions than veterans with higher incomes. Veterans receiving benefits under the "old law" before 1960 were permitted to continue to do so if they wished to, but as pension benefits under the "new law" have been improved, many "old law" veterans have chosen to receive benefits under the current law.

Characteristics of Pensioners

There are presently about 1.9 million pensioners; five-sixths of them receive benefits under the current law, while one-sixth continue to receive benefits under the "old law" in effect before 1960.

Pensioners are primarily older persons; 7 out of 10 veterans receiving pensions served in World War I, and three out of four widows receiving pensions were married to veterans with World War I service. The period of service for pensioners under the current law is shown in table 1 below.

Table 1.—*Pensioners under current law by period of military service*

	Veterans	Widows
World War I	490, 253	474, 860
World War II	347, 566	217, 604
Korean conflict	24, 109	18, 271
Vietnam era	1, 320	1, 303
Total	863, 248	712, 038

A significant number of pensioners under the curent law have virtually no other source of income other than their pension. The income of pensioners (other than their pensions) is shown in table 2 following:

TABLE 2.—*Pensioners under current law by income other than pensions*

Income range	Veteran alone		Veteran with dependents		Widow alone		Widow with children	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Less than $100	74, 700	25	56, 600	10	94, 500	17	8, 700	6
$100 to $500	13, 900	5	12, 100	2	32, 900	6	14, 700	10
$500 to $1,000	94, 300	32	100, 800	18	207, 200	36	38, 700	28
$1,000 to $1,500	73, 100	25	152, 300	27	182, 500	32	37, 400	26
$1,500 to $2,000	37, 300	13	132, 600	23	53, 700	9	16, 600	12
$2,000 to $2,500			56, 600	10			11, 100	8
$2,500 to $3,200			58, 900	10			14, 000	10
Total	293, 300	100	569, 900	100	570, 800	100	141, 200	100

The income pensioners have in addition to their pensions comes from a variety of sources, but three out of four pensioners are social security beneficiaries.

TABLE 3.—*Veterans' pensions in fiscal year 1970*

	Average cases	Average cost	Cost
Pensions (total)	2, 249, 901	$1, 007	$2, 264, 546, 000
Veterans (total)	1, 105, 103	1, 228	1, 357, 113, 000
Indian wars	2	2, 000	4, 000
Spanish-American War	4, 830	1, 564	7, 554, 000
World War I	717, 772	1, 153	827, 316, 000
World War II	356, 339	1, 358	483, 978, 000
Korean conflict	24, 952	1, 448	36, 143, 000
Vietnam era	1, 108	1, 895	2, 100, 000
Peacetime service	100	180	18, 000
Survivors (total)	1, 144, 798	793	907, 433, 000
Indian wars	186	828	154, 000
Civil War	912	1, 022	932, 000
Spanish-American War	43, 661	889	38, 821, 000
World War I	590, 823	716	423, 188, 000
World War II	448, 821	858	385, 277, 000
Korean conflict	57, 917	982	56, 876, 000
Vietnam era	2, 462	886	2, 182, 000
Peacetime service	16	188	3, 000

VETERANS' PENSIONS AND SOCIAL SECURITY

As mentioned above, under current law pensions for veterans are related to need as measured primarily by income. Thus as social security benefits are increased, pension payments decrease. Since many pensioners are also social security beneficiaries, pressure builds up to insulate the pension from the effect of the social security increase.

Several approaches have been tried in the past to soften the impact of social security increases on veterans' pensions. In 1964, when a social security increase was pending in the Congress, a veterans' bill was passed allowing 10 percent of social security benefits (and other types of retirement income) to be disregarded in determining the amount of the pension payment. The remedy raised additional problems, however, for the 10 percent disregard created an inequitable distinction between those veterans who have income subject to the 10-percent exclusion and those who do not. A situation can arise in which two veterans with identical income (and thus identical need) receive different pension amounts.

In landmark legislation enacted in 1968, the pension program was thoroughly revised and improved. Pension benefits were much more closely related to need in order to end the previous situation under which a veteran could lose more in a pension reduction than he gained from a social security increase. In addition, the 1968 legislation pro-

vided for a disregard of the 1968 social security increase during 1968 and 1969. Unfortunately, this temporary disregard approach also proved to have defects.

Under present law, an increase in social security benefits is not taken into account for pension purposes until the calendar year after it goes into effect. Thus the social security benefit increase which became effective in 1970 will have no impact on veterans' pensions until January 1971.

If no legislation is enacted in 1970, the Veterans' Administration estimates that about 1,230,000 pensioners—69 percent of those on the rolls under current law—will face a pension loss beginning January 1971. Of course, a veteran receiving a pension in 1971 would find that his total income will still be higher than it was before the social security benefit increase, since the pension reduction is considerably less than the social security increase.

Under the proposed pension schedule in the committee bill, only 160,000 pensioners—9 percent of those on the rolls under current law—would face a pension loss. This 9 percent represents the pensioners who have received a relatively substantial increase in social security benefits this year; their reduction under the committee bill would of course be less than under present law.

More than a million pensioners would face pension reductions next January under present law but not under the committee bill.

Under the committee bill, the discriminatory exclusion of 10 percent of social security and certain other types of income would be eliminated, but the increased pension schedule in the committee bill is so devised that no veteran or widow would receive a lower benefit as a result of the elimination of the 10 percent exclusion. In fact, almost all pensioners would receive some increase.

Income Limitations

Under present law pension benefits are related to income, but no veteran or widow alone is eligible for a pension if his or her income exceeds $2,000. The committee bill would increase the income limitation from $2,000 to $2,300.

The income limitation for veterans or widows with dependents would be increased from $3,200 to $3,600.

Revised Pension Schedules

Pension benefits under present law and under the committee bill are shown in the following tables:

TABLE 4.—*Veteran alone*

Annual income		Monthly pension	
More than—	But equal to or less than—	Present law	Committee bill
----------	$300	$110	$120
$300	400	108	120
400	500	106	117
500	600	104	114
600	700	100	110
700	800	96	106
800	900	92	102
900	1,000	88	98
1,000	1,100	84	94
1,100	1,200	79	90
1,200	1,300	75	86
1,300	1,400	69	81
1,400	1,500	63	76
1,500	1,600	57	70
1,600	1,700	51	64
1,700	1,800	45	58
1,800	1,900	37	52
1,900	2,000	29	46
2,000	2,100	----------	38
2,100	2,200	----------	34
2,200	2,300	----------	30

TABLE 5.—*Veteran with dependents*

Annual income		Monthly pension					
		Veteran with 1 dependent		Veteran with 2 dependents		Veteran with 3 or more dependents	
More than—	But equal to or less than—	Present law	Committee bill	Present law	Committee bill	Present law	Committee bill
	$500	$120	$130	$125	$135	$130	$140
$500	600	118	130	123	135	128	140
600	700	116	128	121	133	126	137
700	800	114	126	119	131	124	134
800	900	112	124	117	129	122	131
900	1, 000	109	122	114	127	119	128
1, 000	1, 100	107	120	107	125	107	125
1, 100	1, 200	105	118	105	122	105	122
1, 200	1, 300	103	116	103	119	103	119
1, 300	1, 400	101	114	101	116	101	116
1, 400	1, 500	99	112	99	113	99	113
1, 500	1, 600	96	110	96	110	96	110
1, 600	1, 700	93	107	93	107	93	107
1, 700	1, 800	90	104	90	104	90	104
1, 800	1, 900	87	101	87	101	87	101
1, 900	2, 000	84	98	84	98	84	98
2, 000	2, 100	81	95	81	95	81	95
2, 100	2, 200	78	92	78	92	78	92
2, 200	2, 300	75	89	75	89	75	89
2, 300	2, 400	72	86	72	86	72	86
2, 400	2, 500	69	83	69	83	69	83
2, 500	2, 600	66	80	66	80	66	80
2, 600	2, 700	62	77	62	77	62	77
2, 700	2, 800	58	74	58	74	58	74
2, 800	2, 900	54	71	54	71	54	71
2, 900	3, 000	50	68	50	68	50	68
3, 000	3, 100	42	64	42	64	42	64
3, 100	3, 200	34	60	34	60	34	60
3, 200	3, 300	----------	56	----------	56	----------	56
3, 300	3, 400	----------	51	----------	51	----------	51
3, 400	3, 500	----------	43	----------	43	----------	43
3, 500	3, 600	----------	35	----------	35	----------	35

TABLE 6.—*Widow alone*

Annual income		Monthly pension	
More than—	But equal to or less than—	Present law	Committee bill
----------	$300	$74	$80
$300	400	73	80
400	500	72	78
500	600	70	76
600	700	67	74
700	800	64	72
800	900	61	69
900	1, 000	58	66
1, 000	1, 100	55	63
1, 100	1, 200	51	60
1, 200	1, 300	48	57
1, 300	1, 400	45	54
1, 400	1, 500	41	51
1, 500	1, 600	37	47
1, 600	1, 700	33	43
1, 700	1, 800	29	39
1, 800	1, 900	23	35
1, 900	2, 000	17	30
2, 000	2, 100	----------	24
2, 100	2, 200	----------	21
2, 200	2, 300	----------	18

TABLE 7.—*Widow with one child*

Annual income		Monthly pension	
More than—	But equal to or less than—	Present law	Committee bill
----------	$600	$90	$97
$600	700	89	96
700	800	88	95
800	900	87	94
900	1, 000	86	93
1, 000	1, 100	85	92
1, 100	1, 200	83	91
1, 200	1, 300	81	89
1, 300	1, 400	79	87
1, 400	1, 500	77	85
1, 500	1, 600	75	83
1, 600	1, 700	73	81
1, 700	1, 800	71	79
1, 800	1, 900	69	77
1, 900	2, 000	67	75
2, 000	2, 100	65	73
2, 100	2, 200	63	71
2, 200	2, 300	61	69
2, 300	2, 400	59	67
2, 400	2, 500	57	65
2, 500	2, 600	55	63
2, 600	2, 700	53	61
2, 700	2, 800	51	59
2, 800	2, 900	48	57
2, 900	3, 000	45	55
3, 000	3, 100	43	53
3, 100	3, 200	41	51
3, 200	3, 300	----------	49
3, 300	3, 400	----------	47
3, 400	3, 500	----------	45
3, 500	3, 600	----------	42

Effect of Committee Bill

The effect of the committee bill is illustrated in the following examples.

A veteran with no dependents who received a social security benefit of $85.90 in December 1969, was eligible for a pension of $88, for a total monthly income of $173.90. The Congress increased his social security benefit to $98.80 in 1970. Under present law, his monthly pension would be cut $4 in January 1971, for a total income of $182.80. Under the committee bill, not only would his pension not be cut—it would actually be increased $2. Thus, the veteran would get both the full benefit of his social security increase plus an additional small increase in his pension for a total income of $188.80.

A married veteran whose social security benefit in December 1969, was $112.70 was eligible for a $103 monthly veterans' pension, for a total income of $215.70. The Congress increased his social security benefit to $129.60 in 1970. Under present law, his pension will be cut to $101 next January, making his total income $230.60. Under the Committee bill, his pension will be increased to $110 instead of cut, and he will have the full benefit of the social security increase plus a $7 pension increase for a total income of $239.60.

A widow with one child whose monthly social security benefit in December 1969, was $106 was eligible for an $83 widow's pension for a total income of $189. The Congress increased her social security benefit to $122 in 1970. Under present law her pension would drop to $79 in January 1971, bringing her total income to $201. Under the committee bill, her pension will not be cut, but instead will be raised to $85, giving her the full benefit of her social security benefit increase and raising her total income to $207.

Dependency and Indemnity Compensation for Parents

Present law provides monthly benefits to the survivors of veterans whose death was related to their military service. Benefits to widows of these veterans were most recently increased in 1969.

The parents of a serviceman or veteran whose death was service-connected may also receive dependency and indemnity compensation. Like pension benefits for veterans and widows, dependency and indemnity compensation payments to parents are related to the income of the parents. The Committee bill would provide increases in the parents' dependency and indemnity compensation schedules as shown in the tables below:

TABLE 8.—*Dependency and indemnity compensation payments to parents of deceased veterans or servicemen whose deaths are service connected*

[1 parent]

Annual income		Monthly payment	
More than—	But equal to or less than—	Present law	Committee bill
----------	$800	$87	$94
$800	900	81	90
900	1, 000	75	86
1, 000	1, 100	69	82
1, 100	1, 200	62	76
1, 200	1, 300	54	69
1, 300	1, 400	46	62
1, 400	1, 500	38	55
1, 500	1, 600	31	48
1, 600	1, 700	25	41
1, 700	1, 800	18	34
1, 800	1, 900	12	28
1, 900	2, 000	10	22
2, 000	2, 100	----------	16
2, 100	2, 200	----------	14
2, 200	2, 300	----------	12

TABLE 9.—*Dependency and indemnity compensation payments to parents of deceased veterans or servicemen whose deaths are service connected*

[2 parents not living together]

Annual income other than DIC		Monthly payment, each parent	
More than—	But equal to or less than—	Present law	Committee bill
----------	$800	$58	$63
$800	900	54	61
900	1, 000	50	58
1, 000	1, 100	46	54
1, 100	1, 200	41	51
1, 200	1, 300	35	47
1, 300	1, 400	29	42
1, 400	1, 500	23	37
1, 500	1, 600	20	32
1, 600	1, 700	16	28
1, 700	1, 800	12	24
1, 800	1, 900	11	21
1, 900	2, 000	10	18
2, 000	2, 100	----------	15
2, 100	2, 200	----------	13
2, 200	2, 300	----------	12

TABLE 10.—*Dependency and indemnity compensation payments to parents of deceased veterans or servicemen whose deaths are service connected*

[2 parents living together]

Combined annual income other than DIC		Monthly payment, each parent	
More than—	But equal to or less than—	Present law	Committee bill
----------	$1,000	$58	$63
$1,000	1,100	56	62
1,100	1,200	54	60
1,200	1,300	52	58
1,300	1,400	49	56
1,400	1,500	46	54
1,500	1,600	44	52
1,600	1,700	42	50
1,700	1,800	40	48
1,800	1,900	38	46
1,900	2,000	35	44
2,000	2,100	33	42
2,100	2,200	31	40
2,200	2,300	29	38
2,300	2,400	26	36
2,400	2,500	23	34
2,500	2,600	21	32
2,600	2,700	19	30
2,700	2,800	17	28
2,800	2,900	15	26
2,900	3,000	12	24
3,000	3,100	11	22
3,100	3,200	10	20
3,200	3,300	----------	18
3,300	3,400	----------	16
3,400	3,500	----------	14
3,500	3,600	----------	12

COST

The Veterans' Administration estimates that the committee bill would increase pension and dependency and indemnity compensation payments by $160 million over present law in the first full year of effectiveness.

X. MISCELLANEOUS AMENDMENTS

Miscellaneous Amendments

CONTENTS

X. MISCELLANEOUS AMENDMENTS

A. TAX AMENDMENTS

Denial of Tax Deduction With Respect to Certain Medical Referral Payments

(Sec. 602 of the bill and sec. 162(c) (2) and (3) of the Code)

Present law.—As a result of the Tax Reform Act of 1969, present law provides that no tax deduction is to be available for illegal bribes or kickbacks paid where, as a result of the payments, there is successful criminal prosecution.[1] If the bribe or kickback does not constitute a criminal act (presumably even if there is a loss of license), or if the taxpayer is not successfully prosecuted, a deduction is available.

In 29 States, medical referral payments are not illegal and, therefore, are clearly deductible under present law. In the remaining 21 States, medical referral fees by physicians are classified as constituting unprofessional conduct and are grounds for revocation of licenses to practice medicine.

The pre-1969 law did not generally state that bribes and kickbacks were not deductible. However, the courts, in effect, denied deductions for payments which were held to be contrary to "public policy." In 1952, the Internal Revenue Service ruled that medical referral payments were generally deductible if they did not "frustrate sharply defined National or State policies evidenced by a governmental declaration proscribing particular types of conduct." While what constituted "public policy" was by no means a settled matter, it is likely that if a State were to revoke a license to practice medicine because of the payment of a medical referral fee, the payment would have been held by the courts to be contrary to public policy. As a result, if the Internal Revenue Service had denied a deduction for a medical referral payment where a license was revoked, it is quite likely that the courts would have upheld the Service. On the other hand, under pre-1969 law, the *Lilly* case refused to deny a deduction for referral payments in the case of opticians where the payments, although questionable ethically, were not illegal or grounds for revocation of license.

General reasons for change.—The committee, when it adopted the provision relating primarily to treble damage payments in the consideration of the Tax Reform Act of 1969, did not intend to relax the deductibility rules in the case of medical referral payments. Such payments are considered to be unethical by the American Medical Association, and their deduction for tax purposes is inimical with public policy.

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[1] A separate rule is provided illegal payments to Government officials. Illegal payments to them are not deductible whether or not there is a successful prosecution. However, in these cases the burden of proof is on the Government to the same extent as in a fraud case.

The difficulty in dealing with this problem lies in the fact that these payments under pre-1969 law, although they may not have been deductible in 21 States, probably were deductible in the remaining 29 States where the payments were not grounds for revocation of the license to practice medicine. Since professional conduct is a matter generally regulated by State law, it seems inappropriate for Congress to make all medical referral payments as a general rule nondeductible.

The Federal Government, however, is directly involved in the field of medical payments to the extent of payments made under either the medicare or medicaid programs. Medical referral payments, where the compensation is provided by the Federal Government through the medicaid or medicare programs, are made criminal acts by section 273 of the bill and, therefore, on this ground would, even under the 1969 Act, not be deductible for tax purposes if there were successful criminal prosecution. However, the committee believes that merely making medical referral payments illegal under the medicare and medicaid programs does not fully effectuate the desired policy in this area, since the requirement of a criminal conviction contained in present law has the effect of unduly limiting the number of deductions for medical referral payments which are disallowed.

Explanation of provision.—The bill deletes the requirement in present law (sec. 162(c)(2)) which requires a conviction in the case of bribes and kickbacks before a deduction for them is denied. Instead the bill provides for the denial of a deduction in the case of bribes and kickbacks which are illegal either under Federal or State law if these laws subject the party involved to liability for criminal or civil penalties (including the loss of license). In the case of a payment which is illegal under State law, the deduction will be denied on the basis of such illegality only if the law is generally enforced. The bill makes clear that referral fees are to be treated as bribes or kickbacks for purposes of the disallowance provision.

Required Information Relating to Excess Medicare Tax Payments by Railroad Employees

(Sec. 603 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.

General 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.

The amendments made by this provision apply to remuneration paid after December 31, 1969.

Reporting of Medical Payments

(Sec. 604 of the bill, sec. 6050A of the Code, and sec. 1122 of title XI of the Social Security Act)

Present law.—Under present law, a person making specified kinds of payments in the course of a trade or business to another person, amounting to $600 or more in a calendar year, must file an information return showing the amounts paid and the name, address and identifying number of the recipient. In November, 1969, the Internal Revenue Service announced a ruling applying this reporting requirement to payments under medical insurance plans and medical assistance programs. Under the ruling, insurance companies (including those participating in medicare), Blue Cross-Blue Shield organizations, State agencies participating in medicaid, and unions and employers with self-insured or self-administered plans must make information returns with respect to payments to doctors, dentists, and other providers of

health care services. Before the ruling, payments to providers of health care services ordinarily were not required by the Internal Revenue Service to be reported on information returns, although such reporting was authorized.

General reasons for change.—The Treasury Department testified before the committee and recommended that its authority to require reporting of medical payments be expanded. Although organizations are required under the ruling to report direct payments (often described as "assigned" payments) to providers of health care services, there is no authority under present law to require the reporting of payments made to the patients themselves ("unassigned" payments), even though in normal circumstances they are paid over to providers of health care services, or represent reimbursement of earlier payments to providers. The Treasury recommended that it be given the authority to require reporting of unassigned payments. In this connection it should be noted that the reporting requirement itself can be expected to have a salutary effect. The Treasury testified before the committee that past experience has demonstrated that information reporting can greatly increase the level of voluntary reporting of income. It said that from 1960 to 1963 the number of individual income tax returns reporting interest income increased more than 100 percent, and reported interest increased from $5.1 to $9.2 billion, largely as a result of the reduction of the level of information reporting on interest from $600 to $10 per year. On the other hand, representatives of the insurance industry testified that reporting of unassigned payments would be very costly in relationship to the benefits expected to be derived.

In view of the above considerations, the committee decided to provide specifically for the payments made to providers of health care services in the case of "assigned" (direct) payments. In the case of "unassigned" (indirect) payments, it decided that it was appropriate to require reporting in those cases where the Federal Government administers the program or funds it to a substantial extent.

The Treasury Department also recommended in its testimony that it be given specific authority to require reporting of payments to professional service corporations, proprietory hospitals and other providers of health care services and to impose a requirement on these organizations to report subsequent payments by them to other providers of health care services. The Treasury also asked for specific authority to require that payers furnish to providers the information reported to the Internal Revenue Service. The committee concurred in these recommendations.

Explanation of provisions.—With respect to assigned (direct) payments, the bill would specifically require the reporting of payments made to providers of health care services, beginning with the calendar year 1971. This provision codifies the existing ruling.

With respect to unassigned (indirect) payments, reporting is limited to payments under Government health care programs, such as medicare, medicaid, and the Federal employees health benefits program. In the case of unassigned payments, the paying organization would be required to report not the amount actually paid to the insured, but the amount shown on the bills submitted by the insured in support of his claim. Reporting with respect to unassigned payments is to begin with calendar year 1972.

The committee was concerned that limiting the reporting of unassigned payments to payments under Government programs might lead to widespread shifts from assigned to unassigned payments, to the detriment of the patient, where a Government program is not involved. The committee resolved its concern by adding a provision to the bill directing the Secretary of the Treasury and the Secretary of Health, Education, and Welfare to study the pattern of billings to determine the extent to which there is a shift from assigned to unassigned payments and to report their findings each year to the committee and to the House Committee on Ways and Means. Should a significant shift occur, the question whether reporting should be required with respect to *all* unassigned payments will be reconsidered.

As under present law, the reporting requirement is to apply only if the aggregate payments to a provider during the calendar year exceed $600. However, assigned and unassigned payments are to be aggregated separately, and a separate $600 minimum is to apply to each category. It is anticipated that the Treasury Department will provide by regulation that payers may report all amounts, if they wish to do so, without regard to the $600 limitation.

The reporting requirements are not to apply to payments to tax-exempt hospitals or other organizations described in section 501(c)(3) and exempt from taxation under section 501(a), or to agencies or instrumentalities of the United States or of any State or political subdivision.

The reporting requirements are not to apply to a payment made by an individual for health care services furnished to himself or any other individual, unless the payment is made in the course of a trade or business. Thus, although the requirement applies to an insurance company that pays an insured patient's doctor bill, it does not apply to the patient himself when he pays a doctor bill, because he is not making the payment in the course of a trade or business.

The reporting requirements also are not to apply to the payment of wages subject to withholding by an employer, if they are reported on a Form W–2 or other statement under section 6051.

The bill authorizes the Secretary of the Treasury or his delegate to establish other exceptions by regulation.

For purposes of the reporting requirements, "health care services" are defined by reference to the services to which the medicare and medicaid provisions apply, and include such other similar or related services as the Secretary or his delegate may prescribe by regulations. The definition includes medical and dental services, and various related items of personal property, including drugs and biologicals.

A "provider of health care services" is defined as a person who furnishes health care services, unless his services are principally the selling or leasing of personal property (such as drugs and biologicals). For example, doctors, dentists, nurses, medical technicians, hospitals, and clinics are providers of services, but proprietory pharmacies and organizations renting health care equipment usually are not.

The bill also provides a definition of Government health care programs, since reporting with respect to unassigned payments is required only with respect to payments under Government programs. "Government health care program" means any program for providing

health care services which is administered by any Department, agency or instrumentality of the Government of the United States or is funded to a substantial extent by the United States. The term includes the medicare and medicaid programs and programs for maternal, child health, and crippled children services (under titles V, XVIII, and XIX of the Social Security Act), the Federal Employees Health Benefits Program (under chapter 89 of title 5, United States Code), military health benefits (under chapter 55 of title 10, United States Code), and veterans benefits (under chapter 17 of title 38, United States Code).

The reporting requirements apply to payments made by the United States, any State or political subdivision, or any of their agencies or instrumentalities. The returns required of these governmental units are to be made by the officers or employees having information as to the payments.

The bill requires every person who makes a return to furnish each person whose name is set forth in the return a written statement showing the name and address of the person making the return and the total amounts reported with respect to assigned and unasssigned payments. The statement is to be furnished on or before January 31 of the year following the calendar year for which the information return was made.

The bill also requires a provider of health care services to furnish, upon request of the payer, his address (and, if different, the address used for purposes of filing his income tax return) and his identifying number. This information must be furnished whether or not assigned payments, or amounts paid or payable with respect to unassigned payments, total $600 or more at the time the request is made.

The payer is required to retain records with respect to the information shown on the return, and to make the records available to the Secretary or his delegate.

The committee also agreed that it was appropriate for the Internal Revenue Service to supply insurance companies making assigned or unassigned payments the names, addresses, and identifying numbers of doctors and others covered by this provision. The names, addresses, and identifying numbers provided the insurers for this purpose, however, are not to be used by them for any other purpose.

The bill also amends title XI of the Social Security Act to require the Secretary of Health, Education, and Welfare to provide for similar reporting with respect to medicare and medicaid payments. Beginning with calendar year 1970, the Secretary is required to keep records showing the identity of each provider of medical or health care items or services who receives payments under medicare and medicaid programs, and under programs for maternal, child health, and crippled children services (under title V of the Social Security Act), the types of items or services rendered, and the aggregate amounts paid to the providers under each program. In order to carry out this requirement, the Secretary is given the authority to require information from all persons, agencies, or agents administering or assisting in the administration of these programs. The providers are required to be identified by their identifying numbers.

The bill requires the Secretary of Health, Education, and Welfare to submit to the Senate Committee on Finance and the House Com-

mittee on Ways and Means an annual report identifying each person paid a total of $25,000 or more during the preceding year under medicare, medicaid, and title V programs. Reports must be submitted for the calendar year, beginning with 1970, not later than June 30 of the following calendar year. These reports will facilitate the committees' exercise of their legislative responsibilities with respect to these programs.

Retirement Income Credit

(Sec. 611 of the bill and sec. 37 of the Code)

Present law.—Present law provides a retirement income credit to taxpayers age 65 or older or who retired under a public retirement system. The credit is 15 percent of eligible retirement income up to $1,524 for single persons and up to $2,286 for married taxpayers, both of whom are age 65 or over for a maximum credit of $228.60 and $342.90, respectively. The maximum base for the credit is reduced by the amount of social security, railroad retirement, and other tax exempt benefits. Because social security and railroad retirement benefits are tax-exempt, the retirement income credit was designed to provide approximately equal tax treatment for taxpayers that receive retirement income in a form other than social security and railroad retirement. In addition, the maximum base of the credit for persons between age 62 and 72 is reduced by earned income in excess of $1,200—a reduction of 50 cents for each dollar of earnings between $1,200 and $1,700, and on the basis of a dollar for each dollar of earnings above $1,700.[1]

General reasons for change.—When the retirement income credit was enacted into law in 1954, the maximum amount of retirement income which could then qualify for the credit ($1,200) was equal to the annual maximum amount which could be received in social security benefits. (Similarly, the amount of nonretirement income which could be received without reduction of the tax credit was approximately equal to the amount of non-retirement income which could be received by recipients of social security without a reduction in social security benefits). Although social security benefits were subsequently increased, the maximum amount of retirement income available for the credit was not changed until 1962. In 1962, the maximum limit of the credit for an individual was increased to $1,524 to correspond with the maximum social security benefits enacted in 1958. In 1964, a corresponding increase in the maximum limit of the credit to $2,286 was provided for married couples. Since then the maximum and average social security benefits have been raised substantially, increasing the difference between social security benefits and the maximum base for the retirement income credit.

The committee concluded that the gap between the level of social security benefits and the base for the retirement income credit has become excessive. As a result, it concluded that the maximum base for the credit should be brought more nearly in line with current levels of social security benefits. The new base provided for the retirement

[1] For taxpayers under age 62 (who have retired under a public retirement system), the base for the credit is reduced dollar for dollar by earnings in excess of $900. For taxpayers age 72 or over, the base is not reduced by earnings.

credit is not as high as the maximum social security benefits provided by the bill, however, in recognition of the fact that most social security beneficiaries—with whom the analogy is usually made—also do not receive maximum benefits. The new base for the retirement credit, however, is well above the average social security benefits provided by the bill.

In addition, the committee concluded that it would be appropriate also to increase the earnings levels above which the base for the credit is reduced. Here, too, the bill aligns these levels more closely with the current amounts social security recipients may earn without a reduction (or with a 50-percent reduction) in benefits.

Explanation of provision.—The bill increases the maximum base for the retirement income credit from $1,524 to $1,872 for a single individual (sec. 37(d) of the Code), and from $2,286 to $2,808 for qualifying married couples (sec. 37(i) of the Code). This increases the maximum credit from $228.60 to $280.80 for a single person and from $342.90 to $421.20 for qualifying married couples. The amount that can be earned without reduction in the base for the credit (sec. 37(d)(2)(B) of the Code) is raised from $1,200 to $1,680. Similarly, the earnings which may be received in the range where the credit base is reduced 50 cents for each dollar of earnings is increased from the previous $1,200 to $1,700 range to a range of $1,680 to $2,880. This also means that the level of earnings which reduce the credit base dollar for dollar is raised from $1,700 to $2,880.

The effective date of this provision is taxable years beginning after December 31, 1970.

This provision is estimated to provide tax reduction of $85 million annually.

Tax Credit for Portion of Salary Paid Participants in Work Incentive Program

(Sec. 612 of the bill and secs. 40, 50, and 50A of the Code)

When the Work Incentive (WIN) Program was enacted in 1967, Congress and the Labor Department were optimistic that it would help relieve the incidence of dependence on welfare by training welfare recipients to qualify for gainful employment. It was an effort to aid recipients in getting off the welfare rolls and onto payrolls.

For many reasons, however, WIN has not been as successful as was originally envisioned. Other amendments in the bill, described in part VIII of this report, seek to modify the WIN program to make it a more effective tool in leading welfare recipients to economic independence.

It is clear that improvements in the operation of the Work Incentive Program will be insufficient by themselves if jobs in the private sector are not available for WIN participants. Therefore, the committee bill would add a special tax credit provision to encourage employers in the private sector to set up on-the-job training programs for and hire welfare recipients participating in the Work Incentive Program.

The committee believes that the dual approach of improving the WIN program on the one hand and seeking greater employer partici-

pation in the program on the other—the latter by allowing this tax credit—will be of great benefit in matching up jobs and welfare recipients. It is convinced that whatever revenue loss is occasioned by enactment of the tax credit will be more than offset by reductions in welfare appropriations as recipients move from welfare to workfare.

The amount of the credit which would be allowed against an employer's income tax liability would be equal to 20 percent of the wage or salary of an individual in on-the-job training or placed through the WIN program during the first 12 months of his employment. As a further incentive to hire individuals covered by the work incentive program, the tax credit would be in addition to the present deduction for business expenses (which includes employee training costs).

Explanation of Provision.—Under this provision, a taxpayer is to be allowed as a credit against his income tax liability for the taxable year an amount equal to 20 percent of "work incentive program expenses" which he has paid or incurred during the year. However, the credit for a taxable year may not exceed $25,000 plus 50 percent of the taxpayer's income tax liability in excess of $25,000. "Work incentive program expenses" are defined as the wages and salaries attributable to the first 12 months of employment of employees who are placed in on-the-job training or employment under a work incentive program established under section 432(b)(1) of the Social Security Act. The amendment makes clear that the credit is not to be available with respect to wages or salaries paid to domestic employees. On the contrary, it is provided that only wages and salaries paid in the course of a trade or business are to qualify.

If the taxpayer terminates the employment of an employee placed under the work incentive program at any time during the first 12 months of employment or at any time during the next 12 months after the first 12 months of employment have been completed, then any tax credit allowed under this provision for the employee is to be recaptured. The tax liability of the taxpayer, for the year of termination, is increased by an amount equal to previous tax credits allowed for work incentive program expenses incurred with respect to the employee. The recapture provision is not to apply if the employee voluntarily leaves the employment of the taxpayer or if the employee becomes disabled.

This provision also permits any unused tax credits under this section to be carried back three taxable years and then to be carried forward seven taxable years. The unused credit carryback may be used to reduce any income tax liability for the years to which it is carried. However, any unused credit for a year may only be carried back to a taxable year beginning after December 31, 1968.

The provision contains several limitations. A credit may not be taken for work incentive program expenses which do not qualify as deductible trade or business expenses, or if the expenses have been reimbursed to the taxpayer. Further, the credit would not be allowed for any expenses of training conducted outside the United States. Also, no work incentive program expenses on behalf of an employee may be used in computing the credit if the expenses are incurred after the end

of the 24-month period beginning with the date of initial employment by the taxpayer. In addition, no work incentive program expenses may be taken into account with respect to an employee who is closely related to the taxpayer. If the taxpayer is a corporation, estate or trust, special rules are provided to achieve a similar result.

The provision is to be effective for taxable years beginning after December 31, 1970.

Refund of Social Security Tax to Members of Certain Religious Faiths Opposed to Insurance

(Sec. 128 of the bill and sec. 6413 of the Code)

The committee bill extends an exemption (by a refund or credit against income taxes at yearend) from the employee portion of social security taxes to members of certain religious sects who have conscientious objections to social security by reason of their adherence to the established teachings of the sect. The employee is required to file an application for exemption from the tax and would have to waive his eligibility for social security and medicare benefits. The provision specifically states that there would be no forgiveness of the employer portion of the social security tax as the committee believes that this would create an undesirable preference in the statute.

This exemption (refund) is more fully described in part III of this report.

B. OTHER AMENDMENTS

Appointment and Confirmation of Administrator of Social and Rehabilitation Service

(Sec. 605 of the bill)

The Social and Rehabilitation Service was established in 1967 by a reorganization within the Department of Health, Education, and Welfare. Its responsibilities are broad, encompassing the Federal welfare programs, medicaid, and programs in the areas of vocational rehabilitation, aging, and juvenile delinquency. The sums involved are huge; these programs accounted for expenditures totaling $9 billion in fiscal year 1970. The bulk of the funds are spent on the public assistance and medicaid programs.

The size of the budget is not the only indication of the responsibilities of the Administrator of the Social and Rehabilitation Service and the commissioners of the bureaus under him. For the Administrator is the agency's top official in formulating policy for such important programs as medicaid and the work incentive program aimed at helping assistance recipients to become economically independent.

At present, three agency heads in the Department of Health, Education, and Welfare with stature equivalent to that of the Administrator of the Social and Rehabilitation Service—the Commissioner of Social Security, the Commissioner of Education, and the Surgeon General of the Public Health Service—all are nominated by the President with the Senate's advice and consent. In fiscal year 1970, the expenditures of the Social and Rehabilitation Service exceeded those of the Office

of Education and Public Health Service combined. The committee bill would end the present anomaly by treating all four agency heads equally. The bill would upgrade the stature of the Administrator of the Social and Rehabilitation Service by having the President select him and by giving him the support of the Senate that his colleagues now enjoy.

Advisory Council Reporting Date

(Sec. 606 of the bill)

In order to provide the current Advisory Council on social security with an opportunity to modify its report so as to take into account social security legislation enacted toward the end of this year, the committee bill would extend the life of the Council for 2 months by requiring that its report be submitted not later than March 1, 1971, rather than by January 1, 1971.

The current members of the Council and its Chairman are expected to continue to serve on the Council until the Council concludes its deliberations and its reports are transmitted to the Congress. It is assumed that a change, occurring in the last weeks or months of the Council's deliberations, in the status which was the basis or a basis for a member's appointment to the Council will not preclude such member from continuing to serve until the Council submits its report.

Pass-Along to Welfare Recipients of Increases Under 1969 Social Security Amendments

(Sec. 608 of the bill)

The Social Security Amendments of 1969 included a provision to assure that recipients of aid to the aged, blind, and disabled would be allowed to keep at least a portion of the social security benefit increases which that act provided effective in 1970. This provision prohibited States from offsetting the full amount of those increases with corresponding reductions in welfare grants. Instead, the act required that each recipient be assured that his total monthly income would be raised by at least $4 or (if less) by the amount of his social security benefit increase. Originally, this pass-along provision was to have expired at the end of June 1970. Subsequent legislation extended the provision through October 1970 and also made it applicable to welfare recipients who received an increase this year in railroad retirement benefits. The committee bill provides a further extension of the provision through the end of 1971.

Though the social security benefit increase in this bill is effective as of January 1, 1971, it is expected that due to processing time, checks reflecting the increase will not be issued until April 1971. During that month, a second check will be mailed out containing the increases not included in the checks for the first months of 1971. The committee bill also requires States to disregard, for public assistance purposes, the retroactive benefit increase check mailed out in April.

Grade Level for Commissioner of Social Security

(Sec. 613 of the bill)

At the present time the Commissioner of Social Security is at level V of the Executive Schedule (salary $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 (salary $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—is much greater than any comparable position in the Department of Health, Education, and Welfare. For example, the Commissioner of Social Security is responsible for expenditures of about $45.7 billion a year—about 70 percent of the expenditures in the entire Department—53,000 employees—about one-half of all the employees in the Department. In contrast, the higher graded Administrator of the Health Services and Mental Health Administration is responsible for expenditures of about $1.5 billion and 25,400 employees; the Director of the National Institutes of Health is responsible for expenditures of about $1.5 billion and for 11,400 employees; the Administrator of the Social and Rehabilitation Services is responsible for expenditures of about $9.2 billion and for 1,900 employees.

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 contains a provision which would place the position of Commissioner of Social Security at level IV of the Executive Schedule which is one grade higher than the grade level of his deputy.

Authorization for the Managing Trustee of the Security Trust Funds To Accept Money Gifts Made Unconditionally to the Social Security Administration

(Sec. 609 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 any of the social security trust funds. While unrestricted bequests can be deposited in the general funds of the Federal Government, bequests restricted to any of the social security trust funds 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, or the National Heart Institute. St. Elizabeths Hospital, and the Cuban refugee program.

There have been some cases where money has been bequeathed to the social security trust funds. Because such a bequest cannot be accepted, confusion and delay in settling the estate may result. The

Department points out that while the amount of money lost to the trust funds is insignificant, it seems unjustifiable that an act presumably motivated by appreciation for, and confidence in, a Government program should cause complicated and perhaps interminable legal problems for the survivors.

The committee bill, therefore, adds a new provision to the House-passed bill to authorize the managing trustee of the social security trust funds to accept money gifts made unconditionally and to deposit them 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.

Loans to Supply Funds to Assist Hospitals and Extended Care Facilities to Meet Requirements of Life Safety Code

(Sec. 610 of the bill)

A relatively small number of hospitals and extended care facilities, constructed of combustible materials, are required to be equipped with automatic sprinklering systems in order to participate in Medicare and Medicaid. Some of these institutions do not presently have such systems and have been permitted to participate in medicare with the understanding that they would install them as soon as possible. Some have been unable to do so because of the lack of funds, as well as the unavailability of sources to which they might look for loans on reasonable terms.

In order to help those institutions presently providing necessary care to a substantial proportion of beneficiaries in the area who need such care, and continue to meet the needs of beneficiaries who would not otherwise have access to needed care without these institutions, the committee bill would authorize the Secretary of Health, Education, and Welfare to approve loans for the purpose of installing sprinklering systems which meet the requirements of the Life Safety Code of the National Fire Protection Association. Loans would be authorized during the period ending December 31, 1975, but only where the appropriate State planning agency finds that the proposed loan should be made to permit the continued participation in Medicare of an institution that was participating in the program on January 1, 1971 and that the proposed investment would not be inconsistent or inappropriate in terms of area needs for the facility concerned. Thus, loans would be made for existing structures only.

Loans would be made only after a finding by the Secretary that the institution is unable to raise the required funds internally, and is unable to obtain a loan at a reasonable rate of interest and on reasonable terms from other sources. The amount of the loan may not exceed an amount that can reasonably be expected to be repaid by the institution.

The interest charged on such loans will be at the average rate of return on assets of the hospital insurance trust fund at the time the loan is made. Loans are to be repaid over a period not to exceed 10 years, in equal periodic payments no less frequently than annually. The loan will become due and payable in full at any time that the facility no longer affords services to a reasonable proportion of Medicare beneficiaries in the area who require such services or if the funds are not used for the purpose intended. Funds necessary for such loans are authorized to be appropriated from the general revenues of the Federal government.

The committee expects that the Secretary, in considering whether to terminate an institution's participation in Medicare by reason of its failure to install a required automatic sprinklering system because of the lack of funds, will take into account the opportunity here provided to obtain such loans on favorable terms, as well as the likelihood that the institution will apply for such a loan and that it would be approved by both the State agency and the Secretary.

XI. CHANGES IN EXISTING LAW

In the opinion of the committee, it is necessary, in order to expedite the business of the Senate, to dispense with the requirements of subsection 4 of rule XXIX of the Standing Rules of the Senate (relating to the showing of changes in existing laws made by the bill, as reported).

SEPARATE AND ADDITIONAL VIEWS OF MEMBERS OF THE COMMITTEE ON FINANCE

Separate and additional views of members of the Committee on Finance

CONTENTS

XII. SEPARATE VIEWS OF MR. FULBRIGHT

Notwithstanding my strong support for title I of H.R. 17550 containing increases in social security benefits, I voted in Finance Committee against reporting this legislation in its present form. As now constituted, the bill contains, in addition to social security provisions, numerous medicare and medicaid amendments, some family assistance proposals, a catastrophic health insurance plan, and a major international trade package. Any one of these proposals would be considered a major piece of legislation. Aside from the merits of these provisions, it is my view that the procedural obstacles likely to result from attaching several quite different and controversial areas of legislation to the bill will jeopardize the bill's passage.

While I am not in agreement with all of the other areas of H.R. 17550 as reported it is the trade provisions which give me the most particular concern. There is substantial and respected evidence that this trade bill will portend grave foreign policy and economic consequences generally, not to mention its associated inflationary pressures.

The Finance Committee has considered an inordinate number of issues this year and, in my opinion, was not able to give adequate time to trade hearings. Considering the scope of this legislation, relatively few witnesses appeared before the committee. One witness who did testify, however, was the Secretary of State. With reference to the likelihood of this bill crippling international commerce, Secretary Rogers' forecast is bleak:

> It may be said that these fears are unjustified, that the proposed legislation merely seeks to deal with certain special and urgent problems of the United States, and that other nations too have restrictions on imports. The fact is, however, that the legislation before you could lead to restrictions on a very large volume of U.S. trade, as much as $3 billion or more, and other nations are acutely aware of this.

Statements such as this one have not been rebutted to my satisfaction, and these unanswered questions about the impact of this bill leave serious misgivings in my mind about supporting it. For example, my State depends to a great extent on agricultural exports, as evidenced by a fiscal year 1970 total of $296 million. I must say that I have not been convinced that this bill will not adversely affect the export markets of such products as soybeans, cotton, and rice.

I am, of course, sympathetic to the problems caused by foreign imports which exist within such industries as textiles and footwear. Indeed, their plight suggests that a review of our international trade policies should be forthcoming. Such a review should, however, be comprehensive and should be undertaken with deliberation and accompanied by adequate hearings. The adjournment rush is no time to attempt to focus on a question of this magnitude.

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Accordingly, I voted in committee to separate the trade amendments from the social security bill, believing such action would enhance the latter becoming law. I regret that this effort was unsuccessful.

Our senior citizens on fixed incomes are those in our society who suffer most seriously from inflation, and it seems indeed ironic that a bill designed to give needed social security increases and reform should become encumbered with, among other things, far-reaching trade proposals, the economic consequences of which could conceivably offset the originally intended benefits of H.R. 17550.

J. W. FULBRIGHT.

XIII. ADDITIONAL VIEWS OF MR. RIBICOFF

Part One—Welfare

Comprehensive welfare reform is the most urgently needed domestic legislation now being considered in Congress.

The necessary improvements have not been provided by the Senate Finance Committee amendments. Therefore, Senator Bennett and I propose a program of substantive reform to go into effect following extensive testing to assure administrative and operational efficiency.

Our proposal is based on the major provisions of the Family Assistance Plan proposed by the Administration. While our amended Family Assistance Plan does not provide everything ultimately required to perfect this nation's welfare program, it is a necessary and significant step forward.

The United States must commit itself to end poverty. Family Assistance can be a major contribution toward fulfilling that commitment.

I. The Principles of Reform

Welfare is not a subject of interest only to the poor and the welfare worker. The measure of a whole society is taken from the adequacy, equity and efficiency of its programs for the needy. Their progress is our progress.

The principles of adequate welfare are simple and paramount:

First, assurance to all members of society of an income adequate to meet their basic needs;

Second, incentives and opportunity for the employment of all citizens;

Third, encouragement and support of the basic family structure;

Fourth, a uniform system of national standards supported and financed by the federal government; and

Fifth, simple and efficient administration dedicated to assisting rather than demeaning the poor.

We are a wealthy people. As the prerequisites of citizenship have increased, so too have our responsibilities to our society and our fellow man. As a nation we can no longer tolerate a system of public assistance which fails to meet the most basic principles of humanity.

II. The Present Welfare System and the Finance Committee Amendments

The present public welfare system in the United States is a failure.

Assistance payments are insufficient to meet minimal needs. Family and work incentives are lacking. Eligibility is based on arbitrary categories rather than need. While Congress has established a legal right to assistance, it has provided a system which frustrates the exercise of these rights and demeans those who do exercise them.

The welfare amendments of the Senate Finance Committee have ignored these very basic failures and therefore are inadequate to the challenge of reform.

I share the view of the Committee that far-reaching and innovative social legislation should be tested thoroughly before implementation on a nationwide basis.

But, testing alone in a time of urgent need is not enough.

In August 1969, the President outlined reform legislation which, while not perfect, would take several significant and constructive steps toward a strong welfare system.

The House of Representatives passed legislation embodying the basic principles of the President's proposal—the Family Assistance Plan.

After many weeks of hearings, however, the Senate Finance Committee regrettably refused to consider this plan in detail and substituted an amendment calling merely for two years of tests.

Clearly, passage of a two year test program requiring more legislation at the end of that test period means no welfare reform until 1974 or beyond. Reform is much more urgent than that.

The proposal Senator Bennett and I intend to make provides for extensive testing in the period between enactment and the effective date of welfare reform. The most innovative proposal, to assist the "working poor", would be tested in several areas for more than a year.

Extensive pre-testing of this nature would provide more than adequate time to iron out the problems in organization and administration of Family Assistance. Furthermore, information gained from careful evaluation of *existing* "working poor" programs in six states would be readily available.

III. A Plan of Welfare Reform

The full Senate should have an opportunity this year to debate and pass on a substantive plan of welfare reform. We intend to propose such a plan.

It contains the major elements of the Family Assistance Plan first announced by the President in 1969; refined by the House of Representatives in H.R. 16311, passed on April 16, 1970; and revised further on October 13, 1970 by the Administration.

It contains substantial changes suggested in my letter to Secretary Richardson dated December 2, 1970.

The plan also couples a program of pre-testing with authorization for substantive welfare reform.

A. FAMILY ASSISTANCE

The Family Assistance Plan would provide a basic income floor for *all* families with children. Families headed by a fully employed male, the "working poor", would be included for the first time as well as all families now eligible for AFDC. The concept of a federally-supported income floor for all families in need regardless of other classifications is a forward step toward a strong welfare system.

The income floor would be computed on the basis of $500 each for

the first two members of a family, and $300 for each additional member, or $1,600 for a family of four without income. The minimum Family Assistance payment would be entirely financed by the federal government.

The Family Assistance payment level would provide increased incentives to earn outside income. The FAP benefit would be gradually reduced as the family income increased. In computing the benefit, the first $720 of income ($60/month) would be disregarded. Each dollar of income above $720 annually, would reduce the FAP payment by 50 cents.

TABLE 1.—FAMILY OF FOUR FAP BENEFIT

Income	$0	$500	$720	$1,000	$2,000	$3,000
FAP payment	1,600	1,600	1,600	1,460	960	460
Total income	1,600	2,100	2,320	2,460	2,960	3,460

No payments would be made above an income level of $3,920 for a family of four.

B. STATE SUPPLEMENTARY PAYMENTS

Above the basic Family Assistance allowance, each state in which the AFDC payment level in November 1970 was higher than the Family Assistance level must supplement the FAP payment up to that level or the poverty line whichever is lower.

The federal government would share 30% of the cost of these supplements, up to the poverty level.

The states would not be required to supplement the "working poor"—intact families with an employed male—and federal sharing would not be available for states which did supplement these families voluntarily.

Special rules would apply in computing the amount of state supplementary payments. A state would be required to disregard (1) $720 per year plus (2) one-third of the remaining income.

Thus, in a state which presently pays a family of four up to $3,000, a family with $2,800 income would receive a state supplement of $1,053 in addition to FAP benefits of $560.

TABLE 2

Earned income	$2,800
Disregard	−720
Total	2,080
Disregard ⅓ of $2,080	−693
Total	1,387
FAP payment to family of four earning $2,800	+560
Chargeable income	1,947
State supplement	1,053
Total FAP and State supplement and earnings	4,413

C. WORK REQUIREMENTS

Eligibility for Family Assistance benefits is conditioned on registration for manpower training and employment programs. These requirements are applicable to all members of an eligible family except:

(a) Persons unable to engage in work by reason of illness, incapacity or advanced age;

(b) Mothers of children under six;

(c) Mothers or other female caretakers of a child if a male member of the family is working;

(d) Children under 16 or a student;

(e) A person whose presence in the home is required because of the illness or incapacity of another member of the household.

Following suggestions by Senator Talmadge, our plan establishes priorities in the placement of welfare recipients into work or training slots. These priorities are:

(1) unemployed fathers
(2) persons over 16, not regularly employed and not students
(3) regularly employed persons
(4) all others required to register

D. PENALTIES FOR REFUSAL TO WORK OR ACCEPT TRAINING WITHOUT GOOD CAUSE

If a member of a family refuses, without good cause, to accept work or training under the provisions of this program, the family cash payment under Family Assistance will be reduced by $500. In addition, state supplementary payments will be reduced accordingly.

E. PROPOSED CHANGES IN THE FAMILY ASSISTANCE PLAN

On December 2, 1970, I communicated to the Secretary of Health, Education, and Welfare a list of ten suggested improvements in the proposed Family Assistance Plan.

These changes should be incorporated into any welfare reform legislation considered by the Senate, and most have been included in the Ribicoff-Bennett disposal.

(1) A National Goal:

Today, one in every eight Americans is poor. In the wealthiest nation in history, our poor outnumber the total population of Canada. More than a third of our poor are children. Many of the rest are ill, disabled or elderly.

These people are tragic evidence of our neglect, and lack of commitment to end poverty.

Our growing national affluence has not been fully shared. In a future which promises greater riches for many but continued poverty for some, we have, in the words of the President's Commission on Income Maintenance Programs, "the potential for social division unparalleled in our country".

Our failure has been a failure of commitment rather than resources. We have the means to end poverty. Let us resolve to do so.

As a beginning step, Congress must establish a national goal to end poverty in this decade.

(*2*) *Unemployed Parents Program:*

As passed by the House of Representatives, H.R. 16311 provided for mandatory state supplementation (with federal sharing) of families headed by an unemployed father. (AFDC–UP) Under present law, this is an optional program existing in 23 states.

In the Administration revisions of H.R. 16311, this mandatory AFDC–UP has been deleted.

I strongly support inclusion of this program—as provided by the House of Representatives and the original Administration proposal. Restoration of this provision would benefit some 90,000 families, or more than 300,000 poor people.

(*3*) *Restoration of the Requirements in Sec. 452 of H.R. 16311 for Using "standard of need" for Families With Income:*

In August 1969, the President, in his welfare address to the Nation, spoke strongly for the principle that no recipient would be worse off under his proposal than under existing law. Unfortunately, a subsequent revision of H.R. 16311 would adversely affect families with outside income in 22 states by reducing state supplements. Restoration of the "standard of need" provision in Sec. 452 will remedy this unwise provision.

(*4*) *Minimum Wage Levels for Welfare Recipients Taking Employment:*

A universally recognized objective of welfare reform, clearly stated in the President's welfare message, is the great need to move the poor from relief rolls to payrolls. Legislation toward this laudable goal, however, must not sacrifice very basic objections to providing a ready-made pool of forced labor for employers paying substandard wages.

Substandard wages perpetuate poverty. At $1.00 an hour, a fully employed husband and father of two children falls almost $2,000 below the barest minimum income required for his family.

Therefore, I propose that provisions be added to this reform legislation stipulating that welfare recipients required to accept work be paid a reasonable wage, preferably the basic minimum wage of $1.60 an hour. The Ribicoff-Bennett proposal takes a major step in this direction by guaranteeing wages of at least $1.20 an hour.

(*5*) *Adequate Safeguards for State and Local Employees Taken Under Federal Programs:*

There must be assurances that state and local welfare employees, who would be encompassed by the new federal program, are treated fairly with respect to their seniority, salary and pension rights earned under their previous employers.

(*6*) *Federal Administration of Fully Federally Financed Welfare Programs:*

Welfare reform must reduce the major inequities and complexities that result from over 50 different welfare systems with their varied forms, requirements, and regulations. In many states today, the system is operated by three separate levels of government: federal, state

and local. The redtape, inequities, and sheer complexity of these arrangements must be reduced.

Therefore, I propose that reform legislation include a provision for mandatory federal administration of all welfare programs which are 100% funded by federal monies. This provision will be a major step toward our goal of universally applied standards for all recipients.

(7) *Public Service Employment:*

The major goal of any public assistance program should be the provision of adequate employment opportunities permitting recipients to supplement and eventually replace welfare payments by earned wages.

Regrettably, the original Family Assistance Plan presented to Congress contained not a single job opportunity.

Senator Harris and I have suggested an amendment establishing a strong program of public service employment. Such an amendment would complement the training provisions already suggested above by assuring a greater number of jobs at the end of the training cycle.

Therefore, I propose a public service employment program for recipients of FAP benefits or state supplementation.

Under the amendment, the Secretary of Labor would enter into grants or contracts with public or private nonprofit agencies to create jobs in a wide variety of enumerated fields of benefit to the public.

Special provisions were designed to assure that such jobs are not dead-end jobs and that they offer opportunities for career advancement. The Secretary of Labor is required to review each employment record at least once every six months.

The jobs provided must meet standards with regard to health, safety, and working conditions, not jeopardize existing employment, and otherwise conform to certain protections. Wages paid must at least equal the federal minimum wage or, if higher, any applicable state or local minimum wage or the prevailing wage for such jobs in the same labor market area.

In order to encourage movement by participating individuals into regular jobs and to ensure that these jobs involve the performance of useful work, provision is made for declining federal matching over time. Ninety percent matching is provided for the first 24 months during which such employment is provided, and 80 percent thereafter.

The Secretary of Labor is obligated to expend at least $150 million annually on such public service jobs. The funds may come from appropriations pursuant to part C of title IV of the Social Security Act or from any other funds available to the Secretary or the Department of Labor under other acts.

(8) *Work Requirements for Mothers of School-Age Children:*

In 1967, the Senate recognized the inherent social difficulties of forcing mothers of school-age children to accept employment. At that time, the Senate passed an amendment which exempted mothers of school-age children from required employment during the hours children are home from school.

The most cursory examination of history shows that the victims of legislation forcing mothers to work are the children of those mothers. Our own national traditions are based on the belief that the best interests of the child are best protected by its mother. The decision whether to accept employment while the child remains at home should be left solely with the mother.

While not exempting mothers of school-age children from work, the proposal of Senator Bennett and myself will guarantee that mothers of these children will only be required to work if adequate child care facilities are available. In actual fact, the work priorities practically assure that mothers of schoolchildren will not be affected by work requirements.

(*9*) *Additional Safeguards for the Legal Rights of Welfare Recipients:*

The Administration's Family Assistance legislation provided for a marked and regressive change affecting the legal rights of welfare recipients by requiring that stepfathers assume legal responsibility for their stepchildren. Most states do not impose an obligation of support on a stepfather. Generally, our federal system has left matters of domestic relations laws to the wisdom of the states. Thus, the effect of the original FAP provision was to impose a discriminatory obligation on the stepfathers of poor families. Senator Bennett and I have proposed that this unwise provision be eliminated.

(*10*) *Adjustment of the Base Payment of FAP to Reflect Cost of Living Increases:*

Administration estimates have shown that increasing the level of payment above $1,600 for a family of four would cost approximately $400 million annually in federal revenues for every $100 increase in benefits.

While it is certainly preferable that the base benefits of FAP be increased, it is more important that effective reform legislation be enacted this year.

However, as the barest minimum objective, it is imperative that FAP should include a provision to reflect additional costs of living.

IV. Effects of Welfare Reform

A. THE COSTS OF WELFARE REFORM

The plan outlined in the preceding pages has been estimated to increase federal welfare costs by approximately $4.3 billion.

These costs are comparable to those estimated for the Administration's original proposal and for the bill, H.R. 16311, passed by the House of Representatives earlier this year.

It is estimated that the proposal would make 24 million Americans eligible for some federal welfare assistance compared to 11.6 milion now eligible under AFDC and the adult categories.

The following charts give detailed information on costs and caseloads.

TABLE 3.—*Estimated net cost*

[In billions]

Payments to Families	$2.1
Fiscal Relief to States	.4
Adult Category	.9
Day Care and Training	.6
Administration	.4
Increased Costs Due to Food Stamp Check Off	—.1
Total	4.3

TABLE 4

COMPARISON OF PROJECTED ELIGIBLES UNDER THE FAMILY ASSISTANCE PLAN AND PROJECTED RECIPIENTS UNDER CURRENT LAW, 1972-76 (ASSUMES 100 PERCENT FAP PARTICIPATION) [1]

[Millions of persons]

	1972	1973	1974	1975	1976
Under family assistance plan:					
Persons in families eligible for FAP only	11.7	11.3	10.2	9.1	8.0
Persons in families eligible for FAP and State supplemental	9.0	9.5	10.7	12.0	13.4
Adult category recipients	3.3	3.5	3.6	3.8	3.9
Total	24.0	24.3	24.5	24.9	25.3
Under current law:					
AFDC recipients	9.6	10.8	12.1	13.6	15.3
Adult category recipients	3.2	3.4	3.5	3.7	3.8
Total	12.8	14.2	15.6	17.3	19.1

[1] Comparison not directly appropriate since FAP projections include all eligibles (100 percent participation) while AFDC projections show only actual recipients (reduced participation).

Revised Estimates

The above figures are based on 100 percent participation by all eligible recipients. However, it is not realistic to assume full participation in a new welfare program. As was pointed out by Mayor Lindsay of New York before the committee, actual participation rates in New York City programs for the "working poor" are about 33 percent even after twenty years of operation.

Actual participation in the program will vary in accordance with the amount of benefits available to a family. A breakdown of Family Assistance eligibles by amount of benefits is shown below:

TABLE 5

Amount of annual family benefit	Number of persons (in thousands)	Amount of annual family benefit	Number of persons (in thousands)
0 to $100	965.9	$701 to $800	707.1
$101 to $200	1,177.6	$801 to $901	721.5
$201 to $300	689.9	$901 to $1,000	1,077.0
$301 to $400	875.6	$1,001 to $1,499	3,310.1
$401 to $500	981.0	$1,501 to $1,999	3,228.4
$501 to $600	676.2	$2,001 plus	3,350.3
$601 to $700	697.6		
		Total	[1] 18,458.2

[1] Does not include persons in families eligible only for State supplemental benefits.

A plausible relationship between benefits and participation is shown in the next table:

TABLE 6

Annual benefit	Participation rate (percent)	Annual benefit	Participation rate (percent)
$0 to $200	10	$601 to $800	70
$201 to $400	30	$801 to $1,000	90
$401 to $600	50	$1,000 plus	95

Assuming less than 100 percent participation, the net additional federal welfare costs would be $3.9 billion.

TABLE 7

[In billions]

Payments to Families	$1.7
Fiscal Relief to States	.4
Adult Category	.9
Day Care and Training	.6
Administration	.4
Increased Costs Due to Food Stamp Check Off	—.1
Total	3.9

Estimates of actual recipients, assuming less than 100 percent participation are:

TABLE 8

COMPARISON OF PROJECTED RECIPIENTS UNDER THE FAMILY ASSISTANCE PLAN AND CURRENT LAW, 1972–76 (ASSUMES REDUCED FAP PARTICIPATION)[1]

[In millions of persons]

	1972	1973	1974	1975	1976
Under family assistance plan:					
Persons in families receiving FAP only	8.0	7.7	6.8	5.9	5.0
Persons in families receiving FAP and State supplemental	8.1	8.4	9.3	10.2	11.1
Adult category recipients	3.3	3.5	3.6	3.8	3.9
Total	19.4	19.6	19.7	19.9	20.0
Under current law:					
AFDC recipients	9.6	10.8	12.1	13.6	15.3
Adult category recipients	3.2	3.4	3.5	3.7	3.8
Total	12.8	14.2	15.6	17.3	19.1

[1] Assumes projected FAP participation rates at less than 100 percent and some impact of training programs.

B. FISCAL RELIEF FOR THE STATES

The program proposed by Senator Bennett and I would provide substantial and vitally needed relief to states now burdened by rapidly increasing welfare costs.

This relief is provided through two different approaches. First, the federal minimum payments in both the family and adult categories combined with federal sharing in supplementary programs will provide over $400 million of immediate relief to state treasuries. Second, a "freeze" provision included in the Ribicoff-Bennett proposal will guarantee that state costs required under this program cannot exceed

90 percent (plus a cost of living factor) of welfare costs incurred by the state in calendar year 1971.

C. SUMMARY

The Beginning of a More Equitable, Efficient System

The welfare proposal outlined above represents a significant step toward a stronger, fairer and more efficient public assistance system.

The principles of the plan are directly related to solving the problems now facing welfare in the United States.

First, it provides more uniform national standards, including a federally supported minimum welfare benefit and national eligibility rules;

Second, it provides more efficient organization through simplified application and payment procedures and strengthened federal administration;

Third, it provides increased work incentives by including the "working poor" and expanding training and employment opportunities; and

Fourth, it provides increased assistance to presently eligible recipients now mired in poverty.

Let us be clear about the overall effects of this program. It will not reduce the number of eligible recipients. Nor will it reduce welfare expenditures. The needs of our poor, our sick, our elderly, and our children will not permit such reductions. Today, almost three out of every four poor children receive no benefit from federal welfare programs. Close to fifteen million poor Americans do not receive any assistance.

We must learn that we cannot save money by wasting lives.

The plan which Senator Bennett and I will introduce is far from perfect. It fails to include many of the steps I believe will be ultimately necessary for a strong welfare program.

Among other things, it does not cover single persons, or childless couples under 65. Eligibility for these people is a prerequisite for a truly universal assistance program. The basic federal payment of $1,600 for a family of four is barely adequate. Federal sharing should be expanded to include state supplements to the "working poor".

However, it is fair to say that if the plan is not perfect, it is necessary.

Authorization of a program similar to that outlined above is a necessary first step in reforming American welfare.

V. Other Committee Amendments to Present Welfare Laws

In addition to the test program of Family Assistance, the committee has also recommended some amendments to present welfare laws. Several of these amendments are retrogressive and self-defeating; four of these are particularly important.

Use of Federal Funds to Support the Legal Process

One committee amendment prohibits the use of federal funds to pay directly or indirectly the salary of any individual who participates in legal actions designed to interpret or test federal legislation.

In a time when much emphasis is given to the desirability of settling our differences within established legal institutions, this provision seems particularly regressive and divisive.

No federal legislation should be immune from established and recognized judicial scrutiny. In our adversary system of justice, this scrutiny is best developed by legal actions originated by the parties in interest. Powerful corporations are fully entitled, in our system, to test laws in courts and deduct the costs of legal representation. In many cases, the only advocates for the poor are Community Legal Services personnel who, by a conscious policy decision of Congress, are often supported by federal funds. To deny these funds is to deny the right of effective advocacy to a large segment of our society.

American justice is based on the theory that all citizens are equal before the law. By denying effective representation in cases involving laws most directly affecting the immediate lifestyle of the poor, equality of rich and poor before the law becomes a myth.

Man In The House

The committee has resurrected a provision permitting states to deny AFDC benefits to children in families where a man may be occasionally present, even though he has no legal duty to support the child.

In 1968, the Supreme Court struck down a similar "man in the house" provision on the ground that an unrelated adult in the home has no legal obligation to support the child, and therefore, the child may be eligible for AFDC.

The committee's amendment set forth a long list of criteria by which a parental-type relationship could be established and the man be held responsible financially for the child.

In addition to the unrealistic burdens this would place on welfare administration, the provision would penalize the children for the conduct of the mother.

An unrelated man who visits a child's mother, no matter how regularly, cannot be relied upon to provide a meaningful parent-child relationship. If he does make financial contributions, these are counted in determining the family's benefits now.

Residence Requirements

Another committee amendment raises an additional issue recently ruled on by the Supreme Court.

In 1969, the Court declared durational residence requirements unconstitutional because they interfere with the right to travel.

The committee has sought to re-establish residence requirements, requiring that a recipient only receive payments equal to the lower benefit level from which he moved.

Whether this provision would correct the constitutional defect cannot be predicted, but it certainly would create inequities between residents of the same state. It would penalize new arrivals who were not previously on welfare but come to require it in the state to which they move, and would restrict the mobility of the poor who wish to seek better economic opportunity in a different state.

Definition of an Unemployed Parent

Present law authorizes a program, at state option, to support families in which the father is unemployed. This program is now operational in 22 states. In its regulations the Department of Health, Education, and Welfare has defined "unemployed" to mean less than 30 and in some cases 35 hours of work per week.

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The committee amendment defining unemployment to mean less than 10 hours a week or 80 hours a month, is far too restrictive, and, in effect, defeats the purpose of the unemployed father program (AFDC-UP). It is hard to conceive that a man working 12 hours a week is fully employed. More to the point, it is unrealistic to expect that the wages of a few hours of work a week can adequately support a family. A more reasonable definition of employment will provide greater incentives for the partially employed to continue and improve their work skills.

VI. Aid to the Blind, Aged and Disabled

The Finance Committee has adopted minimum support levels for the 3 million recipients under the aged, blind and disabled program which are too low to support an adequate standard of living for an adult couple. The committee has adopted minimum payments of $130 per individual and $200 per couple per month. In addition, the committee has eliminated food stamps for these recipients. In comparison, the House bill passed payment levels of $110 for an individual and $220 for a couple, plus food stamps.

I propose setting minimum payments for needy adults at least at the level of $130 for an individual and $230 for a needy couple under the adult programs.

VII. Conclusion

Welfare reform is so urgent that the 91st Congress should not adjourn until the United States Senate has debated and voted on the merits of the issue.

Part Two—Trade

The trade features of this bill do not belong in the social security measure. They are so important they should be debated and voted upon separately and on their merits.

The portions of this bill containing the committee's foreign trade proposals bear vitally on the future direction of our own country's trade policies and those of our major trading partners. The proposed changes are of much greater potential importance to world stability than the particular situations they seek to remedy.

Fears have been raised abroad that because of its current economic difficulties, the United States will be tempted to pursue short-sighted protectionist policies with damaging and far reaching consequences. Some commentators have gone so far as to state that this legislation would spark a chain of reprisals and signal a return to mercantilism. There is an unfortunate tendency to paint the United States as the only villain here. But all industrialized nations do not have clean hands as far as their trade practices go.

By now it should be clear that trade problems will increasingly go to the root of our foreign relations with our European allies and Japan. With the United Kingdom negotiating its membership in the Common Market, we must begin planning now how we will get along with a trading bloc which will account for 40% of total world imports. Our trade policies will undoubtedly have a great influence on the political direction of Europe and Japan in the last quarter of the 20th Century.

Until now, our NATO and Asian policies and our conceptions of the future of Europe and Asia have been formed largely by geopolitical considerations. But with the growing prospects for poltical detente in Europe and the shifting of power in Asia, it will be the geoeconomic problems that will come to the fore. It is essential that we do not get on the wrong track at the outset. In an area where complexity is the rule, we have become bogged down in detail while paying insufficient attention to the larger issues involved.

Since the completion in 1967 of the Kennedy Round, world trade policy has been allowed to drift. While tariffs on certain items in world commerce still remain obstacles, it is the nontariff barriers to trade which are becoming major irritants in international commerce. The increasing use of new varieties of protectionism by ourselves and by other countries raises the real possibility that the great international conflicts of the 70's might well be trade wars.

In seeking to prevent damaging and senseless trade disputes, we seem to fashion our responses on a piecemeal basis. The brief hearings in the Senate on the legislation before us reflects this lack of depth. In addition, the Department and agencies in our government making and implementing our trade policies appear to operate without overall policy guidance and suffer from a lack of continuing high level attention. As economic issues are resolved on their own merits in isolation from our overall foreign policy objectives, they will continue to be subjected to special domestic pressures which too often prove irresistible because of their persistence, rather than their logic.

Our present decisionmaking processes in this area should be replaced by a more integrated framework, where policy can be more consciously arrived at. It follows that the Executive Branch of our government must be significantly strengthened to perform this task.

Given the enormity of the stakes here, we can no longer afford the luxury of thinking small when it comes to our foreign trade relations. If we and our trading partners devote our energies to planning reprisals rather than proposing initiatives, and to imposing new restrictions rather than seeking greater cooperation, it is clear that we will be working to the detriment of all. The chaos which must inevitably ensue from a failure to devise a workable set of international rules will poison foreign relations between nations and do harm to domestic economies.

The burden of creating a workable system of international trade, however, cannot be borne by America alone. Movement toward freer trade should not be a one-way street. The growing economic strength of the European Economic Community and Japan calls for corresponding give on their side and greater sensitivity on their part to our own problems. For example, the difficulties we face in negotiating a textile agreement with Japan is to some extent due to the barriers erected by the EEC countries against Japan's apparel exports. Also, the Common Agricultural Policy of the EEC affects American agricultural exports to Common Market countries, while the subsidization of EEC agricultural products inhibits American exports to other markets.

A willingness on the part of the EEC and Japan to join us in establishing guidelines and workable rules for international trade is essential. If nations are to stop trying to pass on the costs of their own

domestic problems to each other, they must first realize the mutuality of interest involved, and do more to harmonize and rationalize their trade relations.

For the United States this might mean seeking more flexibility in providing timely adjustment assistance for our own workers and industries. For European countries and Japan this could involve stricter adherence to agreed-upon groundrules.

Given the magnitude and potential significance of economic problems to world stability and progress in the years ahead we certainly need more complete and frank discussions of the basic issues involved. In the Senate we must have full and comprehensive hearings where we can hear from our best informed people and have all points of view presented. Only then can we begin to take responsible legislative action to resolve the paradoxes and baffling contradictions in our current trade policies.

I hope that in the next Congress we will have more opportunity to pay greater attention to these problems and gain new perspectives.

ABE RIBICOFF.

XIV. SEPARATE VIEWS OF MR. HARRIS

Introduction

The initial objectives of H.R. 17550 were to provide more adequate social security benefits and to make needed improvements in medicare, medicaid and maternal and child health programs.

The objective of H.R. 16311 was to effect urgently needed reform of a failing welfare system.

These objectives are highly laudable. However, by the addition of unrelated matters, unwise amendments and weak substitutions for some provisions, these original objectives have been made hostage to other, less noble, aims.

The Trade Act of 1970 was added as an amendment to H.R. 17550.

Various amendments to the present welfare laws were agreed to which can only be characterized as regressive and punitive.

An amendment to establish a Federal Child Care Corporation, which would represent a substantial and objectionable change in child care programs, was adopted.

I, therefore, voted against reporting the bill. My reasons for doing so are here set forth in detail.

Social Security

A. Increase in Benefits and Minimums

The committee made several greatly needed improvements in the social security provisions of H.R. 17550.

The 5 percent increase in benefits, adopted by the House, was stepped up to a 10 percent increase. The committee also rightly voted to provide a $100 minimum social security benefit level.

With these increases, H.R. 17550 became an acceptable advance this year toward fairness in our social security program.

B. Workmen's Compensation Offset

The committee made certain other changes in the House bill provisions regarding social security which were undesirable.

The provision in the House bill, amending present law which requires social security disability benefits to be reduced when workmen's compensation is also payable and when the combined payments exceed 80 percent of average current earnings before disablement, was stricken.

The House bill called for a reduction in benefits by the amount by which the combined payments under both programs exceed 100 percent of average current earnings before disability. This provision should be restored.

C. Financing

When the committee finished its work, it had voted approximately $10 billion in additional benefits. It then turned to financing.

I believe the committee was mistaken in not properly taking into account the presently regressive nature of the social security tax system and in not fully considering the economic impact of the financing arrangements which it approved.

The social security tax system is not as nearly based upon ability to pay as is the Federal income tax. There is an upward limit—presently $7,800, and $9,000 under the committee bill—on the amount of salary which is taxed. The tax is in a flat rate basis; it is not graduated.

I believe that the payroll tax under social security has reached the saturation point. I, therefore, supported an effort to finance a portion of benefits from general revenue. This effort failed.

Alternatively, I offered a financing plan which would make the social security tax system more progressive by raising the wage base to $12,000 in 1971. This allows actuarial soundness with less of an increase in the tax rate over a period of years. The following table shows the financing plan which I offered and which was rejected by the committee. As indicated, in addition to providing actuarial soundness over the long term in each of the funds involved—OASDI, health insurance and the new catastrophic health insurance—the plan which I offered would avoid a cash deficit in any year in any of the funds.

[In percent]

	OASDI	HI	CI	Total
1971	4.1	0.7		4.8
1972–74	4.1	.8	0.3	5.2
1975–79	5.0	.9	.35	6.25
1980–84	5.5	1.0	.35	6.85
1985 plus	5.85	1.0	.4	7.25
	−.15	−.06	+.02	

Note: The excesses of income over outgo resulting from this schedule follow:

[In millions of dollars]

	OASDI	HI	CI
Fiscal year 1972	1,079	1,044	589
Calendar year 1971	97	560	
Calendar year 1972	1,519	1,303	565
Calendar year 1973	2,843	851	403

The financing plan which I offered would also provide an additional and very important economic impact. It would postpone an increase in the tax rate from 4.8 to 5.2, which is otherwise scheduled to go into effect in January 1971 under present law. Unless this rate increase is postponed, it will have a seriously dampening effect on consumer demand at a time when the economy is much too sluggish and unemployment intolerably high. Stimulation of consumer demand through postponement of the presently scheduled tax rate increase and through increased benefits would not be inflationary by serving to cause expanded production volume, allowing some reduction in unit costs.

The revised manner in which Federal budgets are now made up and presented, taking into account income and expenditures from social security and other trust funds, more clearly points up the fiscal impact of decisions concerning social security benefits and rates.

In addition to the right of social security beneficiaries to more adequate benefits, the payment of increased benefits will provide a much-needed increase in consumer demand, aiding economic recovery. This fiscal impact should not be offset by immediate rate increases, primarily the way in which the automatic adjustment of the benefits vent an annual deficit in the various funds or to provide general actuarial soundness.

D. Cost-of-Living Increase

The committee worked long and hard on the problem of how to insure that the purchasing power of social security benefits is maintained. On the whole the committee acted wisely in this regard; however, I disagree with some aspects of the automatic adjustment provisions—primarily the way in which the automatic adjustment of the benefits is financed.

The committee made some major changes in the automatic adjustment provisions that were proposed by the administration and passed by the House of Representatives. Many of the changes are reasonable, but some aspects of the provisions agreed to by the committee should be changed if they are to be fully acceptable and are to operate smoothly.

There are two major difficulties with the committee provisions concerning automatic adjustment of social security benefits and automatic financing.

First, the committee bill would require the Secretary of Health, Education, and Welfare to promulgate increases in both social security tax rates and the earnings base in order to finance the automatic increases in benefits, even though such increases in social security taxes would be unnecessary and would greatly over-finance the program. Under the committee bill, whenever an automatic cost-of-living increase in benefits occurs, the Secretary would be required to increase social security taxes. Such increases in taxes would not be necessary because a large part of the cost of the automatic benefit increase would be met from rising earnings levels without increasing either the tax rate or the earnings base.

Second, the provision for automatic increases in the earnings base as wages rise, proposed by the administration and passed by the House, does not constitute a discretionary delegation to the executive branch. The increases would be automatic and the determination of the amount would be routine on the basis of social security wage record statistics.

Under the committee revision, on the other hand, it would be necessary for the Secretary of Health, Education, and Welfare, as a part of the automatic provisions, to determine both the short-range and long-range "cost" of each automatic benefit increase, and we would in effect be turning over to the Secretary of Health, Education, and Welfare the tax-setting function of the Congress.

The provision approved by the House would merely carry out automatically the policy which the Congress has been following on an *ad hoc* basis since 1950—that is, periodically increasing the social security

earnings base so as to cover the same proportion of payroll as had been covered earlier, when wage levels were lower. As wages have risen, the $3,600 base that became effective in 1951 has been changed by the Congress, in steps, to $7,800—as it would have been under the automatic provisions. It is important to increase the base to keep up to date with rising wages, not only from the standpoint of the income of the program but to prevent a deterioration in the coverage of the program. For example, a job which paid $3,600 in 1950 pays around $9,000 today. If the base had not been increased over the years the benefits payable to a man in such a job would provide a much smaller proportion of wage replacement than they were originally intended to, and there would have been a major deterioration in the protection afforded by the program. If the base is kept up to date with rising wage levels, there will be little if any need for an increase in the tax rate to cover the cost of the automatic cost-of-living increase.

The House provisions in this regard are, therefore, preferable to the provisions adopted by the Senate, and they should be restored.

The House bill requires the Secretary of Health, Education, and Welfare to increase social security benefits any January, commencing January 1973, if he finds that the cost of living has increased by 3 percent or more between the last July-to-September calendar quarter preceding a secretarially determined benefit increase and the most recent July-to-September quarter. The automatic increases would be in addition to any increases which might be passed by Congress. The taxable wage base would increase automatically every 2 years based on increases in the average taxable wages after 1971.

Medicare and Medicaid

A. Health Maintenance Organizations

Medical costs have risen enormously. There are many causes for this. One cause is the greatly increased demand for medical services without a concurrently increased supply in personnel and facilities.

It is imperative that there be a massive increase in medical and paramedical personnel and in medical facilities. The shortages are already acute, and they are growing alarmingly.

It is also vital that there be much better use of existing personnel and facilities. Toward that end, the committee approved the health maintenance organization concept contained in H.R. 17550. Under this provision, medical payments can be made to physicians on a per capita basis, rather than on a fee-for-service basis only.

This provision is an important step forward toward encouraging prepayment for group medical practice and toward greater emphasis on preventative medicine.

B. Professional Standards Review Organization

The committee adopted a proposal to establish professional standards review organizations at local and State levels throughout the country to review such functions as examination of patient and practitioner profiles; independent medical audits; on-site audits: and the development and application of norms of care and treatment.

The Secretary of Health, Education, and Welfare would be required

to enter into agreements with qualified professional standards review organizations, principally local medical societies, to review the totality of care rendered or ordered by physicians for medicare and medicaid patients. Where medical societies are unable or unwilling to undertake the responsibility, the Secretary could contract with States or local health departments or other suitable organizations.

This provision has a laudable purpose: to insure quality care and to hold down unnecessary costs.

However, the proposal contains many unknown and unpredictable factors. Further, there are serious objections that it grants organized medicine too much control over utilization of facilities and payments of claims.

The proposal should be tested before Congress puts it into effect on a total basis as the committee bill would do. I am not satisfied that this proposal will result in the savings which have been claimed by its proponents, nor am I satisfied that the review procedure is the best and most workable which can be devised.

The House provisions on peer review should be strengthened, and the Senate committee provisions should be stricken.

C. State Maintenance of Effort

Under present law States are required to maintain their present financial efforts in support of medicaid and are required to build toward comprehensive medicaid programs by 1977.

The State of Missouri asked the committee to pass legislation giving it a special one-time exemption from the maintenance of effort requirement. The committee could have granted this special request, based upon unique circumstances, without upsetting the present law.

But the committe went far beyond the Missouri request and repealed the entire section 1902(d) of the present law, under which States are required to maintain their financial efforts under medicaid. The House of Representatives had previously stricken section 1903(e) which requires States to enact comprehensive medicaid programs by 1977.

The repeal of both these sections is most unfortunate. The poor people covered by medicaid are entitled to better medical attention and care—not less. Their needs should not be ignored in order to slow the rising costs of this program and medical care generally. Section 1902(d) and section 1903(e) should be restored in the bill.

D. Physical Therapy

The House bill provides for reimbursement of up to $100 of the cost of physical therapy on an outpatient basis in the office of an independent practitioner under part B of medicare. This provision was rejected by the Senate committee.

A great many beneficiaries need the services of a physical therapist, and these services can often best be performed in the office of the therapist. The limited reimbursement that the House approved, which in effect puts it on a trial basis, should be reinstated in the bill.

E. Blood Replacement

The committee rejected a proposal to eliminate the requirement in the present law for a medicare patient to pay for or replace the first

three pints of blood used by such patient. This requirement seems unreasonable. It places an undue burden on medicare patients, and it should be eliminated.

F. Medicare Premium Increases

The premium for part B, supplementary medical insurance, under medicare has increased by more than 80 percent in the last 4 years. Originally the premium was $3 a month per person. It was increased from $4 to $5.30 on July 1, 1970. For those living on social security, this increase is almost prohibitive and it should be eliminated if the aim of medicare is to be realized.

Welfare Reform

A. Need for Reform

During the past few years, the need for reform of our welfare system has assumed crisis proportions. Three parallel developments have dramatized the urgency: sharply increasing welfare rolls, growing recognition of the inefficiency and failures of the system itself, and ever more crippling fiscal burdens on States and localities.

Neither the poor—a group that is widening every day in the current economic climate—the Nation's stability, nor any pretense to sound social policy can wait longer for a rational income maintenance system.

This case has been made so often and so convincingly by mayors, Governors, welfare administrators, recipients, social scientists, and political figures of every persuasion that there is no need for it being made again.

Toward this end, I introduced with seven other Senators the National Basic Income and Incentive Act, S. 3433. This bill calls for the federalization of the presently outdated, unworking, and inhumane welfare system, replacing it with a Federal income maintenance system. It represents a significant departure from our present thinking about welfare and represents true reform.

I had hoped that improvements in H.R. 16311 could be made that would move the family assistance plan closer to the concepts of the National Basic Income and Incentive Act and real reform. Unfortunately, the committee moved in the opposite direction and was willing to approve only a test of various pilot reform programs.

Passage of a test proposal alone will surely delay congressional consideration of real reform for at least 3 years. I do not believe that the Nation can wait.

There is good reason to predict that the number of families and individuals requiring financial aid will continue to increase, that State and local funds crucially needed for programs to reduce dependency will be drained by the demands of public assistance, that the inequities of the present system will continue to demean recipients so as to destroy their incentive, and that the entire Nation will suffer from a welfare system that must be revised.

B. Requirements for Real Reform

Perhaps if the administration had been willing to make progressive changes in the House-passed version of the family assistance plan, rather than regressive changes during the consideration of the bill by the committee, something more substantial than a test would have been reported by the committee. Elimination of mandatory coverage of families headed by an unemployed father (AFDC–UP) and elimination of the requirement that States maintain current benefit levels for families with income, provisions that were in the President's original welfare reform proposal, weakened support for the bill in the committee by those of us who were advocating more meaningful reform of our welfare system.

A failure to recognize the importance of requiring the minimum or prevailing wage, whichever is higher, also weakened support for the bill.

While I do not believe that the administration has gone as far as it should, I am pleased that it has now agreed to some of the changes in the family assistance plan which Senator McCarthy, Senator Ribicoff and I and others advocated. The changes the administration has now approved are embodied in the amendments offered by Senator Ribicoff and Senator Bennett.

I believe that additional improvements can and should be made.

Recognizing that Congress is not willing to completely federalize the welfare system at this time, a goal should nevertheless be established for moving within a time certain toward a welfare system that is federally financed and administered. Included within the goal should be a commitment to move the level of payment to an adequate income. Our goal is to assist people in getting out of poverty, but a floor at a low level, instead of raising families out of poverty, means only continued poverty with little prospects for breaking out.

Any system of reform should also require that the prevailing or minimum wage, whichever is higher, should be paid for those who are forced to take a job. Otherwise, a captive work force with insufficient standard of wage to be paid will be available to employers, and the effect will be to keep wages so low that millions will remain in poverty though working full time.

Any version of the family assistance plan that is adopted by the Senate should not require mothers with school-age children to work. Mothers should have some control over whether day care centers are good enough for their children.

Furthermore, a provision to provide for cost-of-living increases in payments to recipients should be adopted. We have recognized this principle with regard to those who are receiving social security payments, and the same arguments can be made in support of providing cost-of-living increases for those on public assistance.

Any system of welfare reform should also fully protect the rights of present recipients and of applicants to insure that the new law does not create different classes of citizens.

A national system of income maintenance, recognizing the needs of the working poor, setting uniform national minimums of assistance and removing present barriers to incentive and initiative is desperately needed.

These principles can and must be embodied in real welfare reform, together with programs which assure that, through expanded public service jobs and otherwise, people have a real chance to get a job.

C. Regressive Amendments

Unfortunately, the committee adopted a number of amendments to our present system that are regressive.

The most disappointing action of the committee was the barring of legal service lawyers from representing welfare recipients. Much of the work of these lawyers in the past few years has been to secure benefits guaranteed by law, but not received by poor people due to illegal regulations and administrative practice.

During the past 3 years welfare recipients and lawyers associated with federally funded legal service programs have compiled a remarkable record of service to poor people. Significant court decisions have begun to nudge the welfare system toward a more equitable and enlightened program. Cruel and demeaning regulations, irrelevant to the purposes of the Social Security Act, have been overturned in the courts.

The Finance Committee has proposed that this record of progress be nullified. This restrictive amendment, adopted by the committee, should be defeated.

Other undesirable amendments were adopted by the committee.

The committee would make the leaving of a family and moving across State lines a Federal misdemeanor. This is an unwarranted extension of Federal police power into intimate aspects of family life and, in view of the State laws now regulating this subject, would prove to be unworkable.

The action taken by the committee in instituting a 1-year residency requirement for people in need of assistance, was likewise regrettable. The committee provision is in conflict with the Supreme Court's opinion in *Shapiro* v. *Thompson*, 394 U.S. 618, in which it was held that citizens have a constitutional right to travel throughout the States and that welfare eligibility regulations should not impede that right. The committee position would restrict the right to travel precisely in the manner prohibited by the Court.

The committee was also mistaken, in my opinion, in resurrecting the onerous man-in-the-house rule. This rule, knocked down by court decision, would base eligibility not on actual resources but on imagined income from people not legally obligated to support the children involved.

Provisions were also adopted that require the return of amounts paid to welfare recipients who do not prevail at hearings; that eliminate progress made in the declaration system; that cut back on the Federal assistance now available to families with a father in the home; and that provide eligibility requirements wholly unrelated to the need of poor children.

Adoption of these provisions represents a step backward in our efforts to devise a more workable and humane system of welfare—an entrenchment of old myths about welfare and welfare recipients that should have been cast aside years ago.

D. Aid to Aged, Blind, and Disabled

The committee made substantial changes in the House bill with regard to benefits for the aged, blind and disabled. The House bill provided for a minimum of $110 a month for single individuals and $220 for couples. The committee approved $130 for single individuals and $200 for couples, cashing out food stamps.

Taking into consideration the fact that an increase in social security benefits reduces Federal and State expenditures for the aged, blind and disabled—and considering their great and growing needs—the Senate should provide for a minimum of at least $130 for single individuals and $230 for couples, not cashing out food stamps for these individuals.

E. Catastrophic Health Insurance Plan

A critical problem has arisen because of the rapidly increasing costs of medical care that have left 90 percent of all Americans medically indigent. No one questions the need to provide a better means for the average American citizen to finance his health care.

While I agree with the objectives of the catastrophic-health insurance plan, I voted against attaching the plan to H.R. 17550. When the plan was presented to the committee for consideration, H.R. 17550 was already heavily loaded with extra, and in some instances nongermane amendments, and it did not seem appropriate to add to the bill such a massive new health program.

The problem which the catastrophic health insurance plan seeks to meet is pressing and must be solved. But it does seem that the problem could be more appropriately solved in a broader context of national health insurance and by considering the whole matter in a more deliberate and careful fashion.

There is little chance that any such new program as this can be adopted this late in the postelection session in any event, and the attachment of the measure to the already overburdened social security bill may tend to defeat the bill to which it is attached.

The chairman is to be congratulated for offering a solution to the crisis and for urging prompt action. With his interest and his strong desire to see legislation enacted, the committee should give this matter prompt attention at the beginning of the next session. At that time there will be full opportunity to give attention to the financing of catastrophic illness costs and to the financing of all health care, including the need for an urgent and massive increase in medical and paramedical personnel and facilities.

F. Federal Child Care Corporation

There is a great shortage of quality child care facilities and services. We need to do more to promote the development of increased facilities and services. But the establishment of a Federal Corporation is not the way to achieve the needed results.

The Corportion under the committee bill would have the responsibility for arranging for child care services in the various communities of each State. Existing public, private nonprofit, and proprietary facilities would be contracted with by the Corporation to serve as child

care providers. Pursuant to the terms of the provision adopted by the committee, the Corporation could provide child care services in its own facilities.

A fee would be charged by the Corporation for its services, to be paid either by the consumer of services or by a public agency.

I have grave concern about this approach to quality child care. Child care is a proper subject for local community concern and planning. The Federal Child Care Corporation approaches child care needs from the top.

Parental involvement is crucial in early childhood programs. If the parent is actively involved, there will be a positive overlap in the home and the community. I feel that this would be unlikely under the operation of the Federal Child Care Corporation.

I question whether the standards set out in the bill are high enough. These standards, coupled with the striking down of local and State regulations, could lead to purely custodial child care.

I am also concerned that with a growing number of commercial franchisers entering the day care field, a great tendency would exist for the Federal Child Care Corporation to contract with these franchise operations. If so, this could lead to a depersonalization of child care services and eliminate or reduce community control and parental involvement—the hallmarks of good child care.

Child care has not received proper attention from the Congress. It should be a matter of top priority for the next session of the Congress. We must soon enact major legislation which will provide quality child care on a universal basis, not stigmatized by welfare alone, not controlled by private business, but controlled by the local community and with full involvement of the parents.

The provision in the present bill does not meet these crucial tests.

Trade Act of 1970

I strongly opposed the attachment of the Trade Act of 1970, H.R. 18970, to the social security amendments. Not only did I object to the Trade Act on its merits, but I also thought it unfortunate to reduce the chances of passing much-needed welfare reform and increases in social security by attaching nongermane legislation.

I have general objections to the overall thrust of the Trade Act, as well as specific objections to its provisions. First, I will set forth my general reservations about the act

A. Balance of Trade

It is presently estimated that in 1970 we will have a healthy surplus of over $3 billion in our trade balance. Last year, the surplus was under $1 billion. In other words, this year our exports have been growing considerably more rapidly than imports.

The argument that U.S. industry is becoming increasingly noncompetitive, which is often made in support of the Trade Act of 1970, is invalidated by these figures. This would therefore seem to be an especially poor time to risk loss of export markets by curtailing imports.

Another effect of quotas which would be imposed under this bill

would be the retardation of economic growth in developing nations. This is at odds with our larger foreign policy to encourage the strength and growth of these less developed countries.

B. Cost to Consumers

Recently, Federal Reserve Board Governor, Andrew Brimmer, said that the textile and shoe quotas in this bill would cost the consumer an extra $3.7 billion, and that these costs would be borne disproportionately by the poor because they must spend a larger share of their income on shoes and clothing than do more affluent citizens. Whatever the merits of the industries' case—and I want to return to this—it would seem that the consumer would have to pay a very heavy price indeed for these quotas.

These costs could multiply if other consumer items were subjected to quotas under the liberalized escape clause.

C. Impact on Inflation

Much attention has rightly been focused on the economy in recent weeks. The inflation alert, the President's speech to the NAM—all focus on the real danger of inflation. Mr. Arthur Burns, in speaking on measures to combat inflation last week, suggested the relaxation of existing quotas on imports. This comes at a time when new inflationary quotas would be imposed by the trade bill. We obviously cannot have it both ways. We must draw the line and choose between control of inflation and protectionism.

Another voice raised in opposition to the import restrictions of the bill is that of the Chamber of Commerce of the United States. The Chamber has urged that a more constructive course on trade legislation be charted in the next session of Congress.

D. Danger of Retaliation

I have also noted in the press an increasing number of statements made by officials of foreign governments, including some of our best customers—Canada, Germany, Latin America, Britain, and Mexico, to name a few—concerning the possible adverse consequences of the enactment of the trade bill. One can, of course, dismiss these statements as bluffing, on the assumption that other countries either could not or would not dare to curtail our exports. But is this assumption necessarily correct? In many instances, other countries would be able to obtain the same goods of comparable quality from alternative sources. Moreover, other countries watch their trade balance with the United States very carefully and would be very prone to reduce their purchases from us if we were to restrict their exports to this country. Finally, I think the element of national pride would be at work here. If they feel—as they seem to—that the textile and shoe quotas, for example, are unjustified, then they will naturally want to strike back. The risk of an old-fashioned trade war is, in my judgment, severe. If that happens, no State will be immune from its effects. In testimony before the Finance Committee, the National Chamber attributed 4 million American jobs to total United States exports. The wheat farmers of western Oklahoma have made Oklahoma the No. 3 wheat exporting

State in the Nation. A generation of eastern Oklahomans have pinned high hopes on the Arkansas River Basin project which the late Senator Kerr spent so many years helping to develop into a navigable access to world commerce. All of these stand in real jeopardy in the face of restrictive trade policies.

E. Renewal of Textile Negotiations

The trade bill was approved by the House Ways and Means Committee after the Secretary of Commerce announced that the United States-Japanese textile negotiations had broken down and that the administration therefore reluctantly supported legislative quotas. In the past weeks, however, these negotiations have been resumed. There is admittedly no assurance that these negotiations will be successful either in the short or long run. But the fact of their resumption is surely significant and affords further reason for pause in considering the trade bill. The Japanese Government feels an early voluntary agreement is desirable because if there is no agreement and no legislation is passed this year, Congress may pass even more restrictive legislation next year.

F. Textile and Shoe Quota

To the best of my knowledge, there has been no objective determination that imports are causing or threatening serious injury to the domestic textile industry. Of course, the industry itself makes vehement allegations of jobs eliminated and production lost because of imports. But has any reasonable independent body like the United States Tariff Commission ever come to that conclusion? I would emphasize that I am not asserting that there are no parts of the textile industry that may be injured by imports. I am rather asking for evidence that there is a serious import-related problem affecting the entire industry.

In the face of such evidence, action is certainly required. Full use of present legal remedies should be made. Stronger and more aggressive diplomatic initiatives by the administration could result in voluntary limitations on specified imports.

However, statistics from the American Textile Manufacturers Institute reflect that annual textile exports have expanded by $200 million over the past 12 years. More U.S. employees are engaged in making textile mill products now than in any year except 1968. The number of employees engaged in apparel manufacturing is at an all time high. Net sales, both in textiles and apparel, are the highest ever, nearly doubling 1960 figures. Taken as a whole, these facts do not support allegations of a severely depressed industry, requiring emergency legislation. In the absence of impartial evidence of harm from imports, I must question the need for, and the wisdom of, unilateral textile quotas, especially in view of their cost to the consumer and the possibility that the United States-Japanese negotiations may be successful.

As for shoes, a task force of the administration itself concluded just several months ago that there is no justification for quotas. Nevertheless, the President has asked the Tariff Commission to determine whether imports are causing or threatening serious injury to the do-

mestic industry. This is the proper way in my judgment to develop a sound basis for informed and intelligent action concerning imports.

G. Escape Clause Provisions

Another provision of the trade bill that is very troublesome is the amended escape clause, which has traditionally authorized the President to impose higher tariffs or quotas on imports found to be injuring a domestic industry. The following aspects of the new escape clause are open to serious question.

First, under the trade bill the Tariff Commission would have to determine whether imports are a "substantial" cause of serious injury. Instead of "substantial," present law reads "major" and the administration's bill would have substituted "primary." These may sound like semantic quibbles, but the difference between "primary" and "substantial" could spell the difference between a reasonable and a promiscuous use of the escape clause.

Second, the bill resurrects the concept of geographic segmentation, which permits the Tariff Commission to carve up an industry and artificially select just that portion that will maximize the chance of an affirmative finding of injury. The Tariff Commission would be given the license to do so even though it made no economic sense and even though the companies and workers concerned were in fact able to make a successful adjustment to whatever import problem may have existed. One of the important features of the Trade Expansion Act of 1962 was its repeal of the geographic segmentation provision. Its resurrection is a major threat to an enlightened foreign trade policy.

H. Foreign Import Restrictions

The committee has gone even further than the House bill in making section 252 of the Trade Expansion Act of 1962 a protectionist device. At the present time, section 252 authorizes—but does not require—the President to impose new restrictions on imports from countries that are illegally or unreasonably restricting our exports. The key issue, of course, is who determines whether a foreign import restriction is illegal or unreasonable. The right of any member of the GATT to impose new restrictions is severely restricted by that agreement—as it should be if any order in international trade is to be preserved.

Under the committee's bill, the Secretary of Commerce would determine if a foreign import restriction is illegal or unreasonable. If he made an affirmative finding, the President would be authorized to work out a solution with the foreign country concerned. If he could not in 3 months, then he would have to take retaliatory action. This is—pure and simple—another radical violation of the GATT and another example of a blind attitude that somehow the United States can flout the rules of the game and get away with it.

I. Status of GATT

The committee struck the new separate authorization for appropriations to finance our annual contribution to the GATT. This will probably not seriously jeopardize future appropriations, since there is a

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general authorization available in the organic legislation of the Department of State. But it is obviously a vote of no confidence in the only international organization that offers any hope of maintaining and strengthening a fair world trading system.

The committee struck the provision on the ground that it would give "statutory recognition of the GATT, which has never been submitted to the Congress for approval." The fact is that the GATT is a valid executive agreement, concluded pursuant to the authority of section 350 of the Tariff Act of 1930. As a statutory executive agreement, it need not, of course, be submitted to the Congress for approval. This question dealt with extensively in a 1956 memorandum of the Legal Adviser of the State Department to the then chairman of the Ways and Means Committee (see H. Rept. 2007, 84th Cong., second sess., 113–131 (1956)).

J. American Selling Price

The committee struck the provision in the House version that would have provided for the elimination of the American selling price (ASP) system of customs valuation as it relates to benzenoid chemicals. This system has been found to be without justification by both the Johnson and Nixon administrations, and the United States is pledged to seeking its abolition in one of the agreements concluded in the Kennedy Round. If this system is not to be abolished, there is little, if any, hope of making further progress for some years to come in the field of nontariff barriers. Once again, the blind approach is at work: Let other countries remove their nontariff barriers, while we stand pat.

K. Failure To Take Positive Action

Beyond the positive and enormous harm done by the bill, it also fails to seize critical opportunities to move ahead:

(1) *Tariff-Reducing Authority.*—The House bill by clear legislative history and the committee's bill by express statutory language would give the President new tariff reducing authority only for the purpose of granting compensatory tariff concessions when we increase import restrictions under the escape clause or by some other means. In other words, this is an authority that at best permits us to stand in the same place, but envisages no further net reduction in tariffs.

The Kennedy Round was concluded in 1967 and the last tariff reductions agreed to will take place on January 1, 1972. Isn't it time to give the President the authority to start moving again in lowering trade barriers? How can the momentum of trade liberalization be maintained if the past leader of that effort is powerless? And especially in the trade field, the absence of progress only invites retrogression.

(2) *Non-Tariff Barriers.*—Even with the provision authorizing the elimination of ASP, the House bill failed to provide for negotiations on nontariff barriers, though everyone agrees that this is the single most serious problem in the trade field. As it stands now, the President must act at his peril if he acts at all. On the one hand, he can negotiate on nontariff barriers without any prior congressional approval and simply hope that the Congress will provide the necessary implementing legislation after the fact. The handling of ASP, of course, affords

little encouragement. On the other hand, the President can request specific authority before beginning any particular negotiations on nontariff barriers. The Congress may then so circumscribe his authority as to render it valueless or give him none at all, since it has not yet seen what reciprocal advantages it might afford the United States.

The only way I can see out of this dilemma is to have the Congress give the President, perhaps in the form of a resolution, the "license" to negotiate, while reserving all of its authority to pass upon any necessary implementing legislation. This would at least give the President the encouragement he does not now have to tackle nontariff barriers and attempt to commence an international negotiation on the subject.

1. Conclusion

The total effect of the trade bill is, in my judgment, antagonistic to constructive ways of dealing with the current problems in international trade. It assumes that the United States can take unjustified and indeed illegal actions and somehow get away with them, without provoking retaliation or undermining the world trading system. This seems to me to be a hopelessly naive and false assumption. It is my opinion that if the Senate will seriously consider how harmful the present trade bill is and how great is the need for a constructive trade bill, then we may still have the time to avert the appalling consequences of a return to protectionism both in this country and throughout the world.

I re-emphasize that I am concerned about the allegations of serious injury resulting from imports being voiced by the textile and other industries. Present law provides for remedies in such cases. Full use of present provisions should be employed where need is indicated. Adjustment assistance should be used to ease the conversion of industries and jobs in cases requiring such relief. Diplomatic negotiations should be pressed. Lastly, the Congress should carefully and deliberately consider additional thoughtful trade legislation, which is in keeping with our past policies of free trade and which does not violate international agreements which we have previously made.

I attempted twice in the committee to have the trade bill stricken from the social security bill. I will renew this effort on the floor of the Senate. Should this motion fail, I intend to offer a series of amendments to improve the Trade Act.

Conclusion

All of the legislative proposals included in H.R. 17550 are in need of thoughtful legislative consideration. My opposition to specific proposals in the bill by no means indicated a lack of concern for responsible action on the problems raised thereby. But, it is too late in this post-election Congress to hope for any fruitful action on so many diverse issues placed under the same umbrella.

Therefore it is imperative, as I have set forth in these separate views, that the Senate in the remaining days devote its time to improving our social security and related programs and to meaningful reform of our failing welfare system. The other matters can and should be set aside for consideration by the next Congress.

FRED R. HARRIS.

XV. ADDITIONAL VIEWS OF MR. WILLIAMS OF DELAWARE AND MR. CURTIS

We believe that there should be some social security legislation at this time. We favor an increase in the benefits, including special consideration to those social security recipients who are receiving the smaller amounts.

There is also a need for certain corrective amendments in reference to medicare and medicaid. There are some changes that need to be made that will be beneficial to the patients involved and also to the local hospital boards and the States. There are some changes in reference to welfare that are urgently needed by local governments and States in order to properly administer the program.

H.R. 17550 and the amendments recommended by the Senate Committee on Finance do some of these things and meet some urgent needs. However, the bill as it comes from the Committee on Finance goes too far. It involves many costly features which will eventually lead to a tax burden greater than should be imposed upon the employees, employers, and self-employed persons, and therefore we cannot support it in its present form.

JOHN J. WILLIAMS.
CARL T. CURTIS.

XVI. SEPARATE VIEWS OF MR. MILLER

I deeply regret that this bill, with many good features, has become so overloaded that I cannot in good conscience support it as it now stands.

First, trade legislation, which could hardly be considered germane to the subject of social security, was tacked onto the bill as an amendment after only brief hearings. Although the amendment represents some degree of improvement over the House-passed trade bill, it goes too far. For example, by a vote of 9–8, the committee rejected my amendment to delete the quota provisions relating to shoes. And this notwithstanding the fact that, as Stanley Nehmer, Deputy Assistant Secretary of Commerce for Resources, pointed out (See Congressional Record for December 3, page S19294) the difference in size of the problems of textiles (30,000 firms) and shoes (675 firms) is so different that they do, in fact, take on a difference in kind. He noted that the loss of 100,000 jobs in the textile industry from January through September of this year equals 50 percent of the total employment in the non-rubber footwear industry.

In any event, trade legislation of the magnitude of the present amendment should stand on its own two feet rather than ride piggyback on a legislative vehicle whose importance might transcend the undesirable features of trade proposals.

Second, the increase in the minimum social security benefits from the present $64 per month to $100 per month at an annual cost of $1.5 billion to the social security trust fund is inequitable. Acting impulsively on the simplistic plea that "no one can live on sixty four dollars a month", the Senate last December adopted such an amendment to the Tax Reform Act of 1969. This was quickly disposed of by the House Conferees during the conference on the bill who noted that a large number of the recipients of the social security minimum already receive benefits from one or two other pensions—civil service retirement, state and local retirement, or private corporation retirement; and that state old age assistance payments prevent anyone from having to live on $64 per month. Instead of applying the proposed 10 percent increase in social security benefits across the boards to include the present minimum, which would mean an increase from $64 to $70.40 per month, the bill provides an increase in the minimum to $100—regardless of need—at a cost to the taxpayers of $1.5 billion per year.

Worse yet, this $1.5 billion plus also the amount needed to cover a 10 percent increase in the minimum would be paid for by those paying social security taxes into the social security trust fund. Inasmuch as those who receive the "minimum" have not paid taxes sufficient to cover their benefits, the load is thrown on those who are

already paying taxes sufficient to cover their benefits. In short, most of the minimum social security benefits provided by the bill represents welfare—not tax paid insurance. It should, therefore, be paid out of the general fund of the Treasury. Moreover, as welfare, the payments should be made on the basis of need, taking into account other resources of the recipient.

The bill makes no attempt to order our priorities. Instead, it contains all major social security proposals—the 10 percent increase, the increase to $100 in the minimum, and coverage of catastrophic illness and disease. It would seem that the single most urgent action to be taken—one that should have been taken long ago, before medicare and medicaid—is coverage of catastrophic illness and disease. Also, it is only fair to bring social security benefits into line with increases in the cost of living which have occurred since benefits were last increased. It would appear that this would fall somewhere between the 5 percent increase provided by the House and the 10 percent increase provided by the Senate Finance Committee. The increase in the "minimum"—particularly the $1.5 billion needed to go beyond a cost-of-living increase—is inequitable and excessive.

Those who would be paying the bill should know what lies in store for them. The tax base would be raised from $7,800 to $9,000, with the following rate changes:

TAX RATES ON BOTH EMPLOYER AND EMPLOYEE

[In percent]

Year	Under present law	Under the bill	Under the bill without $100 minimum
1970	4.8		
1971	5.2	5.2	5.1
1972	5.2	5.5	5.4
1973–74	5.65	5.6	5.5
1975	5.65	6.35	6.35
1976–79	5.7	6.35	6.35
1980–85	5.8	7.0	7.0
TAX RATES ON SELF-EMPLOYED PERSONS			
1970	6.9		
1971	7.5	7.4	7.3
1972	7.5	7.7	7.6
1973–74	7.65	7.8	7.7
1975	7.65	[1] 8.35	[1] 8.35
1976–79	7.7	[1] 8.35	[1] 8.35
1980–85	7.8	[1] 8.5	[1] 8.5

[1] Additional costs of cash benefits are borne by employer-employee rax revenue because of 7 percent limitation on tax for underwriting cash benefits. Excess over 7 percent is attributable to financing medicare and catastrophic coverage.

Applying these various rates to the "maximum" tax base of $7,800 (under present law) and $9,000 under the bill would result in the following maximum tax:

MAXIMUM TAX ON BOTH EMPLOYER AND EMPLOYEE

Year	Under present law	Under the bill	Under the bill without $100 minimum
1970	$374.40		
1971	405.60	$468.00	$459.00
1972	405.60	495.00	486.00
1973-74	440.70	504.00	495.00
1975	440.70	571.50	571.50
1976-79	444.60	571.50	571.50
1980-85	452.40	630.00	630.00

MAXIMUM TAX ON SELF-EMPLOYED PERSONS

1970	$538.20		
1971	585.00	$666.00	$657.00
1972	585.00	693.00	684.00
1973-74	596.70	702.00	693.00
1975	596.70	751.50	751.50
1976-79	600.60	751.50	751.50
1980-85	608.40	765.00	765.00

Although I believe that most people will be willing to pay increased taxes to assure cost-of-living increases in social security benefits, a reasonable degree of medicare coverage, and coverage under the catastrophic illness and disease program, we have reached the point of a taxpayers' revolt against tax increases which are used to fund low-priority and unnecessary, untimely, or inequitable social security benefits.

JACK MILLER.

XVII. SEPARATE VIEWS OF MR. JORDAN OF IDAHO

Provisions of this bill which are of overriding importance are those increasing social security benefits by 10% and increasing veterans pensions up to 9%. These increases are necessary to help social security beneficiaries and veteran pensioners to keep up with the rising cost of living which has been eroding the purchasing power of their fixed incomes. Regardless of the fate of the many and varied other provisions of the bill, it is essential that Congress act on these benefit increases.

The trade provisions, on the other hand, do not appear to me to be either necessary or desirable. I am not convinced that the beneficial effects claimed by the proponents of this legislation would not be greatly outweighed by the unfavorable consequences which it could bring about for the international trading position of the United States. The restrictive quota provisions may invite retaliation in kind from other nations, especially the Common Market nations and Japan. Such retaliation would seriously jeopardize U.S. exports, particularly agricultural exports.

In recent years a major contributor to our balance of payments and to national and regional economies has been agriculture. In fiscal year 1970 record commercial sales for dollars pushed total agricultural exports past the $6.6 billion mark. U.S. exports to Japan alone reached $1.09 billion in 1969/1970—the first time that such exports to a single country have surpassed the billion dollar level. The economy of my own State was boosted by about $64 million in 1969/1970 through agricultural exports. American agriculture has achieved these results only through sustained and intensive work to develop and maintain foreign markets and we cannot afford to jeopardize these markets by enacting restrictive quota legislation.

XVIII. ADDITIONAL VIEWS OF MR. HANSEN ON THE TRADE ACT OF 1970

I support the Trade Act of 1970 as adopted by the Committee on Finance as an amendment to H.R. 17550.

The so-called Trade Act of 1970 has been misrepresented and misunderstood by the public media and by its opponents. It is not a highly restrictive, "protectionist" trade measure. On the contrary, it would achieve much needed reform in our current trade laws which would preserve American jobs for American labor and insure that industries which are suffering from excessive and unfair foreign competition will be given an opportunity to survive as viable entities in the United States. What does the Trade Act of 1970, as adopted by the committee, accomplish?

First, it revises our "escape clause" and "adjustment assistance provisions," very much along the lines that were proposed by Presidents Johnson and Nixon, so that industries, firms, and workers who are seriously or severely injured by increased imports could receive the relief to which they are entitled. Contrary to published reports the committee's amendment on tariff adjustment and adjustment assistance is completely compatible with international obligations of the United States and gives the President great flexibility in determining the adequate remedy.

Second, the Trade Act of 1970 would broaden the President's authority to deal with unfair trade practices including foreign subsidies, dumping or price discrimination and other discriminatory acts against American exporters.

Third, it would provide the President with tariff cutting authority of up to 20 percent to meet certain international obligations whenever an action on our part would affect a trade concession granted by the United States.

Fourth, it would impose quotas on textile and footwear articles *unless:*

(*a*) The President found that it was not in the national interest;

(*b*) The President found that such imports were not disrupting the United States market;

(*c*) The President found that such imports were needed to stem inflationary pressures; or

(*d*) The President was able to conclude voluntary agreements with foreign countries.

Thus, the quota provisions are entirely flexible and would likely never take effect if foreign countries reasonably regulated their exports of these sensitive products to the United States.

Fifth, the Trade Act of 1970 would establish the policy that whenever imports threaten to jeopardize the national security the President should impose quantitative restrictions (import quotas) to regu-

late such imports to a level commensurate with the preservation of the national security. I will go into more detail on this provision later in this statement.

Sixth, the Trade Act of 1970 would maintain the independence of the Tariff Commission from excessive executive influence and control, which is in keeping with the congressional intent for the establishment of the Tariff Commission in 1916.

Seventh, the Trade Act of 1970 would authorize and direct the President to conduct a number of thorough studies on the adequacy of international agreements and with respect to certain outstanding problems in the field of international trade.

Eighth, the Trade Act of 1970 gives the President a stronger negotiating position to achieve complete free trade in automobiles between the United States and Canada which was originally intended by the U.S.-Canadian Automobile Agreement.

Finally, the Trade amendment would: (a) require the Secretary of Commerce to provide more accurate statistics on foreign trade; (b) impose certain quantitative restrictions on mink and glycine; and (c) close a loophole in the current meat quota law.

I am particularly concerned with the national security provision of this bill which has been particularly maligned by its opponents. In the first place, let me describe what the provision accomplishes. Under present law, if the Director of the Office of Emergency Preparedness should find that imports of a particular commodity were threatening to impair the national security, he shall so report to the President who, if he agrees with the Director's finding, would have authority to take whatever action he deems necessary to adjust imports in order to safeguard the national security. In other words, the President has complete flexibility under the present statute.

There is much logic in the position that whenever a national security issue is involved because of imports, imports should be regulated in such a way as to prevent them completely inundating the domestic market and thus driving out United States productive capacity or severely impairing the ability of the domestic industry to meet our civilian and military needs in case the foreign source of the material was cut off. This implies that a certain amount of stability in the level of importations is necessary to accomplish the national security objective of the provision.

The degree of certainty cannot be provided by means of a tariff or duty. If the tariff was set too high it could shut out so much foreign supply that consumer interests would be hurt. On the other hand, if the tariff was set too low it would allow so much imports that domestic production and reserve capacity could be impaired and the national security endangered. There is no scientific approach to the setting of a tariff which would be so precise that it would regulate imports at just the right level to preserve the national security without jeopardizing the interest of American consumers. This is particularly true in the case of oil imports for reasons that I will describe below, but it is also true in the case of other imports which may be found to jeopardize the national security.

I am sure, for example, that if the footwear or textile industry brought a case to the Office of Emergency Preparedness and imports

of these products were found to impair the national security that its proponents would not be advocating a "scientific" tariff to regulate imports of footwear and textile articles. In the interest of "consumerism" they would want the assurance that imports would be set at a level reasonable enough to take a fair share of the market without driving the productive capacity in those industries out of this country. But many of the supporters of quotas for footwear and textile imports, are opponents of oil import quotas, and support a tariff scheme to regulate oil imports.

The opponents of the national security amendment argue that it will cost the American consumer billions of dollars. This is patently false, but even if it were not, one wonders whether their concern for "the consumer" includes those of us who wear shoes and clothing.

The Director of the Office of Emergency Preparedness, who was a member of the Cabinet Task Force on Oil Import Controls, unequivocably stated before the committee that *tariff rather than quotas* on oil would tend to drive up prices. He also informed us that it was a unanimous decision on the part of the Cabinet Committee dealing with oil imports that:

> *Recent developments have increased misgivings about moving to a tariff system at this time and about a tariff system as a feasible method of controlling oil imports.*
>
> *The recent interruption in the flow of oil to Europe; while comparatively small in quantity, has caused significant disruption of the international oil situation.*
>
> *Two other considerations are at least as important to me. First it appears that our country will be in a transitional situation for some time with regard to oil. if only because of the uncertainty as to the date Alaskan oil will be available and the effects of the environmental programs. Secondly, new estimates indicate we have a more severe problem than we estimated six months ago in preventing an unwise dependence on relatively insecure sources of supply by even as early as 1975.*
>
> *The individual members of the Oil Policy Committee are impressed in varying ways by each of the three considerations mentioned above. All of us recognize that the method of control is a means to the national security end, which includes limiting U.S. dependence.*
>
> *Because of these factors, the Oil Policy Committee concurs with my judgment that we discontinue consideration of moving to a tariff system of control, but rather continue with our efforts to improve the current program.* (Page 287 of the committee hearing on the Trade Act of 1970.)

It is ironic to me that those who would advocate the imposition of import quotas to protect the domestic footwear, textile and dairy industries (without apparent regard to the consumer interests) would argue against import quotas on oil—the *only* commodity which has qualified under the national security provision of our trade laws. A recent high official in the U.S. Government has claimed that import quotas on textile and footwear articles will cost the American consumer $3.7 billion a year. Proponents of quotas on these products will conveniently overlook this statement by a high U.S. official or will condemn it as misguided and erroneous thinking, while at the same time

latching on to equally if not more erroneous thinking with respect to the consumer effects of oil import controls.

The oil import program has been supported by four U.S. Presidents of both political parties—Presidents Eisenhower, Kennedy, Johnson, and Nixon. It is a necessary adjunct to preserve our ability to muster sufficient, secure sources of supply of this vital material to meet existing or potential civilian and military needs. President Kennedy was particularly concerned about this matter and he issued the proclamation which established a region formula for controlling oil imports. As President of all these United States, I believe he saw the need to protect the national interest and not to balkanize this country into warring regional producer and consumer interests, as some of the opponents of this program appear to be doing.

Finally, let me say that the national security provision would not in any way affect the President's flexibility to adjust the level of oil imports as he deems necessary. It does not "freeze" or "lock in" the present import program as its opponents contend.

CLIFFORD P. HANSEN.

○

Calendar No. 1443

91ST CONGRESS
2D SESSION

H. R. 17550

[Report No. 91-1431]

IN THE SENATE OF THE UNITED STATES

MAY 27, 1970

Read twice and referred to the Committee on Finance

DECEMBER 11, 1970

Reported by Mr. LONG, with amendments

[Omit the part struck through or enclosed in brackets and insert the part printed in italic]

AN ACT

To amend the Social Security Act to provide increases in benefits, to improve computation methods, and to raise the earnings base under the old-age, survivors, and disability insurance system, to make improvements in the medicare, medicaid, and maternal and child health programs with emphasis upon improvements in the operating effectiveness of such programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act, with the following table of contents, may be cited as the "Social Security Amendments of 1970".

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TITLE II—PROVISIONS RELATING TO MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH

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TITLE I—PROVISIONS RELATING TO OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE

INCREASE IN OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

SEC. 101. (a) Section 215(a) of the Social Security Act is amended by striking out the table and inserting in lieu thereof the following:

"TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS

"I		II	III		IV	V
(Primary insurance benefit under 1939 Act, as modified)		(Primary insurance amount under 1969 Act)	(Average monthly wage)		(Primary insurance amount)	(Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—		At least—	But not more than—		
----------	$16.20	$64.00	----------	$76	$67.20	$100.80
$16.21	16.84	65.00	$77	78	68.30	102.50
16.85	17.60	66.40	79	80	69.80	104.70
17.61	18.40	67.70	81	81	71.10	106.70
18.41	19.24	68.90	82	83	72.40	108.60
19.25	20.00	70.30	84	85	73.90	110.90
20.01	20.64	71.60	86	87	75.20	112.80
20.65	21.28	72.80	88	89	76.50	114.80
21.29	21.88	74.20	90	90	78.00	117.00
21.89	22.28	75.50	91	92	79.30	119.00
22.29	22.68	76.80	93	94	80.70	121.10
22.69	23.08	78.00	95	96	81.90	122.90
23.09	23.44	79.40	97	97	83.40	125.10
23.45	23.76	80.80	98	99	84.90	127.40
23.77	24.20	82.30	100	101	86.50	129.80
24.21	24.60	83.50	102	102	87.70	131.60
24.61	25.00	84.90	103	104	89.20	133.80
25.01	25.48	86.40	105	106	90.80	136.20
25.49	25.92	87.80	107	107	92.20	138.30
25.93	26.40	89.20	108	109	93.70	140.60

"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 1969 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—		
$26.41	$26.94	$90.60	$110	$113	$95.20	$142.80
26.95	27.46	91.90	114	118	96.50	144.80
27.47	28.00	93.30	119	122	98.00	147.00
28.01	28.68	94.70	123	127	99.50	149.30
28.69	29.25	96.20	128	132	101.10	151.70
29.26	29.68	97.50	133	136	102.40	153.60
29.69	30.36	98.80	137	141	103.80	155.70
30.37	30.92	100.30	142	146	105.40	158.10
30.93	31.36	101.70	147	150	106.80	160.20
31.37	32.00	103.00	151	155	108.20	162.30
32.01	32.60	104.50	156	160	109.80	164.70
32.61	33.20	105.80	161	164	111.10	166.70
33.21	33.88	107.20	165	169	112.60	168.90
33.89	34.50	108.60	170	174	114.10	171.20
34.51	35.00	110.00	175	178	115.50	173.30
35.01	35.80	111.40	179	183	117.00	175.50
35.81	36.40	112.70	184	188	118.40	177.60
36.41	37.08	114.20	189	193	120.00	180.00
37.09	37.50	115.60	194	197	121.40	182.10
37.61	38.20	116.90	198	202	122.80	184.20
38.21	39.12	118.40	203	207	124.40	186.60
39.13	39.68	119.80	208	211	125.80	188.70
39.69	40.33	121.00	212	216	127.10	190.70
40.34	41.12	122.50	217	221	128.70	193.10
41.13	41.76	123.90	222	225	130.10	195.20
41.77	42.44	125.30	226	230	131.60	197.40
42.45	43.20	126.70	231	235	133.10	199.70
43.21	43.76	128.20	236	239	134.70	202.10
43.77	44.44	129.50	240	244	136.00	204.00
44.45	44.88	130.80	245	249	137.40	206.10
44.89	45.60	132.30	250	253	139.00	208.50
		133.70	254	258	140.40	210.60
		134.90	259	263	141.70	212.60
		136.40	264	267	143.30	215.00
		137.80	268	272	144.70	217.60
		139.20	273	277	146.20	221.60
		140.60	278	281	147.70	224.80
		142.00	282	286	149.10	228.80
		143.50	287	291	150.70	232.80
		144.70	292	295	152.00	236.00
		146.20	296	300	153.60	240.00
		147.60	301	305	155.00	244.00
		148.90	306	309	156.40	247.20
		150.40	310	314	158.00	251.20
		151.70	315	319	159.30	255.20
		153.00	320	323	160.70	258.40
		154.50	324	328	162.30	262.40
		155.90	329	333	163.70	266.40
		157.40	334	337	165.30	269.60
		158.60	338	342	166.60	273.60
		160.00	343	347	168.00	277.60
		161.50	348	351	169.60	280.80
		162.80	352	356	171.00	284.80
		164.30	357	361	172.60	288.80
		165.60	362	365	173.90	292.00
		166.90	366	370	175.30	296.00
		168.40	371	375	176.90	300.00
		169.80	376	379	178.30	303.20
		171.30	380	384	179.90	307.20
		172.50	385	389	181.20	311.20
		173.90	390	393	182.60	314.40
		175.40	394	398	184.20	318.40
		176.70	399	403	185.60	322.40
		178.20	404	407	187.20	325.60
		179.40	408	412	188.40	329.60
		180.70	413	417	189.80	333.60
		182.00	418	421	191.10	336.80
		183.40	422	426	192.60	340.80
		184.60	427	431	193.90	344.80
		185.90	432	436	195.20	348.80
		187.30	437	440	196.70	350.40
		188.50	441	445	198.00	352.40
		189.80	446	450	199.30	354.40
		191.20	451	454	200.80	356.00
		192.40	455	459	202.10	358.00
		193.70	460	464	203.40	360.00
		195.00	465	468	204.80	361.60
		196.40	469	473	206.30	363.60
		197.60	474	478	207.50	365.60

"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 1969 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—		
		$198.90	$479	$482	$208.90	$367.20
		200.30	483	487	210.40	369.20
		201.50	488	492	211.60	371.20
		202.80	493	496	213.00	372.80
		204.20	497	501	214.50	374.80
		205.40	502	506	215.70	376.80
		206.70	507	510	217.10	378.40
		208.00	511	515	218.40	380.40
		209.30	516	520	219.80	382.40
		210.60	521	524	221.20	384.00
		211.90	525	529	222.50	386.00
		213.30	530	534	224.00	388.00
		214.50	535	538	225.30	389.60
		215.80	539	543	226.60	391.60
		217.20	544	548	228.10	393.60
		218.40	549	553	229.40	395.60
		219.70	554	556	230.70	396.80
		220.80	557	560	231.90	398.40
		222.00	561	563	233.10	399.60
		223.10	564	567	234.30	401.20
		224.30	568	570	235.60	402.40
		225.40	571	574	236.70	404.00
		226.60	575	577	238.00	405.20
		227.70	578	581	239.10	406.80
		228.90	582	584	240.40	408.00
		230.00	585	588	241.50	409.60
		231.20	589	591	242.80	410.80
		232.30	592	595	244.00	412.40
		233.50	596	598	245.20	413.60
		234.60	599	602	246.40	415.20
		235.80	603	605	247.60	416.40
		236.90	606	609	248.80	418.00
		238.10	610	612	250.10	419.20
		239.20	613	616	251.20	420.80
		240.40	617	620	252.50	422.40
		241.50	621	623	253.60	423.60
		242.70	624	627	254.90	425.20
		243.80	628	630	256.00	426.40
		245.00	631	634	257 30	428.00
		246.10	635	637	258.50	429.20
		247.30	638	641	259.70	430.80
		248.40	642	644	260.90	432.00
		249.60	645	648	262.10	433.60
		250.70	649	650	263.30	434.40
			651	655	264.00	436.40
			656	660	265.00	438.40
			661	665	266.00	440.40
			666	670	267.00	442.40
			671	675	268.00	444.40
			676	680	269.00	446.40
			681	685	270.00	448.40
			686	690	271.00	450.40
			691	695	272.00	452.40
			696	700	273.00	454.40
			701	705	274.00	456.40
			706	710	275.00	458.40
			711	715	276.00	460.40
			716	720	277.00	462.40
			721	725	278.00	464.40
			726	730	279.00	466.40
			731	735	280.00	468.40
			736	740	281.00	470.40
			741	745	282.00	472.40
			746	750	283.00	474.40"*

"TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS

"I (Primary insurance benefit under 1939 Act, as modified)		II (Primary insurance amount under 1969 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. 205(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—		
----------	$26.94	$90.60 or less	----------	$113	$100.00	$150.00
$26.95	27.46	91.90	$114	118	101.10	151.70
27.47	28.00	93.30	119	122	102.70	154.10
28.01	28.68	94.70	123	127	104.20	156.30
28.69	29.25	96.20	128	132	105.90	158.90
29.26	29.68	97.50	133	136	107.30	161.00
29.69	30.36	98.80	137	141	108.70	163.10
30.37	30.92	100.30	142	146	110.40	165.60
30.93	31.56	101.70	147	150	111.90	167.90
31.57	32.00	103.00	151	155	113.30	170.00
32.01	32.60	104.50	156	160	115.00	172.50
32.61	33.20	105.80	161	164	116.40	174.60
33.21	33.88	107.20	165	169	118.00	177.00
33.89	34.50	108.60	170	174	119.50	179.30
34.51	35.00	110.00	175	178	121.00	181.50
35.01	35.80	111.40	179	183	122.60	183.90
35.81	36.40	112.70	184	188	124.00	186.00
36.41	37.08	114.20	189	193	125.70	188.60
37.09	37.60	115.60	194	197	127.20	190.80
37.61	38.20	116.90	198	202	128.60	192.90
38.21	39.12	118.40	203	207	130.30	195.50
39.13	39.68	119.80	208	211	131.80	197.70
39.69	40.33	121.00	212	216	133.10	199.70
40.34	41.12	122.50	217	221	134.80	202.20
41.13	41.76	123.90	222	225	136.30	204.50
41.77	42.44	125.30	226	230	137.90	206.90
42.45	43.20	126.70	231	235	139.40	209.10
43.21	43.76	128.20	236	239	141.10	211.70
43.77	44.44	129.50	240	244	142.50	214.80
44.45	44.88	130.80	245	249	143.90	219.20
44.89	45.60	132.30	250	255	145.60	222.70
		133.70	254	258	147.10	227.10
		134.90	259	263	148.40	231.50
		136.40	264	267	150.10	235.00
		137.80	268	272	151.60	239.40
		139.20	273	277	153.20	243.80
		140.60	278	281	154.70	247.30
		142.00	282	286	156.20	251.70
		143.50	287	291	157.90	256.10
		144.70	292	295	159.20	259.60
		146.20	296	300	160.90	264.00
		147.60	301	305	162.40	268.40
		148.90	306	309	163.80	272.00
		150.40	310	314	165.50	276.40
		151.70	315	319	166.90	280.80
		153.00	320	323	168.30	284.30
		154.50	324	328	170.00	288.00
		155.90	329	333	171.50	293.10
		157.40	334	337	173.20	296.60
		158.60	338	342	174.50	301.00
		160.00	343	347	176.00	305.40
		161.50	348	351	177.70	308.90
		162.80	352	356	179.10	313.30
		164.30	357	361	180.80	317.70
		165.60	362	365	182.20	321.20
		166.90	366	370	183.60	325.60
		168.40	371	375	185.30	330.00
		169.80	376	379	186.80	333.60
		171.30	380	384	188.50	338.00
		172.50	385	389	189.80	342.40
		175.90	390	393	191.30	345.90
		175.40	394	398	193.00	350.30
		176.70	399	403	194.40	354.70
		178.20	404	407	196.10	358.20
		197.40	408	412	197.40	362.60
		180.70	413	417	198.80	367.00
		182.00	418	421	200.20	370.50
		183.40	422	426	201.80	374.90
		184.60	427	431	203.10	379.30
		185.90	432	436	204.50	383.70
		187.30	437	440	206.10	385.50
		188.50	441	445	207.40	387.70
		189.80	446	450	208.80	389.90
		191.20	451	454	210.40	391.60
		192.40	455	459	211.70	393.80
		193.70	460	464	213.10	396.00
		195.00	465	468	214.50	397.80
		196.40	469	473	216.10	400.00
		197.60	474	478	217.40	402.20
		198.90	479	482	218.80	404.00
		200.30	483	487	220.40	406.20

"TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS—Contnued

"I (Primary insurance benefit under 1939 Act, as modified)		II (Primary insurance amount under 1969 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—		
		$201.50	$488	$492	$221.70	$408.40
		202.80	493	496	223.10	410.10
		204.20	497	501	224.70	412.30
		205.40	502	506	226.00	414.50
		206.70	507	510	227.40	416.30
		208.00	511	515	228.80	418.50
		209.30	516	520	230.30	420.70
		210.60	521	524	231.70	422.40
		211.90	525	529	233.10	424.60
		213.30	530	534	234.70	426.80
		214.50	535	538	236.00	428.60
		215.80	539	543	237.40	430.80
		217.20	544	548	239.00	433.00
		218.40	549	553	240.30	435.20
		219.70	554	556	241.70	436.50
		220.80	557	560	242.90	438.30
		222.00	561	563	244.20	439.60
		223.10	564	567	245.50	441.40
		224.30	568	570	246.80	442.70
		225.40	571	574	248.00	444.40
		226.60	575	577	249.30	445.80
		227.70	578	581	250.50	447.50
		228.90	582	584	251.80	448.80
		230.00	585	588	253.00	450.60
		231.20	589	591	254.40	451.90
		232.30	592	595	255.60	453.70
		233.50	596	598	256.90	455.00
		234.60	599	602	258.10	456.80
		235.80	603	605	259.40	458.10
		236.90	606	609	260.60	459.80
		238.10	610	612	262.00	461.20
		239.20	613	616	263.20	462.90
		240.40	617	620	264.50	464.70
		241.50	621	623	265.70	466.00
		242.70	624	627	267.00	467.80
		243.80	628	630	268.20	469.40
		245.00	631	634	269.50	471.70
		246.10	635	637	270.80	473.90
		247.30	638	641	272.10	476.20
		248.40	642	644	273.30	478.30
		249.60	645	648	274.60	480.60
		250.70	649	650	275.80	482.70
			651	655	276.80	484.40
			656	660	277.80	486.20
			661	665	278.80	487.90
			666	670	279.80	489.70
			671	675	280.80	491.40
			676	680	281.80	493.20
			681	685	282.80	494.90
			686	690	283.80	496.70
			691	695	284.80	498.40
			696	700	285.80	500.20
			701	705	286.80	501.90
			706	710	287.80	503.70
			711	715	288.80	506.40
			716	720	289.80	507.20
			721	725	290.80	508.90
			726	730	291.80	510.70
			731	735	292.80	512.40
			736	740	293.80	514.20
			741	745	294.80	515.90
			746	750	295.80	517.70".

(b) Section 203 (a) of such Act is amended by striking out paragraph (2) and inserting in lieu thereof the following:

"(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 on the basis of the wages and self-employment income of such insured individual and at least one such person was so entitled for December 1970 on the basis of such wages and self-employment income, such total of benefits for January 1971 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 (including this subsection, but without the application of section 222 (b), section 202 (q), and subsections (b), (c), and (d) of this section), as in effect prior to the enactment of the Social Security Amendments of 1970, for each such person for such ~~monuth~~ *month*, by ~~105~~ *110* percent and raising each such increased amount, if it is not a multiple of $0.10, to the next higher multiple of $0.10;

but in any such case (i) paragraph (1) of this subsection shall not be applied to such total of benefits after the application of subparagraph (B), and (ii) if section 202 (k) (2) (A) was applicable in the case of any such benefits for January 1971, 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 January 1971, or".

(c) Section 215 (b) (4) of such Act is amended by striking out "December 1969" each time it appears and inserting in lieu thereof "December 1970".

(d) Section 215 (c) of such Act is amended to read as follows:

"Primary Insurance Amount Under 1969 Act

"(c) (1) For the purposes of column II of the table appearing in subsection (a) of this section, an individual's primary insurance amount shall be computed on the basis of the law in effect prior to the enactment of the Social Security Amendments of 1970.

"(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 January 1971, or who died before such month."

(e) The amendments made by this section shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970 and with respect to lump-sum death payments under such title in the case of deaths occurring after December 1970.

(f) If an individual was entitled to a disability insurance benefit under section 223 of the Social Security Act for December 1970 and became entitled to old-age insurance benefits under section 202 (a) of such Act for January 1971, or he died in such month, then, for purposes of section 215 (a) (4) of the Social Security Act (if applicable), the amount in column IV of the table appearing in such section 215 (a) for such individual shall be the amount in such column on the line on which in column II appears his primary insurance amount (as determined under section 215 (c) of such Act) instead of the amount in column IV equal to the primary insurance amount on which his disability insurance benefit is based.

INCREASE IN BENEFITS FOR CERTAIN INDIVIDUALS AGE 72 AND OVER

SEC. 102. (a) (1) Section 227 (a) of the Social Security Act is amended by striking out "$46" and inserting in lieu thereof "$48.30", and by striking out "$23" and inserting in lieu thereof "$24.20".

(2) Section 227 (b) of such Act is amended by striking out "$46" and inserting in lieu thereof "$48.30".

(b) (1) Section 228 (b) (1) of such Act is amended by striking out "$46" and inserting in lieu thereof "$48.30".

(2) Section 228 (b) (2) of such Act is amended by striking out "$46" and inserting in lieu thereof "$48.30", and by striking out "$23" and inserting in lieu thereof "$24.20".

(3) Section 228 (c) (2) of such Act is amended by striking out "$23" and inserting in lieu thereof "$24.20".

(4) Section 228 (c) (3) (A) of such Act is amended by striking out "$46" and inserting in lieu thereof "$48.30".

(5) Section 228 (c) (3) (B) of such Act is amended by striking out "$23" and inserting in lieu thereof "$24.20".

(c) The amendments made by subsections (a) and (b) shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970.

~~AUTOMATIC ADJUSTMENT OF BENEFITS~~

~~SEC. 103. (a) Section 215 of the Social Security Act is amended by adding at the end thereof the following new subsection:~~

~~"Cost-of-Living Increases in Benefits~~

~~"(i) (1) For purposes of this subsection—~~

~~"(A) the term 'base quarter' means the period of 3 consecutive calendar months ending on September 30,~~

~~1971, and the period of 3 consecutive calendar months ending on September 30 of each year thereafter.~~

~~"(B) the term 'cost-of-living computation quarter' means any base quarter in which the monthly average of the Consumer Price Index prepared by the Department of Labor exceeds, by not less than 3 per centum, the monthly average of such Index in the later of (i) the 3 calendar-month period ending on September 30, 1971, or (ii) the base quarter which was most recently a cost-of-living computation quarter.~~

~~"(2)(A) If the Secretary determines that a base quarter in a calendar year is also a cost-of-living computation quarter, he shall, effective for January of the next calendar year, 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 as specified in subparagraph (B) of this paragraph, by an amount derived by multiplying 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 next higher one-tenth of 1 percent if such percentage is an odd multiple of .05 of 1 percent and to the nearest one-tenth of 1 percent in any other case) as the percentage by which the monthly average of the Consumer Price Index~~

for such cost-of-living computation quarter exceeds the monthly average of such Index for the base quarter determined after the application of clauses (i) and (ii) of paragraph (1)(B).

"(B) The increase provided by subparagraph (A) with respect to a particular cost-of-living computation quarter shall apply 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, based on the wages and self-employment income of an individual who became entitled to monthly benefits under section 202, 223, 227, or 228 (without regard to section 202(j)(1) or section 223(b)), or who died, in or before December of such calendar year.

"(C) 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 December 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 revised previously 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 show the effective date of the primary insurance amounts set forth in column IV of the table immediately prior to its revision.

"(ii) The amounts on each line of column I, and the amounts on each line of column III except as otherwise provided by clause (v) of this subparagraph, shall be the same as the amounts appearing in 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 amount of each line of column IV shall be increased from the amount shown in the table immediately prior to its revision by increasing such amount by the percentage specified in subparagraph (A) of paragraph (2), raising each such increased amount, if not a multiple of $0.10, to the next higher multiple of $0.10.

"(v) If the contribution and benefit base (as

~~defined in section 230(b)) 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 shall be extended. The amount in the first additional line in column IV shall be the amount in the last line of such column as determined under clause (iv), plus $1.00, rounding such increased amount (if not a multiple of $1.00) to the next higher multiple of $1.00 where such increased amount is an odd multiple of $0.50 and to the nearest multiple of $1.00 in any other case. The amount on each succeeding 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 larger of (I) one thirty-sixth of the contribution and benefit base for the calendar year following the calendar year in which the table of benefits is revised or (II) the last line of such column as determined under clause (iv) plus 20 percent of one-twelfth of the excess of the contribution and benefit base for the calendar year following the calendar year in which the table of benefits is revised over such base for the calendar year in which the table of benefits is revised, rounding such amount (if not a multiple of $1.00) to the next higher multiple of $1.00 where such amount is an odd multiple of $0.50 and to the nearest multiple of $1.00 in any other case.~~

The amount in each additional line of column III shall be determined so that the second figure in the last line of column III is one-twelfth of the contribution and benefits base for the calendar year following the calendar year in which the table of benefits is revised, and the remaining figures in column III shall be determined in consistent mathematical intervals from column IV. The second figure in the last line of column III before the extension of the column shall be increased to a figure mathematically consistent with the figures determined in accordance with the preceding sentence. The amount on each line of column V shall be increased, to the extent necessary, so that each such amount is equal to 40 percent of the second figure in the same line of column III, plus 40 percent of the smaller of (I) such second figure or (II) the larger of $450 or 50 per centum of the largest figure in column III.

"(vi) 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 that is not a multiple of $0.10 shall be increased to the next higher multiple of $0.10."

(b) Section 203(a) of such Act (as amended by section 101(b) of this Act) is amended—

(1) by striking out the period at the end of paragraph (3) and inserting in lieu thereof ", or ", and inserting after paragraph (3) the following new paragraph:

"(4) when two or more persons are entitled (without the application of section 202(j)(1) and section 223(b)) to monthly benefits under section 202 or 223 for December of the calendar year in which occurs a cost-of-living computation quarter (as defined in section 215(i)(1)) on the basis of the wages and self-employment income of such insured individual, such total of benefits for the month immediately following shall be reduced to not less than the amount equal to the sum of the amounts derived by increasing the benefit amount determined under this title (including this subsection, but without the application of section 222(b), section 202(q), and subsections (b), (c), and (d) of this section) as in effect for such December for each such person by the same percentage as the percentage by which such individual's primary insurance amount (including such amount as previously increased) is increased under section 215(i)(2) for such month immediately following, and raising each such increased amount (if not a multiple of $0.10) to the next higher multiple of $0.10."; and

(2) by striking out "the table in section 215(a)" in the matter preceding paragraph (1) and inserting in lieu thereof "the table in (or deemed to be in) section 215(a)".

(c)(1) Section 215(a) of such Act is amended by striking out the matter which precedes the table and inserting in lieu thereof the following:

"(a) The primary insurance amount of an insured individual shall be 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)(C) or section 230(c), determined as follows:

"(1) Subject to the conditions specified in subsections (b), (c), and (d) of this section and except as provided in paragraph (2) of this subsection, such primary insurance amount shall be whichever of the following amounts is the largest:

"(i) The amount in column IV on the line on which in column III of such table appears his average monthly wage (as determined under subsection (b));

"(ii) The amount in column IV on the line on which in column II of such table appears his primary insurance amount (as determined under subsection (c)); or

"(iii) The amount in column IV on the line on which in column I of such table 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 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 (other than a table provided by section 230) 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."

(2) Effective January 1, 1973, section 215(b)(4) of such Act (as amended by section 101(c) of this Act) is amended to read as follows:

"(4) The provisions of this subsection shall be applicable only in the case of an individual—

"(A) who becomes entitled in or after the effective month of a new table that appears in (or is deemed by subsection (i)(2)(C) or section 230(c) to appear in) subsection (a) to benefits under section 202(a) or section 223; or

"(B) who dies in or after such effective month 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) Effective January 1, 1973, section 215(c) of such Act (as amended by section 101(d) of this Act) is amended to read as follows:

"Primary Insurance Amount Under Prior Provisions

"(c)(1) For the purposes of column II of the 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 effective month of the latest such table.

"(2) The provisions of this subsection shall be appli-

~~cable 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."~~

~~(d) Sections 227 and 228 of such Act (as amended by section 102 of this Act) are amended by striking out "$48.30" wherever it appears and inserting in lieu thereof "the larger of $48.30 or the amount most recently established in lieu thereof under section 215 (i)", and by striking out "$24.20" wherever it appears and inserting in lieu thereof "the larger of $24.20 or the amount most recently established in lieu thereof under section 215 (i)".~~

INCREASED WIDOW'S AND WIDOWER'S INSURANCE BENEFITS

SEC. ~~104~~ *103.* (a) *(1)* Section *202* (e) of the Social Security Act is amended—

~~(1) by striking out "82½ percent of" wherever it appears in paragraphs (1) and (2); and~~

(A) by striking out "82½ percent of the primary insurance amount of such deceased individual" wherever it appears in paragraph (1) and inserting in lieu thereof "the amount of the widow's insurance benefit (as determined under paragraph (2)) of such widow or surviving divorced wife"; and

(B) by striking out subparagraph (C) of paragraph (1) and inserting in lieu thereof the following new subparagraph:

"(C)(i) has filed application for widow's insurance benefits, or (ii) was entitled, on the basis of the wages and self-employment income of such individual, to—

"(I) mother's insurance benefits for the month preceding the month in which she attained age 65, or

"(II) wife's insurance benefits for the month preceding the month in which he died, but only if in such preceding month she had attained the age of 65 or was not entitled to benefits under subsection (a) or section 223,";

~~(2)~~ *(C)* by striking out "age 62" ~~in subparagraphs (C) (i) and (C) (ii) of paragraph (1), and~~ in the matter following subparagraph (G) in paragraph (1), and inserting in lieu thereof ~~in each instance~~ "age 65".

(2) Paragraph (2) of section 202(e) of such Act is amended to read as follows:

"(2)(A) Except as provided in subsection (q), paragraph (4) of this subsection, and subparagraph (B) of this paragraph, such widow's insurance benefit for each month shall be equal to the primary insurance amount of such deceased individual.

"(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 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, shall be reduced to an amount equal to 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.

(b) *(1)* Section 202 (f) of such Act is amended—

~~(1) by striking out "82½ percent of" wherever it appears in paragraphs (1) and (3);~~

(A) by striking out "82½ percent of the primary insurance amount of his deceased wife" wherever it appears in paragraph (1) and inserting in lieu thereof "the amount of the widower's insurance benefit (as determined under paragraph (3)) of such widower";

(B) by striking out subparagraph (C) of paragraph (1), and inserting in lieu thereof the following new subparagraph:

"(C)(i) has filed application for widower's insurance benefits or (ii) 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, but only if in such preceding month he had attained the age of 65 or was not entitled to benefits under subsection (a) or section 223,"; and

~~(2) by inserting ", after attainment of age 65," after "was entitled" in paragraph (1)(C); and~~

~~(3)~~*(C)* by striking out "age 62" in the matter following subparagraph (G) in paragraph (1) and inserting in lieu thereof "age 65".

(2) Paragraph (3) of section 202(f) of such Act is amended to read as follows:

"(3)(A) Except as provided in subsection (q), paragraph (4) of this subsection, and subparagraph (B) of this paragraph, such widower's insurance benefit for each month shall be equal to 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 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, be reduced to an amount equal to 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.

(c) (1) The last sentence of section 203 (c) of such Act is amended by striking out all that follows the semicolon and inserting in lieu thereof the following: "nor shall any deduction be made under this subsection from any widow's insurance benefit for any month in which the widow or surviving divorced wife is entitled and has not attained age 65 (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 65 (but only if he became so entitled prior to attaining age 62)."

(2) Clause (D) of section 203 (f) (1) of such Act is amended to read as follows: "(D) for which such individual is entitled to widow's insurance benefits and has not attained

age 65 (but only if she became so entitled prior to attaining age 60), or widower's insurance benefits and has not attained age 65 (but only if he became so entitled prior to attaining age 62), or".

(d) Section 202(k)(3)(A) of such Act is amended by striking out "subsection (q) and" and inserting in lieu thereof "subsection (q), subsection (e)(2) or (f)(3), and".

~~(d)~~ *(e)* (1) Section 202 (q) (1) of such Act is amended to read as follows:

"(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 such month and for any subsequent month shall, subject to the succeeding paragraphs of this subsection, be reduced by—

"(A) 5/9 of 1 percent of such amount if such benefit is an old-age insurance benefit, 25/36 of 1 percent of such amount if such benefit is a wife's or husband's insurance benefit, or 5 7/120 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 the 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;

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) $^{43}/_{240}$ 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 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 age 62."

(2) Section 202 (q) (7) of such Act is amended—

(A) by striking out everything that precedes subparagraph (A) and inserting in lieu thereof the following:

"(7) For purposes of this subsection the 'adjusted reduction period' for an individual's old-age, wife's, husband's, widow's, or widower's insurance benefit is the reduction period 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, excluding from each such period—";

and

(B) by striking out "attained retirement age" in subparagraph (E) and inserting in lieu thereof "attained age 62, and also for any month before the month in which he attained retirement age,".

(3) Section 202 (q) (9) of such Act is amended to read as follows:

"(9) For purposes of this subsection, the term 'retirement age' means age 65."

~~(c)~~ *(f)* Section 202 (m) of such Act is amended to read as follows:

(g) in the case of any individual who is entitled to a widow's or widorer's insurance benefit for the month of December 1970, the provisions of this section shall not operate to reduce such benefit to less than 82½ percent of the primary

insurance amount of the deceased individual on the basis of whose wages and self employment income such benefit is payable.

"Minimum Survivor's Benefit

"(m) (1) In any case in which an individual is entitled to a monthly benefit under this section (other than under subsection (a)) for any month and no other person is (without the application of subsection (j) (1) and section 223 (b)) entitled to a monthly benefit under this section or section 223 for such month on the basis of the same wages and self-employment income, such individual's benefit amount for such month, prior to reduction under ~~subsections (k) (3) and (q) (1)~~ *subsection (k)(3)*, shall be not less than the first amount appearing in column IV of the table in section 215 (a) *; except as provided in paragraph (2).*

"(2) In the case of such an individual who is entitled to a monthly benefit under subsection (e) or (f) ~~and whose benefit is subject to reduction under subsection (q) (1)~~, such benefit amount, after reduction under subsection (q) (1) *and subsection (e)(2)(B) or (f)(3)(B)*, shall not be less than the amount it would be under paragraph (1) after ~~such reduction~~ *reduction under subsection (q)(1), if retirement age as specified in paragraph (6)(A)(ii) of subsection (q) were age 62 rather than retirement age (as defined in subsection (q)(9)).* ~~if such individual had attained (or would attain) retirement age (as defined in subsection (q) (9)) in the month in which he attained (or would attain) age 62.~~

~~"(3) In the case of an individual to whom paragraph (2) applies but whose first month of entitlement to benefits under subsection (c) or (f) was before the month in which he attained age 60, such paragraph (2) shall be applied, for purposes of determining the number of months to be used in computing the reduction under subparagraphs (A) and (B) of subsection (q)(1) (but not for purposes of determining the number of months to be used in computing the reduction under subparagraphs (C) and (D) of such subsection), as though such first month of entitlement had been the month in which he attained such age."~~

~~(f)~~ *(g)* In the case of an individual who is entitled ~~(without the application of section 202(j)(1) and 223(b) of the Social Security Act)~~ to widow's or widower's insurance benefits for the month of December 1970, the Secretary shall redetermine the amount of such benefits *for months after December 1970* under title II of ~~such~~ *the Social Security* Act as if the amendments made by this section had been in effect for the first month of such individual's entitlement to such benefits.

~~(g)~~ *(h)* Where—

(1) two or more persons are entitled ~~(without the application of section 202(j)(1) of the Social Security Act)~~ to monthly benefits under section 202 of ~~such~~ *the Social Security* Act for December 1970 on the basis of the wages and self-employment income of a deceased individual, and one or more of such persons is so

entitled under subsection (e) or (f) of such section 202, and

(2) one or more of such persons is entitled on the basis of such wages and self-employment income to ~~increased~~ monthly benefits under subsection (e) or (f) of such section 202 (as amended by this section) for January 1971, and

(3) the total of benefits to which all persons are entitled under section 202 of such Act on the basis of such wages and self-employment income for January 1971 is reduced by reason of section 203 (a) of such Act, as amended by this Act (or would, but for the penultimate sentence of such section 203 (a), be so reduced),

then the amount of the benefit to which each such person referred to in paragraph (1), ~~other than a person entitled under subsection (e) or (f) of such section 202,~~ is entitled for months after December 1970 shall ~~be adjusted~~ *in no case be less,* after the application of *this section and* such section 203 (a), ~~to an amount no less~~ than the amount it would have been ~~if the person or persons referred to in paragraph (2) had not become entitled to an increased benefit referred to in such paragraph~~ *without the application of this section.*

~~(b)~~ *(i)* The amendments made by this section shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970.

AGE-62 COMPUTATION POINT FOR MEN

SEC. ~~105.~~ *104.* (a) Section 214(a)(1) of the Social Security Act is amended by striking out "before—" and all that follows down through "except" and inserting in lieu thereof "before the year in which he died or (if earlier) the year in which he attained age 62, except".

(b) Section 215(b)(3) of such Act is amended by striking out "before—" and all that follows down through "For" and inserting in lieu thereof "before the year in which he died or, if it occurred earlier but after 1960, the year in which he attained age 62. For".

~~(c) In the case of an individual who is entitled to monthly benefits under section 202 or 223 of the Social Security Act for a month after December 1970, on the basis of the wages and self-employment income of an insured individual who prior to January 1971 became entitled to benefits under section 202(a), or who prior to January 1971 became entitled to benefits under section BBC after the year in which he attained age 62 or who died prior to January 1971 in a year after the year in which he attained age 62 the Secretary shall notwithstanding paragraphs (1) and (2) of section 215(f) of such Act recompute the primary insurance amount of such insured individual. Such recomputation shall be made under whichever of the following alternative computation methods yields the higher primary insurance amount:~~

~~(1) the computation methods in section 215 (b) and (d) of such Act as amended by this Act as such methods would apply in the case of an insured individual who attained age 62 in 1971 except that the provisions of section 215 (d) (3) of such Act shall not apply; or~~

~~(2) the computation methods specified in paragraph (1) without regard to the limitation "but after 1960" contained in section 215 (b) (3) of such Act except that for any such recomputation when the number of an individual's benefit computation years is less than 5, his average monthly wage shall, if it is in excess of $400, be reduced to such amount.~~

~~(d)~~ *(c)* Section 223 (a) (2) of such Act is amended—

(1) by striking out "(if a woman) or age 65 (if a man)",

(2) by striking out "in the case of a woman" and inserting in lieu thereof "in the case of an individual", and

(3) by striking out "she" and inserting in lieu thereof "he".

~~(e)~~ *(d)* Section 223 (c) (1) (A) of such Act is amended by striking out "(if a woman) or age 65 (if a man)".

~~(f)~~ *(e)* Section 227 (a) of such Act is amended by striking out "so much of paragraph (1) of section 214 (a)

as follows clause (C)" and inserting in lieu thereof "paragraph (1) of section 214(a)".

~~(g)~~ *(f)* Section 227(b) of such Act is amended by striking out "so much of paragraph (1) thereof as follows clause (C)" and inserting in lieu thereof "paragraph (1) thereof".

~~(h)~~ *(g)* Sections 209(i)~~, 213(a)(2),~~ and 216(i)(3)(A), of such Act are amended by striking out "(if a woman) or age 65 (if a man)".

~~(i)(1)~~ *(h)* Section 303(g)(1) of the Social Security Amendments of 1960 is amended—

~~(A)~~ *(1)* by striking out "Amendments of 1965 and 1967" and inserting in lieu thereof "Amendments of 1965, 1967, 1969, and 1970"; *and*

~~(B)~~ *(2)* by striking out "Amendments of 1967" wherever it appears and inserting in lieu thereof "Amendments of 1970"~~; and.~~

~~(C) by inserting "(subject to section 104(i)(2) of the Social Security Amendments of 1970)" after "except that" in the last sentence.~~

~~(2) For purposes of monthly benefits payable after December 1970, or a lump-sum death payment in the case of an insured individual who dies after December 1970, "retirement age" as referred to in section 303(g)(1) of~~

~~the Social Security Amendments of 1960 shall mean age 62.~~

~~(j)~~ *(i)* Paragraph (9) of section 3121 (a) of the Internal Revenue Code of 1954 (relating to definition of wages) is amended to read as follows:

"(9) any payment (other than vacation or sick pay) made to an employee after the month in which he attains age 62, if such employee did not work for the employer in the period for which such payment is made;".

~~(k) When two or more persons are entitled (without the application of sections 202 (j) (1) and 223 (b) of the Social Security Act) to monthly benefits under section 202 or 223 of such Act for December 1970, on the basis of the wages and self-employment income of an insured individual, and the total of benefits for such persons is reduced under section 203 (a) of such Act (or would, but for the penultimate sentence of such section 203 (a), be so reduced) for the month of January 1971 and such individual's primary insurance amount is increased for such month under the amendments made by this section, then the total of benefits for such persons for and after January 1971 shall not be reduced to less than the sum of—~~

~~(1) the amount determined under section 203 (a) (2) of such Act for January 1971, and~~

~~(2) an amount equal to the excess of (A) such individual's primary insurance amount for January 1971, as determined under section 215 of such Act (as amended by section 101 of this Act) and in accordance with the amendments made by this section, over (B) his primary insurance amount for January 1971 as determined under such section 215 without regard to such amendments.~~

~~(l) The amendments made by this section shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970 and with respect to lump-sum death payments made under such title in the case of deaths occurring after December 1970, except that in the case of an individual who was not entitled to a monthly benefit under title II of such Act for December 1970 such amendments shall apply only on the basis of an application filed in or after the month in which this Act is enacted.~~

(j)(1) The amendments made by this section (except subsection (i) and subsection (g) as it relates to the amendment to section 209(i) of the Social Security Act) shall apply in the case of a man who attains (or would attain) age 62 after December 1972. The amendment made by subsection (g) as it relates to the amendment to section 209(i) of

the Social Security Act and by subsection (i) shall apply only with respect to payments after 1972.

(2) In the case of a man who attains age 62 prior to 1973, the number of his elapsed years for purposes of section 215(b)(3) of the Social Security Act shall be equal to the number (A) determined under such section, as in effect on January 1, 1970, or (B) if less, determined as though he attained age 65 in 1973, except that monthly benefits under title II of the Social Security Act for months prior to 1971 payable on the basis of his wages and self-employment income shall be determined as though this section had not been enacted.

(3) In the case of a man who attains or will attain age 62 in 1971, the figure "64" should be substituted for the figure "65" in sections 214(a)(1), 223(c)(1)(A), 209 (i) and 216(i)(3)(A) of the Social Security Act and paragraph (9) of section 3121(a) of the Internal Revenue Code of 1954. In the case of a man who attains or will attain age 62 in 1972, the figure "63" should be substituted for the figure "65" in sections 214(a)(1), 223(c)(1)(A), 209 (i), and 216(i)(3)(A) of the Social Security Act and paragraph (9) of section 3121(a) of the Internal Revenue Code."

~~ELECTION TO RECEIVE ACTUARIALLY REDUCED BENEFITS IN ONE CATEGORY NOT TO BE APPLICABLE TO CERTAIN BENEFITS IN OTHER CATEGORIES~~

~~SEC. 106. (a)(1) Section 202(q)(3)(A) of the Social Security Act is amended by striking out all that follows clause (ii) and inserting in lieu thereof the following: "then (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) of this paragraph, in lieu of any reduction under paragraph (1), if the amount of the reduction in such benefit under this paragraph is less than the amount of the reduction in such benefit would be under paragraph (1)."~~

~~(2) Section 202(q)(3) of such Act is further amended by striking out subparagraphs (E), (F), and (G).~~

~~(b) Section 202(r) of such Act is repealed.~~

~~(c)(1)(A) Subject to subparagraph (B), subsection (a) of this section and the amendments made thereby shall apply with respect to benefits for months commencing with the sixth month after the month in which this Act is enacted.~~

~~(B) Subsection (a) of this section and the amendments made thereby shall apply in the case of an individual whose~~

~~entitlement to benefits under section 202 of the Social Security Act began (without regard to sections 202(j)(1) and 223(b) of such Act) before the sixth month after the month in which this Act is enacted only if such individual files with the Secretary of Health, Education, and Welfare, in such manner and form as the Secretary shall by regulations prescribe, a written request that such subsection and such amendments apply. In the case of such an individual who is described in paragraph 2(A)(i) of this subsection, the request for a redetermination under paragraph (2) shall constitute the request required by this subparagraph, and subsection (a) of this section and the amendments made thereby shall apply pursuant to such request with respect to such individual's benefits as redetermined in accordance with paragraph (2)(B)(i) (but only if he does not refuse to accept such redetermination). In the case of any individual with respect to whose benefits subsection (a) of this section and the amendments made thereby may apply only pursuant to a request made under this subparagraph, such subsection and such amendments shall be effective (subject to paragraph (2)(D)) with respect to benefits for months commencing with the sixth month after the month in which this Act is enacted or, if the request required by this subparagraph is not filed before the end of such sixth month, with~~

the second month following the month in which the request is filed.

(C) Subsection (b) of this section shall apply with respect to benefits payable pursuant to applications filed on or after the date of the enactment of this Act.

(2) (A) In any case where an individual—

(i) is entitled, for the fifth month following the month in which this Act is enacted, to a monthly insurance benefit under section 202 of the Social Security Act (I) which was reduced under subsection (q) (3) of such section, and (II) the application for which was deemed (or, except for the fact that an application had been filed, would have been deemed) to have been filed by such individual under subsection (r) (1) or (2) of such section, and

(ii) files a written request for a redetermination under this subsection, on or after the date of the enactment of this Act and in such manner and form as the Secretary of Health, Education, and Welfare shall by regulations prescribe,

the Secretary shall redetermine the amount of such benefit, and the amount of the other benefit (reduced under subsection (q) (1) or (2) of such section) which was taken into account in computing the reduction in such benefit under such

subsection (q) (3), in the manner provided in subparagraph (B) of this paragraph.

(B) Upon receiving a written request for the redetermination under this paragraph of a benefit which was reduced under subsection (q) (3) of section 202 of the Social Security Act and of the other benefit which was taken into account in computing such reduction, filed by an individual as provided in subparagraph (A) of this paragraph, the Secretary shall—

(i) determine the highest monthly benefit amount which such individual could receive under the subsections of such section 202 which are involved (or under section 223 of such Act and the subsection of such section 202 which is involved) for the month with which the redetermination is to be effective under subparagraph (D) of this subsection (without regard to sections 202 (k), 203 (a), and 203 (b) through (l)) if—

(I) such individual's application for one of such two benefits had been filed in the month in which it was actually filed or was deemed under subsection (r) of such section 202 to have been filed, and his application for the other such benefit had been filed in a later month, and

(II) the amendments made by this section

had been in effect at the time each such application was filed; and

(ii) determine whether the amounts which were actually received by such individual in the form of such two benefits during the period prior to the month with which the redetermination under this paragraph is to be effective were in excess of the amounts which would have been received during such period if the applications for such benefits had actually been filed at the times fixed under clause (i)(I) of this subparagraph, and, if so, the total amount by which benefits otherwise payable to such individual under such section 202 (and section 223) would have to be reduced in order to compensate the Federal Old-Age and Survivors Insurance Trust Fund (and the Federal Disability Insurance Trust Fund) for such excess.

(C) The Secretary shall then notify such individual of the amount of each such benefit as computed in accordance with the amendments made by subsections (a) and (b) of this section and as redetermined in accordance with subparagraph (B)(i) of this paragraph, specifying (i) the amount (if any) of the excess determined under subparagraph (B)(ii) of this paragraph, and (ii) the period during which payment of any increase in such individual's benefits resulting from the application of the amendments made by

~~subsections (a) and (b) of this section would under designated circumstances have to be withheld in order to effect the reduction described in subparagraph (B)(ii). Such individual may at any time within thirty days after such notification is mailed to him refuse (in such manner and form as the Secretary shall by regulations prescribe) to accept the redetermination under this paragraph.~~

~~(D) Unless the last sentence of subparagraph (C) applies, a redetermination under this paragraph shall be effective (but subject to the reduction described in subparagraph (B)(ii) over the period specified pursuant to clause (ii) of the first sentence of subparagraph (C)) beginning with the sixth month following the month in which this Act is enacted, or, if the request for such redetermination is not filed before the end of such sixth month, with the second month following the month in which the request for such redetermination is filed.~~

~~(E) The Secretary, by withholding amounts from benefits otherwise payable to an individual under title II of the Social Security Act as specified in clause (ii) of the first sentence of subparagraph (C) (and in no other manner), shall recover the amounts necessary to compensate the Federal Old-Age and Survivors Insurance Trust Fund (and the Federal Disability Insurance Trust Fund) for the excess (described in subparagraph (B)(ii)) attributable to benefits~~

which were paid such individual and to which a redetermination under this subsection applies.

(d) Where—

(1) two or more persons are entitled on the basis of the wages and self-employment income of an individual (without the application of sections 202(j)(1) and 223(b) of the Social Security Act) to monthly benefits under section 202 of such Act for the month preceding the month with which (A) a redetermination under subsection (c) of this section becomes effective with respect to the benefits of any one of them and (B) such benefits are accordingly increased by reason of the amendments made by subsections (a) and (b) of this section, and

(2) the total of benefits to which all persons are entitled under such section 202 on the basis of such wages and self-employment income for the month with which such redetermination and increase becomes effective is reduced by reason of section 203(a) of such Act as amended by this Act (or would, but for the penultimate sentence of such section 203(a), be so reduced), then the amount of the benefit to which each of the persons referred to in paragraph (1), other than the person with respect to whose benefits such redetermination and increase is applicable, is entitled for months beginning with the month

~~with which such redetermination and increase becomes effective shall be adjusted, after the application of such section 203(a), to an amount no less than the amount it would have been if such redetermination and increase had not become effective.~~

LIBERALIZATION OF EARNINGS TEST

SEC. ~~107~~ *105*. (a) (1) Paragraphs (1) and (4) (B) of section 203 (f) of the Social Security Act are each amended by striking out "$140" and inserting in lieu thereof "$166.66⅔ or the exempt amount as determined under paragraph (8)".

(2) Paragraph (1) (A) of section 203 (h) of such Act is amended by striking out "$140" and inserting in lieu thereof "$166.66⅔ or the exempt amount as determined under subsection (f) (8)".

(3) Paragraph (3) of section 203 (f) of such Act is amended to read as follows:

"(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 $166.66⅔ or the exempt amount as determined under paragraph (8) multiplied by the number of months in such year. The excess earnings as derived under the preceding sen-

tence, if not a multiple of $1, shall be reduced to the next lower multiple of $1."

(b) Section 203(f) of such Act is further amended by adding at the end thereof the following new paragraph:

"(8)(A) On or before November 1 of 1972 and of each even-numbered year thereafter, the Secretary shall determine and publish in the Federal Register the exempt amount as defined in subparagraph (B) for each month in any individual's first two taxable years which end with the close of or after the calendar year following the year in which such determination is made.

"(B) The exempt amount for each month of a particular taxable year shall be whichever of the following is the larger:

"(i) the product of $166.66\frac{2}{3}$ and the ratio of (I) the average 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 a determination under subparagraph (A) is made for each such month of such particular taxable year to (II) the average of the taxable wages of all persons for whom wages were reported to the Secretary for the first calendar quarter of 1971, with such product, if not a multiple of $10,

~~being rounded to the next higher multiple of $10 where such product is an odd multiple of $5 and to the nearest multiple of $10 in any other case, or~~

~~"(ii) the exempt amount for each month in the taxable year preceding such particular taxable year;~~

~~except that the provisions in clause (i) shall not apply with respect to any taxable year unless the contribution and earnings base for such year is determined under section 230(b)(1)."~~

~~(c)~~ *(b)* The amendments made by this section shall apply with respect to taxable years ending after December 1970.

EXCLUSION OF CERTAIN EARNINGS IN YEAR OF ATTAINING AGE 72

SEC. ~~108~~ *106*. (a) The first sentence of section 203 (f) (3) of the Social Security Act ~~is~~ *as* amended by *section 105 (a)(3) of this Act is amended by* inserting ~~"(A)"~~ ~~after~~ ~~"except that",~~ ~~and~~ ~~by~~ ~~inserting~~ before the period at the end thereof the following: ", ~~and~~ ~~(B)~~ *except that,* 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 equitable manner under regulations of the Secretary)".

(b) The amendment made by subsection (a) shall apply with respect to taxable years ending after December 1970.

REDUCED BENEFITS FOR WIDOWERS AT AGE 60

SEC. ~~109~~ *107.* (a) Section 202 (f) of the Social Security Act (as amended by section ~~104~~ *103* (b) (2) of this Act) is further amended—

(1) by striking out "age 62" each place it appears *in paragraphs (1), (5), and (6)* and inserting in lieu thereof "age 60"; and

(2) by striking out "or the third month" in the matter following subparagraph (G) in paragraph (1) and inserting in lieu thereof "or, if he became entitled to such benefits before he attained age 60, the third month".

(b) (1) The last sentence of section 203 (c) of such Act (as amended by section ~~104~~ *103* (c) (1) of this Act) is further amended by striking out "age 62" and inserting in lieu thereof "age 60".

(2) Clause (D) of section 203 (f) (1) of such Act (as amended by section ~~104~~ *103* (c) (2) of this Act) is further amended by striking out "age 62" and inserting in lieu thereof "age 60".

(3) Section 222 (b) (1) of such Act is amended by

striking out "a widow or surviving divorced wife who has not attained age 60, a widower who has not attained age 62" and inserting in lieu thereof "a widow, widower or surviving divorced wife who has not attained age 60".

(4) Section 222 (d) (1) (D) of such Act is ~~amended by striking out "age 62" each place it appears and inserting in lieu thereof "age 60"~~ *amended—*

(A) by striking out "age 62" the first place it appears and inserting in lieu thereof "age 60", and

(B) by striking out "wives who have not attained age 60 and are under a disability, the benefits under section 202(f) of widowers who have not attained age 62," and inserting in lieu thereof "wives and the benefits under section 202(f) for widowers who have not attained age 65 and are under a disability,".

(5) Section 225 of such Act is amended by striking out "age 62" and inserting in lieu thereof "age 60".

(c) The amendments made by this section shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970, except that in the case of an individual who was not entitled to a monthly benefit under title II of such Act for December 1970 such amendments shall apply only on the basis of an application filed in or after the month in which this Act is enacted.

ENTITLEMENT TO CHILD'S INSURANCE BENEFITS BASED ON DISABILITY WHICH BEGAN BETWEEN AGE 18 AND 22

SEC. ~~110~~ *108*. (a) Clause (ii) of section 202 (d) (1) (B) of the Social Security Act is amended by striking out "which began before he attained the age of eighteen" and inserting in lieu thereof "which began before he attained the age of 22".

(b) Subparagraphs (F) and (G) of section 202 (d) (1) of such Act are amended to read as follows:

"(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; 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, 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."

(c) Section 202 (d) (1) of such Act is further amended by adding at the end thereof the following new sentence: "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."

(d) Section 202 (d) (6) of such Act is amended by striking out "in which he is a full-time student and has not attained the age of 22" and all that follows and inserting in lieu thereof "in which he—

~~"(A) (i) is a full-time student or (ii) is under a disability (as defined in section 223 (d)), and~~

~~"(B) had not attained the age of 22, but only if he has filed application for such reentitlement.~~

"(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 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 his disability ceased,

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."

(e) Section 202 (s) of such Act is amended—

(1) by striking out "which began before he attained such age" in paragraph (1); and

(2) by striking out "which began before such

child attained the age of 18" in paragraphs (2) and (3).

(f) Where—

(1) one or more persons are entitled (without the application of sections 202 (j) (1) and 223 (b) of the Social Security Act) to monthly benefits under section 202 or 223 of such Act for December 1970 on the basis of the wages and self-employment income of an individual, and

(2) one or more persons (not included in paragraph (1)) are entitled to monthly benefits under such section 202 or 223 for January 1971 solely by reason of the amendments made by this section on the basis of such wages and self-employment income, and

(3) the total of benefits to which all persons are entitled under such section 202 or 223 on the basis of such wages and self-employment income for January 1971 is reduced by reason of section 203 (a) of such Act as amended by this Act (or would, but for the penultimate sentence of such section 203 (a), be so reduced),

then the amount of the benefit to which each person referred to in paragraph (1) of this subsection is entitled for months after December 1970 shall be adjusted, after the application of such section 203 (a), to an amount no less than the

amount it would have been if the person or persons referred to in paragraph (2) were not entitled to a benefit referred to in such paragraph (2).

(g) The amendments made by this section shall apply only with respect to monthly benefits under section 202 of the Social Security Act for months after December 1970, except that in the case of an individual who was not entitled to a monthly benefit under such section 202 for December 1970 such amendments shall apply only on the basis of an application filed after September 30, 1970.

~~ELIMINATION OF SUPPORT REQUIREMENT AS CONDITION OF BENEFITS FOR DIVORCED AND SURVIVING DIVORCED WIVES~~

~~SEC. 111. (a) Section 202 (b) (1) of the Social Security Act is amended—~~

~~(1) by adding "and" at the end of subparagraph (C),~~

~~(2) by striking out subparagraph (D), and~~

~~(3) by redesignating subparagraphs (E) through (L) as subparagraphs (D) through (K), respectively.~~

~~(b) (1) Section 202 (c) (1) of such Act is amended—~~

~~(A) by adding "and" at the end of subparagraph (C),~~

~~(B) by striking out subparagraph (D), and~~

~~(C) by redesignating subparagraphs (E) through~~

~~(G) as subparagraphs (D) through (F), respectively.~~

~~(2) Section 202(e)(6) of such Act is amended by striking out "paragraph (1)(G)" and inserting in lieu thereof "paragraph (1)(F)".~~

~~(c) Section 202(g)(1)(F) of such Act is amended by striking out clause (i), and by redesignating clauses (ii) and (iii) as clauses (i) and (ii), respectively.~~

~~(d) The amendments made by this section shall apply only with respect to benefits payable under title II of the Social Security Act for months after December 1970 on the basis of applications filed on or after the date of the enactment of this Act.~~

~~ELIMINATION OF DISABILITY INSURED-STATUS REQUIREMENT OF SUBSTANTIAL RECENT COVERED WORK IN CASES OF INDIVIDUALS WHO ARE BLIND~~

~~SEC. 112. (a) The first sentence of section 216(i)(3) of the Social Security Act is amended by inserting before the period at the end thereof the following: ", and 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))".~~

~~(b) Section 223(c)(1) of such Act is amended by striking out "coverage." in subparagraph (B)(ii) and inserting in lieu thereof "coverage;", and by striking out "For purposes" and inserting in lieu thereof the following:~~

"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 section 216(i)(1)). For purposes".

(c) The amendments made by this section shall be 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 in which this Act is enacted, or

(2) before the month in which this Act is enacted if the applicant has not died before such month and if—

(A) notice of the final decision of the Secretary of Health, Education, and Welfare has not been given to the applicant before such month; or

(B) the notice referred to in subparagraph (A) has been so given before such month 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 such month) and the decision in such civil action has not become final before such month;

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 months before January 1971.~~

DISABILITY BENEFITS FOR THE BLIND

SEC. 109. (a) The first sentence of section 222(b)(1) of the Social Security Act (as amended by section 107 of this Act) is further amended by inserting "(other than such an individual whose disability is blindness, as defined in section 216(i)(1)(B))" after "an individual entitled to disability insurance benefits".

(b) Section 223(a)(1) of such Act is amended—

(1) by amending subparagraph (B) to read as follows:

"(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,";

(2) by striking out "the month in which he attains age 65" and inserting in lieu thereof "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"; and

(3) by striking out the last sentence thereof.

(c) That part of section 223(a)(2) of such Act (as amended by section 104(c)(1) of this Act) which precedes subparagraph (A) thereof is further amended by inserting

immediately after "age 62" the following: ", 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,".

(d) Section 223(c)(1) of such Act is amended—

(1) by inserting "(other than an individual whose disability is blindness, as defined in section 216(i)(1)(B))," after "An individual"; and

(2) by adding at the end thereof (after the sentence following subparagraph (B)) the following new sentence: "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."

(e) Section 223(d)(1)(B) of such Act is amended to read as follows:

"(B) blindness (as defined in section 216(i)(1)(B))."

(f) The second sentence of section 223(d)(4) of such Act is amended by inserting "(other than an individual whose disability is blindness, as defined in section 216(i)(1)(B))" immediately after "individual".

(g) The amendments made by this section shall be effective with respect to individuals entitled to disability insurance

benefits under section 223 of the Social Security Act for the month of January 1971, and with respect to applications for disability insurance benefits under section 223 of such Act filed—

(1) in or after the month in which this Act is enacted, or

(2) before the month in which this Act is enacted if—

(A) notice of the final decision of the Secretary of Health, Education, and Welfare has not been given to the applicant before such month; or

(B) the notice referred to in subparagraph (A) has been so given before such month 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 such month) and the decision in such civil action has not become final before such month;

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 months before January 1971.

WAGE CREDITS FOR MEMBERS OF THE UNIFORMED SERVICES

SEC. ~~113~~ *110.* (a) Subsection 229 (a) of the Social Security Act is amended—

(1) by striking out "after December 1967" and inserting in lieu thereof "after December 1970"; ~~and~~

(2) by striking out "after 1967" and inserting in lieu thereof ~~"after 1956".~~ *"after 1956"; and*

(3) by striking out all which follows "(in addition to the wages actually paid to him for such service)" and inserting in lieu thereof "of $300.".

(b) The amendments made by subsection (a) shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970 and with respect to lump-sum death payments under such title in the case of deaths occurring after December 1970, except that, in the case of any individual who is entitled, on the basis of the wages and self-employment income of any individual to whom section 229 of such Act applies, to monthly benefits under title II of such Act for December 1970, such amendments shall apply (1) only if an application for recomputation by reason of such amendments 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 1971 or the twelfth month before the month in which such application was filed. Recomputations of benefits as required to carry out the provisions of this paragraph shall be

made notwithstanding the provisions of section 215 (f) (1) of the Social Security Act, and no such recomputation shall be regarded as a recomputation for purposes of section 215 (f) of such Act.

APPLICATIONS FOR DISABILITY INSURANCE BENEFITS FILED AFTER DEATH OF INSURED INDIVIDUAL

SEC. ~~114~~ *111*. (a) (1) Section 223 (a) (1) of the Social Security Act is amended by adding at the end thereof the following new sentence: "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."

(2) Section 223 (a) (2) of such Act is amended by striking out "he filed his application for disability insurance benefits and was" and inserting in lieu thereof "the application for disability insurance benefits was filed and he was".

(3) The third sentence of section 223 (b) of such Act is amended by striking out "if he files such application" and inserting in lieu thereof "if such application is filed".

(4) Section 223 (c) (2) (A) of such Act is amended by striking out "who files such application" and inserting in lieu thereof "with respect to whom such application is filed".

(b) Section 216 (i) (2) (B) of such Act is amended by adding at the end thereof the following new sentence: "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."

(c) The amendments made by this section shall apply in the case of deaths occurring in and after the year in which this Act is enacted. For purposes of such amendments (and for purposes of sections 202 (j) (1) and 223 (b) of the Social Security Act), any application with respect to an individual whose death occurred in such year but before the date of the enactment of this Act which is filed within 3 months after the date of the enactment of this Act shall be deemed to have been filed in the month in which such death occurred).

~~WORKMEN'S COMPENSATION OFFSET FOR DISABILITY INSURANCE BENEFICIARIES~~

~~SEC. 115. (a) Section 224 (a) (5) of the Social Security Act is amended by striking out "80 per centum of".~~

~~(b) The amendment made by subsection (a) shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970.~~

~~COVERAGE OF FEDERAL HOME LOAN BANK EMPLOYEES~~

~~SEC. 116. The provisions of section 210 (a) (6) (B) (ii) of the Social Security Act and section 3121 (b) (6) (B) (ii) of the Internal Revenue Code of 1954, insofar as they relate~~

~~to service performed in the employ of a Federal Home Loan Bank, shall be effective—~~

~~(1) with respect to all service performed in the employ of a Federal Home Loan Bank after December 1970; and~~

~~(2) in the case of individuals who are in the employ of a Federal Home Loan Bank on January 1, 1971, with respect to any service performed in the employ of a Federal Home Loan Bank after December 1965; but this paragraph shall be effective only if an amount equal to the taxes imposed by sections 3101 and 3111 of such Code with respect to the services of all such individuals performed in the employ of Federal Home Loan Banks after December 1965 are paid under the provisions of section 3122 of such Code by July 1, 1971, or by such later date as may be provided in an agreement entered into before such date with the Secretary of the Treasury or his delegate for purposes of this paragraph.~~

~~(b) Subparagraphs (A) (i) and (B) of section 104 (i) (2) of the Social Security Amendments of 1956 are repealed.~~

POLICEMEN AND FIREMEN IN IDAHO *AND POLICEMEN IN MISSOURI*

SEC. ~~117.~~ *112. (a)* Section 218 (p) (1) of the Social Security Act is amended by inserting "Idaho," after "Hawaii,".

(b) Such section 218(p)(1) is further amended by—

(1) inserting "Missouri," after "Maryland,"; and

(2) adding at the end thereof the following new sentence: "Notwithstanding the first sentence of this paragraph, nothing in this paragraph shall be construed to authorize the State of Missouri to modify the agreement entered into by it pursuant to this section so as to apply such agreement to service performed by any employee in a fireman's position."

COVERAGE OF CERTAIN HOSPITAL EMPLOYEES IN NEW MEXICO

SEC. ~~118~~ *113*. Notwithstanding any provisions of section 218 of the Social Security Act, the agreement with the State of New Mexico heretofore entered into pursuant to such section may at the option of such State be modified at any time prior to January 1, ~~1971,~~ *1972*, so as to apply to the services of employees of a hospital which is an integral part of a political subdivision to which an agreement under this section has not been made applicable, as a separate coverage group within the meaning of section 218 (b) (5) of such Act, but only if such hospital has prior to 1966 withdrawn from a retirement system which had been applicable to the employees of such hospital.

PENALTY FOR FURNISHING FALSE INFORMATION TO OBTAIN SOCIAL SECURITY ACCOUNT NUMBER

SEC. ~~119~~ *114.* (a) Section 208 of the Social Security Act is amended by adding "or" after the semicolon at the end of subsection (e), and by inserting after subsection (e) the following new subsection:

"(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);".

(b) The amendments made by subsection (a) shall apply with respect to information furnished to the Secretary after the date of the enactment of this Act.

GUARANTEE OF NO DECREASE IN TOTAL FAMILY BENEFITS

SEC. ~~120~~ *115.* (a) Section 203 (a) of the Social Security Act (as amended by sections 101 (b) and ~~103 (b)~~ *131 (a)* of this Act) is amended by striking out the period at the end of paragraph (4) and inserting in lieu thereof "; or", and by inserting after paragraph (4) the following new paragraph:

"(5) 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 of monthly benefits for all persons on the basis of such wages and self-employment income for months subsequent to such particular month 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 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."

(b) In any case in which the provisions of section 1002 (b) (2) of the Social Security Amendments of 1969 apply, the total of monthly benefits as determined under section 203 (a) of the Social Security Act shall, for months after 1970, be increased to the amount that would be required in order to assure that the total of such monthly benefits (after the application of section 202 (q) of such Act) will not be less than the total of monthly benefits that was applicable (after the application of such sections 203 (a) and 202 (q)) for the first month for which the provisions of such section 1002 (b) (2) applied.

~~CERTAIN ADOPTIONS BY DISABILITY AND OLD-AGE INSURANCE BENEFICIARIES~~

~~SEC. 121. (a) Clause (i) of section 202 (d) (8) (E) of the Social Security Act is amended—~~

~~(1) by inserting "(I)" after "(i)",~~

~~(2) by adding "or" after "child-placement agency;", and~~

~~(3) by adding at the end thereof (after and below clause (i) (I) as designated by paragraph (1) of this subsection) the following:~~

~~"(II) in an adoption which took place after an investigation of the circumstances surrounding the adoption by a court of competent jurisdiction~~

within the United States, or by a person appointed by such a court, if the child was related (by blood, adoption, or steprelationship) to such individual or to such individual's wife or husband as a descendant or as a brother or sister or a descendant of a brother or sister, such individual had furnished one-half of the child's support for at least five years immediately before such individual became entitled to such disability insurance benefits, the child had been living with such individual for at least five years before such individual became entitled to such disability insurance benefits, and the continuous period during which the child was living with such individual began before the child attained age 18,".

(b) The amendments made by subsection (a) shall apply with respect to monthly benefits payable under title II of the Social Security Act for months after December 1967 on the basis of an application filed in or after the month in which this Act is enacted; except that such amendments shall not apply with respect to benefits for any month before the month in which this Act is enacted unless such application is filed before the close of the twelfth month after the month in which this Act is enacted.

ADOPTION BY DISABILITY AND OLD-AGE INSURANCE BENEFICIARIES

SEC. 116. (a) Section 202(d) of the Social Security Act is amended by striking paragraphs (8) and (9) and inserting in lieu thereof the following new paragraph:

"(8) In the case of—

"(A) an individual entitled to old-age insurance benefits (other than an individual referred to in subparagraph (B)),

"(B) an individual entitled to disability insurance benefits, or 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 individ-

ual in an adoption decreed by a court of competent jurisdiction within the United States,

"(ii) was living with such indivdual 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 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"

(b) The amendments made by subsection (a) shall apply with respect to monthly benefits payable under title II of the Social Security Act for months after December 1970, but only on the basis of applications filed after the date of enactment of this Act.

INCREASE OF EARNINGS COUNTED FOR BENEFIT AND TAX PURPOSES

SEC. ~~122.~~ *117.* (a) (1) (A) Section 209 (a) (5) of the Social Security Act is amended by inserting "and prior to 1971" after "1967".

(B) Section 209 (a) of such Act is further amended by adding at the end thereof the following new paragraphs:

"(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 calen-

dar year after 1970 and prior to 1973, is paid to such individual during any 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 the contribution and benefit base (determined under section 230) with respect to employment has been paid to an individual during any calendar year after 1972 with respect to which such contribution and benefit base is effective, is paid to such individual during such calendar year;".

(2) (A) Section 211 (b) (1) (E) of such Act is amended by inserting "and beginning prior to 1971" after "1967", and by striking out "; or" and inserting in lieu thereof "; and ".

(B) Section 211 (b) (1) of such Act is further amended by adding at the end thereof the following new subparagraphs:

"(F) For any taxable year beginning after 1970 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 in any calendar year after 1972, (i) an amount equal to the contribution and benefit base (as determined under section 230) which is effective for such cal-

endar year, minus (ii) the amount of the wages paid to such individual during such taxable year; or".

(3) (A) Section 213 (a) (2) (ii) of such Act is amended by striking out "after 1967" and inserting in lieu thereof "after 1967 and before 1971, or $9,000 in the case of a calendar year after 1970 and before 1973, or an amount equal to the contribution and benefit base (as determined under section 230) in the case of any calendar year after 1972 with respect to which such contribution and benefit base is effective".

(B) Section 213 (a) (2) (iii) of such Act is amended by striking out "after 1967" and inserting in lieu thereof "after 1967 and beginning before 1971, or $9,000 in the case of a taxable year beginning after 1970 and before 1973, or in the case of any taxable year beginning in any calendar year after 1972, an amount equal to the contribution and benefit base (as determined under section 230) which is effective for such calendar year".

(4) Section 215 (e) (1) of such Act is amended by striking out "and the excess over $7,800 in the case of any calendar year after 1967" and inserting in lieu thereof "the excess over $7,800 in the case of any calendar year after 1967 and before 1971, the excess over $9,000 in the case of any calendar year after 1970 and before 1973, 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 1972 with respect to which such contribution and benefit base is effective".

(b) (1) (A) Section 1402 (b) (1) (E) of the Internal Revenue Code of 1954 (relating to definition of self-employment income) is amended by inserting "and beginning before 1971" after "1967", and by striking out "; or" and inserting in lieu thereof "; and".

(B) Section 1402 (b) (1) of such Code is further amended by adding at the end thereof the following new subparagraphs:

"(F) for any taxable year beginning after 1970 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 in any calendar year after 1972, (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) (A) Section 3121 (a) (1) of such Code (relating

to definition of wages) is amended by striking out "$7,800" each place it appears and inserting in lieu thereof "$9,000".

(B) Effective with respect to remuneration paid after 1972, section 3121 (a) (1) of such Code is amended (1) by striking out "$9,000" each place it appears and inserting in lieu thereof "the contribution and benefit base (as determined under section 230 of the Social Security Act)", and (2) by striking out "by an employer during any calendar year", and inserting in lieu thereof "by an employer during the calendar year with respect to which such contribution and benefit base is effective".

(3) (A) The second sentence of section 3122 of such Code (relating to Federal service) is amended by striking out "$7,800" and inserting in lieu thereof "$9,000".

(B) Effective with respect to remuneration paid after 1972, the second sentence of section 3122 of such Code is amended by striking out "$9,000" and inserting in lieu thereof "the contribution and benefit base".

(4) (A) Section 3125 of such Code (relating to returns in the case of governmental employees in Guam, American Samoa, and the District of Columbia) is amended by striking out "$7,800" where it appears in subsections (a), (b), and (c) and inserting in lieu thereof "$9,000".

(B) Effective with respect to remuneration paid after 1972, section 3125 of such Code is amended by striking out

"$9,000" where it appears in subsections (a), (b), and (c) and inserting in lieu thereof "the contribution and benefit base".

(5) Section 6413(c)(1) of such Code (relating to special refunds of employment taxes) is amended—

(A) by inserting "and prior to the calendar year 1971" after "after the calendar year 1967";

(B) by inserting after "exceed $7,800" the following: "or (E) during any calendar year after the calendar year 1970 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 1972, 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

(C) by inserting before the period at the end thereof the following: "and before 1971, or which exceeds the tax with respect to the first $9,000 of such wages received in such calendar year after 1970 and before 1973, or which exceeds the tax with respect to an amount of such wages received in such calendar year after 1972 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".

(6) Section 6413 (c) (2) (A) of such Code (relating to refunds of employment taxes in the case of Federal employees) is amended by striking out "or $7,800 for any calendar year after 1967" and inserting in lieu thereof "$7,800 for the calendar year 1968, 1969, or 1970, or $9,000 for the calendar year 1971 or 1972, 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 1972 with respect to which such contribution and benefit base is effective".

(7) (A) Section 6654 (d) (2) (B) (ii) of such Code (relating to failure by individual to pay estimated income tax) is amended by striking out "$6,600" and inserting in lieu thereof "$9,000".

(B) Effective with respect to taxable years beginning after 1972, section 6654 (d) (2) (B) (ii) of such Code is amended by striking out "$9,000" and inserting in lieu thereof "the contribution and benefit base (as determined under section 230 of the Social Security Act)".

(c) The amendments made by subsections (a) (1) and (a) (3) (A), and the amendments made by subsection (b) (except paragraphs (1) and (7) thereof), shall apply only with respect to remuneration paid after December 1970. The amendments made by subsections (a) (2), (a) (3) (B), (b) (1), and (b) (7) shall apply only with

respect to taxable years beginning after 1970. The amendment made by subsection (a) (4) shall apply only with respect to calendar years after 1970.

AUTOMATIC ADJUSTMENT OF THE CONTRIBUTION AND BENEFIT BASE

SEC. 123. (a) Title II of the Social Security Act is amended by adding at the end thereof the following new section:

"AUTOMATIC ADJUSTMENT OF THE CONTRIBUTION AND BENEFIT BASE

"SEC. 230. (a) On or before November 1 of 1972 and each even-numbered year thereafter, the Secretary shall determine and publish in the Federal Register the contribution and benefit base (as defined in subsection (b)) for the first two calendar years following the year in which the determination is made.

"(b) The contribution and benefit base for a particular calendar year shall be whichever of the following is the larger:

"(1) The product of $9,000 and the ratio of (A) the average 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 a determination under subsection (a) is made for such particular calendar year to (B) the average of the taxable

wages of all persons for whom taxable wages were reported to the Secretary for the first calendar quarter of 1971, with such product, if not a multiple of $600, being rounded to the next higher multiple of $600 where such product is a multiple of $300 but not of $600 and to the nearest multiple of $600 in any other case; or

"(2) The contribution and benefit base for the calendar year preceding such particular calendar year.

"(c)(1) When the Secretary determines and publishes in the Federal Register a contribution and benefit base (as required by subsection (a)), and

"(A) such base is larger than the contribution and benefit base in effect for the year in which the larger base is so published, and

"(B) a revised table of benefits is not required to be published in the Federal Register under the provisions of section 215(i)(2)(C) which extends such table for such larger base on or before the effective date of such base,

then the Secretary shall publish a revised table of benefits (determined under the provisions of paragraph (2)) in the Federal Register on or before December 1 of the year prior to the effective year of the new contribution and benefit base. Such table shall be deemed to be the table appearing in section 215(a).

"(2) The revision of such table shall be determined as follows:

"(A) All of the amounts on each line of columns I, II, III, and IV, except the largest amount in column III, of the table in effect before the revision, shall be the same in the revised table; and

"(B) The additional amounts for the extension of columns III and IV, and the amounts for purposes of column V, shall be determined in accordance with the provisions of section 215(i)(2)(C) (v) and (vi).

"(3) When a revised table of benefits, prepared under the provisions of paragraph (2), becomes effective, the provisions of section 215 (b)(4) and (c) and of section 203 (a)(4) shall be disregarded; and the amounts that are added to columns III and IV, or are changed in or added to column V, by such revised table, shall be applicable only in the case of an insured individual—

"(A) who becomes entitled, after December of the year immediately preceding the effective year of the increased contribution and benefit base (provided by this section), to benefits under section 202(a) or section 223;

"(B) who dies after December of such preceding year without being entitled to benefits under section 202(a) or section 223, or

~~"(C) whose primary insurance amount is required to be recomputed under section 215(f)(2)."~~

~~(b)(1) Section 201(c) of the Social Security Act is amended by inserting before the last sentence the following new sentence: "The report shall further include a recommendation as to the appropriateness of the tax rates in sections 1401(a), 3101(a), and 3111(a) of the Internal Revenue Code of 1954 which will be in effect for the following calendar year, made in the light of the need for the estimated income in relationship to the estimated outgo of the Trust Funds during such year."~~

~~(2) Section 1817(b) of such Act is amended by inserting before the last sentence the following new sentence: "The report shall further include a recommendation as to the appropriateness of the tax rates in sections 1401(b), 3101(b), and 3111(b) of the Internal Revenue Code of 1954 which will be in effect for the following calendar year made in the light of the need for the estimated income in relationship to the estimated outgo of the Trust Fund during such year."~~

CHANGES IN TAX SCHEDULES

SEC. ~~124~~ *118*. (a) (1) Section 1401 (a) of the Internal Revenue Code of 1954 (relating to rate of tax on self-employment income for purposes of old-age, survivors, and disability insurance) is amended by striking out paragraphs

~~(2),~~ ~~(3),~~ *(3)* and (4) and inserting in lieu thereof the following:

"~~(2)~~ *(3)* in the case of any taxable year beginning after December 31, ~~1968~~ *1970*, and before January 1, 1975, the tax shall be equal to ~~6.4~~ *6.6* percent of the amount of the self-employment income for such taxable year; and

"~~(3)~~ *(4)* in the case of any taxable year beginning after December 31, 1974, the tax shall be equal to 7.0 percent of the amount of the self-employment income for such taxable ~~year."~~ *year.*

Such tax with respect to self-employment income for any taxable year shall be increased in accordance with the allocation made by the Secretary of Health, Education, and Welfare under section 230(c) of the Social Security Act."

(2) Section 3101 (a) of such Code (relating to rate of tax on employees for purposes of old-age, survivors, and disability insurance) is amended by striking out paragraphs ~~(2),~~ ~~(3),~~ *(3)* and (4) and inserting in lieu thereof the following:

"~~(2)~~ *(3)* with respect to wages received during the calendar years ~~1969,~~ ~~1970,~~ 1971, 1972, 1973, and 1974, the rate shall be ~~4.2~~ *4.4* percent;

"~~(3)~~ *(4)* with respect to wages received during the

calendar years 1975, 1976, 1977, 1978, and 1979, the rate shall be 5.0 percent; ~~and~~

(5) with respect to wages received during the calendar years 1980, 1981, 1982, 1983, 1984, and 1985, the rate shall be 5.5 percent; and

"~~(4)~~ *(6)* with respect to wages received after December 31, ~~1979~~ *1985*, the rate shall be ~~5.5~~ *6.1* ~~percent.~~" *percent.*

Such tax with respect to wages received during any calendar year shall be increased in accordance with the allocation made by the Secretary of Health, Education, and Welfare under section 230(c) of the Social Security Act."

(3) Section 3111 (a) of such Code (relating to rate of tax on employers for purposes of old-age, survivors, and disability insurance) is amended by striking out paragraphs ~~(2), (3),~~ *(3)* and (4) and inserting in lieu thereof the following:

"~~(2)~~ *(3)* with respect to wages paid during the calendar years ~~1969, 1970,~~ 1971, 1972, 1973, and 1974, the rate shall be ~~4.2~~ *4.4* percent;

"~~(3)~~ *(4)* with respect to wages paid during the calendar years 1975, 1976, 1977, 1978, and 1979, the rate shall be 5.0 percent; ~~and~~

(5) with respect to wages paid during the calendar years 1980, 1981, 1982, 1983, 1984, and 1985, the rate shall be 5.5 percent; and

"~~(4)~~ *(6)* with respect to wages paid after December 31, ~~1979~~ *1985*, the rate shall be ~~5.5~~ *6.1* ~~percent.~~" *percent.*

Such tax with respect to wages received during any calendar year shall be increased in accordance with the allocation made by the Secretary of Health, Education, and Welfare under section 230(c) of the Social Security Act."

(b) (1) Section 1401 (b) of such Code (relating to rate of tax on self-employment income for purposes of hospital insurance) is amended by striking out paragraphs (1) through (5) and inserting in lieu thereof the following:

"(1) in the case of any taxable year beginning after December 31, 1967, and before January 1, 1971, the tax shall be equal to 0.6 percent of the amount of the self-employment income for such taxable year; ~~and~~

"(2) in the case of any taxable year beginning after December 31, 1970, *and before January 1, 1973,* the tax shall be equal to ~~1.0~~ *0.8* percent of the amount of the self-employment income for such taxable ~~year.~~" *year;*

"(3) in the case of any taxable year beginning after December 31, 1972, and before January 1, 1975, the tax shall be equal to 0.9 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, 1974, and before January 1, 1980, the tax shall be equal to 1.0 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, 1979, the tax shall be equal to 1.1 percent of the amount of the self-employment income for such taxable year."

(2) Section 3101 (b) of such Code (relating to rate of tax on employees for purposes of hospital insurance) is amended by striking out paragraphs (1) through (5) and inserting in lieu thereof the following:

~~"(1) with respect to wages received during the calendar years 1968, 1969, and 1970, the rate shall be 0.6 percent; and~~

~~"(2) with respect to wages received after December 31, 1970, the rate shall be 1.0 percent."~~

"(1) with respect to wages received during the calendar years 1968, 1969, and 1970, the rate shall be 0.6 percent;

"(2) with respect to wages received during the calendar years 1971 and 1972, the rate shall be 0.8 percent;

"(3) with respect to wages received during the calendar years 1973 and 1974, the rate shall be 0.9 percent;

"(4) with respect to wages received during the cal-

endar years 1975, 1976, 1977, 1978, and 1979, the rate shall be 1.0 percent; and

"(5) with respect to wages received after December 31, 1979, the rate shall be 1.1 percent."

(3) Section 3111(b) of such Code (relating to rate of tax on employers for purposes of hospital insurance) is amended by striking out paragraphs (1) through (5) and inserting in lieu thereof the following:

~~"(1) with respect to wages paid during the calendar years 1968, 1969, and 1970, the rate shall be 0.6 percent; and~~

~~"(2) with respect to wages paid after December 31, 1970, the rate shall be 1.0 percent."~~

"(1) with respect to wages paid during the calendar years 1968, 1969, and 1970, the rate shall be 0.6 percent;

"(2) with respect to wages paid during the calendar years 1971 and 1972, the rate shall be 0.8 percent;

"(3) with respect to wages paid during the calendar years 1973 and 1974, the rate shall be 0.9 percent;

"(4) with respect to wages paid during the calendar years 1975, 1976, 1977, 1978, and 1979, the rate shall be 1.0 percent; and

"(5) with respect to wages paid after December 31, 1979, the rate shall be 1.1 percent."

(c) The amendments made by subsections (a) (1) and (b) (1) shall apply only with respect to taxable years beginning after December 31, 1970. The remaining amendments made by this section shall apply only with respect to remuneration paid after December 31, 1970.

ALLOCATION TO DISABILITY INSURANCE TRUST FUND

SEC. ~~125~~ *119*. (a) Section 201 (b) (1) of the Social Security Act is amended—

(1) by striking out "and (D)" and inserting in lieu thereof "(D)"; and

~~(2) by striking out "after December 31, 1969, and so reported," and inserting in lieu thereof the following: "after December 31, 1969, and before January 1, 1971, and so reported, (E) 0.90 of 1 per centum of the wages (as so defined) paid after December 31, 1970, and before January 1, 1975, and so reported, (F) 1.05 per centum of the wages (as so defined) paid after December 31, 1974, and before January 1, 1980, and so reported, and (G) 1.15 per centum of the wages (as so defined) paid after December 31, 1979, and so reported,".~~

(2) by striking out "after December 31, 1969, and

so reported," and inserting in lieu thereof the following: "after December 31, 1969, and before January 1, 1971, and so reported, (E) 0.90 of 1 per centum of the wages (as so defined) paid after December 31, 1970, and before January 1, 1972, and so reported, (F) 0.95 of 1 per centum of the wages (as so defined) paid after December 31, 1971, and before January 1, 1975, and so reported, (G) 1.05 per centum of the wages (as so defined) paid after December 31, 1974, and before January 1, 1980, and so reported, (H) 1.35 per centum of the wages (as so defined) paid after December 31, 1979, and before January 1, 1986, and (I) 1.45 per centum of the wages (as so defined) paid after December 31, 1985, and so reported,".

(b) Section 201 (b) (2) of such Act is amended—

(1) by striking out "and (D)" and inserting in lieu thereof "(D)"; and

(2) by inserting after "December 31, 1969," the following: "and before January 1, 1971, (E) 0.675 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1970, and before January 1, 1972, (F) 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, 1971, and before January 1, 1975, (G) 0.7350 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1974, and before January 1, 1980, (H) 0.8600 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1979, and before January 1, 1986, and (I) 0.8300 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1985,".

INCREASE OF AMOUNTS IN TRUST FUNDS AVAILABLE TO PAY COSTS OF REHABILITATION SERVICES

SEC. 120. The first sentence of section 222(d)(1) of the Social Security Act (as amended by section 107(b)(4) of this Act) is further amended by striking out "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" and inserting in lieu thereof the following: "except that the total amount so made available pursuant to this subsection may not exceed—

"(i) 1 percent in the fiscal year ending June 30, 1971,

"(ii) 1.25 percent in the fiscal year ending June 30, 1972,

"(iii) 1.5 percent in the fiscal year ending June 30, 1973, and thereafter,

of the total of the benefits under section 202(d) for children who have attained age 18 and are under a disability".

SELF-EMPLOYMENT INCOME OF CERTAIN INDIVIDUALS TEMPORARILY LIVING OUTSIDE THE UNITED STATES

SEC. 121. (a) Section 211(a) of the Social Security Act is amended—

(1) by striking out "and" at the end of paragraph (8);

(2) by striking out the period at the end of paragraph (9) and inserting in lieu thereof "; and"; and

(3) by inserting after paragraph (9) the following new paragraph:

"(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."

(b) Section 1402(a) of the Internal Revenue Code of 1954 (relating to definition of net earnings from self-employment) is amended—

(1) by striking out "and" at the end of paragraph (9);

(2) by striking out the period at the end of paragraph (10) and inserting in lieu thereof "; and"; and

(3) by inserting after paragraph (10) the following new paragraph:

"(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."

(c) The amendments made by this section shall apply with respect to taxable years beginning after December 31, 1970.

MODIFICATION OF AGREEMENT WITH NEBRASKA WITH RESPECT TO CERTAIN STUDENTS AND CERTAIN PART-TIME EMPLOYEES

SEC. 122. (a) Notwithstanding any provision of section 218 of the Social Security Act, the agreement with the State of Nebraska or any modifications thereof entered into pursuant to such section may, at the option of such State, be modified at any time prior to January 1, 1973, so as to exclude either or both of the following:

(1) service in any class or classes of part-time positions; or

(2) 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) Any modification of such agreement pursuant to this section shall be effective with respect to services performed after the end of the calendar quarter following the calendar quarter in which such agreement is modified.

(c) If any such modification terminates coverage with respect to service in any class or classes of part-time positions in any coverage group, the Secretary of Health, Education, and Welfare and the State may not thereafter modify such agreement so as to again make the agreement applicable to service in such positions in such coverage group; if such modification terminates coverage with respect to service performed in the employ of a school, college, or university, by a student who is enrolled and regularly attending classes at such school, college, or university, the Secretary of Health, Education, and Welfare and the State may not thereafter modify such agreement so as to again make the agreement applicable to such service performed in the employ of such school, college, or university.

TEMPORARY EMPLOYEES OF THE GOVERNMENT OF GUAM

SEC. 123. (a) Section 210(a)(7) of the Social Security Act is amended by striking out "or" after subparagraph (C) and by striking out the semicolon after subparagraph (D) and inserting in lieu thereof ", or", and by adding the following new subparagraph:

"(E) service (except service performed by an elected official or a member of the legislature) 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 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;".

(b) Section 3121(b)(7) of the Internal Revenue Code of 1954 is amended by striking out "or" after subparagraph (B), and by striking out the semicolon at the end of subparagraph (C) and inserting in lieu thereof ", or", and by adding the following new subparagraph:

"(D) service (except service performed by an elected

official or a member of the legislature) 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 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;".

(c) The amendments made by this section shall apply with respect to service performed after December 31, 1970.

CHILD BENEFITS IN CASE OF A CHILD ENTITLED TO SUCH BENEFITS ON MORE THAN ONE WAGE RECORD

SEC. 124. (a) Section 202(k)(2)(A) of the Social Security Act is amended to read as follows:

"(2)(A) Any child who under the preceding provisions of this section is entitled for any month to child's insurance 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 child insurance benefits

for such month shall be based on the wages and self-employment of—

"(i) the insured individual who has the greatest primary insurance amount, or

"(ii) an insured individual not included under clause (i), but only if (I) it results in larger child's insurance benefits (after the application of section 203 (a) but without regard to any deductions under sections 203 and 222(b)) for such month and (II) would not result in smaller benefits (after the application of section 203(a) but without regard to any deductions under sections 203 and 222(b) for such month for any other person entitled to benefits based on the wages and self-employment income of the insured individual referred to in this clause.

Where there is more than one insured individual with respect to whom the provisions of clause (ii) are applicable for such month, such child's insurance benefits for such month shall be based on the wages and self-employment income of the insured individual which results in the highest child's insurance benefits."

(b) The amendments made by the preceding subsection shall apply with respect to monthly benefits under title II of such Act for months after December 1970.

RECOMPUTATION OF BENEFITS BASED ON COMBINED RAILROAD AND SOCIAL SECURITY EARNINGS

SEC. 125. (a) Subsection (f) of section 215 of the Social Security Act is amended by—

(1) striking out subparagraph (B) of paragraph (2) and inserting in lieu thereof the following:

"(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."; and

(2) adding at the end the following new paragraph:

"(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."

(b) Subsection (d) of section 215 of such Act is amended by striking out the period at the end of paragraph (2) and inserting in lieu thereof "or (6).".

UNDERPAYMENTS

SEC. 126. Section 204(d)(7) of the Social Security Act is amended by striking out ", if any" and inserting in lieu

thereof "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".

REDUCTION FROM 6 TO 4 MONTHS OF WAITING PERIOD FOR DISABILITY BENEFITS

SEC. 127. (a) Section 223(c)(2) of the Social Security Act is amended—

(1) by striking out "six" and inserting in lieu thereof "four", and

(2) by striking out "eighteenth" each place it appears and inserting in lieu thereof "sixteenth".

(b) Section 202(e)(6) of such Act is amended—

(1) by striking out "six" and inserting in lieu thereof "four",

(2) by striking out "eighteenth" and inserting in lieu thereof "sixteenth", and

(3) by striking out "sixth" and inserting in lieu thereof "fourth".

(c) Section 202(f)(7) of such Act is amended—

(1) by striking out "six" and inserting in lieu thereof "four",

(2) by striking out "eighteenth" and inserting in lieu thereof "sixteenth", and

(3) by striking out "sixth" and inserting in lieu thereof "fourth".

(d) Section 216(i)(2)(A) of such Act is amended by striking out "6" and inserting in lieu thereof "four".

(e) The amendments made by this section shall be effective 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, and applications for disability determinations under section 216(i) of such Act, filed—

(1) in or after the month in which this Act is enacted, or

(2) before the month in which this Act is enacted if—

(A) notice of the final decision of the Secretary of Health, Education, and Welfare has not been given to the applicant before such month; or

(B) the notice referred to in subparagraph (A) has been so given before such month 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 such month) and the decision in such civil action has not become final before such month;

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 1971.

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

SEC. 128. (a)(1) Section 6413 of the Internal Revenue Code of 1954 (relating to special rules applicable to certain employment taxes) is amended by adding at the end thereof the following new subsection:

"(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 described

in such section of such sect or division. 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 1970 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)."

(2) Section 31(b)(1) of such Code (relating to credit for special refunds of social security tax) is amended by striking out "section 6413(c)" and inserting in lieu thereof "section 6413 (c) or (e)".

(b)(1) Sections 201(g)(2) and 1817(f)(1) of the Social Security Act are each amended by striking out "section 6413(c)" and inserting in lieu thereof "sections 6413 (c) and (e)".

(2) Section 202(v) of the Social Security Act is amended—

(1) by inserting "(1)" after "(v)"; and

(2) by adding at the end thereof the following new paragraph:

"(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."

BENEFITS FOR REMARRIED WIDOWS AND WIDOWERS

SEC. 129. (a) Section 202(e)(4) of the Social Security Act is amended to read as follows:

"(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. The amount of such widow's benefit shall be determined under paragraph (2) except that, notwithstanding the provisions of such paragraph (2) and subsection (q), the amount of such benefit shall be equal to one-half of the primary insurance amount of the deceased person on whose wages and self-employment income such benefit is based—

"(A) if such individual at the time of such marriage, or at any time thereafter, is entitled (or, with respect to clause (i) or (iii) of this subparagraph, upon filing proper application would be entitled) to—

"(i) benefits under subsection (a) (deeming for such purposes, if he has not attained age 62, that he has attained such age in the month in which such marriage occurs),

"(ii) benefits under section 223, or

"(iii) any periodic benefits under a governmental pension system (as defined in section 228(h)

(2) and (3)) (deeming for such purposes, if he has not attained the required eligibility age, that he has attained such age in the month in which such marriage occurs),

for the month in which such marriage occurs and each month thereafter prior to the month in which such individual dies or such marriage is otherwise terminated, and

"(B) if such individual is not an individual referred to in subparagraph (A) of this paragraph, for the first month for which he becomes entitled to any of the benefits referred to in such subparagraph (A) and each month thereafter prior to the month in which such individual dies or such marriage is otherwise terminated."

(b) Section 202(f)(5) of such Act is amended to read as follows:

"(5) If a widower, after attaining the age of 60, 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. The amount of such widower's benefit shall be determined under paragraph (3); except that, notwithstanding the provisions of such paragraph (3) and subsection (q), the amount of such benefit shall be equal to one-half of the primary insurance amount of the deceased person on whose wages and self-employment income such benefit is based—

"(A) if such individual at the time of such marriage is entitled (or, with respect to clause (i) or (iii) of this subparagraph, upon filing proper application would be entitled) to—

"(i) benefits under subsection (a) (deeming for such purposes, if she has not attained age 62, that she has attained such age in the month in which such marriage occurs),

"(ii) benefits under section 223, or

"(iii) any periodic benefits under a governmental pension system (as defined in section 228 (h) (2) and (3)) (deeming for such purposes, if she has not attained the required eligibility age, that she has attained such age in the month in which such marriage occurs),

for the month in which such marriage occurs and each month thereafter prior to the month in which such individual dies or such marriage is otherwise terminated, and

"(B) if such individual is not an individual referred to in subparagraph (A) of this paragraph, for the first month for which she becomes entitled to any of the benefits referred to in such subparagraph (A) and each month thereafter prior to the month in which such individual dies or such marriage is otherwise terminated."

(c) The amendments made by this section shall apply

with respect to monthly benefits under title II of the Social Security Act for months after December 1970, but only on the basis of applications filed after the date of enactment of this Act.

PAYMENT IN CERTAIN CASES OF DISABILITY INSURANCE BENEFITS WITH RESPECT TO PERIODS OF DISABILITY WHICH ENDED PRIOR TO 1968

SEC. 130. (a) If an individual would (upon the timely filing of an application for a disability determination under section 216(i) of the Social Security Act and of an application for disability insurance benefits under section 223 of such Act) have been entitled to disability insurance benefits under such section 223 for a period which began after 1959 and ended prior to 1964, such individual shall, upon filing application for disability insurance benefits under such section 223 with respect to such period not later than 6 months after the date of enactment of this section, be entitled, notwithstanding any other provision of title II of the Social Security Act, to receive in a lump-sum, as disability insurance benefits payable under section 223, an amount equal to the total amounts of disability insurance benefits which would have been payable to him for such period if he had timely filed such an application for a disability determination and such an application for disability insurance benefits with respect to such period; but only if—

(1) prior to the date of enactment of this section and after the date of enactment of the Social Security Amendments of 1967, such period was determined (under section 216(i) of the Social Security Act) to be a period of disability as to such individual; and

(2) the application giving rise to the determination (under such section 216(i)) that such period is a period of disability as to such individual would not have been accepted as an application for such a determination except for the provisions of section 216(i)(2)(F).

(b) No payment shall be made to any individual by reason of the provisions of subsection (a) except upon the basis of an application filed after the date of enactment of this section.

AUTOMATIC ADJUSTMENT IN BENEFITS, WAGE BASE, TAX RATES, AND EARNINGS TEST

SEC. 131. (a)(1) Section 215 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"Cost-of-Living Increases in Benefits

"(i)(1) For purposes of this subsection—

"(A) the term 'base quarter' means the period of 3 consecutive calendar months ending on June 30, 1971, and the period of 3 consecutive calendar months ending on June 30 of each year thereafter.

"(B) the term 'cost-of-living computation quarter' means any base quarter (beginning no earlier than April 1, 1972) in which the Consumer Price Index prepared by the Department of Labor exceeds, by not less than 3 per centum, such index in the latest of (i) January 1971, or (ii) the base quarter which was most recently a cost-of-living computation quarter, or (iii) the most recent calendar month (after January 31, 1971) in which a general increase (other than an increase under this subsection) in the primary insurance amounts of all individuals entitled to benefits under this title became effective based upon an Act of Congress; and

"(C) the Consumer Price Index for a base quarter shall be the monthly average of such index in such quarter.

"(2)(A) If the Secretary determines that a base quarter in a calendar year is also a cost-of-living computation quarter, he shall, effective for January of the next calendar year, 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 as specified in subparagraph (B) of this paragraph, by an amount derived by multiplying 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 next higher one-tenth of 1 percent if such percentage is an odd multiple of .05 of 1 percent and to the nearest one-tenth of 1 percent in any other case) as the percentage by which the Consumer Price Index for such cost-of-living computation quarter exceeds such Index for the base quarter determined after the application of paragraph (1)(B).

"(B) The increase provided by subparagraph (A) with respect to a particular cost-of-living computation quarter shall apply 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, based on the wages and self-employment income of an individual who became entitled to monthly benefits under section 202, 223, 227, or 228 (without regard to section 202(j)(1) or section 223(b)), or who died, in or before December of such calendar year.

"(C) Notwithstanding the provisions of subparagraphs (A) and (B), the increase provided by subparagraph (A) with respect to a particular cost-of-living computation quarter shall not be effective as provided in such subparagraph (A) if in the calendar year in which such cost-of-living computation quarter occurs a law has been enacted which provides for (i) a general increase in the primary insurance amounts of all individuals entitled to benefits under this title, or (ii) a change in the rate of tax on wages and self-employ-

ment income under the Internal Revenue Code of 1954 for old-age, survivors, and disability insurance, or (iii) an increase in the amount of earnings of individuals that may be counted for benefits under this title and that may be taxed under the Internal Revenue Code of 1954 for old-age, survivors, and disability insurance.

"(D) Except as may be provided in subparagraph (C). 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 August 15 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 revised previously 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 show the effective date of the primary insurance amounts

set forth in column IV of the table immediately prior to its revision.

"(ii) The amounts on each line of column I, and the amounts on each line of column III, except as otherwise provided by clause (v) of this subparagraph, shall be the same as the amounts appearing in 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 amount of each line of columns IV and V shall be increased from the amount shown in the table immediately prior to its revision by increasing such amount by the percentage specified in subparagraph (A) of paragraph (2), raising each such increased amount, if not a multiple of $0.10, to the next higher multiple of $0.10.

"(v) Columns III, IV, and V shall be extended. The amount in each additional line of column III shall be determined so that the second figure in the last line of column III is one-twelfth of the contribution and benefit base for the calendar year following the calendar year in which the table of benefits is revised, and the amounts on each additional line of column III shall be the amount on the preceding line increased by $5. 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 contribution and benefit base for the calendar year following the calendar year in which the table of benefits is revised 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 175 percent of the amounts appearing on the same line in column IV. Any such increased amount that is not a multiple of $0.10 shall be increased to the next higher multiple of $0.10."

(2) Section 203(a) of such Act (as amended by section 101(b) of this Act) is further amended—

(A) by striking out the period at the end of paragraph (3) and inserting in lieu thereof ", or", and inserting after paragraph (3) the following new paragraph:

"(4) when two or more persons are entitled (without the application of section 202(j)(1) and section 223(b)) to monthly benefits under section 202 or 223 for December of the calendar year in which occurs a cost-of-living computation quarter (as defined in section 215(i)(1)) on the basis of the wages and self-employment income of such insured individual, such total of benefits for months following such December shall be reduced to not less than the amount equal to the sum of the amounts

derived by increasing the benefit amount determined under this title (including this subsection, but without the application of section 222(b), section 202(q), and subsections (b), (c), and (d) of this section) as in effect for such December for each such person by the same percentage as the percentage by which such individual's primary insurance amount (including such amount as previously increased) is increased under section 215(i)(2) for such month immediately following, and raising each such increased amount (if not a multiple of $0.10) to the next higher multiple of $0.10."; and

(B) by striking out "the table in section 215(a)" in the matter preceding paragraph (1) and inserting in lieu thereof "the table in (or deemed to be in) section 215(a)".

(3)(A) Section 215(a) of such Act is amended by striking out the matter which precedes the table and inserting in lieu thereof the following:

"(a) The primary insurance amount of an insured individual shall be 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), determined as follows:

"(1) Subject to the conditions specified in subsections (b), (c), and (d) of this section and except as provided

in paragraph (2) of this subsection, such primary insurance amount shall be whichever of the following amounts is the largest:

"(i) The amount in column IV on the line on which in column III of such table appears his average monthly wage (as determined under subsection (b));

"(ii) The amount in column IV on the line on which in column II of such table appears his primary insurance amount (as determined under subsection (c)); or

"(iii) The amount in column IV on the line on which in column I of such table 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 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 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."

(B) Effective January 1, 1973, section 215(b)(4) of such Act (as amended by section 101(c) of this Act) is amended to read as follows:

"(4) The provisions of this subsection shall be applicable only in the case of an individual—

"(A) who becomes entitled in or after the effective month of a new table that appears in (or is deemed by subsection (i)(2)(D) to appear in) subsection (a) to benefits under section 202(a) or section 223; or

"(B) who dies in or after such effective month 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) or (6)."

(C) Effective January 1, 1973, section 215(c) of such Act (as amended by section 101(d) of this Act) is amended to read as follows:

"Primary Insurance Amount Under Prior Provisions

"(c)(1) For the purposes of column II of the 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 effective month of the latest such table.

"(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."

(D) Section 215(f)(2) of such Act is amended by striking out "(a) (1) and (3)" and inserting in lieu thereof "(a)(1) (i) and (ii)".

(4) Sections 227 and 228 of such Act (as amended by sections 102 and 104 of this Act) are amended by striking out "$48.30" wherever it appears and inserting in lieu thereof "the larger of $48.30 or the amount most recently established in lieu thereof under section 215(i)", and by striking out "$24.20" wherever it appears and inserting in lieu thereof "the larger of $24.20 or the amount most recently established in lieu thereof under section 215(i)".

(b)(1) Title II of the Social Security Act is amended by adding at the end thereof the following new section:

"ADJUSTMENT OF THE TAX AND BENEFIT BASE

"SEC. 230. (a) If the Secretary determines pursuant

to subsection (i) of section 215 that an increase in benefits provided by subparagraph (A) of such subsection applies in the case of monthly benefits under sections 202 and 223 for months of a calendar year immediately following a cost-of-living computation quarter he shall also estimate the long-range additional level-cost (without regard to any estimated actuarial surplus which may exist at such time) of such benefits. He shall also determine the increase that is necessary in (1) the amount of earnings that may be taxed under the Internal Revenue Code of 1954 for old-age, survivors, and disability insurance and (2) the rate of tax specified in sections 1401(a), 3101(a), and 3111(a) of the Internal Revenue Code of 1954, to meet the total of such level cost and the cost (not previously taken into account under this subsection) of increasing the exempt amount pursuant to section 203(f)(8) for years prior to the year in which such increase in benefits becomes effective where one-half (or approximately one-half) of such total is to be met by the increase specified in clause (1) and the remainder is to be met by the increase specified in clause (2).

"(b) The contribution and benefit base for the calendar year referred to in subsection (a) and all succeeding calendar years, prior to the first calendar year thereafter in which an increase in benefits authorized by subsection (i) of section 215 becomes effective, shall be the sum of the amount of

earnings of individuals that may be counted for benefits under this title and that may be taxed under the Internal Revenue Code of 1954 for old-age, survivors, and disability insurance with respect to the calendar year immediately preceding the calendar year referred to in subsection (a) and the increase referred to in subsection (a), with such sum, if not a multiple of $300, being rounded to the nearest multiple of $300; except that—

"(1) if prior to such first calendar year a law is enacted which provides that for any calendar year a different amount of earnings may be so counted and may be so taxed, such different amount shall be the contribution and benefit base for the calendar years specified in such law but only until the first calendar year thereafter in which an increase in benefits is authorized by subsection (i) of section 215; and

"(2) the contribution and benefit base for any year after 1972 and prior to the first calendar year in which the first increase in benefits pursuant to section 215(i) becomes effective shall be $9,000 or (if applicable) such other amount as may be specified in a law enacted subsequent to the Social Security Amendments of 1970.

"(c) The Secretary shall allocate the increase specified in clause (2) of subsection (a) of this section among the

rates of tax specified in sections 1401(a), 3101(a) and 3111 (a) of the Internal Revenue Code of 1954 so that—

"(A) the rate of tax under section 3101(a) of such Code with respect to wages (as defined in section 3121 (a) of such Code) received during a calendar year is equal to the rate of tax under section 3111(a) of such Code with respect to wages (as defined in section 3121 (a) of such Code) received during such calendar year;

"(B) the rate of tax under section 1401(a) of such Code with respect to self-employment income (as defined in section 1402(b) of such Code) for any taxable year beginning during a period specified in such section 1401(a) shall be equal to 150 percent of the rate of tax under section 3101(a) of such Code with respect to wages (as defined in section 3121(a) of such Code) received during any calendar year occurring in such period.

After such allocation, the Secretary shall round any such tax rate, increased by reason of such allocation, to the nearest one-tenth of 1 percent.

"(d) At the time the Secretary publishes in the Federal Register the table required by section 215(i)(1)(D), he shall also publish in such Register—

"(1) the actuarial assumptions and methodology

used in estimating the additional long-range level-cost referred to in subsection (a), and

"(2) the contribution and benefit base resulting pursuant to subsection (b), and

"(3) the amount of the increase in tax rates required pursuant to such subsection (a) and the allocation of such increase determined under subsection (b) (including any rounding authorized by such subsection)."

(c) Section 203(f) of such Act is amended by adding at the end thereof the following new paragraph:

"(8)(A) On or before November 1 of 1972 and of each even-numbered year thereafter, the Secretary shall determine and publish in the Federal Register the exempt amount as defined in subparagraph (B) for each month in any individual's first two taxable years which end with the close of or after the calendar year following the year in which such determination is made.

"(B) The exempt amount for each month of a particular taxable year shall be whichever of the following is the larger:

"(i) the product of $166.66\frac{2}{3}$ and the ratio of (I) the average 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 a determination under subparagraph (A) is made for each such month of such particular taxable year to (II) the average of the taxable wages of all persons for whom wages were reported to the Secretary for the first calendar quarter of 1971, with such product, if not a multiple of $10, being rounded to the next higher multiple of $10 where such product is an odd multiple of $5 and to the nearest multiple of $10 in any other case, or

"(ii) the exempt amount for each month in the taxable year preceding such particular taxable year."

CHILD'S INSURANCE BENEFITS NOT TO BE TERMINATED BY REASON OF ADOPTION OF CHILD BY STEPGRANDPARENT

SEC. 132. (a) Section 202(d)(1)(D) of the Social Security Act is amended by inserting "stepgrandparent," immediately after "grandparent,".

(b) Any child—

(1) whose entitlement to child's insurance benefits under section 202(d) of the Social Security Act was terminated by reason of his adoption, prior to the date of enactment of this Act, by reason of his adoption by his stepgrandparent; and

(2) who, except for such adoption, would be entitled to child's insurance benefits under such section for a month after December 1970,

may, upon filing application for child's insurance benefits under the Social Security Act after the date of enactment of this Act, become reentitled to such benefits; except that no child shall, by reason of the enactment of this section, become reentitled to such benefits for any month prior to the month of January 1971.

TERMINATION OF COVERAGE OF REGISTRARS OF VOTERS IN LOUISIANA

SEC. 133. (a) Notwithstanding the provisions of section 218(g)(1) of the Social Security Act, the Secretary may, under such conditions as he deems appropriate, permit the State of Louisiana to modify its agreement entered into under section 218 of such Act so as to terminate the coverage of all employees who are in positions under the Registrars of Voters Employees' Retirement System, effective December 31, 1972, but only if such State files with him notice of termination on or before December 31, 1971.

(b) If the coverage of such employees in positions under such retirement system is terminated pursuant to subsection (a), coverage cannot later be extended to employees in positions under such retirement system.

TITLE II—PROVISIONS RELATING TO MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH

PART A—COVERAGE UNDER MEDICARE PROGRAM

PAYMENT UNDER MEDICARE PROGRAM TO INDIVIDUALS COVERED BY FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

SEC. 201. Section 1862 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(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, 1972, 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 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 upon or after attaining age 65, in addition to the health benefits plans available before he attains such age, one or more health benefits plans which offer protection supplementing the combined protection pro-

vided under parts A and B of this title and one or more health benefits plans which offer protection supplementing the protection provided under part B of this title alone, and

"(2) the Government 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 coverage under parts A and B (or part B alone) of this title, or (C) a combination of such contribution and such payment."

HOSPITAL INSURANCE BENEFITS FOR UNINSURED INDIVIDUALS NOT ELIGIBLE UNDER PRESENT TRANSITIONAL PROVISION

SEC. 202. (a) Section 103 (a) of the Social Security Amendments of 1965 is amended—

(1) by redesignating clauses (A) and (B) in paragraphs (2) and (4) as clauses (i) and (ii), respectively, and by redesignating paragraphs (1), (2), (3),

(4), and (5) as subparagraphs (A), (B), (C), (D), and (E), respectively;

(2) by striking out all that follows "Anyone who—" and precedes subparagraph (B) (as redesignated by paragraph (1) of this subsection) and inserting in lieu thereof the following:

"(1) (A) has attained the age of 65,";

(3) by adding "or" at the end of subparagraph (E) (as so redesignated);

(4) by striking out "shall (subject to the limitations in this section)" and all that follows *down* through the period at the end of the first sentence and inserting in lieu thereof the following:

"(2) (A) meets the provisions of subparagraphs (A), (C), and (D) of paragraph (1),

"(B) *(i)* does not meet the provisions of subparagraph (B) of paragraph (1), ~~and~~ *or (ii) is not included within the provisions of paragraph (1) of this subsection by reason of the provisions of subsection (b) (3) of this section, and*

"(C) has enrolled (i) under section 1837 of the Social Security Act and (ii) under subsection (d) of this section,

shall (subject to the limitations in this section) be deemed,

solely for purposes of section 226 of the Social Security Act, to be entitled to monthly insurance benefits under such section 202 for each month, beginning—

"(i) in the case of an individual who meets the provisions of paragraph (1), with the first month in which he meets the requirements of such paragraph, or

"(ii) in the case of an individual who meets the provisions of paragraph (2), with the day on which his coverage period (as provided in subsection (d)) begins,

and ending with the month in which he dies, or, if earlier, the month before the month in which he becomes (or upon filing application for monthly insurance benefits under section 202 of such Act would become) entitled to hospital insurance benefits under section 226 or *subsection (a)(1) of this section, or* becomes certifiable as a qualified railroad retirement beneficiary.";

(5) (A) by striking out "the preceding requirements of this subsection" in the second sentence and inserting in lieu thereof "the requirements of paragraph (1) of this subsection" and (B) by striking out "paragraph (5) hereof" and inserting in lieu thereof "subparagraph (E) of such paragraph"; ~~and~~

(6) by striking out "paragraphs (1), (2), (3),

and (4)" in the third sentence and inserting in lieu thereof "subparagraphs (A), (B), (C), and (D) of paragraph ~~(1)".~~ *(1)"; and*

(7) by adding at the end the following new sentence: "For purposes of paragraph (1) of this subsection, an individual will be deemed to have met the provisions of subparagraph (E) of such paragraph, if he is alive on the last day of the month in which his deemed entitlement by reason of paragraph (2) ends."

(b) Section 103 (b) of such Amendments is amended (1) by inserting "(i)" after "individual" in the second sentence, and (2) by adding before the period at the end thereof the following: ", or (ii) (with respect to an enrollment under subsection (d) (1)) for any month during his coverage period (as provided in subsection (d))".

(c) Section 103 (c) (1) of such Amendments is amended by striking out "this section" and inserting in lieu thereof "paragraph (1) of subsection (a) of this section".

(d) Section 103 of such Amendments is further amended by adding at the end thereof the following new subsections:

"(d) (1) An individual who meets the conditions of subparagraphs (A) and (B) of paragraph (2) of subsection (a) and has enrolled under section 1837 of the

Social Security Act may enroll for the hospital insurance benefits provided under subsection ~~(a)~~ *(a); except that an individual who is eligible to enroll under this paragraph by reason of subparagraph (B)(ii) of paragraph (2) of subsection (a) must so enroll within the period ending on December 31 of the year following (A) the year in which he first meets the requirements of subparagraphs (A) and (B) of paragraph (2) of subsection (a) or (B) (if later) the year in which the Social Security Amendments of 1970 are enacted.*

"(2) The provisions of sections 1837, 1838, 1839, and 1840 (relating to enrollments under part B of title XVIII of the Social Security Act) shall be applicable to the enrollment authorized by paragraph (1) in the same manner, to the same extent, and under the same conditions as such sections are applicable to enrollments under such part B, except that for purposes of this subsection such sections 1837, 1838, 1839, and 1840 are modified as follows:

"(A) the term 'paragraphs (1) and (2) of section 1836' shall be considered to read 'subparagraphs (A) and (B) of paragraph (2) of section 103 (a) of the Social Security Amendments of 1965';

"(B) the term 'March 1, 1966' shall be considered to read '~~March 31, 1971~~ *July 1, 1971*';

"(C) the term 'May 31, 1966' shall be considered to read ~~'March 31, 1971~~ *September 30, 1971';*

"(D) the term '1969' shall be considered to read '1972';

"(E) subsection (a)(1) of such section 1838 shall be considered to read as follows:

"'(1) in the case of an individual who enrolls for benefits under subsection ~~(a)~~ *(d)* of section 103 of the Social Security Amendments of 1965 pursuant to subsection (c) of section 1837 (as made applicable by section 103(d)(2) of such Amendments), ~~January~~ *July* 1, 1971, or, if later, the first day of the month following the month in which he so enrolls; or';

~~"(F) subsection (b) of such section 1838 shall be considered amended by adding at the end thereof the following new sentence: 'An individual's enrollment under subsection (d) of section 103 of the Social Security Amendments of 1965 shall also terminate (i) when he satisfies subparagraphs (B) and (E) of paragraph (1) of subsection (a) of such section, with such termination taking effect on the first day of the month in which he satisfies such subparagraphs, or (ii) when his enrollment under section 1837 terminates, with such~~

~~termination taking effect as provided in the second sentence of this subsection.';~~

"(F) the second sentence of subsection (b) of section 1838 shall be considered to read as follows: 'The termination of a coverage period under paragraph (1) shall take effect on the last day of the month following the calendar month in which the notice is filed or, if earlier, the last day of the month in which his enrollment under section 1837 terminates.';

"(G) subsection (a) of such section 1839 shall be considered to read as follows:

"'(a) The monthly premium of each individual for each month in his coverage period before July 1972 shall be $27.';

"(H) the term '1967' when used in subsection (b) (1) of such section 1839 shall be considered to read 'June 1972';

"(I) subsection (b) (2) of such section 1839 shall be considered to read as follows:

"'(2) The Secretary shall, during December of 1971 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 for months occurring in the 12-month period commencing July 1 of the next year. Such amount shall be equal to $27 multiplied by the ratio of (1) the inpatient hospital deductible for such next year, as promulgated under section 1813(b)(2), to (2) such deductible promulgated for 1971. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1.'; and

"(J) the term 'Federal Supplementary Medical Insurance Trust Fund' shall be considered to read 'Federal Hospital Insurance Trust Fund'.

"(e) Payment of the monthly premiums on behalf of any individual who meets the conditions of subparagraphs (A) and (B) of paragraph (2) of subsection (a) and has enrolled for the hospital insurance benefits provided under 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."

(e) Section 226(b) of the Social Security Act is amended by (1) striking out the period at the end of paragraph (2) and inserting in lieu thereof "; and" and (2) adding at the end thereof the following new paragraph:

"(3) an individual shall be deemed entitled to

monthly benefits under section 202 beginning with the first month after the month in which his deemed entitlement to such benefits by reason of section 103(a)(2) of the Social Security Amendments of 1965 ends, if on the first day of such first month he is alive and would be entitled to such benefits for such month had he filed an application in such month."

(f) Section 1837(e) of the Social Security Act is amended by striking out the period and inserting in lieu thereof the following: "; except that the enrollment period beginning January 1, 1971, shall end on September 30, 1971, in the case of any individual who has an enrollment period for hospital insurance benefits under section 103(d) of the Social Security Amendments of 1965 beginning on the first day of the second month following the month of enactment of the Social Security Amendments of 1970 and ending on September 30, 1971, and so enrolls in such period."

(g) Section 1837(b) of such Act (as amended by section 258 of this Act) is further amended by striking out the period and inserting in lieu thereof the following: "; except that any enrollment of an individual shall not be counted if the coverage period resulting for such enrollment terminated before the date on which such individual first enrolls for hospital insurance benefits under section 103(a) of the Social Security Amendments of 1965."

INCLUSION OF CERTAIN SERVICES BY OPTOMETRISTS UNDER SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

SEC. 203. (a) Section 1861(r) of the Social Security Act is amended by (1) striking out "or (3)" and inserting in lieu thereof "(3)", and (2) inserting before the period at the end thereof the following: "or (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".

(b) The amendment made by this section shall apply only with respect to services performed after the date of enactment of this Act.

COVERAGE OF SUPPLIES RELATED TO COLOSTOMIES

SEC. 204. (a) Section 1861(s)(8) of the Social Security Act is amended by inserting after "organs" the following: "(including colostomy bags and supplies directly related to colostomy care)".

(b) The amendment made by this section shall apply on and after the date of enactment of this Act.

INCLUSION OF CHIROPRACTOR'S SERVICES UNDER MEDICARE

SEC. 205. (a) Section 1861(r) of the Social Security Act (as amended by section 203 of this Act) is further amended by—

(1) striking out "or (4)" and inserting in lieu thereof "(4)", and

(2) inserting before the period at the end thereof the following ", 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".

(b) The amendments made by this section shall be effective with respect to services furnished after June 30, 1971.

PART B—IMPROVEMENTS IN THE OPERATING EFFECTIVENESS OF THE MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS

LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

SEC. 221. (a) Title XI of the Social Security Act is amended by adding at the end thereof the following new section:

"LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

"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 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 body 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, ~~and~~

"(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 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 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;~~ *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 not be consistent with the effective organization and delivery of health services or the effective administration 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 pur-

chase, 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, the Medical Assistance 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."

(b) The amendment made by subsection (a) shall apply

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) June 30, 1971, 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.

(c) (1) Section 505 (a) (6) of such Act (as amended by section 229 (b) of this Act) is further amended by inserting ", consistent with section 1122," after "standards" where it first appears.

(2) Section 506 of such Act (as amended by sections 224 (c), 227 (d), 230 (d), and 235 (b) of this Act) is further amended by adding at the end thereof the following new subsection:

"(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."

(3) Clause (2) of the second sentence of section 509 (a) of such Act is amended by inserting ", consistent with section 1122," after "standards".

(4) Section 1861 (v) of such Act is amended by adding at the end thereof the following new paragraph:

"(5) 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."

(5) Section 1902(a)(13)(D) of such Act (as amended by section 229(a) of this Act) is further amended by inserting ", consistent with section 1122," after "standards" where it first appears.

(6) Section 1903(b) of such Act is amended by adding at the end thereof the following new paragraph:

"(3) 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."

REPORT ON PLAN FOR PROSPECTIVE REIMBURSEMENT; EXPERIMENTS AND DEMONSTRATION PROJECTS TO DEVELOP INCENTIVES FOR ECONOMY IN THE PROVISION OF HEALTH SERVICES

SEC. 222. (a)(1) The Secretary of Health, Education, and Welfare, directly or through contracts with public or private agencies or organizations, shall develop and carry out experiments and demonstration projects designed to determine the relative advantages and disadvantages of various alternative methods of making payment on a prospective basis to hospitals, extended care facilities, and other pro-

viders of services for care and services provided by them under title XVIII of the Social Security Act and under State plans approved under titles XIX and V of such Act, including alternative methods for classifying providers, for establishing prospective rates of payment, and for implementing on a gradual, selective, or other basis the establishment of a prospective payment system, in order to stimulate such providers through positive financial incentives to use their facilities and personnel more efficiently and thereby to reduce the total costs of the health programs involved without adversely affecting the quality of services by containing or lowering the rate of increase in provider costs that has been and is being experienced under the existing system of retroactive cost reimbursement.

(2) The experiments and demonstration projects developed under paragraph (1) shall be of sufficient scope and shall be carried out on a wide enough scale to permit a thorough evaluation of the alternative methods of prospective payment under consideration while giving assurance that the results derived from the experiments and projects will obtain generally in the operation of the programs involved (without committing such programs to the adoption of any prospective payment system either locally or nationally).

(3) In the case of any experiment or demonstration project under paragraph (1), the Secretary may waive com-

pliance with the requirements of titles XVIII, XIX, and V of the Social Security Act insofar as such requirements relate to methods of payment for services provided; and costs incurred in such experiment or project in excess of those which would otherwise be reimbursed or paid under such titles may be reimbursed or paid to the extent that such waiver applies to them (with such excess being borne by the Secretary). No experiment or demonstration project shall be developed or carried out under paragraph (1) until the Secretary obtains the advice and recommendations of specialists who are competent to evaluate the proposed experiment or project as to the soundness of its objectives, the possibilities of securing productive results, the adequacy of resources to conduct it, and its relationship to other similar experiments or projects already completed or in process; and no such experiment or project shall be actually placed in operation until a written report containing a full and complete description thereof has been transmitted to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate.

(4) Grants, payments under contracts, and other expenditures made for experiments and demonstration projects under this subsection 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). 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 subsection. With respect to any such grant, payment, or other expenditure, the amount to be paid from each of such trust funds shall be determined by the Secretary, giving due regard to the purposes of the experiment or project involved.

(5) The Secretary shall submit to the Congress no later than ~~July 1, 1972,~~ *January 1, 1973*, a full report on the experiments and demonstration projects carried out under this subsection and on the experience of other programs with respect to prospective reimbursement together with any related data and materials which he may consider appropriate. Such report shall include detailed recommendations with respect to the specific methods which could be used in the full implementation of a system of prospective payment to providers of services under the programs involved.

(6) Section 1875(b) of the Social Security Act is amended by inserting "and the experiments and demonstration projects authorized by section 222(a) of the Social Security Amendments of 1970" after "1967".

(b) (1) Section 402 (a) of the Social Security Amendments of 1967 is amended to read as follows:

"(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 1970) 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 to organizations and institutions which have the capability of providing comprehensive health care services or 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 programs;~~

"(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, or

"(ii) mental health care services (as defined by section 401(c) of the Mental Retardation Facilities and Community Health Centers Construction Act of 1963), or

"(iii) ambulatory health care services, but only where the Secretary determines, after appropriate study, that payment for such health care services would result in a more economical provision of such services.

"(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; and

"(E) to determine whether utilization review and medical review mechanisms established on an areawide or communitywide basis would have the effect of providing more effective controls under such programs over excessive utilization of services.

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). 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 shall be determined by the Secretary, giving due regard to the purposes of the experiment or project involved."

(2) Section 402 (b) of such Amendments is amended—

(A) by striking out "experiment" each time it appears and inserting in lieu thereof "experiment or demonstration project";

(B) by striking out "experiments" and inserting in lieu thereof "experiments and projects";

(C) by striking out "reasonable charge" and insert-

ing in lieu thereof "reasonable charge, or to reimbursement or payment only for such services or items as may be specified in the experiment"; and

(D) by inserting before the period at the end thereof the following: "; and no such experiment or project shall be actually placed in operation until a written report containing a full and complete description thereof has been transmitted to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate".

(3) Section 1875(b) of the Social Security Act is amended by striking out "experimentation" and inserting in lieu thereof "experiments and demonstration projects".

LIMITATIONS ON COVERAGE OF COSTS UNDER MEDICARE PROGRAM

SEC. 223. (a) The first sentence of section 1861(v)(1) of the Social Security Act is amended by inserting immediately before "determined" where it first appears the following: "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".

(b) The third sentence of section 1861(v)(1) of such Act is amended by striking out the comma after "services" where it last appears and inserting in lieu thereof the follow-

ing: ", 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,".

(c) The fourth sentence of section 1861 (v) (1) of such Act is amended by inserting after "services" where it first appears the following: " (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) ".

(d) The fourth sentence of section 1861 (v) (1) of such Act is further amended by striking out "costs with respect" where they first appear and inserting in lieu thereof the following: "necessary costs of efficiently delivering covered services".

(e) Section 1866 (a) (2) (B) of such Act is amended (1) by inserting " (i) " after " (B) ", and (2) by adding at the end thereof the following new clause:

" (ii) Where a provider of services customarily furnishes an individual items or services which are more ex-

pensive 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 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 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 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 in excess of the cost determined to be necessary in

the efficient delivery of needed health services under this title."

(f) Section 1861 (v) of such Act (as amended by section 221 (c) (4) of this Act) is further amended by redesignating paragraphs (4) and (5) as paragraphs (5) and (6), respectively, and by inserting after paragraph (3) the following new paragraph:

"(4) If a provider of services furnishes items or services to an individual which are *grossly* 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."

(g) Section 1866 (a) (2) of such Act is amended by adding at the end thereof the following new subparagraph:

"(D) Where a provider of services customarily furnishes items or services which are *grossly* 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."

(h) The amendments made by this section shall be effective with respect to accounting periods beginning after ~~the date of the enactment of this Act~~ *June 30, 1971.*

LIMITS ON PREVAILING CHARGE LEVELS

SEC. 224. (a) Section 1842 (b) (3) of the Social Security Act is amended by adding at the end thereof the following new sentences: "No charge may be determined to be reasonable *in the case of bills submitted or requests for payments made* under this part ~~for services rendered~~ after ~~June 30, 1970,~~ *the date of enactment of this Act* and before July 1, 1971, if it exceeds the higher of (i) the prevailing charge recognized by the carrier for similar services in the same locality in administering this part on June 30, 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 calendar year 1969. With

respect to ~~services rendered~~ *bills submitted or requests for payment made under this part* after June 30, 1971, the charges recognized as prevailing within a locality may be increased in any fiscal year only to the extent found necessary, on the basis of statistical data and methodology acceptable to the Secretary, to cover 75 percent of the customary charges made for similar services in the same locality during the last preceding elapsed calendar year but may not be increased (in the aggregate) beyond the levels described in clause (ii) of the preceding sentence except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such adjustments are 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 ~~June 30, 1970,~~ *the date of enactment of this Act* determined to be reasonable may *not* exceed the ~~lowest~~ *lower* charge levels at which such services, supplies, and equipment are widely *and consistently* available in a locality ~~only~~ *except* to the extent and under the circumstances specified by the Secretary."

(b) Section 1903 of such Act is amended by adding at the end thereof the following new subsection:

"(g) Payment under the preceding provisions of this section shall not be made with respect to any amount paid

for items or services furnished under the plan after ~~June 30, 1970,~~ *the date of enactment of this Act* 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)."

(c) Section 506 of such Act is amended by adding at the end thereof the following new subsection:

"(f) Notwithstanding the preceding provisions of this section, no payment shall be made to any State thereunder with respect to any amount paid for items or services furnished under the plan after ~~June 30, 1970,~~ *the date of enactment of this Act* 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)."

~~ESTABLISHMENT OF INCENTIVES FOR STATES TO EMPHASIZE OUTPATIENT CARE UNDER MEDICAID PROGRAMS~~

~~SEC. 225. (a) (1) Section 1903 of the Social Security Act (as amended by section 228 of this Act) is further amended by inserting after subsection (d) the following new subsection:~~

~~"(e) The amount determined under subsection (a) (1) for any State shall be adjusted as follows:~~

~~"(1) With respect to the following services furnished under the State plan after December 31, 1970, the~~

Federal medical assistance percentage shall be increased by 25 per centum thereof, except that the Federal medical assistance percentage as so increased may not exceed 95 per centum:

"(A) outpatient hospital services and clinic services (other than physical therapy services); and

"(B) home health care services (other than physical therapy services); and

"(2) with respect to the following services furnished under the State plan after December 31, 1970, the Federal medical assistance percentage shall be decreased as follows:

"(A) after an individual has received inpatient hospital services (including services furnished in an institution for tuberculosis) on sixty days (whether or not such days are consecutive) during any calendar year (which for purposes of this section means the four calendar quarters ending with June 30), the Federal medical assistance percentage with respect to any such services furnished thereafter to such individual in the same calendar year shall be decreased by $33\frac{1}{3}$ per centum thereof;

"(B) after an individual has received care as an inpatient in a skilled nursing home on ninety days (whether or not such days are consecutive) during

any calendar year, the Federal medical assistance percentage with respect to any such care furnished thereafter to such individual in the same calendar year shall be decreased by 33⅓ per centum thereof; and

"(C) after an individual has received inpatient services in a hospital for mental diseases on ninety days occurring after December 31, 1970 (whether or not such days are consecutive), the Federal medical assistance percentage with respect to any such services furnished to such individual on an additional two hundred and seventy-five days (whether or not such days are consecutive) shall be decreased by 33⅓ per centum thereof and no payment may be made under this title for any such services furnished to such individual on any day after such two hundred and seventy-five days.

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) Section 1903(a)(1) of such Act is amended by inserting ", subject to subsection (c) of this section" after "section 1905(b)".

~~(b) (1) Section 1121 of such Act is amended by adding at the end thereof the following new subsection:~~

~~"(f) (1) If the Secretary determines for any calendar quarter beginning after December 31, 1970, with respect to any State that there does not exist a reasonable cost differential between the cost of skilled nursing home services and the cost of intermediate care facility services in such State, the Secretary may reduce the amount which would otherwise be considered as expenditures for which payment may be made under subsection (c) 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 cost of skilled nursing home services and the 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 (re-~~

~~gardless 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."~~

~~(2) Section 1121(c) of such Act is amended by adding at the end thereof the following new sentence: "Effective January 1, 1971, the term 'intermediate care facility' shall not include any public institution (or distinct part thereof) for mental diseases or mental defects."~~

ESTABLISHMENT OF INCENTIVES FOR STATES TO MAINTAIN ADEQUATE UTILIZATION REVIEW PROCEDURES IN MEDICAID PROGRAMS

SEC. 225. Section 1903 of the Social Security Act (as amended by section 228 of this Act) is further amended by inserting after subsection (d) the following new subsection:

"(e)(1) The Secretary shall, not less frequently than once during any 12-month period, study, review, and evaluate the operation of each State plan approved under this title with a view to determining whether there are in effect, in the administration and operation of such plan, such utilization review, independent medical and professional audits and other procedures as are adequate to assure that, in the provision of health care services to individuals entitled to receive medical assistance under the plan—

"(A) inpatient services in hospitals, skilled nursing

homes, and other institutional health care facilities (including intermediate care facilities) will be provided to an individual only when, and to the extent, that the health care needs of such individual cannot, consistent with the provision of appropriate medical care, be effectively provided on an outpatient basis or more economically in an inpatient health care facility of a different type;

"(B) costs of or charges for services by physicians and other health care personnel will be reimbursed only when such services are medically necessary; and

"(C) costs of or charges for drugs and other health care items or devices will be reimbursed only when medically necessary.

"(2) If the Secretary determines, as the result of his study, review, and evaluation under paragraph (1) of any such State plan that there is not in effect, in the administration and operation of such plan, such utilization review, independent professional and medical audit, and other procedures as are adequate to assure that, in the provision of health care services to individuals entitled to receive medical assistance under the plan, the criteria set forth in clauses (A), (B), or (C) are not met, he shall notify the State agency that the Federal medical assistance percentage of such State will be reduced until such time as the Secretary is satisfied that there is in effect, in the administration and operation of such State plan, such utilization review, independent medical

and professional audit and other procedures as are adequate to meet the criteria set forth in such clauses (A), (B), and (C).

"(3) Any reduction in the Federal medical assistance percentage of any State under this subsection shall be of such per centum as the Secretary determines will assure, insofar as possible, that the amount of Federal funds payable to such State under this title during the period that the reduction is in effect will be equal to the amount of such funds which would have been payable to such State under this title for such period, if, for such period, there was no failure on the part of such State, in the administration of the State plan approved under this title, to have in effect such utilization review, independent medical and professional audit and other procedures as are adequate to meet the criteria set forth in clauses (A), (B), and (C) of paragraph (1).

"(4) No reduction under this subsection in the Federal medical assistance percentage of any State shall become effective prior to the first calendar quarter which commences more than 90 days after the date the Secretary notifies the State agency of such State that such a reduction will be made.

~~PAYMENT FOR SERVICES OF TEACHING PHYSICIANS UNDER MEDICARE PROGRAM~~

~~SEC. 226. (a) (1) Section 1833 (a) (1) of the Social Security Act is amended by striking out "and" before "(B)", and by inserting before the semicolon at the end thereof the~~

following: ", and (C) with respect to expenses incurred for services which are furnished to a patient of a hospital by a physician and for which payment may be made under this part, the amounts paid shall be equal to 100 percent of the reasonable cost, to the hospital or other medical service organization incurring such cost, of such services if (i) (I) such services are furnished under circumstances comparable to the circumstances under which similar services are furnished to all persons, or all members of a class of persons, who are patients in such hospital and who are not covered by the insurance program established by this part (and not covered under a State plan approved under title XIX), and (II) none of such persons, or members of such class of persons, are required to pay the reasonable charges for such similar services even when they have private insurance covering such similar services (or are otherwise able to pay reasonable charges for all such similar services as determined in accordance with regulations), or (ii) (I) none of the patients in such hospital who are covered by such program are required to pay any charges for services furnished by physicians, or (II) such patients are required to pay reasonable charges for such services but payment of the deductible and coinsurance applicable to such services is not obtained from or on behalf of some or all of them, in addition to the portion of such charges payable as insurance benefits under

this part, even though they have private insurance covering such services (or are otherwise able to pay reasonable charges for all such services as determined in accordance with regulations)".

(2) The first sentence of section 1833(b) of such Act is amended by striking out "and" before "(2)", and by inserting before the period at the end thereof the following: ", and (3) such total amount shall not include expenses incurred for services to which clause (C) of subsection (a)(1) applies."

(b) Section 1861(v)(1) of such Act is amended—

(1) by inserting "(A)" after "(1)";

(2) by striking out "(A) take" and "(B) provide" and inserting in lieu thereof "(i) take" and "(ii) provide", respectively.

(3) by inserting "(B)" immediately preceding "Such regulations in the case of extended care services"; and

(4) by adding at the end thereof the following new subparagraph:

"(C) Where a hospital has an arrangement with a medical school under which the faculty of such school provides services at such hospital and under which reimbursement to such school by such hospital is less than the reasonable cost of such services to the medical school, the reasonable

~~cost of such services to the medical school shall be included in determining the reasonable cost to the hospital of furnishing services 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 if such services were furnished by the hospital, and~~

~~"(ii) such hospital pays to the medical school the reasonable cost of such services to the medical school."~~

~~(c) (1) The amendments made by subsection (a) shall apply with respect to bills submitted and requests for payment made after the date of the enactment of this Act.~~

~~(2) The amendments made by subsection (b) shall be effective with respect to accounting periods beginning after the date of the enactment of this Act.~~

PAYMENT UNDER MEDICARE PROGRAM FOR SERVICES OF PHYSICIANS RENDERED AT A TEACHING HOSPITAL

SEC. 226. (a) Section 1861(b) of the Social Security Act is amended by striking out the second sentence thereof and inserting in lieu thereof the following:

"Paragraph (4) shall not apply to services provided in a hospital 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

"(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) where 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 part from at least 50 percent of all inpatients."

(b)(1) So much of section 1814(a) of the Social Security Act as precedes paragraph (1) is amended by striking "subsection (d)," and inserting in lieu thereof "subsections (d) and (g),".

(2) Section 1814 is further amended by adding at the end thereof the following new subsection:

"PAYMENT FOR SERVICES OF A PHYSICIAN RENDERED IN A TEACHING HOSPITAL

"(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) 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)."

(c) Section 1861(v)(1) of such Act is amended—

(1) by inserting "(A)" after "(1)";

(2) by striking out "(A) take" and "(B) provide"

and inserting in lieu thereof "(i) take" and "(ii) provide", respectively;

(3) by inserting "(B)" immediately preceding "Such regulations in the case of extended care services"; and

(4) by adding at the end thereof the following new subparagraphs:

"(C) Where a hospital has an arrangement with a medical school 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.

"(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 physcians 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).

(d)(1) Section 1861(u) of such Act is amended by striking out the period and inserting in lieu thereof the fol-

lowing: "or for purposes of section 1814(g) and section 1835(e), a fund.".

(2) So much of section 1866(a)(1) of such Act as precedes subparagraph (A) is amended by inserting "(except a fund designated for purposes of section 1814(g) and section 1835(e))" after "provider of services".

(e)(1) Section 1832(a)(2)(B) of such Act is amended to read as follows:

> *"(B) medical and other health services furnished by a provider of services or by others under arrangements with them made by a provider of services, 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), unless either clause (A) (whether or not such patient is an inpatient of such hospital), 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); and".

(2)(A) So much of section 1835(a) of the Social Security Act as precedes paragraph (1) is amended by striking "subsections (b) and (c)," and inserting in lieu thereof "subsections (b), (c), and (e),".

(B) Section 1835 is further amended by adding at the end thereof the following new subsection:

"(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 11 of section 1802(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 if—

"(1) such hospital has an agreement with the Secretary under section 1866, and

"(2) the Secretary has received written assurances that 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 of any moneys incorrectly collected)."

(3) Section 1842 of such Act is amended by inserting after "which involve payments for physicians' services" the following: "on a reasonable charge basis".

(f) The amendments made by this section shall apply with respect to accounting periods beginning after June 30, 1971.

AUTHORITY OF SECRETARY TO TERMINATE PAYMENTS TO SUPPLIERS OF SERVICES

SEC. 227. (a) Section 1862 of the Social Security Act (as amended by section 201 of this Act) is further amended by adding at the end thereof the following new subsection:

"(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 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, 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)~~, *(4) (except in the case of a provider of services)* 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 appropriate program review team appointed pursuant to paragraph (4) who are physicians or other professional personnel in the health care field, to be ~~substantially~~ *grossly* 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, posthospital 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."

(b) Section 1866(b)(2) of such Act is amended by striking out the period at the end thereof and inserting in lieu thereof the following: ", 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~~ *grossly* in excess of the needs of individuals or to be harmful to individuals or to be of a grossly inferior quality."

(c) Section 1903 (g) of such Act (as added by section 224 (b) of this Act) is further amended by striking out "shall not be made" and all that follows and inserting in lieu thereof the following: "shall not be made—

"(1) with respect to any amount paid for items or services furnished under the plan after ~~June 30, 1970,~~ *July 1, 1971,* 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 ~~June 30, 1970,~~ *July 1, 1971,* 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)."

(d) Section 506 (f) of such Act (as added by section 224 (c) of this Act) is further amended by striking out "no payment shall be made" and all that follows and inserting in lieu thereof the following: "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 ~~June 30, 1970,~~ *July 1, 1971,* 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 ~~June 30, 1970,~~ *July 1, 1971,* 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)."

ELIMINATION OF REQUIREMENT THAT STATES MOVE TOWARD COMPREHENSIVE MEDICAID PROGRAMS

SEC. 228. Section 1903 (e) of the Social Security Act, and section 2 (b) of Public Law 91-56 (approved August 9, 1969), are repealed.

DETERMINATION OF REASONABLE COST OF INPATIENT HOSPITAL SERVICES UNDER MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

SEC. 229. (a) Section 1902 (a) (13) (D) of the Social Security Act is amended to read as follows:

"(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards which shall be developed by the State and included in the plan and shall not result in any part of the cost of any such services provided to individuals covered by the plan being borne by individuals not so covered or in any part of the cost of any such services provided to individuals not so covered being borne by the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861 (v) as the reasonable cost of such services for purposes of title XVIII;".

(b) Section 505 (a) (6) of such Act is amended to read as follows:

"(6) provides for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards which shall be developed by the State and included in the plan and shall not result in any part of the cost of any such services provided to individuals covered by the plan being borne by individuals not so covered or in any part of the costs of any such services provided to individuals not so covered being borne by the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861 (v) as the reasonable cost of such services for purposes of title XVIII;".

(c) The amendments made by this section shall be effective July 1, 1971 (or earlier if the State plan so provides).

AMOUNT OF PAYMENTS WHERE CUSTOMARY CHARGES FOR SERVICES FURNISHED ARE LESS THAN REASONABLE COST

SEC. 230. (a) Section 1814 (b) of the Social Security Act is amended to read as follows:

"Amount Paid to Providers

"(b) The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1813, be—

"(1) the lesser of (A) the reasonable cost of such services, as determined under section 1861 (v), or (B) the customary charges with respect to such services; or

"(2) 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 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."

(b) Section 1833 (a) (2) of such Act is amended to read as follows:

"(2) in the case of services described in section 1832 (a) (2)—80 percent of—

"(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)."

(c) Section 1903(g) of such Act (as added by section 224(b) and amended by section 227(c) of this Act) is further amended by striking out the period at the end of paragraph (2) and inserting in lieu thereof "; or", and by adding after paragraph (2) the following new paragraph:

"(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."

(d) Section 506(f) of such Act (as added by section 224(c) and amended by section 227(d) of this Act) is further amended by striking out the period at the end of paragraph (2) and inserting in lieu thereof "; or", and by adding after paragraph (2) the following new paragraph:

"(3) with respect to any amount expended for in-

patient 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."

(e) Clause (2) of the second sentence of section 509 (a) of such Act (as amended by section 221 (c) (3) of this Act) is further amended by inserting "(A)" before "the reasonable cost", and by inserting after "under the project," the following: "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".

(f) The amendments made by subsections (a) and (b) shall apply to services furnished by hospitals and extended

care facilities in accounting periods beginning after June 30, ~~1970~~ *1971*, and to services furnished by home health agencies in accounting periods beginning after June 30, ~~1970~~ *1971*. The amendments made by subsections (c), (d), and (e) shall apply with respect to services furnished ~~in calendar quarters~~ *by hospitals in accounting periods* beginning after June 30, ~~1970~~ *1971*.

INSTITUTIONAL PLANNING UNDER MEDICARE PROGRAM

SEC. 231. (a) The first sentence of section 1861 (e) of the Social Security Act is amended—

(1) by striking out "and" at the end of paragraph (7);

(2) by redesignating paragraph (8) as paragraph (9); and

(3) by inserting after paragraph (7) the following new paragraph:

"(8) has in effect an overall plan and budget that meets the requirements of subsection (z); and".

(b) Section 1861 (f) (2) of such Act is amended to read as follows:

"(2) satisfies the requirements of paragraphs (3) through (9) of subsection (e);".

(c) Section 1861 (g) (2) of such Act is amended to read as follows:

"(2) satisfies the requirements of paragraphs (3) through (9) of subsection (e);".

(d) The first sentence of section 1861 (j) of such Act is amended—

(1) by striking out "and" at the end of paragraph (9);

(2) by redesignating paragraph (10) as paragraph (11); and

(3) by inserting after paragraph (9) the following new paragraph:

"(10) has in effect an overall plan and budget that meets the requirements of subsection (z); and".

(e) Section 1861 (o) of such Act is amended—

(1) by striking out "and" at the end of paragraph (4);

(2) by redesignating paragraph (5) as paragraph (6); and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) has in effect an overall plan and budget that meets the requirements of subsection (z); and".

(f) Section 1861 of such Act is further amended by adding at the end thereof the following new subsection:

"Institutional Planning

"(z) An overall plan and budget of a hospital, extended care 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 budget, an item-by-item identification of each type of the components of each such 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."

(g) (1) Section 1814 (a) (2) (C) and section 1814 (a) (2) (D) of such Act are each amended by striking out "and (8)" and inserting in lieu thereof "and (9)".

(2) Section 1863 of such Act is amended by striking out "subsections (e) (8), (f) (4), (g) (4), (j) (10), and (o) (5)" and inserting in lieu thereof "subsections (e) (9), (f) (4), (g) (4), (j) (11), and (o) (6)".

(h) Section 1865 of such Act is amended—

(1) by striking out "(except paragraph (6) thereof)" in the first sentence and inserting in lieu thereof "(except paragraphs (6) and (8) thereof)", and

(2) by striking out the second sentence and inserting in lieu thereof the following: "If such Commission, as a condition for accreditation of a hospital, (1) requires a utilization review plan as defined in section 1861 (k) or imposes another requirement which serves substantially the same purpose, or (2) requires institutional plans as defined in section 1861 (z) 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) or 1861 (e) (8), as the case may be."

(i) The amendments made by this section shall apply with respect to any provider of services for fiscal years (of

such provider) ~~beginning after the fifth month following the month in which this Act is enacted~~ *for fiscal years beginning after June 30, 1971.*

PAYMENTS TO STATES UNDER MEDICAID PROGRAMS FOR INSTALLATION AND OPERATION OF CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS

SEC. 232. (a) Section 1903 (a) of the Social Security Act is amended by redesignating paragraph (3) as paragraph (4), and by inserting after paragraph (2) the following new paragraph:

"(3) an amount equal to—

"(A) 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such mechanized claims processing and information retrieval systems as the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of title XVIII, including the State's share of the cost of installing such a system to be used jointly in the administration of such State's plan and the plan of any other State approved under this title, and

"(B) 75 per centum of so much of the sums

expended during such quarter as are attributable to the operation of systems of the type described in subparagraph (A) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by the plan of the specific services so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services; plus".

(b) The amendments made by subsection (a) shall apply with respect to expenditures under State plans approved under title XIX of the Social Security Act made after June 30, ~~1970~~ *1971*.

~~ADVANCE APPROVAL OF EXTENDED CARE AND HOME HEALTH COVERAGE UNDER MEDICARE PROGRAM~~

~~SEC. 233. (a) Section 1862 of the Social Security Act (as amended by sections 201 and 227(a) of this Act) is further amended by adding at the end thereof the following new subsection:~~

~~"(c)(1) In any case where post-hospital extended care~~

services or post-hospital home health services are furnished to an individual and—

"(A) a physician provides the certification referred to in subparagraph (C) or (D) of section 1814(a)(2), as the case may be, and the condition of the individual with respect to which such certification is made is a condition designated in regulations,

"(B) such physician (in the case of such extended care services) submitted to the extended care facility which is to provide such services, prior to the admission of such individual to such facility, a plan for the furnishing of such services, or (in the case of such home health services) submitted to the home health agency which is to furnish such services, prior to the first visit to such individual, a plan specifying the type and frequency of the services required, and

"(C) there is compliance with such other requirements and procedures as may be specified in regulations,

the provisions of paragraphs (1) and (9) of subsection (a) shall not apply (except as may be provided in section 1814(a)(7)) for such periods of time, with respect to such conditions of the individual, as may be prescribed in regulations.

"(2) In specifying the conditions included under paragraph (1) and the periods for which paragraphs (1) and

~~(9) of subsection (a) shall not apply, the Secretary shall take into account the medical severity of such conditions, the period over which such conditions generally require the services specified in subparagraphs (C) and (D) of section 1814(a)(2), the length of stay in an institution generally needed for the treatment of such conditions, and such other factors affecting the type of care to be provided as the Secretary deems pertinent.~~

~~"(3) 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 such paragraph."~~

~~(b) The amendments made by this section shall be effective with respect to admissions to extended care facilities, and home health plans initiated, on or after January 1, 1971.~~

PAYMENT FOR EXTENDED CARE AND HOME HEALTH SERVICES

SEC. 233. (a)(1) Section 1814(a)(2)(C) of the Social Security Act is amended by striking the phrase, "skilled

nursing care on a continuing basis" and inserting in lieu thereof, "posthospital institutional care which requires the continuing availability of skilled nursing and related skilled services";

(2) Section 1814 of such Act (as amended by section 226 of this Act) is amended by adding at the end thereof the following new subsections:

"Payment for Posthospital Extended Care Services

"(h) An individual shall be presumed to require the care specified in subsection (a)(2)(C) of this section and payment shall be made to an extended care facility (subject to the provisions of section 1812) for posthospital extended care services which are furnished by such facility to such individual if—

"(1) the certification referred to in subsection (a)(2)(C) of this section is submitted for approval in timely fashion prior to the time of admission of such individual to such extended care facility, and

"(2) such certification is accompanied by (A) a plan of treatment for providing such services, and (B) as may be required by regulations, an estimate of the period for which such services will be required, and

"(3) there has not been a finding prior to or at the time of such admission by a review group desig-

nated by the Secretary that such individual does not require the care specified in subsection (a)(2)(C) of this section,

but only for services furnished—

"(4) during the first ten days of the individual's stay in the extended care facility, or

"(5) if less, during such period as may be certified under subparagraph (2)(B) or as may be approved by the review group under paragraph (3).

A similar presumption and payment for services furnished thereafter (for such number of days as are specifically approved by the review group) shall be made pursuant to the preceding sentence if, prior to the third day before the last day for which such payment may be made or (if earlier) a day specified by such review group, appropriate medical and related evidence is submitted on the basis of which such review group finds that such individual continues to require for a period determined in accordance with paragraph (4) or (5) the care specified in subsection (a)(2)(C) of this section; except that where such evidence is submitted in timely fashion but does not support such a finding, payment may be made for such services as are furnished by such extended care facility before the third day after the day on which such facility receives notice of the review group's determination.

"Payment for Posthospital Home Health Services

"(i) An individual shall be presumed to require the services specified in subsection (a)(2)(D) of this section and payment shall be made 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—

"(1) the certification and plan referred to in subsection (a)(2)(D) of this section, accompanied by such estimate of the number of visits which will be required by such individual as may be required in regulations, is submitted in timely fashion prior to the first visit by such agency, and

"(2) there has not been a finding prior to such first visit by a review group designated by the Secretary that such individual does not require skilled nursing care on an intermittent basis or physical or speech therapy,

but only for services furnished—

"(3) during the first ten such visits, or

"(4) if less, for such number of visits as may be certified under paragraph (1) and as may be approved by the review group under paragraph (2).

A similar presumption and payment for services furnished (for such number of visits as are specifically approved by the

review group) during subsequent visits by such agency shall be made pursuant to the preceding sentence if, prior to the seventh day before the final visit for which such payment may be made or (if earlier) a day specified by such review group, appropriate medical and related evidence is submitted on the basis of which such review group finds that such individual continues for a number of visits determined in accordance with paragraph (3) or (4) to require skilled nursing care on an intermittent basis or physical or speech therapy; except that where such evidence is submitted in timely fashion, but does not support such a finding, payment may be made for such services as are furnished by such home health agency before the day on which such agency receives notice of the review group's determination."

(3) Section 1835 of such Act is amended by adding at the end thereof the following new subsection:

"(e) An individual shall be presumed to require the services specified in subsection (a)(2)(A) of this section and payment shall be made to a home health agency (subject to the provisions of section 1832) for home health services furnished by such agency to such individual if—

"(1) the certification and plan referred to in subsection (a)(2)(A) of this section, accompanied by such estimate of the number of visits which will be required

by such individuals as may be required by regulations, is submitted in timely fashion prior to the first visit by such agency, and

"(2) there has not been a finding prior to such first visit by a review group designated by the Secretary that such individual does not require skilled nursing care on an intermittent basis or physical or speech therapy,

but only for services furnished—

"(3) during the first ten such visits, or

"(4) if less, for such number of such visits as may be certified under paragraph (1) or as may be approved by the review group under paragraph (2).

Payment for services furnished during subsequent visits (for such number of visits as are specifically approved by the review group) by such agency shall be made pursuant to the preceding sentence if, prior to the seventh day before the final visit for which such payment may be made or (if earlier) a day specified by such review group, appropriate medical and related evidence is submitted on the basis of which such review group finds that such individual continues to require for a number of visits determined in accordance with paragraph (3) or (4) skilled nursing care on an intermittent basis or physical or speech therapy; except that where such evidence is submitted in timely fashion, but does not support such a finding, payment may be made for such services as are furnished

by such home health agency before the day on which such agency receives notice of the review group's determination. The amendments made by this section shall apply to plans of care initiated after June 30, 1971."

PROHIBITION AGAINST REASSIGNMENT OF CLAIMS TO BENEFITS

SEC. 234. (a) Section 1842 (b) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

"(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~~ *for a service shall be made pursuant to an assignment under subparagraph (B) (ii) of paragraph (3) of this subsection or under subsection (f) of section 1870 to anyone other than the physician or other person who furnishes 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 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."

(b) Section 1902 (a) of such Act is amended—

(1) by striking out "and" at the end of paragraph (29);

(2) by striking out the period at the end of paragraph (30) and inserting in lieu thereof "; and"; and

(3) by inserting after paragraph (30) the following new paragraph:

"(31) 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."

(c) The amendment made by subsection (a) shall apply with respect to bills submitted and requests for payments made after ~~the date of the enactment of this Act~~ *February 28, 1971*. The amendments made by subsection (b) shall be effective July 1, 1971 (or earlier if the State plan so provides).

UTILIZATION REVIEW REQUIREMENTS FOR HOSPITALS AND SKILLED NURSING HOMES UNDER MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

SEC. 235. (a) (1) Section 1903 (g) of the Social Security Act (as added by section 224 (b) and amended by sections 227 (c) and 230 (c) of this Act) is further amended by striking out the period at the end of paragraph (3) and inserting in lieu thereof "; or", and by adding after paragraph (3) the following new paragraph:

"(4) with respect to any amount expended for care or services furnished under the plan by a hospital or skilled nursing home unless such hospital or skilled nursing home 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 stand-

ards and procedures and the same review committee or group) as a condition of payment under this title."

(2) Section 1902(a)(30) of such Act is amended by inserting "(including but not limited to utilization review plans as provided for in section 1903(g)(4))" after "plan" where it first appears.

(b) Section 506(f) of such Act (as added by section 224(c) and amended by sections 227(d) and 230(d) of this Act) is further amended by striking out the period at the end of paragraph (3) and inserting in lieu thereof "; or", and by adding after paragraph (3) the following new paragraph:

"(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."

(c)(1) The amendments made by subsections (a)(1) and (b) shall apply with respect to services furnished in calendar quarters beginning after June 30, 1971.

(2) The amendment made by subsection (a) (2) shall be effective July 1, 1971.

ELIMINATION OF REQUIREMENT THAT COST-SHARING CHARGES IMPOSED ON INDIVIDUALS OTHER THAN CASH RECIPIENTS UNDER MEDICAID BE RELATED TO THEIR INCOME

SEC. 236. (a) Section 1902 (a) (14) of the Social Security Act is amended to read as follows:

"(14) provide that in the case of individuals receiving aid or assistance under State plans approved under titles I, X, XIV, and 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 services furnished him under the plan;".

(b) The amendment made by subsection (a) shall be effective January 1, 1971 (or earlier if the State plan so provides).

NOTIFICATION OF UNNECESSARY ADMISSION TO A HOSPITAL OR EXTENDED CARE FACILITY UNDER MEDICARE PROGRAM

SEC. 237. (a) Section 1814 (a) (7) of the Social Security Act is amended by striking out "as described in section 1861 (k) (4)" and inserting in lieu thereof "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".

(b) The amendment made by subsection (a) shall apply with respect to services furnished after the second month following the month in which this Act is enacted.

USE OF STATE HEALTH AGENCY TO PERFORM CERTAIN FUNCTIONS UNDER MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

SEC. 238. (a) Section 1902 (a) (9) of the Social Security Act is amended to read as follows:

"(9) provide—

"(A) that the State health, *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;".

(b) Section 1902(a) of such Act (as amended by section 234(b) of this Act) is further amended—

(1) by striking out "and" at the end of paragraph (30);

(2) by striking out the period at the end of paragraph (31) and inserting in lieu thereof "; and"; and

(3) by inserting after paragraph (31) the following new paragraph:

"(32) 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 health agency, or, if the

services of another State or local agency are ~~being~~ utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), such other agency, 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."

(c) Section 505(a) of such Act is amended—

(1) by striking out "and" at the end of paragraph (13);

(2) by striking out the period at the end of paragraph (14) and inserting in lieu thereof "; and "; and

(3) by adding after paragraph (14) the following new paragraph:

"(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 health agency, or, if the services of another State or local agency are ~~being~~ utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), such other agency, will perform the function of determining whether institutions and agencies meet the requirements for participation in the program under the plan under this title."

(d) The amendments made by this section shall be effective July 1, 1971.

~~PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS~~

~~SEC. 239. (a) Title XVIII of the Social Security Act is amended by adding after section 1875 the following new section:~~

~~"PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS~~

~~"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, with respect to any health maintenance organization, a combined part A and part B, prospective, per capita rate of payment for services~~

provided for enrollees in such organization who are entitled to hospital insurance benefits under part A and enrolled for medical insurance benefits under part B.

"(2) Such rate of payment shall be determined annually in accordance with regulations, taking into account the health maintenance organization's premiums with respect to its other enrollees (with appropriate actuarial adjustments to reflect the difference in utilization between its members who are under age 65 and its members who are age 65 and over) and such other pertinent factors as the Secretary may prescribe in regulations, and shall be designed to provide payment at a level not to exceed 95 per centum of the amount that the Secretary estimates (with appropriate adjustments to assure actuarial equivalence) would be payable for services covered under this title if such services were to be furnished by other than health maintenance organizations.

"(3) The payments to health maintenance organizations under this subparagraph 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 product of (A) the number of covered enrollees of such organization for such month, and (B) the monthly premium

rate for supplementary medical insurance for such month as has been determined and promulgated under section 1839 (b) (2). The remainder of such payment shall be paid by the former trust fund.

"(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 enrollees on a per capita prepayment basis;

"(2) provides with respect to enrollees to whom this section applies (through institutions, entities, and persons meeting the applicable requirements of section 1861) all of the services and benefits covered under parts A and B of this title;

"(3) provides physicians' services directly through physicians who are either employees or partners of such organization or under an arrangement with an organized group or groups of physicians which is or are reimbursed for services on the basis of an aggregate fixed sum or on a per capita basis;

"(4) 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;

"(5) has enrolled members at least half of whom consist of individual under age 65;

"(6) has arrangements for assuring 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

"(7) has an open enrollment period at least once every two years, under which it accepts eligible persons (as defined under subsection (d)) without underwriting restrictions and on a first-come first-accepted basis up to the limit of its capacity (unless to do so would result in failure to meet the requirement of paragraph (5)).

"(e) the benefits provided to an individual under this section shall consist of—

"(1) 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 (c) of this section; and

"(2) entitlement to have payment made by such health maintenance organization to him or on his behalf for such emergency services (as defined in regulations) 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.

"(d) Subject to the provisions of subsection (c), every individual who is entitled to hospital insurance benefits under part A and is enrolled for medical insurance benefits under part B shall be eligible to enroll with a 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 de-

scribed in subsection (c), its premium rate for such enrollees shall not exceed the actuarial value of the cost-sharing provisions applicable under part A and part B.

"(2) If the health maintenance organization provides its enrollees under this section with additional services over those described in subsection (c), it shall furnish such enrollees with information as to the division of its premium rate between the portion applicable to such additional services and the portion applicable to the services described in subsection (c), subject to the limitation that the latter portion may not exceed the actuarial value of the cost-sharing provisions applicable under part A and part B."

(b) Section 1866 of such Act is amended by adding at the end thereof the following new subsection:

"(f) For purposes of this section, the term 'provider of services' shall include a health maintenance organization if such organization meets the requirements of section 1876."

(c) Notwithstanding the provisions of section 1833 of the Social Security Act, any health maintenance organization which has entered into an agreement with the Secretary pursuant to section 1866 of such Act shall, for the duration of such agreement, be entitled to reimbursement only as provided in section 1876 of such Act.

(d) The effective date of any agreement with any health maintenance organization pursuant to section 1866 of such

~~Act shall be specified in such agreement pursuant to regulations.~~

~~(c)(1) Section 1814(a) of such Act is amended by striking out "Except as provided in subsection (d)," and inserting in lieu thereof the following: "Except as provided in subsection (d) or in section 1876,".~~

~~(2) Section 1833(a) of such Act is amended by striking out "Subject to" and inserting in lieu thereof the following: "Except as provided in section 1876, and subject to".~~

~~(3) Section 1866(b)(2) of such Act is amended by inserting after "1861" in clause (B) the following: "(or of section 1876 in the case of a health maintenance organization)".~~

~~(f) The amendments made by this section shall be effective with respect to services provided on or after January 1, 1971.~~

PAYMENT TO HEALTH MAINTENANCE ORGANIZATIONS

SEC. 239. (a) Title XVIII of the Social Security Act is amended by adding after section 1875 the following new section:

"PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

"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, as provided in

this section, with respect to any health maintenance organization, a prospective 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)(A) Each such rate of payment shall be determined annually in accordance with regulations, based on established actuarial methods taking into account the health maintenance organization's premiums with respect to its other enrollees (with appropriate actuarial adjustments to reflect the difference in utilization of resources between its members who are under age 65 and its members who are age 65 or over) and such other pertinent factors as the Secretary may prescribe in regulations, and shall be designed to provide payment at a level not to exceed the lesser of—

"(i) The portion of such organization's net premium with respect to its members who are under age 65 which represents its average per capita cost of providing benefits to such members (excluding administrative expenses), adjusted to the extent necessary to reflect the difference

in utilization of services between its members who are under age 65 and its members who are age 65 or over, and also, in the selection of risk arising from underwriting procedures, plus—

"(I) A percentage of such adjusted net premium equal to the percentage by which such organization's weighted average premium with respect to its members who are under age 65 exceeds the portion of such premium which represents such organization's average per capita cost of providing services to such members and its administrative expenses, or

"(II) If less, 150 per centum of the dollar amount by which such organization's weighted average premium rate with respect to members who are under age 65 exceeds the portion of such premium rate which represents such organization's average per capita cost of providing services to them and its administrative expenses, or

"(ii) Ninety-five per centum of the amount which the Secretary estimates (with appropriate adjustment to assure actuarial equivalence) would otherwise be payable under this title for costs of such services (excluding administrative expenses) if they were furnished by other than health maintenance organizations.

"(B) In addition to the amount determined pursuant to

subparagraph (A), there shall be payable to a health maintenance organization a reasonable allowance for its administrative costs which are not normally incurred by providers of services (as defined in regulations). Such allowance shall, however, in no case exceed 95 per centum of the national average (determined on a per capita basis) of administrative costs incurred by organizations described in sections 1816 and 1842, as determined by the Secretary on the basis of recent reliable data.

"(C) If the conditions specified in subparagraph (D) are met, the Secretary may pay any health maintenance organization at the 95 per centum actuarially equivalent rate specified in clause (ii) of subparagraph (A) even though it may be larger than the rate specified in clause (i), plus an allowance for administrative expenses as specified in subparagraph (B).

"(D) Payment at the rate specified in subparagraph (C) may be made to a health maintenance organization only if such organization provides the Secretary with satisfactory assurance that any amounts attributable to the difference between payment at such rate and payment at the rate specified in subparagraph (A) will be used in full by such organization for providing its enrollees under this section benefits in addition to those specified in subsection (c) or reducing the premium rates charged to such enrollees pursuant to subsection (g).

"(3) The payments to health maintenance organizations under this subsection for each month shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as follows: The amount payable to such an organization for such a month from the Federal Supplementary Medical Insurance Trust Fund shall be equal to 200 percent of the product of (A) the number of individuals enrolled under subsection (e) with such organization for such month, and (B) the monthly premium for supplementary medical insurance applicable for such month under section 1839(b)(2). The remainder of such payment for such month to such organization shall be paid by the Federal Hospital Insurance 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 under subsection (e) on a per capita prepayment basis;

"(2) provides, to the extent applicable in subsection (c) (through institutions, entities, and persons meeting

the applicable requirements of section 1861), all of the services and benefits covered under parts A and B of this title;

"(3) provides physicians' services (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) 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;

"(5) except as provided in subsections (h) and (i), has enrolled members at least half of whom are individuals under age 65;

"(6) has arrangements for assuring that the health services required by its members are received promptly and appropriately and that the services which are received meet standards of quality which it establishes in accordance with regulations:

"(7) 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 requirement of paragraph (5)); and

"(8)(A) has an enrollment of not less than 10,000 members, or (as determined by the Secretary) is expected to have such enrollment within 3 years from the date such determination is made and (B) is expected to maintain such enrollment.

"(c) The benefits provided under this section 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 such emergency services and prescribed maintenance therapy (as defined in regulations) 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;

"(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) shall be eligible to enroll with a 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). 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 provided in section 205(g).

"(g)(1) If the health maintenance organization provided its enrollees under this section only the services described in subsection (c), its premium rate 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) A health maintenance organization may provide additional services for which premium charges may be made, but such charges must be reasonable as determined by the Secretary in accordance with regulations. If the health maintenance organization provides to its enrollees under this section services in addition to those described in subsection (c), it shall furnish such enrollees with information on the portion of its premium rate applicable to such additional services and the portion applicable to the services described in subsection (c). Such portion applicable to the services described in subsection (c) may 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.

"(h) The provisions of paragraph (5) of subsection (b) shall not apply with respect to any health maintenance organization for such period not to exceed five years from the date such organization enters into an agreement with the Secretary pursuant to subsection (j), 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 (5) within such five year period.

"(i) The Secretary may waive the requirements of paragraph (5) of subsection (b) with respect to any health maintenance organization if he finds that such organization has made reasonable efforts to achieve compliance with such paragraph and, that because of its geographic location or other circumstances beyond its control, such organization would be unable to achieve compliance with such paragraph except through a reduction of enrollment under this section.

"(j)(1) The Secretary is authorized to enter into a contract with any health maintenance organization which undertakes to provide, on a 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) Each contract under this section shall be for a term 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 health maintenance organization 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 this section.

"(3) The effective date of any contract executed pursuant to this subsection shall be specified in such contract pursuant to regulations.

"(4) Payment for services provided by any health maintenance organization to eligible enrollees under the contract shall be made pursuant to subsection (a)(2) except that if the Secretary determines within a three year period following the termination of any accounting period of any such organization that the estimates made pursuant to subsection (a)(2) were substantially incorrect, because they were based upon erroneous data or because actuarial assumptions were materially different from the actual experience with the result that such organization received substantially more or less

than it should have received pursuant to subsection (a)(2), the Secretary is authorized to make appropriate retroactive adjustments in such payments.

"(5) 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 under such contract; and

"(B) shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary."

(b) Notwithstanding the provisions of section 1814 and section 1833 of the Social Security Act, any health maintenance organization which has entered into an agreement with the Secretary pursuant to section 1876 of such Act shall, for the duration of such agreement, be entitled to reimbursement only as provided in section 1876 of such Act for individuals who are members of such organization; except that with respect to individuals who were members of such organi-

zation prior to July 1, 1971, and who, although eligible to have payment made pursuant to section 1876 of such Act for services rendered to them, chose (in accordance with regulations) not to have such payment made pursuant to such section, the Secretary shall, for a period not to exceed three years commencing on July 1, 1971, pay such organization on the basis of prospective per capita rates, determined in accordance with the provisions of section 1876(a) of such Act, with appropriate actuarial adjustments to reflect the difference in utilization of out-of-plan services between such individuals and individuals who are enrolled with such organization pursuant to section 1876 of such Act.

(c)(1) Section 1814(a) of such Act, as amended by section 226(b) of this Act, is further amended by striking out "Except as provided in subsections (d) and (g)," and inserting in lieu thereof the following: "Except as provided in subsections (d) and (g) and in section 1876,".

(2) Section 1833(a) of such Act is amended by striking out "Subject to" and inserting in lieu thereof the following: "Except as provided in section 1876 and subject to".

(d) The amendments made by this section shall be effective with respect to services provided on or after July 1, 1971.

UNIFORM HEALTH, SAFETY, ENVIRONMENTAL, AND STAFFING STANDARDS FOR EXTENDED CARE FACILITIES AND SKILLED NURSING HOMES

SEC. 240. (a) Title XI of the Social Security Act (as amended by section 221 of this Act) is further amended by adding at the end thereof the following new section:

"UNIFORM HEALTH, SAFETY, ENVIRONMENTAL, AND STAFFING STANDARDS FOR EXTENDED CARE FACILITIES AND SKILLED NURSING HOMES

"SEC. 1123. (a) If any State has a State plan approved under title XIX which imposes (as a condition for payment of skilled nursing services under the plan) on nursing homes in such State standards with respect to health, safety, environmental quality, or staffing which are higher than the standards (relating to health, safety, environmental quality, or staffing) which are imposed under title XVIII with respect to extended care facilities, the Secretary shall impose, on the extended care facilities in such State, like standards as a condition of payment under title XVIII for extended care services provided by such facilities.

"(b) In addition to the requirements imposed by law as a condition of approval of any State plan under title XIX, there is hereby imposed the requirement (and the plan shall be deemed to require) that, as a condition of payment under the plan for skilled nursing home services provided by facili-

ties in such State, such facilities must meet the standards (relating to health, safety, environmental quality, and staffing) applicable to facilities providing extended care services for which payment may be made under title XVIII, if, and to the extent that, such standards are higher than the standards (relating to health, safety, environmental quality, and staffing) which are otherwise imposed under the plan as a condition of payment thereunder for skilled nursing home services."

(b) The amendments made by subsection (a) shall be applicable with respect to skilled nursing home services provided after June 30, 1971, under a State plan approved under title XIX of the Social Security and extended care services provided after such date under title XVIII of such Act.

SIMPLIFIED REIMBURSEMENT OF EXTENDED CARE FACILITIES

SEC. 241. (a) Section 1861(v)(1) of the Social Security Act is amended by—

(a) inserting "(A)" after "(v)(1)";

(b) inserting "(B)" immediately before "Such" the first time it appears in the second paragraph thereof; and

(c) adding at the end the following new paragraph:

"(C) Such regulations may, in the case of extended care facilities in any State, provide for the use of rates, developed by the State in which such facilities are located, for the payment of the cost of

skilled nursing home 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 requirement 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 extended care 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 an extended care facility specified in clause (ii) of this subparagraph, the reasonable 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)).".

(b) The amendments made by subsection (a) shall be applicable only in the case of accounting periods beginning after June 30, 1971.

WAIVER OF REQUIREMENT OF REGISTERED PROFESSIONAL NURSES IN HOSPITALS IN RURAL AREAS

SEC. 242. Section 1861(e)(5) of the Social Security Act is amended by (1) inserting "(i)" after "(5)", (2) inserting "(ii)" after "and", and (3) adding at the end thereof the following: "except that the Secretary is authorized to waive the requirement of clause (i) of this paragraph for any one-year period (or less) ending no later than December 31, 1975 with respect to any institution where immediately preceding such 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, and

"(B) the failure of such institution to qualify as a hospital would seriously reduce the availability of such services to beneficiaries in such area; 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; and

"(D) the requirements of such clause (i) were met for a regular daytime shift."

INDEPENDENT PROFESSIONAL REVIEW IN INTERMEDIATE CARE FACILITIES

SEC. 243. Section 1902(a) of the Social Security Act (as amended by sections 234, 238, 251, and 253 of this Act) is further amended (A) by striking out "and" at the end of paragraph (31), (B) by striking out the period at the end of paragraph (33) and inserting in lieu of such period "; and", and (C) by adding after paragraph (32) the following new paragraph:

"(33) Effective July 1, 1971, 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; (B) for periodic inspections to be made in all 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 noninstitutional 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."

DIRECT LABORATORY BILLING OF PATIENTS

SEC. 244. (a) Section 1833(a)(1) of the Social Security Act is further amended by—

(1) striking out "and" before "(B)";

(2) inserting before the semicolon at the end thereof the following: ", and (C) 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)".

(b) Section 1833 of such Act is further amended by adding at the end thereof the following subsection:

"(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."

PROFESSIONAL STANDARDS REVIEW

SEC. 245. (a) The heading to title XI of the Social Security Act is amended by striking out

"TITLE XI—GENERAL PROVISIONS"

and inserting in lieu thereof

"TITLE XI—GENERAL PROVISIONS AND PROFESSIONAL STANDARDS REVIEW

"PART A—GENERAL PROVISIONS".

(b) Title XI of such Act is further amended by adding after section 1123 thereof (as added by section 240(a) of this Act) the following:

"PART B—PROFESSIONAL STANDARDS REVIEW

"DECLARATION OF PURPOSE

"SEC. 1151. In order to promote the effective, efficient, and economical delivery of health care services for which

payment may be made (in whole or in part) under title XVIII, or under State plans approved under title XIX, and in recognition of the interests of patients and the public 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 standards 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, 1972, 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 thereafter enter into an agreement with a qualified organization whereby such an organization shall be designated 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) a nonprofit professional association (i) (or a component organization thereof) which is composed of physicians engaged in the practice of medicine or surgery in such area, (ii) the membership of which includes a substantial proportion of all such physicians in such area, and (iii) which has 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, or

"(B) such other public, nonprofit private, or other agency or organization, which the Secretary determines, in accordance with criteria prescribed by him in regulations, to be of professional competence and otherwise suitable; and

"(2) which the Secretary, on the basis of his exam-

ination 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 and timely 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 agreement 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 (nor has its predecessor 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 will result in an improvement in the performance in such area of the duties and functions required of such Organizations under this part.

"(d)(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 function and such information and keep and maintain such records 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.

"(3) Any such agreement under this part with an organization shall be for a term of twelve months; except that, prior to the expiration of such term, such agreement may be terminated—

"(A) 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

"(B) 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) No Professional Standards Review Organization

shall utilize the services of any individual who is not a physician to make final determinations with respect to the professional conduct of any physician, or any act performed by any physician in the exercise of his profession.

"REVIEW PENDING DESIGNATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATION

"SEC. 1153. Pending the assumption by a Professional Standards Review Organization for any area, of 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 title XVIII, or under State plans approved under title XIX, any review with respect to such services which has not been designated by the Secretary as the responsibility of such organization, shall be reviewed in the manner otherwise provided for under law.

"TRIAL PERIOD FOR PROFESSIONAL STANDARDS REVIEW ORGANIZATION

"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 Organizations 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 the activities and functions required of Professional Standards Review Organizations under this part with respect to the review of health care services provided by physicians and other practitioners and institutional health care facilities. 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.

"(d) 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 or similar activities otherwise required under or pursuant to any provision 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 and similar activities otherwise so required, are not needed for the provision of adequate review and control.

"DUTIES AND FUNCTIONS OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

"SEC. 1155. (a)(1) 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 providers of health care services in the provision of health care services for which payment may be made (in whole or in part) under title XVIII, or under State plans

approved under title XIX, for the purpose of determining whether—

"(A) such services are or were medically necessary;

"(B) the quality of such services meets professionally recognized standards of health care; and

"(C) in case such services are proposed to be provided in a hospital or other health care facility on an in-patient basis, such services could, consistent with the provision of appropriate medical care, be effectively provided on an out-patient 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, 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 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.

"(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, if he or any member of his family has, directly or indirectly, any financial interest in such institution. 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 physical facilities in which care is rendered or services provided (which are located in such area) of any practitioner or provider.

"(c) 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 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 feasible, medical periodicals and similar publications to publicize the functions and activities of Professional Standards Review Organizations.

"(d)(1) Each Professional Standards Review Organization is authorized to utilize the services of, and accept the findings of, the review committees of hospitals located in the area served by such Organization, but only when and only to the extent that such committees have demonstrated to the satisfaction of such Organization their capacity effectively and in timely fashion to review activities in such hospitals (including the medical necessity of admissions, services ordered, and lengths of stay) so as to aid in accomplishing the purposes and responsibilities described in subsection (a)(1).

"(2) Each Professional Standards Review Organization is authorized to utilize the services of medical societies and similar organizations to assist such Organization in performing one or more of its professional review activities, but only when and only to the extent that such societies or other organizations have demonstrated to the satisfaction of such Organization their capacity effectively and in timely fashion to perform such activities so as to aid in accomplishing the purposes described in subsection (a)(1).

"(3) The Secretary may prescribe regulations to carry out the provisions of this subsection.

"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 and treatment based upon typical patterns of practice in their region (including 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 and treatment. Where the actual norms of care and treatment in a Professional Standards Review Organization area are significantly different from professionally developed regional norms of care 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 such unusual norms in the area concerned, the Professional Standards Review Organization may apply such actual norms in such area as are approved by the National Professional Standards Review Council.

"(b) Any such norm with respect to treatment for any particular illness or health condition 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, are considered within the range of appropriate 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 title XVIII, or under State plans approved under title XIX, 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 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 criterion 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 in-patient care in a health care institution, at which the physician attending such patient shall execute a certification stating that further in-patient 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 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 institu-

tions 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 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.

"REQUIREMENT OF REVIEW APPROVAL AS CONDITION OF PAYMENT OF CLAIMS

"SEC. 1158. Notwithstanding any other provision of law, no Federal funds appropriated under any title of this

Act for the provision of health care services shall be used (directly or indirectly) for the payment, under any such title or any program established pursuant thereto, of any claim for the provision of such services if—

"(1) the provision of such services is subject to review 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 giving rise to such claim, and has, prior to the provision of such services, notified the practitioner or provider providing such services and the individual to receive such services of its disapproval of the provision of such services to such individual.

"NOTICE TO CLAIMS PAYMENT AGENCY OF DISAPPROVAL OF SERVICES

"SEC. 1159. 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 furnished by any practitioner or provider, such organization shall promptly notify the agency or organization having responsibility for acting upon claims for payment for or on account of such services.

"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) who provides health care services for which payment may be made (in whole or in part) under title XVIII, or under any State plan approved under title XIX, to assure that services ordered or provided by such practitioner or person—

"(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 it shall be the obligation of any health care practitioner, in ordering, authorizing, directing, or arranging for the provision by any other person (including a hospital or other health care facility) 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 will be provided—

"(C) only when, and to the extent, medically necessary; and

"(D) 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 an 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 in-patient in or to continue as an in-patient in any hospital or other health care facility unless—

"(A) in-patient 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 in-patient 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 avail-

able 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 recommendation to the Secretary pursuant to section 1157 (which report and recommendation shall be submitted through the Statewide Professional Standards Review Council 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 title XVIII, or under any State plan approved under title XIX, 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 determination 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 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) 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. (a) Whenever any Professional Standards Review Organization takes any action or makes any determination—

"(1) which denies any request, by a health care practitioner or other provider of health care services, for approval of a health care service proposed to be ordered or provided by such practitioner or provider; or

"(2) 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—

"(A) one representative from and designated by each Professional Standards Review Organization in the State;

"(B) 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

"(C) 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, to coordinate the activities of, and disseminate information and data among, the various Professional Standards Review Organizations within such State.

"(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 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.

"(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, 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, 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 and assist 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 title XIX, 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 State plans approved under title XIX 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, 1972; 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, 1972, 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, 1971.

"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 usage of existing mechanical and other data-gathering capacity), between—

"(A)(i) agencies and organizations which are parties to agreements entered into pursuant to section 1816, (ii) carriers which are parties to contracts entered into pursuant to section 1842, and (iii) 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 title XIX.

"PROHIBITION AGAINST DISCLOSURE OF INFORMATION

"SEC. 1166. (a) Any data or information acquired by any 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 (A) to the extent that may be necessary to carry out the purposes of this part or (B) 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 crimi-

nal 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).

"(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 health care practitioner and no provider 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 accepted norms of care and treatment applied by a Professional Standards Review Organization operating in the area where such practitioner 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 health care practitioner 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—

"(1) funds in the Federal Hospital Insurance Trust Fund;

"(2) funds in the Federal Supplementary Medical Trust Funds; and

"(3) funds appropriated to carry out the provisions of title XIX;

in such amounts from each of the sources of funds (referred

to in clauses (1), (2), and (3)) 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—

"(1) express a desire to be designated as a Professional Standards Review Organization; and

"(2) the Secretary determines 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.

"AUTHORIZATION OF DEMONSTRATION PROJECTS

"SEC. 1170. (a) In order to determine the feasibility and potential economies of methods whereby Professional Standards Review Organizations, in addition to their responsibilities under this part, assume responsibility and risk with

respect to the review and payment of claims for health care services, payment for which may be made (in whole or in part) under any program established by or pursuant to this Act, the Secretary is authorized to enter into agreements in periods ending not later than December 31, 1975, with such number of Professional Standards Review Organizations, in the same or in different areas of the Nation, as may be necessary to permit adequate and proper comparison of results, with respect to the review and payment of claims for such services, as between areas in which risk is assumed by Professional Standards Review Organizations and areas in which such risk is not assumed by such organizations. The Secretary shall submit reports to the Congress on the results of such demonstration projects from time to time but not less than annually.

"(b)(1) The Secretary shall undertake such agreements with Professional Standards Review Organizations which indicate willingness and capacity to assume responsibility for review and full payment for all care and services for which beneficiaries or recipients resident in such geographic areas are eligible. Reimbursement to such Professional Standards Review Organizations for such commitments may be on a capitation, prepayment, insured or related basis for renewable contract periods not in excess of one year. Such amounts may not, on an annualized basis for

the initial agreement period, exceed per capita beneficiary costs in the geographic area concerned during the 12-month period prior to the effective date of the agreement. For any subsequent periods the base 12-month period per capita beneficiary costs shall also be applicable and adjusted by appropriate factors representing unit cost increases in covered services.

"(2) Where such agreements are negotiated, provision shall be made for assumption of risk by the underwriting Professional Standards Review Organizations through agreement to make contingent payment for physicians' services of not in excess of 80 per centum of the amounts otherwise allowable for such services in the absence of such agreement.

"(3) From any amounts remaining at the end of the agreement period, provision shall be made for equal division of such amounts between the Secretary (and the State in the case of a federally matched program) and the Professional Standards Review Organizations. The amounts actually paid to the Professional Standards Review Organizations from the divided excess may not exceed the 20 per centum of otherwise allowable amounts withheld plus an incentive payment not in excess of 25 per centum of the total amounts allowable and payable for physicians' services during that year. Any remaining amounts of the Professional

Standards Review Organizations calculation in excess shall revert to the Secretary or to the State in the case of a federally matched health care program.

"(4) Any deficit shall be assumed by the Secretary or State agency in order to assure beneficiaries and recipients of payment for necessary care. The Professional Standards Review Organizations shall not be entitled to the 20 per centum of the otherwise allowable amounts for physicians' services withheld in such period. In any subsequent year, the Secretary shall recover from any excess amounts remaining such additional amounts as had been paid by him or by a State agency to eliminate deficits in prior periods before calculation of any payments of withheld and incentive amounts to the Professional Standards Review Organizations.

"EXEMPTION OF CHRISTIAN SCIENCE SANATORIUMS

"SEC. 1171. 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."

PART C—MISCELLANEOUS AND TECHNICAL PROVISIONS

COVERAGE PRIOR TO APPLICATION FOR MEDICAL ASSISTANCE

SEC. 251. (a) Section 1902 (a) of the Social Security Act (as amended by sections ~~234 (b)~~ ~~and~~ ~~238 (b)~~ *234(b), 238(b) and 243* of this Act) is further amended—

(1) by striking out "and" at the end of paragraph ~~(31)~~ *(32)*;

(2) by striking out the period at the end of paragraph ~~(32)~~ *(33)* and inserting in lieu thereof "; and"; and

(3) by inserting after paragraph ~~(32)~~ *(33)* the following new paragraph:

"~~(33)~~ *(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."

(b) The amendments made by subsection (a) shall be effective July 1, 1971.

HOSPITAL ADMISSIONS FOR DENTAL SERVICES UNDER MEDICARE PROGRAM

SEC. 252. (a) Section 1814 (a) (2) of the Social Security Act is amended by striking out "or" at the end of subparagraph (C), by adding "or" after the semicolon at the end of subparagraph (D), and by inserting after subparagraph (D) the following new subparagraph:

"(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;".

(b) Section 1861(r) of such Act ~~is~~ *(as amended by sections 203 and 205 of this Act) is further* amended by inserting after "or any facial bone" the following: ", or (C) the certification required by section 1814(a)(2)(E) of this Act,".

(c) Section 1862(a)(12) of such Act is amended by inserting before the semicolon the following: ", 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".

(d) The amendments made by this section shall apply with respect to admissions occurring after the second month following the month in which this Act is enacted.

EXEMPTION OF CHRISTIAN SCIENCE SANATORIUMS FROM CERTAIN NURSING HOME REQUIREMENTS UNDER MEDICAID PROGRAMS

SEC. 253. (a) Section 1902(a) of the Social Security Act is amended by adding at the end thereof the following new sentence: "For purposes of paragraphs (26), (28)(B), (D), and (E), and (29), and of section 1903(g)

(4), the terms 'skilled nursing home' and 'nursing home' do not include a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts."

(b) Section 1908 (g) (1) of such Act is amended by inserting after "Secretary" the following: ", but does not include a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts".

(c) The amendments made by this section shall be effective on the date of the enactment of this Act.

PHYSICAL THERAPY *AND OTHER* SERVICES UNDER MEDICARE PROGRAM

~~SEC. 254. (a) (1) Section 1861 (p) of the Social Security Act is amended by adding at the end thereof (after and below paragraph (4) (B)) the following new sentence: "Under regulations, the term 'outpatient physical therapy services' also includes physical therapy services furnished an individual by a physical therapist (in his office or in such individual's home) who meets licensing and other standards prescribed by the Secretary in regulations, otherwise than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health agency, if the furnishing of such services meets such conditions relating to health and safety as the Secretary may find necessary."~~

~~(2) Section 1833 of such Act is amended by adding at the end thereof the following new subsection:~~

~~"(g) In the case of services described in the next to last sentence of section 1861(p), with respect to expenses incurred in any calendar year, no more than $100 shall be considered as incurred expenses for purposes of subsections (a) and (b).~~"

~~(3) Section 1833(a)(2) of such Act (as amended by section 230(b) of this Act) is further amended by striking out the period at the end of subparagraph (B) and inserting in lieu thereof "; or", and by adding after subparagraph (B) the following new subparagraph:~~

~~"(C) if such services are services to which the next to last sentence of section 1861(p) applies, the reasonable charges for such services.~~"

~~(4) Section 1832(a)(2)(C) of such Act is amended by striking out "services." and inserting in lieu thereof "services, other than services to which the next to last sentence of section 1861(p) applies.~~"

~~(b)(1) Section 1861(p) of such Act (as amended by subsection (a)(1) of this section) is further amended by adding at the end thereof the following new sentence: "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 extended care facility.~~"

SEC. 254. (a)(1) Section 1861(p) of the Social Security Act is amended by adding at the end thereof (after and below paragraph (4)(B)) the following new sentence: "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 extended care facility."

(2) Section 1835(a)(2)(C) of such Act is amended by striking out "on an outpatient basis".

~~(c)~~ *(b)* Section 1861(v) of such Act (as amended by sections 221(c)(4) and 223(f) of this Act) is further amended by redesignating paragraphs (5) and (6) as paragraphs (6) and (7), respectively, and by inserting after paragraph (4) the following new paragraph:

~~"(5) Where physical therapy services are furnished by a provider of services or other organization specified in the first sentence of section 1861(p), or by others under an arrangement with such a provider or other organization, the amount included in any payment to such provider or organization under this title as the reasonable cost of such services shall not exceed an amount equal to the salary which would reasonably have been paid for such services to the person performing them if they had been performed in an employ-~~

~~ment relationship with such provider or organization rather than under such arrangement."~~

"(5) Where physical therapy services, occupational therapy services or other therapy services or services of other health-related personnel (other than physicians) are furnished by a provider of services, or other organization specified in the first sentence of section 1861(p), or by others under an arrangement with such a provider or other organization, the amount included in any payment to such provider or organization under this title as the reasonable cost of such services shall not exceed an amount equal to the salary which would reasonably have been paid for such services to the person performing them if they had been performed in an employment relationship with such provider or organization (rather than under such arrangement) plus the cost of such other expenses incurred by such person not working as a full-time employee, as the Secretary may in regulations determine to be appropriate."

~~(d) (1) The amendments made by subsections (a) and (b) shall apply with respect to services furnished on or after January 1, 1971.~~

(c)(1) The amendments made by subsection (a) shall apply with respect to services furnished after June 30, 1971.

(2) The amendments made by subsection ~~(c)~~ *(b)* shall be effective with respect to accounting periods beginning on or after ~~January 1~~ *June 30*, 1971.

EXTENSION OF GRACE PERIOD FOR TERMINATION OF SUPPLEMENTARY MEDICAL INSURANCE COVERAGE WHERE FAILURE TO PAY PREMIUMS IS DUE TO GOOD CAUSE

SEC. 255. (a) Section 1838(b) of the Social Security Act is amended by striking out "(not in excess of 90 days)" in the third sentence, and by adding at the end thereof the following new sentence: "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."

(b) The amendments made by subsection (a) shall apply with respect to nonpayment of premiums which become due and payable on or after the date of the enactment of this Act or which became payable within the 90-day period immediately preceding such date; and for purposes of such amendments any premium which became due and payable within such 90-day period shall be con-

sidered a premium becoming due and payable on the date of the enactment of this Act.

EXTENSION OF TIME FOR FILING CLAIM FOR SUPPLEMENTARY MEDICAL INSURANCE BENEFITS WHERE DELAY IS DUE TO ADMINISTRATIVE ERROR

SEC. 256. (a) Section 1842(b)(3) of the Social Security Act (as amended by section 224(a) of this Act) is further amended by adding at the end thereof the following new sentence: "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."

(b) The amendment made by subsection (a) shall 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. 257. (a) Section 1837 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(f) In any case where the Secretary finds that an individual's enrollment or nonenrollment in the insurance program established by this part is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Department of Health, Education, and Welfare, 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."

(b) The amendment made by subsection (a) shall be effective as of July 1, 1966.

ELIMINATION OF PROVISIONS PREVENTING ENROLLMENT IN SUPPLEMENTARY MEDICAL INSURANCE PROGRAM MORE THAN THREE YEARS AFTER FIRST OPPORTUNITY

SEC. 258. Section 1837 (b) of the Social Security Act is amended to read as follows:

"(b) No individual may enroll under this part more than twice."

WAIVER OF RECOVERY OF INCORRECT PAYMENTS FROM SURVIVOR WHO IS WITHOUT FAULT UNDER MEDICARE PROGRAM

SEC. 259. (a) Section 1870(c) of the Social Security Act is amended by striking out "and where" and inserting in lieu thereof the following: "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".

(b) The amendment made by subsection (a) shall apply with respect to waiver actions considered after the date of the enactment of this Act.

REQUIREMENT OF MINIMUM AMOUNT OF CLAIM TO ESTABLISH ENTITLEMENT TO HEARING UNDER SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

SEC. 260. (a) Section 1842(b)(3)(C) of the Social Security Act is amended by inserting after "a fair hearing by the carrier" the following: ", in any case where the amount in controversy is $100 or more,".

(b) The amendment made by subsection (a) shall apply with respect to hearings requested (under the procedures established under section 1842(b)(3)(C) of the

Social Security Act) after the date of the enactment of this Act.

COLLECTION OF SUPPLEMENTARY MEDICAL INSURANCE PREMIUMS FROM INDIVIDUALS ENTITLED TO BOTH SOCIAL SECURITY AND RAILROAD RETIREMENT BENEFITS

SEC. 261. (a) Section 1840 (a) (1) of the Social Security Act is amended by striking out "subsection (d)" and inserting in lieu thereof "subsections (b) (1) and (c)".

(b) Section 1840 (b) (1) of such Act is amended by inserting "(whether or not such individual is also entitled for such month to a monthly insurance benefit under section 202)" after "1937", and by striking out "subsection (d)" and inserting in lieu thereof "subsection (c)".

(c) Section 1840 of such Act is further amended by striking out subsection (c), and by redesignating subsections (d) through (i) as subsections (c) through (h), respectively.

(d) (1) Section 1840 (e) of such Act (as so redesignated) is amended by striking out "subsection (d)" and inserting in lieu thereof "subsection (c)".

(2) Section 1840 (f) of such Act (as so redesignated) is amended by striking out "subsection (d) or (f)" and inserting in lieu thereof "subsection (c) or (e)".

(3) Section 1840 (h) of such Act (as so redesignated)

is amended by striking out "(c), (d), and (e)" and inserting in lieu thereof "(c), and (d)".

(4) Section 1841 (h) of such Act is amended by striking out "1840 (e)" and inserting in lieu thereof "1840 (d)"

(e) Section 1841 of such Act is amended by adding at the end thereof the following new subsection:

"(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 in making deductions 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 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."

(f) The amendments made by this section shall apply with respect to premiums becoming due and payable after ~~the fourth month following the month in which this Act is enacted~~ *June 30, 1971.*

PAYMENT FOR CERTAIN INPATIENT HOSPITAL SERVICES FURNISHED OUTSIDE THE UNITED STATES

SEC. 262. (a) Section 1814 (f) of the Social Security Act is amended to read as follows:

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

"(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 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 in a place within the United States 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)."

(b) Section 1861 (e) of such Act is amended—

(1) by striking out "except for purposes of sections 1814 (d) and 1835 (b)" and inserting in lieu thereof "except for purposes of sections 1814 (d), 1814 (f), and 1835 (b)";

(2) by inserting ", section 1814 (f) (2)," immediately after "For purposes of sections 1814 (d) and 1835 (b) (including determinations of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections)"; and

(3) by inserting after the third sentence the following new sentence: "For purposes of section 1814 (f) (1), such term includes an institution which (i) is a hospital for purposes of section 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."

~~(c) Section 1862 (a) (4) of such Act is amended by striking out "emergency".~~

(c)(1) Section 1862(a)(4) of such Act is amended by—

(1) striking out "emergency"; and

(2) inserting after "1814(f)" the following: "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;".

(2) Section 1861(r) of such Act (as amended by sections 203, 205(a), and 252(b) of this Act) is further amended by adding the following sentence: "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."

(3) Section 1842(b)(3)(B)(ii) of such Act is amended by striking out "service;" and inserting in lieu thereof the following: "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));"

(4) Section 1833(a)(1) of such Act (as amended by section 244(a) of this Act) is further amended by striking out "and" before "(C)", and by inserting before the semicolon at the end thereof the following: ", and (D) 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".

(d) The amendments made by this section shall apply to services furnished with respect to admissions occurring after ~~December 31, 1970~~ *June 30, 1971.*

~~STUDY OF CHIROPRACTIC COVERAGE~~

~~SEC. 263. The Secretary, utilizing the authority conferred by section 1110 of the Social Security Act, shall conduct a study of the coverage of services performed by chiropractors under State plans approved under title XIX of such Act in order to determine whether and to what extent such services should be covered under the supplementary medical insurance program under part B of title XVIII of such Act, giving particular attention to the limitations which should be placed upon any such coverage and upon payment therefor. Such study shall include one or more experimental, pilot, or demonstration projects designed to assist in providing under controlled conditions the information necessary to achieve the objectives of the study. The Secretary shall report the results of such study to the Congress within two~~

~~years after the date of the enactment of this Act, together with his findings and recommendations based on such study (and on such other information as he may consider relevant concerning experience with the coverage of chiropractors by public and private plans).~~

MISCELLANEOUS TECHNICAL AND CLERICAL AMENDMENTS

SEC. ~~264~~ *263.* (a) Clause (A) of section 1902 (a) (26) of the Social Security Act is amended by striking out "evaluation" and inserting in lieu thereof "evaluation)", and by striking out "care)" and inserting in lieu thereof "care".

(b) Section 1908 (d) of such Act is amended by striking out "subsection (b) (1)" and inserting in lieu thereof "subsection (c) (1)".

(c) Section 408 (f) of such Act is amended by striking out "522 (a)" and inserting in lieu thereof "422 (a)".

PROGRAM FOR DETERMINING QUALIFICATIONS FOR CERTAIN HEALTH CARE PERSONNEL

SEC. 264. Title XI of the Social Security Act is amended by adding after section 1123 (as added by section 240(a) of this Act) and before section 1151 (as added by section 245 (b) of this Act) the following new section:

"PROGRAM FOR DETERMINING QUALIFICATIONS FOR CERTAIN HEALTH CARE PERSONNEL

"SEC. 1124. (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, 1975, 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, X-ray technicians, psychiatric technicians or other health care technicians and technologists) to perform the duties and functions of practical nurses, therapists, laboratory technicians, X-ray technicians, psychiatric technicians, or other health care technicians or 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 ap-

proved 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. 265. (a) Title XI of the Social Security Act is amended by adding after section 1124 (as added by section 264 of this Act) and before section 1151 (as added by section 245(b) of this Act) the following new section:

"INSPECTOR GENERAL FOR HEALTH ADMINISTRATION

"SEC. 1125. (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, 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 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 (i) in the case of any existing regulation, the Secretary may, at any time after any such suspension by the Inspector General, issue an order revoking such suspension, and (ii) in the case of a suspension of a practice or procedure or the application of a proposed regulation, the Secretary may, at any time later than 30 days after any such suspension by the Inspector General, issue an order revoking such suspension.

"(B) Whenever the Secretary issues an order revoking any such 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 of such order and shall submit to each such committee information explaining his reasons for the issuance of such order.

"(f)(1) The Inspector General may, from time to time, submit such reports to the Committee on Finance of the Senate and the Committee 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 procedures 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 of such order and shall submit to each such Committee information explaining his reasons for the issuance of such order.

"(g) The Inspector General may make expenditures (not in excess of $50,000 in any fiscal year) of a confiden-

tial 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.

"(h)(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.

"(i) The Secretary shall provide the Inspector General

and his staff with appropriate 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."

(b) Section 5315 of title 5, United States Code, is amended by inserting:

"(93) Inspector General for Health Administration."

immediately below

"(92) Executive Vice President, Overseas Private Investment Corporation."

INCREASE IN LIMITATION ON PAYMENTS TO PUERTO RICO FOR MEDICAL ASSISTANCE

SEC. 266. (a) Section 1108(c)(1) of the Social Security Act is amended by striking "$20,000,000" and inserting in lieu thereof "$30,000,000".

(b) The amendment made by this section shall apply with respect to fiscal years beginning after June 30, 1971.

ESTABLISHMENT OF PRIORITIES FOR SCREENING OF CHILDREN UNDER MEDICAL ASSISTANCE PROGRAMS

SEC. 267. Section 1905(a)(4)(B) of the Social Security Act is amended by inserting immediately after the semi-

colon at the end thereof the following: "and, in order to assure the orderly implementation of this subclause (B), such regulations shall establish priorities with respect to the screening of eligible individuals in order of age groups;".

TREATMENT IN MENTAL HOSPITALS FOR INDIVIDUALS UNDER AGE 21

SEC. 268. (a) Section 1905(a) of the Social Security Act is amended—

(1) by striking the word "and" in paragraph (14);

(2) by redesignating paragraph (15) as paragraph (17);

(3) by inserting after paragraph (14) the following new paragraph:

"(15) effective July 1, 1971, inpatient psychiatric hospital services for individuals under 21, as defined in subsection (c);".

(b) Section 1905 of such Act is further amended by adding after subsection (b) the following new subsection:

"(c)(1) For purposes of paragraph (15) of subsection (a), the term '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, equivalent to standards applicable with respect to inpatient psychiatric hospital services under title XVIII, as may be prescribed 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 services included under paragraph (1) is less than the average quarterly amount of the funds expended, during the 4-quarter period ending December 31, 1970, by the State (and the political subdivisions thereof) from non-Federal funds for such services."

(c) Section 1905(a) is further amended by striking out, in the part which follows paragraph (17) (as redesignated by subsection (a) of this section), "except that"

and inserting in lieu thereof "except as otherwise provided in paragraph (15),".

INCLUSION UNDER MEDICAID OF CARE IN INTERMEDIATE CARE FACILITIES

SEC. 269. (a) Section 1905(a) of the Social Security Act is amended by inserting after clause (15) (as added by section 268 of this Act) the following new clause:

"(16) effective July 1, 1971, 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)(33)(A), to be in need of such care;".

(b) Section 1905 of such Act is amended by adding at the end thereof the following new subsections:

"(d) For purposes of this title the term 'intermediate care facility' means an institution or distinct part thereof which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing home is designed to provide, but who because of their mental or physical condition require care and services (beyond the level of room and board) which can be made available to them only through institutional facilities, (2) has on its staff at least one full-time licensed practical nurse, (3) meets such standards prescribed by the

Secretary as he finds appropriate for the proper provision of such care, and (4) meets such standards of safety and sanitation as are applicable to nursing homes under State law. 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 (e), any public institution or distinct part thereof for mental diseases or mental defects. Clause (2) shall not apply to any such institution or distinct part thereof which meets the requirements of subsection (e).

"(e) The term 'intermediate care facility services' may include services in a public institution (or distince 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."

(c) Effective July 1, 1971, section 1121 of such Act is repealed.

USE OF CONSULTANTS FOR EXTENDED CARE FACILITIES

SEC. 270. Section 1864(a) of the Social Security Act is amended by adding at the end the following new sentence: "Any State agency which has such an agreement may, subject to approval of the Secretary, furnish to an extended care facility, after proper request by such facility, such specialized consultative services (which such agency is able and willing to furnish) 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."

TERMINATION OF NATIONAL ADVISORY COUNCIL ON NURSING HOME ADMINISTRATION

SEC. 271. Section 1908(f)(5) of the Social Security Act is amended by striking out "December 31, 1971" and inserting in lieu thereof "December 31, 1970".

AUTHORITY FOR MISSOURI TO MODIFY ITS MEDICAL ASSISTANCE PROGRAM: REPEAL OF SECTION 1902(d) OF THE SOCIAL SECURITY ACT

SEC. 272. (a) The State of Missouri is hereby authorized to modify its State plan approved under title XIX of the Social Security Act, effective for the fourth-quarter period commencing July 1, 1970, in accordance with the provisions of section 1902(d) of such Act (but without application of clause (1) of the first sentence thereof).

(b) Section 1902(d) of the Social Security Act is repealed.

PENALTIES FOR FRAUDULENT ACTS AND FALSE REPORTING UNDER MEDICARE AND MEDICAID

SEC. 273. (a) Section 1872 of the Social Security Act is amended by striking out "208,".

(b) Title XVIII of the Social Security Act is amended by adding at the end thereof (after section 1876 added to such Act by section 239(a) of this Act) the following new section:

"PENALTIES

"SEC. 1877 (a) The provisions of section 208 of this Act shall apply with respect to this title to the same extent as they are applicable with respect to title II, except that in the case of penalties applicable to this title, such penalties

shall be a fine of not more than $10,000 or imprisonment for not more than one year, or both.

"(b) Notwithstanding the provisions of subsection (a), any provider of services, supplier, physician, or other person who 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 as a hospital, extended care 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."

(c) Title XIX of such Act is amended by adding after section 1908 the following new section:

"PENALITIES

"SEC. 1909. (a) Any person who 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.

"(b) 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

as a hospital, skilled nursing home, 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) The provisions of subsection (a) shall not be applicable to any acts, statements, or representations made or committed prior to the enactment of this Act.

PUBLIC ACCESS TO RECORDS CONCERNING AN INSTITUTION'S QUALIFICATION

SEC. 274. Section 1866 of the Social Security Act is amended by (1) redesignating subsection (e) as subsection (f) and (2) inserting after subsection (d) the following new subsection:

"(e) If the Secretary finds that a hospital or extended care facility which has entered into an agreement under this section has failed to comply with one or more of the applicable provisions of section 1861 and regulations issued thereunder, but that such failure is not sufficient to justify a termination of such agreement, he shall notify such hospital or extended care facility of such failure. If after a reasonable length of time, not to exceed 90 days from the date of such notification, such failure still exists, the Secretary shall make public (as provided in regulation) in readily available form and place information as to such failure by such hospital or extended care facility."

LIEN IN FAVOR OF UNITED STATES WHERE OVERPAYMENT DETERMINED

SEC. 275. Title XVIII of the Social Security Act is amended by adding at the end thereof (after section 1877 added to such Act by section 273 of this Act) the following new section:

"LIEN IN FAVOR OF UNITED STATES WHERE OVERPAYMENT IS DETERMINED

"SEC. 1878. (a) Where the Secretary determines that a provider of services or other person who has furnished items or services to an individual is indebted to the United States by reason of payments made to such provider or other person under this title, and after demand by the Secretary, the provider of services or other person neglects or refuses to pay the amount of such indebtedness, such amount (including any interest) shall be a lien in favor of the United States upon all property and rights to property, whether real or personal, belonging to such provider or person.

"(b) Unless another date is specifically fixed by law, the lien imposed by subsection (a) shall arise at the time the Secretary makes the demand referred to in such subsection (a) and shall continue until the liability for the amount determined to be due the United States (or a judgment against the provider or person arising out of an action pursuant to subsection (d)) is satisfied or becomes unenforceable by reason of lapse of time.

"(c) The provisions of section 6323 (relating to the validity and priority against certain persons) and section 6325 (relating to release of lien or discharge of property) of the Internal Revenue Code of 1954 shall be applicable to the lien imposed by subsection (a) of this section in the same manner, to the same extent, and under the same conditions as such sections 6323 and 6325 are applicable to the lien imposed by section 6321 of such code, and for purposes of this section, the following terms used in such sections 6323 and 6325 shall have the meanings assigned to them in this subsection—

"(1) the term 'lien imposed by section 6321' shall mean 'the lien imposed by subsection (a)';

"(2) the term 'Secretary or his delegate' shall mean the 'Secretary of Health, Education, and Welfare';

"(3) the term 'tax lien filing' shall mean the 'filing of notice of the lien imposed by subsection (a)';

"(4) the terms 'lien imposed with respect to any internal revenue tax' or 'lien imposed by this chapter' shall mean 'lien imposed under subsection (a)';

"(5) reference to the assessment of an amount or the assessment of a tax shall be a reference to the amount determined due by the Secretary with respect to which a lien is imposed under subsection (a).

"(d) In the case of any provider of services or other

persons furnishing services under this title with respect to whose property or rights to property a lien has been filed pursuant to this section and who is dissatisfied with such filing, such provider or person shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for a 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(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). In any such hearing, such provider or person shall have the right to challenge the Secretary's determination of overpayment which gave rise to the filing of such lien and the burden of proof shall be upon the provider or person challenging the Secretary's determination of overpayment."

EXTENSION OF TITLE V TO AMERICAN SAMOA AND THE TRUST TERRITORY OF THE PACIFIC ISLANDS

SEC. 276. (a) Section 1101(a)(1) of the Social Security Act is amended by adding at the end thereof the following sentence: "Such term when used in title V also includes American Samoa and the Trust Territory of the Pacific Islands."

(b) Section 1108(d) is amended by inserting, after "allot such smaller amount to Guam", the following: ", American Samoa, and the Trust Territory of the Pacific Islands".

(c) The amendments made by this section shall apply with respect to fiscal years beginning after June 30, 1971.

RELATIONSHIP BETWEEN MEDICAID AND COMPREHENSIVE HEALTH CARE PROGRAMS

SEC. 277. Section 1902(a)(23) of the Social Security Act is amended by adding at the end thereof the following: "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 excess of 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;"

REFUND OF EXCESS PREMIUMS UNDER MEDICARE

SEC. 278. Section 1870 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(g) If an individual, who is enrolled under section 103 (d) of the Social Security Amendments of 1965 or under section 1837, 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 sentence such premiums shall be refunded to the person or persons in the priorities specified in paragraphs (2) through (7) of subsection (e)."

CLARIFICATION OF MEANING OF "PHYSICIANS' SERVICES" UNDER TITLE XIX

SEC. 279. Section 1905(a)(5) of the Social Security Act is amended by inserting "furnished by a physician (as defined in section 1861(r)(1))" after "physicians' services".

CHIROPRACTORS' SERVICES UNDER MEDICAID

SEC. 280. (a) Section 1905 of the Social Security Act (as amended by sections 268(b), 269(b), and 279 of this Act) is further amended by adding after subsection (d) the following new subsection:

"(e) 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.

(b) The amendment made by this section shall be effective with respect to services furnished after June 30, 1971.

PROVIDER REIMBURSEMENT APPEALS BOARD

SEC. 281. (a) Title XVIII of the Social Security Act is amended by inserting after section 1878 (as added by section 275 of this Act) the following new section:

"PROVIDER REIMBURSEMENT APPEALS BOARD

"SEC. 1879. (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 the Provider Reimbursement Appeals Board (hereinafter referred to as 'the Board') 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 reasonable cost of the items and services furnished to individuals for which payment may be made under this title for the period covered by such report, or

"(B) has not received such final determination

from such intermediary within ninety days from the date of 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 within ninety days of filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply, and

"(2) the amount in controversy is $10,000 or more, and

"(3) such provider files a request for a hearing within 180 days after—

"(A) notice of the intermediary's final determination under paragraph (1)(A), or

"(B) the filing of the cost report under paragraph (1)(B), or

"(C) the filing of the supplementary cost report under paragraph (1)(C).

"(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 inadmissable under rules of evidence applicable to court procedure.

"(d) A decision by the Board shall be based upon the record made 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 revise 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 service) even though such matters were not considered by the intermediary in making such final determination. Where the Board grants a hearing pursuant to subparagraphs (B) and (C) of paragraph (1) of subsection (a) it shall have the power to make a final determination with respect to the cost report to the same extent as the fiscal intermediary.

"(e) The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the

provisions of this title, 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 to subpenas 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 and shall be affirmed by the Secretary within 60 days after the date such decision is made unless the Secretary, on his own motion, and within a 90-day period after the provider of services in notified of the Board's decision, reverses or modifies adversely to such provider the Board's decision. In any case where such reversal or modification or nonaffirmation occurs the provider of services may obtain a review of such decision by a civil action commenced within sixty 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 findings 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.

"(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 service. Two of such members shall be selected from representatives of organizations representing providers of services. Such members shall be persons knowledgeable in the field of cost reimbursement, at least one of whom shall be a certified public accountant, and shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the rate specified (at the time service is rendered by such members) for grade GS-18 in title 5, section 5332. The term of office shall be three years, except that the Secretary shall appoint initial members of the Board for shorter terms to the extent necessary to permit staggered terms of office."

(b) The amendments made by this section shall apply with respect to cost reports of providers of services, as defined in title XVIII of the Social Security Act, for accounting periods ending after June 30, 1971.

LIMITATION ON ADJUSTMENT OR RECOVERY OF INCORRECT PAYMENTS UNDER THE MEDICARE PROGRAM

SEC. 282. (a)(1) Section 1870(b)(1) of the Social Security Act is amended by—

(A) inserting "(A)" after "the Secretary determines"; and

(B) inserting at the end of paragraph (1) the following:

"(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".

(2) Section 1870(b) of such Act is amended by adding at the end the following new sentence: "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."

(b) Section 1870(c) of such Act is amended by—

(1) inserting "or title XVIII" after "title II", and

(2) adding at the end the following new sentence: "Adjustment or recovery of an incorrect payment (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."

(c) Section 1866 (a)(1) of such Act is amended by—

(1) redesignating subparagraph (B) as subparagraph (C), and

(2) inserting after subparagraph (A) the following new subparagraph:

"(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 paragraphs (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, and".

(d) Section 1842(b)(3)(ii) of such Act is amended by—

(1) inserting "(I)" after "of which"; and

(2) inserting after "service" the following: "and (II) the physician or other person furnishing such serv-

ice 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 were 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 was made subsequent to the third year following the year in which notice of such payment was sent to such individual".

(e) Section 1814(a)(1) of such Act is amended to read as follows:

"(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 administration so requires, such period may be reduced to not less than 1 calendar year;"

(f) Section 1835(a)(1) of such Act is amended to read as follows:

"(1) written request, signed by such individual, ex-

cept 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 administration so requires, such period may be reduced to not less than 1 calendar year; and"

(g) The provisions of subsections (a), (b), (c), and (d) of this section shall apply in the case of notices of payment sent to individuals after 1968. The provisions of subsections (e) and (f) shall apply in the case of requests for payment filed after December 31, 1971.

PROVIDE FOR 75 PERCENT MATCHING UNDER MEDICAID OF EXPENDITURES FOR PROFESSIONAL REVIEW OF SKILLED NURSING HOMES AND INTERMEDIATE CARE FACILITIES

SEC. 283. Section 1903(a)(2) of the Social Security Act is amended—

(1) by inserting "(A)" immediately after "attributable to", and

(2) by inserting immediately before "; plus" the following: "and (B) payment for professional review activities, performed by skilled professional medical personell and staff directly supporting such personell pursuant to section 1902(a) (26) and (33), regardless of whether such activities are performed by State agency personnel or by others under an arrangement with such agency".

TITLE III—TRADE ACT OF 1970

PART A—AMENDMENTS TO THE TRADE EXPANSION ACT OF 1962

SUBPART 1—TRADE AGREEMENTS

SEC. 301. BASIC AUTHORITY FOR TRADE AGREEMENTS.

(a) Section 201(a)(1) of the Trade Expansion Act of 1962 (19 U.S.C. 1821(a)(1)) is amended by striking out "July 1, 1967" and inserting in lieu thereof "July 1, 1975".

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

"(1) decreasing any rate of duty—

"(A) in order to carry out a trade agreement entered into before July 1, 1967, to a rate below 50 percent of the rate existing on July 1, 1962; or

"(B) in order to carry out a trade agreement entered into after June 30, 1967, and before July 1, 1975, to a rate below the lower of—

"(i) the rate 20 percent below the rate existing on July 1, 1967; or

"(ii) the rate 2 percent ad valorem (or ad valorem equivalent) below the rate existing on July 1, 1967; or".

(c) Section 201 of such Act is amended by adding at the end thereof the following new subsection:

"(c) No proclamation pursuant to subsection (a) shall be made in order to carry out a trade agreement entered into after June 30, 1967, and before July 1, 1975, except to proclaim (1) increased or additional import restrictions and (2) such modifications as may be necessary to fulfill concessions granted as compensation for import restrictions imposed by the United States."

(d) Sections 202, 211 (a) and (e), 212, 213(a), and 221 of such Act are each amended by striking out "201 (b)(1)" and inserting in lieu thereof "201(b)(1)(A)".

(e) Section 256 of such Act (19 U.S.C. 1886) is amended by adding at the end thereof the following new paragraph:

"(8) The term 'existing on July 1, 1967', as applied to a rate of duty, refers to the lowest nonpreferential rate of duty (however established, and even though temporarily suspended by Act of Congress or otherwise) existing on such date or (if lower) the lowest nonpreferential rate to which the United States was committed on July 1, 1967, and with respect to which a proclamation was in effect on July 1, 1970."

SEC. 302. STAGING REQUIREMENTS.

(a) Section 253(a) of the Trade Expansion Act of 1962 (19 U.S.C. 1883) is amended by striking out "trade agreement under this title" and inserting in lieu thereof "trade agreement entered into before July 1, 1967, under this title".

(b) Section 253(c) of such Act is amended by striking out "trade agreement entered into under section 201(a)" and inserting in lieu thereof "trade agreement entered into before July 1, 1967, under this title".

(c) Section 253 of such Act is amended by redesignating subsection (d) as subsection (e) and by inserting after subsection (c) the following new subsection:

"(d) Except as otherwise provided in section 254, the aggregate reduction in the rate of duty on any article which is in effect on any day pursuant to a trade agreement entered into under this title after June 30, 1967, and before July 1,

1975, shall not exceed the aggregate reduction which would have been in effect on such day if—

"(1) one-half of the aggregate reduction under such agreement for such article had taken effect on the date of the first proclamation pursuant to section 201(a) to carry out such trade agreement, and

"(2) the remaining one-half of such aggregate reduction had taken effect 1 year after the date referred to in paragraph (1).

In applying the preceding sentence to any article, if, on the date referred to in paragraph (1) of the preceding sentence, there remained reductions pursuant to a prior trade agreement which had not yet taken effect, such remaining reductions shall be deemed to be included within the aggregate reduction under the trade agreement entered into after June 30, 1967, and before July 1, 1975."

(d) Subsection (e) of such section 253 (as redesignated by subsection (c) of this section) is amended—

(1) by striking out "a reduction takes effect" and inserting in lieu thereof "a reduction under any trade agreement entered into under this title takes effect"; and

(2) by striking out "subsection (c)" in paragraph (2) thereof and inserting in lieu thereof "subsection (c) or (d)(2)".

SEC. 303. FOREIGN IMPORT RESTRICTIONS AND DISCRIMINATORY ACTS.

(a) Section 252(a)(3) of the Trade Expansion Act of 1962 (19 U.S.C. 1882(a)(3)) is amended by striking out the word "agricultural" each place it appears.

(b) Section 252(b) of such Act is amended by striking out "or" at the end of paragraph (1), by adding "or" at the end of paragraph (2), and by adding after paragraph (2) the following new paragraph:

"(3) provides subsidies (or other incentives having the effect of subsidies) on its exports of one or more products to other foreign markets which unfairly affect sales of the competitive United States product or products to those other foreign markets,".

(c) Section 252(b) of such Act is further amended by striking out "or" at the end of clause (A), by striking out the period at the end of clause (B) and inserting in lieu thereof ", or", and by adding at the end thereof the following new clause:

"(C) notwithstanding any provision of any trade agreement under this Act and to the extent he deems necessary and appropriate, impose duties or other import restrictions on the products of any foreign country or instrumentality maintaining such nontariff trade restrictions, engaging in such acts or policies, or providing such incentives when he deems such duties and other im-

port restrictions necessary and appropriate to prevent the establishment or obtain the removal of such restrictions, acts, policies, or incentives and to provide access for United States products to foreign markets on an equitable basis."

(d) Section 252(c) of such Act is amended by striking out "President may" and inserting in lieu thereof "President shall".

(e) Section 252(c)(1) of such Act is amended to read as follows:

"(1) impose duties or other import restrictions on, or suspend, withdraw, or prevent the application of trade agreement concessions to, products of such country or instrumentality, or".

(f) Section 252(d) of such Act is amended to read as follows:

"(d)(1) Upon request of any interested party, the Secretary of Commerce shall immediately make an investigation to determine whether any specified restriction established or maintained by, act engaged in, or subsidy provided by a foreign country or instrumentality constitutes—

"(A) a foreign import restriction referred to in subsection (a),

"(B) a nontariff trade restriction, discriminatory or other act, or subsidy or other incentive referred to in subsection (b), or

"(C) an unreasonable import restriction referred to in subsection (c).

"(2) Within 3 months after the submission of a request under paragraph (1), the Secretary of Commerce shall publish in the Federal Register the results of the investigation made pursuant to such request, together with his findings with respect thereto. In any case in which the Secretary makes an affirmative determination of a restriction, act, or subsidy referred to in subsection (a), (b), or (c) he shall immediately report such finding to the President. Within 3 months after receipt of such report, the President shall report to the Congress the action taken by him under subsection (a), (b), or (c) with respect to such restriction, act, or subsidy."

(g) The heading of such section is amended to read as follows:

"SEC. 252. FOREIGN IMPORT RESTRICTIONS AND DISCRIMINATORY ACTS."

SEC. 304. DETERMINATIONS AND IMPORT ADJUSTMENTS FOR SAFEGUARDING NATIONAL SECURITY.

(a) The second sentence of section 232(b) of the Trade Expansion Act of 1962 (19 U.S.C. 1862(b)) is amended by striking out the period at the end thereof and inserting the following: ": Provided, however, That any adjustment of imports shall not be accomplished by the imposition or increase of any duty, or of any fee or charge having the effect of a duty."

(b) Section 232(b) of such Act is further amended by adding at the end thereof the following new sentence: "In the case of any investigation under this subsection initiated by request or application, the Director shall make and announce the determination required by this subsection not later than 1 year after the date on which such request or application was made."

(c) The amendment made by subsection (b) shall apply with respect to requests or applications made to the Director of the Office of Emergency Preparedness under section 232(b) of the Trade Expansion Act of 1962 on or after January 1, 1968; except that, in the case of such a request or application made more than 1 year before the date of the enactment of this Act, the determination required by such section 232(b) shall be made on or before the 60th day after such date of enactment.

SUBPART 2—TARIFF ADJUSTMENT AND ADJUSTMENT ASSISTANCE

SEC. 311. PETITIONS AND DETERMINATIONS.

(a) Section 301 of the Trade Expansion Act of 1962 (19 U.S.C. 1901) is amended to read as follows:

"SEC. 301. PETITIONS AND DETERMINATIONS.

"(a)(1) A petition for tariff adjustment under section 351 may be filed with the Tariff Commission by a trade association, firm, certified or recognized union, or other representative of an industry.

"(2) A petition for a determination of eligibility to

apply for adjustment assistance under chapter 2 may be filed with the President by a firm or its representative, and a petition for a determination of eligibility to apply for adjustment assistance under chapter 3 may be filed with the President by a group of workers or by their certified or recognized union or other duly authorized representative. A petition filed under this paragraph by or on behalf of a group of workers shall apply only with respect to individuals who are, or who have been within 1 year before the date of filing of such petition, employed regularly in the firm involved.

"(b)(1) Upon the request of the President, upon resolution of either the Committee on Finance of the Senate or the Committee on Ways and Means of the House of Representatives, upon its own motion, or upon the filing of a petition under subsection (a)(1), the Tariff Commission shall promptly make an investigation to determine whether an article upon which a concession has been granted under a trade agreement is, as a result, in whole or in part, of the duty or other customs treatment reflecting such concession, being imported into the United States in such increased quantities, either actual or relative, as to contribute substantially (whether or not such increased imports are the major factor or the primary factor) toward causing or threatening to cause serious injury to the domestic industry producing articles like or directly competitive with the imported article.

"(2) In arriving at a determination under paragraph

(1), the Tariff Commission, without excluding other factors, shall take into consideration a downward trend of production, prices, profits, or wages in the domestic industry concerned, a decline in sales, an increase in unemployment or underemployment, an increase in imports, either actual or relative to domestic production, a higher or growing inventory, and a decline in the proportion of the domestic market supplied by domestic producers.

"(3) For purposes of paragraph (1), the term 'domestic industry producing articles like or directly competitive with the imported article' means that portion or subdivision of the producing organizations manufacturing, assembling, processing, extracting, growing, or otherwise producing like or directly competitive articles in commercial quantities. In applying the preceding sentence, the Tariff Commission shall (so far as practicable) distinguish or separate the operations of the producing organizations involving the like or directly competitive articles referred to in such sentence from the operations of such organizations involving other articles.

"(4) If a majority of the Commissioners present and voting make an affirmative injury determination under paragraph (1), the Commissioners voting for such affirmative injury determination shall also determine the amount of the increase in, or imposition of, any duty or other import restriction on such article which is necessary to prevent or remedy such injury. For purposes of this title, a remedy

determination by a majority of the Commissioners voting for the affirmative injury determination shall be treated as the remedy determination of the Tariff Commission.

"(5) If a majority of the Commissioners present and voting make an affirmative injury determination under paragraph (1), the Commissioners voting for such affirmative injury determination shall make an additional determination under this paragraph which shall consist of determining whether the article is being imported in such quantities, and disposed of in the United States under such conditions, as to acutely or severely injure the domestic industry or threaten to acutely or severely injure the domestic industry. For purposes of section 351(a), an affirmative determination under this paragraph by a majority of the Commissioners voting for the affirmative injury determination under paragraph (1) shall be treated as an additional affirmative determination of the Tariff Commission.

"(6) In the course of any proceeding initiated under paragraph (1), the Tariff Commission shall investigate any factors which in its judgment may be contributing to increased imports of the article under investigation; and, whenever in the course of its investigation the Tariff Commission has reason to believe that the increased imports are attributable in part to circumstances which come within the purview of the Antidumping Act, 1921, section 303 or 337 of the Tariff Act of 1930, or other remedial provisions of

law, the Tariff Commission shall promptly notify the appropriate agency and take such other action as it deems appropriate in connection therewith.

"(7) In the course of any proceeding initiated under paragraph (1), the Tariff Commission shall, after reasonable notice, hold public hearings and shall afford interested parties opportunity to be present, to present evidence, and to be heard at such hearings.

"(8) The Tariff Commission shall report to the President the determinations and other results of each investigation under this subsection, including any dissenting or separate views, and any action taken under paragraph (6).

"(9) The report of the Tariff Commission of its determinations under this subsection shall be made at the earliest practicable time, but not later than 6 months after the date on which the petition is filed (or the date on which the request or resolution is received or the motion is adopted, as the case may be). Upon making such report to the President, the Tariff Commission shall promptly make public such report, and shall cause a summary thereof to be published in the Federal Register.

"(10) No investigation for the purposes of this subsection shall be made, upon petition filed under subsection (a)(1), with respect to the same subject matter as a previous investigation under this subsection, unless 1 year has elapsed

since the Tariff Commission made its report to the President of the results of such previous investigation.

"(c)(1) In the case of a petition by a firm for a determination of eligibility to apply for adjustment assistance under chapter 2, the President shall determine whether an article like or directly competitive with an article produced by the firm, or an appropriate subdivision thereof, is being imported into the United States in such increased quantities, either actual or relative, as to contribute substantially (whether or not such increased imports are the major factor or the primary factor) toward causing or threatening to cause serious injury to such firm or subdivision. In making such determination the President shall take into account all economic factors which he considers relevant, including idling of productive facilities, inability to operate at a level of reasonable profit, and unemployment or underemployment.

"(2) In the case of a petition by a group of workers for a determination of eligibility to apply for adjustment assistance under chapter 3, the President shall determine whether an article like or directly competitive with an article produced by such workers' firm, or an appropriate subdivision thereof, is being imported into the United States in such increased quantities, either actual or relative, as to contribute substantially (whether or not such increased imports are the major factor or the primary factor) toward causing or threatening to cause unemployment or underemployment of

a significant number or proportion of the workers of such firm or subdivision.

"(3) In order to assist him in making the determinations referred to in paragraphs (1) and (2) with respect to a firm or group of workers, the President shall promptly transmit to the Tariff Commission a copy of each petition filed under subsection (a)(2) and, not later than 5 days after the date on which the petition is filed, shall request the Tariff Commission to conduct an investigation relating to questions of fact relevant to such determinations and to make a report of the facts disclosed by such investigation. In his request, the President may specify the particular kinds of data which he deems appropriate. Upon receipt of the President's request, the Tariff Commission shall promptly institute the investigation and promptly publish notice thereof in the Federal Register.

"(4) In the course of any investigation under paragraph (3), the Tariff Commission shall, after reasonable notice, hold a public hearing, if such hearing is requested (not later than 10 days after the date of the publication of its notice under paragraph (3)) by the petitioner or any other interested person, and shall afford interested persons an opportunity to be present, to produce evidence, and to be heard at such hearing.

"(5) The report of the Tariff Commission of the facts disclosed by its investigation under paragraph (3) with re-

spect to a firm or group of workers shall be made at the earliest practicable time, but not later than 60 days after the date on which it receives the request of the President under paragraph (3)."

(b)(1) For purposes of section 301(b)(1) of the Trade Expansion Act of 1962, reports made by the Tariff Commission during the 1-year period ending on the date of the enactment of this Act shall be treated as having been made before the beginning of such period.

(2) Any investigation by the Tariff Commission under subsection (b) or (c) of section 301 of the Trade Expansion Act of 1962 (as in effect before the date of the enactment of this Act) which is in progress immediately before such date of enactment shall be continued under such subsection (b) or (c) (as amended by subsection (a) of this section) in the same manner as if the investigation had been instituted originally under the provisions of such subsection (b) or (c) (as so amended). For purposes of section 301(b)(9) or (c)(5) of the Trade Expansion Act of 1962 (as added by subsection (a) of this section) the petition for any investigation to which the preceding sentence applies shall be treated as having been filed, or the request or resolution as having been received or the motion having been adopted, as the case may be, on the date of the enactment of this Act.

(3) If, on the date of the enactment of this Act, the

President has not taken any action with respect to any report of the Tariff Commission containing an affirmative determination resulting from an investigation undertaken by it pursuant to section 301(c)(1) or (2) of the Trade Expansion Act of 1962 (as in effect before the date of the enactment of this Act) such report shall be treated by the President as a report received by him under section 301(c)(5) of the Trade Expansion Act of 1962 (as added by subsection (a) of this section) on the date of the enactment of this Act.

(4) No petition may be filed under section 301(a) of the Trade Expansion Act of 1962 during the period beginning on the date of the enactment of this Act and ending on the 90th day after such date or, if earlier, on the 10th day after the date of publication of rules and regulations prescribed by the Tariff Commission to carry out its duties and functions under section 301 of such Act (as amended by subsection (a) of this section).

SEC. 312. PRESIDENTIAL ACTION WITH RESPECT TO ADJUSTMENT ASSISTANCE.

(a) Section 302(a) of the Trade Expansion Act of 1962 (19 U.S.C. 1902(a)) is amended to read as follows:

"(a)(1) If after receiving a report from the Tariff Commission containing an affirmative injury determination under section 301(b) with respect to any industry, the Presi-

dent provides tariff adjustment for such industry pursuant to section 351 or 352, he may—

"(A) provide, with respect to such industry that its firms may request the Secretary of Commerce for certifications of eligibility to apply for adjustment assistance under chapter 2,

"(B) provide, with respect to such industry, that its workers may request the Secretary of Labor for certifications of eligibility to apply for adjustment assistance under chapter 3, or

"(C) provide that both firms and workers may request such certifications.

"(2) If after receiving a report from the Tariff Commission containing an affirmative injury determination under section 301(b) with respect to any industry the President does not provide tariff adjustment for such industry pursuant to section 351 or 352, he shall promptly provide that both firms and workers of such industry may request certifications of eligibility to apply for adjustment assistance under chapters 2 and 3.

"(3) Notice shall be published in the Federal Register of each action taken by the President under this subsection in providing that firms or workers may request certifications of eligibility to apply for adjustment assistance. Any request for such a certification must be made to the Secretary con-

cerned within the 1-year period (or such longer period as may be specified by the President) after the date on which such notice is published."

(b) Section 302(b) of such Act is amended—

(1) by striking out "subsection (a)(2)," in paragraph (1) and inserting in lieu thereof "subsection (a),";

(2) by striking out "subsection (a)(3)," in paragraph (2) and inserting in lieu thereof "subsection (a),"; and

(3) by adding at the end of paragraph (2) thereof the following new sentence: "A certification under this paragraph shall apply only with respect to individuals who are, or who have been, employed regularly in the firm involved within 1 year before the date of the institution of the Tariff Commission investigation under section 301(b) relating to the industry with respect to which the President has acted under subsection (a)."

(c) Section 302(c) of such Act is amended to read as follows:

"(c)(1) After receiving a report of the Tariff Commission of the facts disclosed by its investigation under section 301(c)(3) with respect to any firm or group of workers, the President shall make his determination under section 301 (c)(1) or (c)(2) at the earliest practicable time, but

not later than 30 days after the date on which he receives the Tariff Commission's report, unless, within such period, the President requests additional factual information from the Tariff Commission. In this event, the Tariff Commission shall, not later than 25 days after the date on which it receives the President's request, furnish such additional factual information in a supplemental report, and the President shall make his determination not later than 15 days after the date on which he receives such supplemental report.

"(2) The President shall promptly publish in the Federal Register a summary of each determination under section 301(c) with respect to any firm or group of workers.

"(3) If the President makes an affirmative determination under section 301(c) with respect to any firm or group of workers, he shall promptly certify that such firm or group of workers is eligible to apply for adjustment assistance.

"(4) The President is authorized to exercise any of his functions with respect to determinations and certifications of eligibility of firms or workers to apply for adjustment assistance under section 301 and this section through such agency or other instrumentality of the United States Government as he may direct."

(d) The heading of such section 302 is amended to read as follows:

"SEC. 302. PRESIDENTIAL ACTION WITH RESPECT TO ADJUSTMENT ASSISTANCE."

SEC. 313. TARIFF ADJUSTMENT.

(a) Paragraphs (1) and (2) of section 351(a) of the Trade Expansion Act of 1962 (19 U.S.C. 1981(a)) are amended to read as follows:

"(1)(A) After receiving an affirmative injury determination of the Tariff Commission under paragraph (1) of section 301(b), which is not combined with an additional affirmative determination of the Tariff Commission under paragraph (5) of section 301(b), the President shall proclaim such increase in, or imposition of, any duty or other import restriction on the article concerned as he determines to be necessary to prevent or remedy serious injury to the industry, unless he determines that such action would not be in the national interest.

"(B) After receiving an affirmative injury determination of the Tariff Commission under paragraph (1) of section 301(b) which is combined with an additional affirmative determination of the Tariff Commission under paragraph (5) of section 301(b), the President shall proclaim the increase in, or imposition of, any duty or other import restriction on the article concerned determined and reported by the Tariff Commission pursuant to section 301(b), unless

he determines that such action would not be in the national interest.

"(2) If the President does not, within 60 days after the date on which he receives an affirmative injury determination, proclaim the increase in, or imposition of, any duty or other import restriction on such article determined and reported by the Tariff Commission pursuant to section 301 (b)—

"(A) he shall immediately submit a report to the House of Representatives and to the Senate stating why he has not proclaimed such increase or imposition, and

"(B) such increase or imposition shall take effect (as provided in paragraph (3)) upon the adoption by both Houses of Congress (within the 60-day period following the date on which the report referred to in subparagraph (A) is submitted to the House of Representatives and the Senate), by the yeas and nays by the affirmative vote of a majority of the authorized membership of each House, of a concurrent resolution stating in effect that the Senate and House of Representatives approve the increase in, or imposition of, any duty or other import restriction on the article determined and reported by the Tariff Commission pursuant to section 301(b).

Nothing in subparagraph (A) shall require the President to state considerations of national interest on which his decision was based. For purposes of subparagraph (B), in the computation of the 60-day period there shall be excluded the days on which either House is not in session because of adjournment of more than 3 days to a day certain or an adjournment of the Congress sine die. The report referred to in subparagraph (A) shall be delivered to both Houses of the Congress on the same day and shall be delivered to the Clerk of the House of Representatives if the House of Representatives is not in session and to the Secretary of the Senate if the Senate is not in session."

(b) Paragraph (3) of such section 351(a) is amended by striking out "found and reported by the Tariff Commission pursuant to section 301(e)." and inserting in lieu thereof "determined and reported by the Tariff Commission pursuant to section 301(b)."

(c) Paragraph (4) of such section 351(a) is amended by striking out "affirmative finding" each place it appears and inserting in lieu thereof "affirmative injury determination".

(d) Section 351(d) of such Act is amended to read as follows:

"(d)(1) So long as any increase in, or imposition of, any duty or other import restriction pursuant to this section

or pursuant to section 7 of the Trade Agreements Extension Act of 1951 remains in effect, the Tariff Commission shall keep under review developments with respect to the industry concerned, including the specific steps taken by the firms in the industry to enable them to compete more effectively with imports, and shall make annual reports to the President concerning such developments.

"(2) Upon request of the President or upon its own motion, the Tariff Commission shall advise the President of its judgment, in the light of specific steps taken by the firms in such industry to enable them to compete more effectively with imports and all other relevant factors, as to the probable economic effect on the industry concerned, and (to the extent practicable) on the firms and workers therein of the reduction or termination of the increase in, or imposition of, any duty or other import restriction pursuant to this section or section 7 of the Trade Agreements Extension Act of 1951.

"(3) Upon petition on behalf of the industry concerned, filed with the Tariff Commission not earlier than the date which is 1 year, and not later than the date which is 9 months, before the date any increase or imposition referred to in paragraph (1) or (2) of subsection (c) is to terminate by reason of the expiration of the applicable period prescribed in paragraph (1) or an extension thereof under paragraph (2), the Tariff Commission shall advise the

President of its judgment as to the probable economic effect on such industry of such termination. The report of the Tariff Commission on any investigation initiated under this paragraph shall be made not later than the 90th day before the expiration date referred to in the preceding sentence.

"(4) In advising the President under this subsection as to the probable economic effect on the industry concerned the Tariff Commission shall take into account all economic factors which it considers relevant, including idling of productive facilities, inability to operate at a level of reasonable profit, and unemployment or underemployment.

"(5) Advice by the Tariff Commission under this subsection shall be given on the basis of an investigation during the course of which the Tariff Commission shall hold a hearing at which interested persons shall be given a reasonable opportunity to be present, to produce evidence, and to be heard.

"(6) In the course of any investigation under this subsection, the Tariff Commission shall also determine and report to the President—

"(A) if the termination of the increase or imposition referred to in paragraph (1) or (2) of subsection (c) threatens to cause serious injury to the industry concerned, and

"(B) if the determination under subparagraph (A) is affirmative—

"(i) the limit to which such increase or imposition may be reduced without threatening to cause serious injury to the industry concerned, and

"(ii) whether, in lieu of such termination, additional increases or impositions of duties and other import restrictions are required to prevent or remedy serious injury to the industry concerned."

SEC. 314. ORDERLY MARKETING AGREEMENTS.

Section 352(a) of the Trade Expansion Act of 1962 (19 U.S.C. 1982(a)) is amended to read as follows:

"(a) If the President has received an affirmative injury determination of the Tariff Commission under section 301 (b) with respect to an industry, he may at any time negotiate international agreements with foreign countries limiting the export from such countries and the import into the United States of the article causing or threatening to cause serious injury to such industry whenever he determines that such action would be appropriate to prevent or remedy serious injury to such industry. Any agreement concluded under this subsection may replace in whole or in part any action taken pursuant to the authority contained in paragraph (1) of section 351(a); but any agreement concluded under this

subsection before the close of the period during which a concurrent resolution may be adopted under paragraph (2) of section 351(a) shall terminate not later than the effective date of any proclamation issued by the President pursuant to paragraph (3) of section 351(a)."

SEC. 315. INCREASED ASSISTANCE FOR WORKERS.

(a) Section 323(a) of the Trade Expansion Act of 1962 (19 U.S.C. 1942(a)) is amended by striking out "an amount equal to 65 percent of his average weekly wage or to 65 percent of the average weekly manufacturing wage," and inserting in lieu thereof "an amount equal to 75 percent of his average weekly wage or to 75 percent of the average weekly manufacturing wage,".

(b) The second sentence of section 326(a) of such Act is amended to read as follows: "To this end, and subject to this chapter, adversely affected workers shall be afforded, where appropriate, the testing, counseling, training, and placement services and supportive and other services provided for under any Federal law."

(c) The amendment made by subsection (a) shall apply with respect to assistance under chapter 3 of the Trade Expansion Act of 1962 for weeks of unemployment beginning on or after the date of the enactment of this Act.

SEC. 316. CONFORMING AMENDMENTS.

(a) Section 242(b)(2) of the Trade Expansion Act

of 1962 (19 U.S.C. 1872(b)(2)) is amended by striking out "section 301(e)" and inserting in lieu thereof "section 301(b)".

(b) Section 302(b)(1) of such Act (19 U.S.C. 1962 (b)) (as amended by section 512(b) of this Act) is further amended by striking out "(which the Tariff Commission has determined to result from concessions granted under trade agreements) have caused serious injury or threat thereof to such firm" and inserting in lieu thereof "have contributed substantially toward causing or threatening to cause serious injury to such firm".

(c) Section 302(b)(2) of such Act (as amended by section 512(b) of this Act) is further amended by striking out "(which the Tariff Commission has determined to result from concessions granted under trade agreements) have caused or threatened to cause unemployment or underemployment" and inserting in lieu thereof "have contributed substantially toward causing or threatening to cause unemployment or underemployment".

(d) Section 311(b)(2) of such Act is amended by striking out "by actions taken in carrying out trade agreements, and" and by inserting in lieu thereof "by the increased imports identified by the Tariff Commission under section 301(b)(1) or by the President under section 301(c)(1), as the case may be, and".

(e) Section 317(a)(2) of such Act is amended by striking out "by the increased imports which the Tariff Commission has determined to result from concessions granted under trade agreements" and inserting in lieu thereof "by the increased imports identified by the Tariff Commission under section 301(b)(1) or by the President under section 301(c)(1), as the case may be".

PART B—QUOTAS ON CERTAIN TEXTILE AND FOOTWEAR ARTICLES

SUBPART 1—TEXTILE AND FOOTWEAR ARTICLES

SEC. 321. ANNUAL QUOTAS.

(a) The total quantity of each category of textile articles (as defined in section 326(1)), and the total quantity of each category of footwear articles (as defined in section 326(2)), produced in any foreign country which may be entered during 1971 shall not exceed the average annual quantity of such category produced in such country and entered during 1967, 1968, and 1969.

(b)(1) The total quantity of each category of textile articles, and the total quantity of each category of footwear articles, produced in any foreign country which may be entered during any calendar year after 1971 shall not exceed the sum of—

(A) the total quantity determined for such category for such country under subsection (a) or this sub-

section for the immediately preceding calendar year, plus

(B) the increase (if any) applicable under paragraph (2).

(2)(A) The President may increase the total quantity of each category of textile articles, and the total quantity of each category of footwear articles, produced in any foreign country which may be entered during any calendar year after 1971 by such percentage (not to exceed 5 percent of the total quantity determined for such category for such country under subsection (a) or this subsection for the immediately preceding calendar year) as he determines to be consistent with the purposes of this section.

(B) Any increase under this paragraph for any category for any calendar year shall be the same percentage for all foreign countries.

(C) A determination shall be made under this paragraph for each category for each foreign country for each calendar year after 1971 without regard to the nonapplication (or partial nonapplication) of this subsection to such category for such country for such year by reason of subsection (d) of this section, section 322 or 323, or the Arrangement or the Agreement referred to in section 324(b).

(3) If the application of this subsection to any article produced in a foreign country begins or resumes after a

period of nonapplication which terminates on or after January 1, 1972, and if the President determines—

(A) that the average annual quantity of the article produced in such country, which was entered during 1967, 1968, and 1969 was insignificant, and

(B) that the application of this paragraph to the category which includes such article for such country is consistent with the purposes of this section,

then for the calendar year in which such termination occurs and for calendar years thereafter this subsection shall be applied by determining the total quantity for the category which includes such article for such country for the calendar year of termination as being equal to the average annual quantity of such category, produced in such country, which was entered during the 3 calendar years immediately preceding such calendar year of termination.

(c)(1) Any annual quantitative limitation under subsection (a) or (b) shall be applied on a calendar quarter or other intra-annual basis if the President determines that such application is necessary or appropriate to carry out the purposes of this section.

(2) If the application of subsection (a) or (b) to any category for any foreign country begins or resumes after the first day of any calendar year, the amount of the quantitative limitation for such category for such country for the

remainder of such calendar year shall be the annual amount determined under subsection (a) or (b), adjusted pro rata according to the number of full months remaining in the calendar year after the date of such beginning or such resumption.

(d)(1) The President may exempt from subsections (a) and (b) for an initial period of not to exceed 1 year any textile article or footwear article produced in any foreign country if he determines that imports of such article produced in such country are not contributing to, causing, or threatening to cause market disruption in the United States. The President may extend any exemption under the preceding sentence for one or more additional periods of not in excess of 1 year each if he makes the determination described in the preceding sentence before each such extension. Any exemption made under this subsection may be terminated by the President at any time upon his finding that the article covered by such exemption is contributing to, causing, or threatening to cause market disruption in the United States.

(2) The President may exempt from subsections (a) and (b) any textile article or footwear article produced in any foreign country whenever he determines that such an exemption is in the national interest. The President may terminate any exemption made by him under the preceding

sentence whenever he determines that such termination is in the national interest.

(3) No exemption, extension of an exemption, or termination of an exemption under paragraph (1) or paragraph (2) shall take effect before the 30th day after the day on which notice of such exemption, extension, or termination is published in the Federal Register.

(e) The Secretary of Commerce shall compute the quantities provided for in subsections (a) and (b).

SEC. 322. ARRANGEMENTS OR AGREEMENTS REGULATING IMPORTS.

(a) The President is authorized to conclude bilateral or multilateral arrangements or agreements with the governments of foreign countries regulating, by category, the quantities of textile articles or footwear articles, or both, produced in such foreign countries which may be exported to the United States or entered and to issue regulations necessary to carry out the terms of such arrangements or agreements. In concluding any arrangement or agreement under this subsection, the President shall take into account conditions in the United States market, the need to avoid disruption of that market, and such other factors as he deems appropriate in the national interest.

(b) Whenever a multilateral arrangement or agreement concluded under subsection (a) is in effect among the coun-

tries, including the United States, which account for a significant part of world trade in the article concerned and such arrangement or agreement contemplates the establishment of limitations on the trade in the article produced in countries not parties to such arrangement or agreement, the President may by regulation prescribe the total quantity of the article produced in each country not a party to such arrangement or agreement which may be entered; but the total quantity for any category for any country for any calendar year may not be less than the total quantity which would be permitted to be entered if section 321 (a) and (b) applied to such category for such country for such year.

(c) Section 321 shall not apply to articles produced in foreign countries which are subject to an arrangement or agreement entered into under subsection (a) or to regulations issued under subsection (b).

SEC. 323. INCREASED IMPORTS WHERE SUPPLY IS INADEQUATE TO MEET DOMESTIC DEMAND AT REASONABLE PRICES.

In carrying out sections 321 and 322, the President may authorize increased exports to the United States or increased entries in the United States of textile articles or footwear articles of any category whenever he determines that the supply of textile articles or footwear articles similar

to those subject to limitation under such sections will be inadequate to meet domestic demand at reasonable prices.

SEC. 324. EXCLUSIONS.

(a) The import restrictions provided for in this part do not apply to any article exempted from duty under part 2 of schedule 8 of the Tariff Schedules of the United States or to any article the entry of which is regulated pursuant to paragraph (4), (5), (6), or (7) of section 498(a) of the Tariff Act of 1930 (19 U.S.C. 1498(a)). To the extent provided in regulations prescribed by the Secretary of Commerce, the import restrictions provided for in this part shall not apply to other articles imported in noncommercial quantities for noncommercial purposes.

(b) This part shall not apply to (1) articles subject to the Long-Term Arrangement Regarding International Trade in Cotton Textiles, so long as the United States is a party thereto, or (2) the articles produced in the Philippines provided for in item B (cordage) in the schedule to paragraph 1 of article II of the 1955 Agreement With the Philippines Concerning Trade and Related Matters, so long as such Agreement remains in effect.

(c) Nothing in this part shall affect the authority provided for under section 22 of the Agricultural Adjustment Act of 1933, as amended.

SEC. 325. ADMINISTRATION.

(a) The rulemaking provisions of subchapter II of chapter 5 of title 5, United States Code, shall apply with respect to sections 321(b)(2), 321(b)(3), 321(d)(1), 322(b), 323, 324(a), and 326.

(b) All quantitative limitations established under this part or pursuant to any arrangement or agreement entered into under this part, all exemptions established under this part and all extensions or terminations thereof, and all regulations promulgated to carry out this part shall be published in the Federal Register. The Secretary of Commerce shall certify to the Secretary of the Treasury for each period the total quantity of each textile article and footwear article produced in each foreign country the entry of which is affected by such a quantitative limitation on importation; and the Secretary of the Treasury shall take such action as may be necessary to ensure that the total quantity so entered during such period shall not exceed the total quantity so certified.

(c) There shall be promulgated as a part of the appendix to the Tariff Schedules of the United States, Annotated, all quantitative limitations and exemptions established under this part or pursuant to any arrangement or agreement entered into under this part and all quantitative

limitations established pursuant to the Arrangement referred to in section 324(b).

SEC. 326. DEFINITIONS.

For purposes of this part—

(1) The term "textile article" includes any article if wholly or in part of cotton, wool or other animal hair, human hair, man-made fiber, or any combination or blend thereof, or cordage of hard (leaf) fibers, classified under schedule 3 of the Tariff Schedules of the United States; any article classified under subpart B or C of part 1 of schedule 7 of such Schedules if wholly or in substantial part of cotton, wool, or man-made fiber; any other article specified by the Secretary of Commerce which he has been advised by the Secretary of the Treasury would be classified under any of the foregoing provisions of such Schedules but for the inclusion of some substance, material, or other component, or because of its processing, which causes the article to be classified elsewhere; and any of the foregoing articles if entered under item 807.00 of such Schedules, or under the appendix to such Schedules; but such term does not include articles classified under any of items 300.10 through 300.50, 306.00 through 307.40, 309.60 through 309.75, and 390.10 through 390.60, inclusive, of such Schedules.

(2) The term "footwear article" includes footwear

provided for in any of items 700.05 through 700.45, inclusive, item 700.55, items 700.66 through 700.80, inclusive, and item 700.85 of the Tariff Schedules of the United States.

(3) The term "category" means a grouping of textile articles, or a grouping of footwear articles, as the case may be, as determined by the Secretary of Commerce, for the purposes of this part, using the five-digit and seven-digit item numbers applied to such articles in the Tariff Schedules of the United States, Annotated, as published by the United States Tariff Commission.

(4) The term "entered" means entered, or withdrawn from warehouse, for consumption in the customs territory of the United States.

(5) The term "produced" means manufactured or produced.

(6) The term "foreign country" includes a foreign instrumentality.

SUBPART 2—EFFECTIVE PERIOD

SEC. 331. TERMINATION OF PART, EXTENSION UNDER CERTAIN CONDITIONS.

(a) Unless extended under subsection (b), this part shall terminate on July 1, 1976.

(b) The effective period of this part may be extended in whole or in part by the President after July 1, 1976, for such

periods (not to exceed 5 years at any one time) as he may designate if he determines, after seeking advice of the Tariff Commission and of the Secretary of Commerce and of the Secretary of Labor, that such extension is in the national interest.

(c) The President shall promptly report to Congress with respect to any action taken by him under subsection (b).

(d) Nothing in this section shall affect the validity of any arrangement or agreement entered into under section 322(a) before the termination of this part or of any regulations issued under section 322 in connection with any such arrangement or agreement.

PART C—OTHER TARIFF AND TRADE PROVISIONS

SUBPART 1—AMENDMENTS TO THE ANTIDUMPING AND COUNTERVAILING DUTY LAWS

SEC. 341. ANTIDUMPING ACT, 1921.

(a) Section 201(b) of the Antidumping Act, 1921 (19 U.S.C. 160(b)) is amended to read as follows:

"(b) In the case of any imported merchandise of a class or kind as to which the Secretary has not so made public a finding, he shall, within 4 months after the question of dumping was raised by or presented to him or any person to whom authority under this section has been delegated—

"(1) determine whether there is reason to believe or suspect, from the invoice or other papers or from

information presented to him or to any other person to whom authority under this section has been delegated, that the purchase price is less, or that the exporter's sales price is less or likely to be less, than the foreign market value (or, in the absence of such value, than the constructed value); and

"(2) if his determination is affirmative, publish notice of that fact in the Federal Register, and require, under such regulations as he may prescribe, the withholding of appraisement as to such merchandise entered, or withdrawn from warehouse for consumption, on or after the date of publication of that notice in the Federal Register (unless the Secretary determines that the withholding should be made effective as of an earlier date in which case the effective date of the withholding shall be not more than 120 days before the question of dumping was raised by or presented to him or any person to whom authority under this section has been delegated), until the further order of the Secretary, or until the Secretary has made public a finding as provided for in subsection (a) in regard to such merchandise; or

"(3) if his determination is negative, publish notice of that fact in the Federal Register, but the Secretary may within 3 months thereafter order the withholding of appraisement if he then has reason to believe or sus-

pect, from the invoice or other papers or from information presented to him or to any other person to whom authority under this section has been delegated, that the purchase price is less, or that the exporter's sales price is less or likely to be less, than the foreign market value (or, in the absence of such value, than the constructed value) and such order of withholding of appraisement shall be subject to the provisions of paragraph (2).

If within 2 months after the question of dumping was raised or presented to him or any person to whom authority under this section has been delegated, the Secretary concludes that the determination required under paragraph (1) cannot reasonably be made within 4 months after the question was so raised or presented, he shall publish notice to that effect in the Federal Register and shall make such determination (and publish the notice required by paragraph (2) or (3)) within 7 months after the question was so raised or presented. For purposes of this subsection, the question of dumping shall be deemed to have been raised or presented on the date on which a notice is published in the Federal Register that information relating to dumping has been received in accordance with regulations prescribed by the Secretary."

(b) Section 205 of the Antidumping Act, 1921 (19 U.S.C. 164), is amended by inserting "(a)" immediately

after "SEC. 205.", and by adding at the end thereof the following new subsection:

"(b) If available information indicates to the Secretary that the economy of the country from which the merchandise is exported is state-controlled to an extent that sales or offers of sales of such or similar merchandise in that country or to countries other than the United States do not permit a determination of foreign market value under subsection (a), the Secretary shall determine the foreign market value of the merchandise on the basis of the normal costs, expenses, and profits as reflected by either—

"(1) the prices at which such or similar merchandise of a non-state-controlled-economy country is sold either (A) for consumption in the home market of that country, or (B) to other countries, including the United States; or

"(2) the constructed value of such or similar merchandise in a non-state-controlled-economy country as determined under section 206 of this Act."

(c)(1) Section 210 of such Act (19 U.S.C. 169) is amended by inserting "(a)" after "SEC. 210.", and by adding at the end thereof the following new subsection:

"(b) The right of protest referred to in subsection (a) includes the right of an American manufacturer, producer, or wholesaler of merchandise of the same class or kind as

foreign merchandise which is the subject of a determination by the Secretary under section 201(c)."

(2) Section 516 of the Tariff Act of 1930 (19 U.S.C. 1516) is amended by redesignating subsections (d), (e), (f), and (g) as subsections (e), (f), (g), and (h), respectively, and by inserting after subsection (c) the following new subsection:

"(d) Within 30 days after a determination by the Secretary pursuant to section 201(c) of the Antidumping Act, 1921 (19 U.S.C. 160(c)), that a class or kind of foreign merchandise is not being, nor likely to be, sold in the United States at less than its fair value, an American manufacturer, producer, or wholesaler of merchandise of the same class or kind as that described in such determination may file with the Secretary a written notice of a desire to contest such determination. Upon receipt of such notice the Secretary shall cause publication to be made of such manufacturer's, producer's, or wholesaler's desire to contest the determination and shall furnish the manufacturer, producer, or wholesaler with such information as to the entries and consignees of such merchandise, entered after the publication of the Secretary's determination at such ports of entry designated by the manufacturer, producer, or wholesaler in his notice of desire to contest, as will enable him to contest such determination with respect to such merchandise in the

liquidation of one such entry. The Secretary shall direct the appropriate customs officer at such ports to notify the manufacturer, producer, or wholesaler by mail immediately when the first of such entries is liquidated."

(3) Section 2631(b) of title 28, United States Code, is amended by striking out "516(c)" and inserting in lieu thereof "516 (c) or (d)".

(d) The amendment made by subsection (a) of this section shall take effect on the 180th day after the date of the enactment of this Act.

SEC. 342. COUNTERVAILING DUTIES.

(a) Section 303 of the Tariff Act of 1930 (19 U.S.C. 1303) is amended to read as follows:

"SEC. 303. COUNTERVAILING DUTIES.

"(a) LEVY OF COUNTERVAILING DUTIES.—(1) Whenever any country, dependency, colony, province, or other political subdivision of government, person, partnership, association, cartel, or corporation, shall pay or bestow, directly or indirectly, any bounty or grant upon the manufacture or production or export of any article or merchandise manufactured or produced in such country, dependency, colony, province, or other political subdivision of government, then upon the importation of such article or merchandise into the United States, whether the same shall be imported di-

rectly from the country of production or otherwise, and whether such article or merchandise is imported in the same condition as when exported from the country of production or has been changed in condition by remanufacture or otherwise, there shall be levied and paid, in all such cases, in addition to any duties otherwise imposed, a duty equal to the net amount of such bounty or grant, however the same be paid or bestowed. The Secretary of the Treasury shall determine, within 12 months after the date on which the question is presented to him, whether any bounty or grant is being paid or bestowed.

"(2) In the case of any imported article or merchandise which is free of duty, duties may be imposed under this section only if there is an affirmative determination by the Tariff Commission under subsection (b)(1).

"(3) The Secretary of the Treasury shall from time to time ascertain and determine, or estimate, the net amount of each such bounty or grant, and shall declare the net amount so determined or estimated.

"(4) The Secretary of the Treasury shall make all regulations he may deem necessary for the identification of such articles and merchandise and for the assessment and collection of the duties under this section. All determinations by the Secretary under this subsection and all determinations by the Tariff Commission under subsection (b)(1), whether

affirmative or negative, shall be published in the Federal Register.

"(b) INJURY DETERMINATIONS WITH RESPECT TO DUTY-FREE MERCHANDISE; SUSPENSION OF LIQUIDATION.—(1) Whenever the Secretary of the Treasury has determined under subsection (a) that a bounty or grant is being paid or bestowed with respect to any article or merchandise which is free of duty, he shall—

"(A) so advise the United States Tariff Commission, and the Commission shall determine within 3 months thereafter, and after such investigation as it deems necessary, whether an industry in the United States is being or is likely to be injured, or is prevented from being established, by reason of the importation of such article or merchandise into the United States; and the Commission shall notify the Secretary of its determination; and

"(B) require, under such regulations as he may prescribe, the suspension of liquidation as to such article or merchandise entered, or withdrawn from warehouse, for consumption, on or after the 30th day after the date of the publication in the Federal Register of his determination under subsection (a)(1), and such suspension of liquidation shall continue until the further order of the Secretary or until he has made public an

order as provided for in paragraph (2) of this subsection.

"(2) If the determination of the Tariff Commission under subparagraph (A) is in the affirmative, the Secretary shall make public an order directing the assessment and collection of duties in the amount of such bounty or grant as is from time to time ascertained and determined, or estimated, under subsection (a).

"(c) APPLICATION OF AFFIRMATIVE DETERMINATION.—An affirmative determination by the Secretary of the Treasury under subsection (a)(1) with respect to any imported article or merchandise which (1) is dutiable, or (2) is free of duty but with respect to which the Tariff Commission has made an affirmative determination under subsection (b)(1), shall apply with respect to articles entered, or withdrawn from warehouse, for consumption on or after the 30th day after the date of the publication in the Federal Register of such determination by the Secretary.

"(d) SPECIAL RULE FOR ANY ARTICLE SUBJECT TO A QUANTITATIVE LIMITATION.—No duty shall be imposed under this section with respect to any article which is subject to a quantitative limitation imposed by the United States on its importation, or subject to a quantitative limitation on its exportation to or importation into the United States imposed under an agreement to which the United States is a

party, unless the Secretary of the Treasury determines, after seeking information and advice from such agencies as he may deem appropriate, that such quantitative limitation is not an adequate substitute for the imposition of a duty under this section."

(b)(1) Except as provided in paragraph (2), the amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

(2) The last sentence of section 303(a)(1) of the Tariff Act of 1930 (as added by subsection (a) of this section) shall apply only with respect to questions presented on or after the date of the enactment of this Act.

SUBPART 2—TARIFF COMMISSION

SEC. 351. INDEPENDENT STATUS OF TARIFF COMMISSION.

Section 330 of the Tariff Act of 1930 (19 U.S.C. 1330) is amended by adding at the end thereof the following new subsection:

"(e) INDEPENDENT STATUS.—Except as otherwise specifically provided by law, the Commission shall be a Federal agency independent of the Executive departments and agencies."

SUBPART 3—STUDIES OF UNITED STATES TRADE POLICIES

SEC. 361. COMPREHENSIVE STUDY BY THE PRESIDENT.

(a) The President is authorized and directed to conduct a comprehensive study of United States international trade

policies and the position of the United States in international trade. Such study shall involve the provisions of all trade agreements and other international agreements to which the United States is a party, and the interpretations of such provisions, and shall include (but not be limited to) the following provisions of such agreements:

(1) the most favored nation principle, the special exceptions thereto, and the effect of these exceptions on United States trade and investment patterns;

(2) the provisions for export subsidies and border taxes and the rationale underlying the different treatment of direct and indirect taxes insofar as border tax adjustments are concerned;

(3) the adequacy of provisions on agricultural trade;

(4) the adequacy of provisions dealing with balance-of-payments matters;

(5) the provisions on unfair trade practices and relief from injurious imports; and

(6) the provisions on "compensation" and "retaliation".

(b) The comprehensive study required by subsection (a) shall also involve all problems and issues affecting the position of the United States in international trade and shall

include (but not be limited to) the following problems and issues:

(1) a United States negotiating position with respect to the quantitative restrictions that remain in effect in many countries;

(2) the border tax-export rebate system of the European Economic Community with particular reference to United States countervailing duty laws;

(3) the common agricultural policies of the European Economic Community;

(4) discriminatory government procurement policies;

(5) the probable effects of British entry into the European Economic Community on United States trade and balance of payments;

(6) the effect of foreign exchange rate changes on United States trade and trade concessions;

(7) an analysis of whether greater flexibility in foreign exchange rates would serve in the interests of the United States and world trade;

(8) the nature and extent to which other countries subsidize their exports directly or indirectly;

(9) a comparative analysis of various proposals to extend "tariff preferences" to the products of less developed countries with particular emphasis on the effects

on United States trade and investment patterns and on United States labor; and

(10) the various agency responsibilities within the executive branch for handling all United States foreign trade matters, and the means by which policy coordination is achieved.

(c) The President shall as soon as practicable, but not later than December 31, 1971, submit to the Congress a report of the comprehensive study required by subsection (a), together with his recommendations with respect thereto.

SEC. 362. STUDIES BY TARIFF COMMISSION.

The Tariff Commission shall conduct studies of the following matters, and submit reports thereon to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives not later than December 31, 1971:

(1) the tariff and nontariff barriers imposed by the principal trading nations among industrialized countries, including an analysis of disparities in tariff treatment of similar articles of commerce by different countries, and the reasons for the disparities;

(2) the nature and extent of the tariff concessions granted in trade agreements and other international agreements to which the United States is a party by the principal trading nations among industrialized countries;

(3) the customs valuation procedures of foreign countries and those of the United States, with a view to developing and suggesting uniform standards of custom valuation which would operate fairly among all classes of shippers in international trade, and the economic effects which would follow if the United States adopted such standards of valuation, based on rates of duty which will become effective on January 1, 1972; and

(4) the present and potential effects of the operations of multinational firms on the patterns of world trade and investment and on United States trade and labor.

SUBPART 4—MISCELLANEOUS PROVISIONS

SEC. 371. AMENDMENTS TO AUTOMOTIVE PRODUCTS ***TRADE ACT OF 1965.***

(a) Section 302(a) of the Automotive Products Trade Act of 1965 (19 U.S.C. 2022) is amended by striking out "After the 90th day after the date of the enactment of this Act and before July 1, 1968, a petition under section 301" and inserting in lieu thereof "A petition under section 301".

(b) The heading of section 302 of such Act is amended to read as follows: "SPECIAL AUTHORITY".

(c) Subsections (c), (d), and (g)(2) of section 302 of such Act are amended by striking out "the primary factor" and inserting in lieu thereof "a substantial factor".

(d) The amendments made by this section shall apply

with respect to petitions filed after the date of the enactment of this Act; except that—

(1) such amendments shall apply only with respect to dislocations which began after June 30, 1968, and

(2) such amendments shall apply with respect to dislocations which began after June 30, 1968, and before July 1, 1970, only if the petition is filed on or before the 90th day after the date of the enactment of this Act.

(e) The President shall endeavor to secure elimination by the Government of Canada of its duties and other import restrictions on automobiles produced in the United States. If the elimination of such duties and import restrictions has not been secured before January 1, 1973, the President shall consider the failure to secure such elimination as grounds (1) for terminating United States participation in the Agreement Concerning Automotive Products Between the Government of the United States of America and the Government of Canada, signed on January 16, 1965, and (2) for exercising the authority conferred on him by section 204 of the Automotive Products Trade Act of 1965 to terminate in whole or in part proclamations issued under such Act.

SEC. 372. RATES OF DUTY ON MINK FURSKINS; REPEAL ***OF EMBARGO ON CERTAIN FURS.***

(a)(1) Schedule 1, part 5, subpart B of the Tariff Schedules of the United States (19 U.S.C. 1202) is amended by inserting after item 123.50 the following:

	Furskins of mink, whether or not dressed:			
	Plates, mats, linings, strips, crosses, or similar forms, all the foregoing made wholly of heads, paws, tails, gills, and similar trimming-scrap pieces of mink furskin; and any such trimming-scrap pieces not sewn together:			
123.60	*Not dyed*	*12% ad val.*	*35% ad val.*	
123.62	*Dyed*	*14% ad val.*	*40% ad val.*	
	Other:			
	For an aggregate quantity of not over 900,000 skins (or pieces of skins) entered during any calendar quarter:			
123.70	*Raw or not dressed*	*Free*	*30% ad val.*	
	Dressed:			
	Plates, mats, linings, strips, crosses, or similar forms:			
123.72	*Not dyed*	*12% ad val.*	*35% ad val.*	
123.73	*Dyed*	*14% ad val.*	*40% ad val.*	
	Other:			
123.75	*Not dyed*	*3.5% ad val.*	*25% ad val.*	
123.76	*Dyed*	*5.5% ad val.*	*30% ad val.*	
123.78	*Other*	*25% ad val.*	*40% ad val.*	"

(2) Schedule 1, part 5, subpart B of such Schedules is further amended by striking out item 124.10 and inserting in lieu thereof the following:

	Raw or not dressed:			
124.08	*Ermine, fox, kolinsky, marten, muskrat, and weasel*	*Free*	*30% ad val.*	
124.10	*Other*	*Free*	*Free*	"

(3) Schedule 7, part 13, subpart B of such Schedules is amended by inserting after item 791.10 the following new item:

"	*791.12*	*Of mink*	*14% ad val.*	*50% ad val.*	"

(b) Headnote 4 of subpart B, part 5, schedule 1 of such Schedules is repealed.

(c) The amendments and repeal made by this section shall apply with respect to articles entered, or withdrawn from warehouse, for consumption on or after January 1, 1971.

SEC. 373. RATE OF DUTY ON GLYCINE AND CERTAIN RELATED PRODUCTS.

(a) Schedule 4, part 13, subpart B of the Tariff Schedules of the United States (19 U.S.C. 1202) is amended by inserting after item 493.35 the following new item:

"

	Aminoacetic acid (glycine) and salts thereof, and mixtures containing such acid or its salts if such acid or salts individually or in combination are the chief component by weight of such mixtures, all the foregoing however provided for elsewhere in this schedule.		
493.37	*For an aggregate quantity of not over 1,500,000 pounds entered during any calendar year of which an aggregate quantity of not over 375,000 pounds may be entered during any calendar quarter.....*	*8.5% ad val.*	*25% ad val.*
493.38	*Other.....*	*8.5% ad val. plus 25¢ per lb.*	*25% ad val. plus 25¢ per lb.*

"

(b) The amendment made by subsection (a) shall apply with respect to articles entered, or withdrawn from warehouse, for consumption, on or after January 1, 1971.

SEC. 374. PARTS OF SKI BINDINGS.

(a) Schedule 7, part 5, subpart D of the Tariff Sched-

ules of the United States is amended by renumbering item 734.97 as 734.98 and by inserting after item 734.96 the following new item:

" | 734.97 | Parts of ski bindings.....| 3% ad val.| 45% ad val.| "

(b) The amendments made by subsection (a) shall apply with respect to articles entered, or withdrawn from warehouse, for consumption on or after January 1, 1971.

(c) The rates of duty in rate column numbered 1 of the Tariff Schedules of the United States for item 734.97 (as amended by subsection (a)) shall be treated as not having the status of statutory provisions enacted by the Congress, but as having been proclaimed by the President as being required or appropriate to carry out foreign trade agreements to which the United States is a party. References to item 734.97 of such Schedules in annex III to Proclamation 3822, dated December 16, 1967, shall be treated as referring to item 734.98 of such Schedules (as renumbered by subsection (a)).

SEC. 375. INVOICE INFORMATION.

Section 481(a) of the Tariff Act of 1930 (19 U.S.C. 1481(a)) is amended—

(1) by redesignating paragraph (10) thereof as paragraph (11);

(2) by striking out "and" at the end of paragraph (9); and

(3) by inserting immediately after such paragraph (9) the following new paragraph:

"(10) Such information as to product description as is required to be made a part of the entry by provisions of the Tariff Schedules of the United States, Annotated, issued pursuant to section 484(e) of this Act; and".

SEC. 376. REPORTS OF IMPORTS AND EXPORTS.

(a) Section 301 of title 13, United States Code is amended—

(1) by inserting "(a)" before "The Secretary";

(2) by striking out "shall compile" and inserting in lieu thereof "shall, subject to the provisions of subsections (b) and (c), compile"; and

(3) by adding at the end thereof the following new subsections:

"(b) The Secretary shall publish, as promptly as possible after the close of each month and each year, information on imports by categories using the seven-digit item numbers set forth in the Tariff Schedules of the United States, Annotated, as published by the United States Tariff Commission, and showing such imports from each foreign country. In publishing any information under this chapter with respect to imports, the Secretary shall state—

"(1) the value of imported articles based on their

dutiable value as determined under section 402 or 402a of the Tariff Act of 1930, and

"(2) the purchase price (transaction value) of imported articles plus, when not included in such price, all charges, costs, and expenses incurred in bringing the imported articles to the customs territory of the United States (or, in the case of articles not acquired by purchase in an arm's-length transaction, the equivalent of such price, charges, costs, and expenses).

"(c) In publishing any information under this chapter with respect to exports, the Secretary shall state separately from the total value of all exports—

"(1)(A) the value of agricultural commodities exported under the Agricultural Trade Development and Assistance Act of 1954, as amended; and

"(B) the total amount of all export subsidies paid to exporters by the United States under such Act for the exportation of such commodities; and

"(2) the value of goods exported under the Foreign Assistance Act of 1961."

(b) Section 303 of such title is amended by—

(1) amending the section caption to read as follows: ***"Duties of the Secretaries of Treasury, Agriculture, and State"****;*

(2) by inserting (a) before "To assist"; and

(3) by adding at the end thereof the following new subsection:

"(b) To assist the Secretary to carry out the provisions of this chapter—

"(1) the Secretary of Agriculture shall furnish information to the Secretary concerning the value of agricultural commodities exported under provisions of the Agricultural Trade Development and Assistance Act of 1954, as amended, and the total amounts of all export subsidies paid to exporters by the United States under such Act for the exportation of such commodities; and

"(2) the Secretary of State shall furnish information to the Secretary concerning the value of goods exported under the provisions of the Foreign Assistance Act of 1961, as amended."

(c) The table of sections for chapter 9 of such title is amended by striking out the item relating to section 303 and inserting in lieu thereof the following:

"303. Duties of the Secretaries of Treasury, Agriculture, and State."

(d) Section 484(e) of the Tariff Act of 1930 (19 U.S.C. 1484(e)) is amended—

(1) by striking out "and" before "the value" and inserting in lieu thereof a comma; and

(2) by inserting before the period at the end thereof the following: ", and all charges, costs, and expenses incurred in bringing the imported merchandise to the customs territory of the United States".

(e) The amendments made by subsection (a) shall apply with respect to information published under the provisions of chapter 9 of title 13, United States Code, on or after July 1, 1971.

SEC. 377. CERTAIN MEAT AND MEAT PRODUCTS.

(a) Section 2(a) of the Act entitled "Act to provide for the free importation of certain wild animals, and to provide for the imposition of quotas on certain meat and meat products", approved August 22, 1964 (Public Law 88-482), is amended to read as follows:

"(a) It is the policy of the Congress that the aggregate quantity of the articles specified in—

"(1) item 106.10 of the Tariff Schedules of the United States (relating to fresh, chilled, or frozen cattle meat),

"(2) item 106.20 of such Schedules (relating to fresh, chilled, or frozen meat of goats and sheep (except lambs)), and

"(3) item 107.60 of such Schedules (relating to prepared or preserved beef and veal), but only insofar as such item relates to beef and veal which is prepared and

in a fresh, chilled, or frozen state, but not otherwise preserved,

which may be imported into the United States in any calendar year beginning after December 31, 1964, should not exceed 726,700,000 pounds; except that this quantity shall be increased or decreased for any calendar year by the same percentage that the estimated average annual domestic commercial production in that calendar year and the two preceding calendar years of articles described in items 106.10 and 106.20 of such Schedules increases or decreases in comparison with the average annual domestic commercial production of such articles during the years 1959 through 1963, inclusive."

(b) Section 2(c)(1) of such Act is amended by striking out "during such calendar year, to the aggregate quantity" and inserting in lieu thereof "during each quarter of such calendar year to one-fourth of the aggregate quantity".

(c) The amendments made by this section shall apply with respect to the calendar year 1971 and succeeding calendar years. The Secretary of Agriculture shall carry out the duties and functions imposed on him by section 2 of the Act of August 22, 1964 (as amended by this Act), with respect to the calendar year 1971 and the first quarter of such year as soon as possible after the date of the enactment of this Act.

SEC. 378. TRADE WITH FOREIGN COUNTRIES PERMITTING UNCONTROLLED PRODUCTION OF OR TRAFFICKING IN CERTAIN DRUGS.

The President of the United States shall have the authority to impose an embargo or suspension of trade with a nation which permits the uncontrolled or unregulated production of or trafficking in opium, heroin, or other poppy derivatives in a manner to permit these drug items to fall into illicit commerce for ultimate disposition and use in this country.

SUBPART 5—SHORT TITLE

SEC. 381. SHORT TITLE.

This title may be cited as the "Trade Act of 1970".

TITLE IV—CATASTROPHIC HEALTH INSURANCE PROGRAM

CATASTROPHIC HEALTH INSURANCE PROGRAM

SEC. 401. The Social Security Act, is amended by adding after title XIX the following new title:

"TITLE XX—CATASTROPHIC HEALTH INSURANCE PROGRAM

"DESCRIPTION OF PROGRAM

"SEC. 2001. The insurance program established by this title provides protection against the costs of high-cost catastrophic illnesses and establishes the conditions individuals must meet to become entitled thereto.

"ELIGIBLE INDIVIDUALS

"SEC. 2002. (a) Every individual who—

"(1) has not attained the age of 65; and

"(2) (A) is fully or currently insured (as such terms are defined in section 214 of this Act), or (B) is entitled to monthly insurance benefits under title II of this Act, or (C) is the spouse or dependent child (as defined in regulations) of an individual who is fully or currently insured, or (D) is the spouse or dependent child (as defined in regulations) of an individual entitled to monthly insurance benefits under title II of this Act; and

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

shall be entitled to catastrophic health insurance benefits provided by this title for each month in which he meets the conditions specified in paragraphs (1) and (2), beginning with the first month after December 1971 in which he meets such conditions and ending with the month in which he dies, or if earlier, the month before the month in which he no longer meets the conditions of either paragraph (1) or (2) of this subsection.

"(b) For purposes of subsection (a)—

"(1) entitlement of an individual to catastrophic health insurance benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, this title to him or on his behalf for the services described in section 2003 which are furnished him in the United States (or outside the United States in the case of services specified in section 2003(a)(2)(B)); and

"(2) in determining whether (A) an individual, who has not attained age 62, is a fully insured individual with respect to a calendar year he shall be deemed to have attained age 62 in such year and (B) an individual who is not entitled to benefits under section 202(a) is a currently insured individual with respect to a quarter, he shall be deemed to be entitled to benefits under such section in such quarter;

"(3) an individual who is not (nor deemed to be) a fully insured individual with respect to a calender year shall be deemed to be such for such calendar year and 6 months thereafter if in the preceding calendar year he was (or is deemed, pursuant to paragraph (2), to be), a fully insured individual;

"(4) an individual who is not (nor deemed to be) a currently insured individual with respect to any

quarter shall be deemed to be such for such quarter if such quarter is in the 13-quarter period following the last quarter of any such period in which he was (or is deemed, pursuant to paragraph (2), to be), a currently insured individual.

"SCOPE OF BENEFITS

"SEC. 2003. (a) The benefits provided to an individual by the insurance program under this title shall be—

"(1) hospital insurance benefits which shall consist of entitlement to have payment made on behalf of an individual for—

"(A) inpatient hospital services (as defined in section 1861(b));

"(B) post-hospital extended care services (as defined in section 1861(i) but only if with respect to at least one of the 3 days of hospitalization required by such section payment may be made pursuant to section 2004(a)(1)(A) for services furnished on such day);

"(C) home health services (as defined in 1861 (m));

"(D) outpatient physical therapy services (as defined in section 1861(p));

"(E) medical and other health services (as defined in section 1861(s), but subject to the limita-

tion and conditions prescribed in section 1832(a)(2)(B)); and

"(2) medical insurance benefits which shall consist of entitlement to have payment made to an individual or on his behalf for—

"(A) medical and other health services (as defined in section 1861(s), except those described in subsection (b)(5);

"(B) services of the type described by section 1814(d)(1) for which payment cannot be made under paragraph (1)(A) or subparagraph (A) of this paragraph solely because the hospital does not elect to claim payment, but only if the provisions of section 1814(d)(2)(B) or section 1835(b)(2)(B) are met);

"(C) services described in section 1814(f).

"(b)(1) Notwithstanding the previous provisions of this section, no payment may be made with respect to expenses incurred for items or services if pursuant to section 1802(a),(b), or (d) payment may not be made for such expenses under title XVIII.

"(2) 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, 1972, 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 the Federal employees health benefits program under chapter 89 of such title 5 has been modified so as to assure that—

"(A) there is available, to each Federal employee or annuitant who has not attained age 65, one or more health benefits plans which offer protection supplementing the protection provided by this title, and

"(B) the Government 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 contribution toward the supplementary protection referred to in subparagraph (A).

"PAYMENT, DEDUCTIBLES, AND COINSURANCE

"SEC. 2004. (a) Subject to the succeeding provisions of this section, there shall be paid from the Federal Catastrophic Health Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this title and incurs expenses for services with

respect to which benefits are payable under this title, amounts equal to—

"(1) (A) in the case of services described in subparagraph (A) of section 2003(a)(1), the reasonable cost of such services (as defined in section 1861(v)) furnished after the 60th day of inpatient hospital services (as defined in section 1861(b)) to such individual in any calendar year, reduced by a coinsurance amount equal to one-fourth of the inpatient hospital deductible (as determined under section 1813(b)(2) of the Social Security Act) for each day after such 60th day on which such individual is furnished such services, except that (i) the days on which such individual was an inpatient of a hospital in the last three months of the preceding calendar year and which were included in the 60-day period for which no benefits were payable during such calendar year shall be included in determining such 60-day period and (ii) 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);

"(B) in the case of services described in subparagraph (B) of section 2003(a)(1), the reasonable cost of such services (as defined in section 1861(v)) reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible (as determined under section 1813(b)(2)) for each day on which such individual is furnished such services;

"(2) in the case of services described in subparagraphs (C), (D) and (E) of section 2004(a)(1), 80 percent of the reasonable cost of the services (as determined under section 1861(v);

"(3) in the case of services described in subsection (a)(2) of section 2003, 80 percent of the reasonable charges for such services.

"(b) Before applying paragraphs (2) and (3) of 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, but for this subsection, constitute incurred expenses from which benefits payable under paragraphs (2) and (3) of subsection (a) are determinable) shall be reduced by a deductible of $2,000; 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 toward such individual's deductible under this section for such preceding year, and

"(2) any such expenses so incurred by other members of such individual's family shall be deemed to have been incurred by such individual.

For the purposes of paragraph (2), a family may consist of one or more individuals (i) one of whom is entitled to benefits under this title by reason of section 2002(a)(2) (A) or (B) and (ii) such others of whom are so entitled by reason of section 2002(a)(2) (C) or (D), but only to the extent that the individuals included under clause (i) and (ii) are living in a place of residence maintained by one or more of them as his or her own home.

"(c) The Secretary shall between July 1 and October 1, 1972, and each year thereafter, determine and promulgate the deductible which shall be applicable for purposes of subsection (b) in the succeeding calendar year. Such deductible shall be equal to whichever is the higher—

"(1) $2,000 or

"(2) 2,000 multiplied by the ratio of the component of the Consumer Price Index, prepared by the Department of Labor for June of the year in which such determination is made and promulgated, which represents fees

for physician services to such component of such Consumer Price Index for the month of December 1971, with such product, if not a multiple of $50, being rounded to the nearest multiple of $50.

"(d) Payment for services under this title shall also be subject to the limitations described in section 1812 (c) and (e) and section 1833 (c) and (e).

"CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

"SEC. 2005. (a) To the extent that payment may be made for services described in section 2003(a)(1), the provisions of sections 1814, 1815, 1816, 1833(f), 1835 shall apply.

"(b) To the extent that payment may be made for services described in section 2003(a)(2), the provisions of section 1842 shall apply.

"APPLICABILITY OF CERTAIN PROVISIONS OF TITLE XVIII

"SEC. 2006. (a) The provisions of section 1861 (except subsection (a) and (y), 1866, 1867, 1869, 1870, 1871, 1872, 1873, 1874, 1875, 1876, 1877, 1878, and 1879 shall apply with respect to this title to the same extent as they are applicable with respect to title XVIII.

"(b) The provisions of part B of title XI, section 1122, and 1124, 1125, and 1130 shall apply with respect

to the title to the same extent as they are applicable with respect to title XVIII.

"(c) The provisions of section 222 of the Social Security Amendments of 1970 and section 402(a) of the Social Security Amendments of 1967 shall be applicable to this title to the same extent as they are applicable to title XVIII.

"STATE AGREEMENTS FOR COVERAGE OF ANNUITANTS AND MEMBERS OF A RETIREMENT SYSTEM AND THEIR DEPENDENTS AND SURVIVORS

"SEC. 2007. (a) The Secretary shall, at the request of a State which has entered into an agreement under section 218, enter into an agreement with such State pursuant to which all individuals in any of the coverage groups described in subsection (b) (as specified in the agreement) will be entitled to benefits under this part.

"(b) For purposes of this section—

"(1) the term 'retirement system' means a pension, annuity, retirement, or similar fund or system established by a State or by a political subdivision thereof.

"(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 political subdivisions.

"(3) the term 'State' includes an instrumentality of two or more States.

"(4) the term 'coverage group' means (A) annuitants under a retirement system, (B) members of a retirement system who are not annuitants, (C) the widows or widowers of annuitants under a retirement system, and (D) the widows or widowers of members of a retirement system who were not annuitants; except that such term shall not include any individual who is entitled to catastrophic health insurance benefits under this title by reason of section 2002(a).

"(c)(1) An agreement entered into with any State under this section shall be applicable to one or more coverage groups, referred to in clause (A) of subsection (b)(4), and as designated by the State in such agreement.

*"(2) An agreement entered into with any State under this section may be applicable to one or more of the coverage groups referred to in any of the clauses of subsection (b)(4) (except clause (A)) but only with respect to retirement systems (A) the annuitants of which are individuals in a coverage group designated, pursuant to paragraph (1), as a coverage group to which such agreement applies and (B) in the case of widows, and widowers, referred to in clause (D), the members of which are individuals in a coverage

group designated, pursuant to this paragraph, as a coverage group to which this agreement applies.

"(d) The Secretary shall, at the request of any State, modify the agreement with such State under this section to include any coverage group to which the agreement did not previously apply; 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.

"(e) For purposes of this section an individual who is in a coverage group to which the agreement under this section applies, shall (subject to the succeeding provisions of this section) be entitled to benefits under this title in the same manner and under the same conditions as though he established such entitlement under section 2002(a).

"(f) The entitlement to benefits under this title of an individual, who is in a coverage group to which the agreement under this section applies, shall—

"(1) begin on whichever of the following is the latest:

"(A) January 1972,

"(B) the first day of the month following the first month in which he is in such coverage group,

"(C) the first day of the second month following the month in which such agreement is entered into, or

"(D) the first day of the second month following the month to which such agreement, pursuant to a modification, becomes applicable to such coverage group, and

"(2) end on whichever of the following is the earliest—

"(A) the last day of the month in which such individual dies,

"(B) the last day of the month preceding the first month for which he becomes entitled to benefits under this title by reason of section 2002(a),

"(C) the first day of the month following the month in which he ceases to be in the coverage group to which such agreement is applicable,

"(D) the day on which such agreement terminates, or

"(E) the day on which such agreement terminates with respect to such coverage group.

"(g) Each such agreement shall provide that the State—

"(1) will, at such time or times as the Secretary specifies, reimburse the Federal Catastrophic Health Insurance Trust Fund (A) for payments made from such Fund to pay for the services furnished to individuals entitled to have payment made for such services by reason of such agreement and (B) for the administra-

tive expenses incurred by the Department of Health, Education, and Welfare in carrying out such agreement and by such public or private agencies that such Department may utilize for such purpose,

"(2) will comply with such rules and regulations as the Secretary may issue in carrying out such agreement,

"(3) will furnish the Secretary such timely information and reports as he may find necessary in performing his functions under this section and 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 this paragraph and otherwise carry out this agreement,

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary and appropriate.

"(h) Upon giving at least six months notice in writing to the Secretary, a State may terminate, effective at the end of a calendar quarter specified in the notice, its agreement with the Secretary either in its entirety or with respect to a coverage group.

"(i) If the Secretary, after giving 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 substantially to comply 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 as he deems appropriate, unless prior to such time he finds there no longer is any such failure or that the cause for such legal inability has been removed.

"(j) A determination by a State, which has entered into an agreement with the Secretary under this section, as to whether an individual is an annuitant or member of a retirement system or the widow or widower of such an annuitant or member shall, for purposes of this section, be final and conclusive upon the Secretary.

"(k) (1) If more or less than the correct amount due under an agreement pursuant to this section is paid, 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.

"(2) 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."

"FEDERAL CATASTROPHIC HEALTH INSURANCE TRUST FUND

"SEC. 2008. (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Catastrophic Health Insurance Trust Fund' (hereinafter in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such amounts as may be deposited in, or appropriated to, such fund as provided in this part. There are hereby appropriated to the Trust Fund for the fiscal year ending June 30, 1972, 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(c) and 3111(c) 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, 1971, 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(c) of the Internal Revenue Code of 1954 with respect to self-

employment income reported to the Secretary of the Treasury or his delegates 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 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 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 purpose 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 marketbale 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 one per centum, the rate of interest on such obligations shall be the multiple of one-eighth of one 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 from 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(c) which are subject to refund under section 6413(c) of the Internal Revenue Code of 1954 with respect to wages

paid after December 31, 1971. 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 pursuant to sec-

tion 1870(b) of this Act as made applicable to this title by section 2006.

"(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).

"APPROPRIATIONS FOR CONTINGENCY RESERVE

"SEC. 2009. In order to assure prompt payment of benefits provided under this title and the administrative expenses thereunder during the early months of the program established by this title, and to provide a contingency reserve, there is authorized to be appropriated, out of any moneys in the Treasury not otherwise appropriated, to remain available for the 3 calendar years immediately following December 31, 1971, for repayable advances (without interest) to the Trust Fund, an amount equal to one-half of the amount of benefits estimated to be paid under this title in each of such calendar years.

"PAYMENTS TO PREPAYMENT ORGANIZATIONS

"SEC. 2010. (a) In lieu of amounts which would otherwise be payable under this title, the Secretary is authorized to determine, by actuarial methods, with respect to any health maintenance organization, as defined in section 1876, or an

organization eligible for payment under section 1833(a)(1)(A) a per capita rate of payment for services provided to enrollees in such organization who are eligible for benefits under this title, provided such organization agrees to comply with the provisions of section 1876(g) with respect to such payments;

"(b) Such rate of payment shall be determined annually in accordance with the methods described in subsections 1876(a)(1) and (2) with appropriate actuarial adjustments to reflect utilization of services by such enrollees not furnished by such organization."

(b) Section 201(g) of the Social Security Act is amended by—

(1) inserting after "title XVIII" the first time it appears the following: "and the Federal Catastrophic Health Insurance Trust Fund established by title XX";

(2) inserting after "title XVIII" each time it appears therein after the first time the following: "and title XX".

(c)(1) Section 1401 of the Internal Revenue Code of 1954 is amended by adding after subsection 1401(b) the following new subsection:

"(c) CATASTROPHIC HEALTH INSURANCE PROTECTION.—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, 1971, and before January 1, 1975, the tax shall be equal to 0.30 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, 1974, and before January 1, 1980, the tax shall be equal to 0.35 percent of the amount of the self-employment income for such taxable year; and

"(3) in the case of any taxable year beginning after December 31, 1979, the tax shall be equal to 0.40 percent of the amount of the self-employment income for such taxable year."

(2) Section 3101 of the Internal Revenue Code of 1954 is amended by adding after subsection 3101(b) the following new subsection:

"(c) CATASTROPHIC HEALTH INSURANCE PROTECTION.—In addition to the taxes imposed by the preceding subsections, there is hereby imposed on the income of every individual a tax equal to the following percentages of wages (as defined in section 3121(a)) received by him with respect to employment (as defined in section 3121(b))—

"(1) with respect to wages received during the

calendar years 1972, 1973, and 1974, the rate shall be 0.30 percent;

"(2) with respect to wages received during the calendar years 1975, 1976, 1977, 1978, and 1979, the rate shall be 0.35 percent; and

"(3) with respect to wages received after December 31, 1979, the rate shall be 0.40 percent."

(3) Section 3111 of the Internal Revenue Code of 1954 is amended by adding after subsection 3111(b) the following new subsection:

"(c) CATASTROPHIC HEALTH INSURANCE PROTECTION.—In addition to the taxes imposed by the preceding subsections, 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 3321(a)) paid by him with respect to employment (as defined in section 3121(b))—

"(1) with respect to wages paid during the calendar years 1972, 1973, and 1974, the rate shall be 0.30 percent;

"(2) with respect to wages paid during the calendar years 1975, 1976, 1977, and 1979, the rate shall be 0.35 percent; and

"(3) with respect to wages paid after December 31, 1979, the rate shall be 0.40 percent."

TITLE V—PROVISIONS RELATING TO WELFARE

GUARANTEED MINIMUM INCOME FOR RECIPIENTS OF OLD-AGE ASSISTANCE, AID TO THE BLIND, AID TO THE DISABLED, OR AID TO THE AGED, BLIND, OR DISABLED

SEC. 501. (a) Section 2(a)(10)(A) of the Social Security Act is amended by inserting after the semicolon at the end thereof "and except that, in the case of any State (other than the Commonwealth of Puerto Rico, Guam, or the Virgin Islands), the sum of the financial assistance provided to each individual who is eligible under the plan (other than one who is a patient in a medical institution or is receiving institutional services in an intermediate care facility to which section 1121 applies), plus his income which is not disregarded pursuant to clause (i) or (ii) and the reasonable value of shelter and other needed items which are regularly provided to such individual (to the extent they are provided without cost), shall not be less than $130 per month (or in the case of two or more such eligible individuals who are, as determined in accordance with regulations of the Secretary, members of the same household, $130 per month plus $70 per month for each of such individuals in addition to one);

(b) Section 1002(a)(8) of such Act is amended by inserting before the semicolon at the end thereof ", and except that, in the case of any State (other than the Commonwealth

of Puerto Rico, Guam, or the Virgin Islands), the sum of the financial assistance provided to each individual who is eligible under the plan (other than one who is a patient in a medical institution or is receiving institutional services in an intermediate care facility to which section 1121 applies), plus his income which is not disregarded pursuant to clause (A), (B), or (C) and the reasonable value of shelter and other needed items which are regularly provided to such individual (to the extent they are provided without cost), shall not be less than $130 per month (or in the case of two or more such eligible individuals who are, as determined in accordance with regulations of the Secretary, members of the same household, $130 per month plus $70 per month for each of such individuals in addition to one); and".

(c) Section 1402(a)(8) of such Act is amended by inserting before the semicolon at the end thereof ", and except that, in the case of any State (other than the Commonwealth of Puerto Rico, Guam, or the Virgin Islands), the sum of the financial assistance provided to each individual who is eligible under the plan (other than one who is a patient in a medical institution or is receiving institutional services in an intermediate care facility to which section 1121 applies), plus his income which is not disregarded pursuant to clause (A), (B), or (C) and the reasonable value of shelter and other needed items which are regularly provided to such indi-

vidual (to the extent they are provided without cost), shall not be less than $130 per month (or in the case of two or more such eligible individuals who are, as determined in accordance with regulations of the Secretary, members of the same household, $130 per month plus $70 per month for each of such individuals in addition to one); and".

(d) Section 1602(a)(14) of such Act is amended by inserting after and below clause (D) the following:

"and except that, in the case of any State (other than the Commonwealth of Puerto Rico, Guam, or the Virgin Islands), the sum of the financial assistance provided to each individual who is eligible under the plan (other than one who is a patient in a medical institution or is receiving institutional services in an intermediate care facility to which section 1121 applies), plus his income which is not disregarded pursuant to clause (A), (B), (C), or (D) and the reasonable value of shelter and other needed items which are regularly provided to such individual (to the extent they are provided without cost), shall not be less than $130 per month (or in the case of two or more such eligible individuals who are, as determined in accordance with regulations of the Secretary, members of the same household, $130 per month plus $70 per month for each of such individuals in addition to one); and ".

(e) The amendments made by the preceding subsections

of this section shall apply with respect to expenditures under a State plan approved under title I, X, XIV, and XVI, respectively of the Social Security Act made for aid or assistance under such plan for periods after March 1971.

(f) Any individual with respect to whom old-age assistance, aid to the blind, aid to the disabled, or aid to the aged, blind, or disabled is paid under such a State plan shall not be eligible to participate in the food stamp program conducted under the Food Stamp Act of 1964 or the program conducted under section 416 of the Act of October 31, 1969, or any similar programs for distribution of surplus agricultural commodities effective April 1, 1971.

INCREASE IN STANDARD OF NEED FOR AGED, BLIND, AND DISABLED RECIPIENTS

SEC. 502. Title XI of the Social Security Act is amended by adding after section 1125 (as added by section 266 of this Act) and before section 1151 (as added by section 245 of this Act) the following new section:

"INCREASING STANDARD OF NEED UNDER ASSISTANCE PROGRAMS

"SEC. 1126. In addition to the requirements imposed by law as a condition of approval of a State plan of any State (other than the Commonwealth of Puerto Rico, Guam, or the Virgin Islands) to provide aid or assistance to individuals under title I, X, XIV, or XVI of the Social Security Act, there is hereby imposed the requirement (and the plan

shall be deemed to require) that, in the case of an individual found eligible (as a result of the requirement imposed by this section or otherwise), for aid or assistance for any month after March 1971—

"(1) the total of the amounts used to determine the needs of such individual shall be at least $10 higher than the total thereof which would have been used to determine needs of such individual under the State plan as in effect for March 1971, or

"(2) in the case of two or more such individuals who are, as determined in accordance with regulations of the Secretary, members of the same household, the sum of such totals used for such month after March 1971 shall exceed such total for March 1971 by the sum of $10 plus $5 for each such individual in excess of one

except that, in the case of any such State plan which provides for meeting a fixed percentage of unmet needs as so determined, the Secretary shall prescribe the method or methods for achieving as much as possible the results provided for under the preceding provisions of this section."

UNIFORM DEFINITIONS OF DISABILITY UNDER TITLES XIV AND XVI

SEC. 503. (a)(1) Title XIV of the Social Security Act is amended by striking out the term "permanently and totally disabled" wherever it appears in such title and inserting in lieu thereof "disabled".

(2) Section 1405 of such Act is amended by—

(A) striking out, in the caption, "Definition", and inserting "Definitions";

(B) striking out "Sec. 1405." and inserting "Sec. 1405. (a)"; and

(C) inserting after such subsection (a) the following new subsection:

"(b) For purposes of this title an individual is 'disabled' only if he is under a disability. The term 'disability' means inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 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 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)(1) Title XVI of such Act is amended by striking out the term "permanently and totally disabled" wherever it appears in such title and inserting in lieu thereof "disabled".

(2) Section 1605 of such Act is amended by adding at the end thereof the following new subsection:

"(c) For purposes of this title an individual is 'disabled' only if he is under a disability. The term 'disability' means inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 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 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)(1) No State plan for aid to the disabled shall be regarded as having failed to comply with the requirements of title XIV of the Social Security Act by reason of the fact that such plan provides aid to individuals who do not meet the definition of "disabled" (as contained in section 1405(b) of such Act) if such individuals are individuals who—

(A) were receiving aid under such plan for the month before the month in which the term "disabled" (as contained in such section 1405(b)) is first put into effect in the administration of such plan; and

(B) would be regarded as disabled, for purposes of the administration of such plan, if the term "disabled" (as contained in such section 1405(b)) had not been put into effect in the administration of such plan.

(2) No State plan for aid to the aged, blind, or disabled shall be regarded as having failed to comply with the requirements of title XVI of the Social Security Act by reason of the fact that such plan provides aid to individuals who do not meet the definition of "disabled" (as contained in section 1605 (c) of such Act) if such individuals are individuals who—

(A) were receiving aid under such plan for the month before the month in which the term "disabled" (as

contained in such section 1605(c)) is first put into effect in the administration of such plan; and

(B) would be regarded as disabled, for purposes of the administration of such plan, if the term "disabled" (as contained in such section 1605(c)) had not been put into effect in the administration of such plan.

(d)(1) Sections 1121(a), 1901, 1902(a)(17)(D), and 1902(a)(18) of the Social Security Act are amended by striking out "permanently and totally disabled" wherever it appears and inserting in lieu thereof "disabled".

(2) Section 1905(a)(v) of such Act is amended by striking out "permanently and totally disabled" and inserting in lieu thereof "disabled (as defined in section 1405(b))".

(e) The amendments made by this section shall take effect April 1, 1971.

UNIFORM DEFINITIONS OF BLINDNESS UNDER TITLES X AND XVI

SEC. 504. (a) Section 1006 of the Social Security Act is amended (1) by inserting "(a)" immediately after "SEC. 1006.", and (2) by adding at the end thereof the following new subsection:

"(b)(1) For purposes of this title, an individual shall be considered to be blind only if he suffers from blindness (as defined in paragraph (2)).

"(2) 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."

(b) Section 1605 of such Act (as amended by section 503(b) of this Act) is further amended by adding at the end thereof the following new subsection:

"(d)(1) For purposes of this title, an individual shall be considered to be blind only if he suffers from blindness (as defined in paragraph (2)).

"(2) 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.'

(c)(1) No State plan for aid to the blind shall be regarded as having failed to comply with the requirements of title X of the Social Security Act by reason of the fact that such plan provides aid to individuals who do not meet the definition of blindness (as contained in section 1006(b) of such Act) if such individuals are individuals who—

(A) were receiving aid under such plan for the month before the month in which the term blindness (as contained in such section 1006(b)) is first put into effect in the administration of such plan; and

(B) would be regarded as blind, for purposes of the administration of such plan, if the term blindness (as contained in such section 1006(b)) had not been put into effect in the administration of such plan.

(2) No State plan for aid to the aged, blind, or disabled shall be regarded as having failed to comply with the requirements of title XVI of the Social Security Act by reason of the fact that such plan provides aid to individuals who do not meet the definition of blindness (as contained in section 1605(d) of such Act) if such individuals are individuals who—

(A) were receiving aid under such plan for the month before the month in which the term blindness (as contained in such section 1605(d)) is first put into effect in the administration of such plan; and

(B) would be regarded as blind, for purposes of the administration of such plan, if the term blindness (as contained in such section 1605(d)) had not been put into effect in the administration of such plan.

(d) The amendments made by this section shall take effect April 1, 1971.

PROHIBITION AGAINST IMPOSING LIENS ON PROPERTY OF THE BLIND

SEC. 505. (a) Section 1002(a) of the Social Security Act is amended by striking out "and" at the end of clause (12), and by inserting before the period at the end thereof the following: "; and (14) provide that no individual claiming aid to the blind shall be required as a condition of such aid to subject any property to a lien or to transfer to the State or to any of its political subdivisions title to or any interest in any property, and that no person shall be required to reimburse the State or any of its political subdivisions for any aid lawfully received by a blind individual under the State plan."

(b) Section 1602(a) of the Social Security Act is amended by striking out "and" at the end of paragraph (16), by striking out the period at the end of paragraph (17) and inserting in lieu thereof "; and", and by adding immediately after paragraph (17) the following new paragraph:

"(18) provide that no blind individual claiming aid or assistance under the plan shall be required as a condition thereof to subject any property to a lien or to transfer to the State or to any of its political subdivisions title to or any interest in any property, and that no

person shall be required to reimburse the State or any of its political subdivisions for any aid or assistance lawfully received by a blind individual under the State plan."

(c) The amendments made by this section shall be effective April 1, 1971.

FISCAL RELIEF FOR STATES

SEC. 506. Title XI of the Social Security Act is amended by adding after section 1126 (as added by section 502 of this Act) the following new section:

"FISCAL RELIEF FOR STATES

"SEC. 1127. (a) The Secretary shall pay to any State (other than the Commonwealth of Puerto Rico, Guam, or the Virgin Islands) which has a State plan approved under title I, X, XIV, or XVI of the Social Security Act, for each quarter beginning after March 1971, in addition to the amounts otherwise payable to such State under such title, an amount equal to the excess if any of—

"(1) the non-Federal share of (A) the expenditures, under the State plan approved under such title, as cash assistance which would be made under such plan as in effect for December 1970, and (B) so much of the rest of such expenditures made under such plan as are required (as determined by the Secretary) by reason of

the amendments made by the Social Security Amendments of 1970, over

"(2) 90 per centum of the non-Federal share of the total average quarterly expenditures, under such plan, as cash assistance during the 4-quarter period ending December 31, 1970.

"(b) For purposes of subsection (a), the non-Federal share of expenditures for any quarter under a State plan approved under title I, X, XIV, or XVI of the Social Security Act as cash assistance, referred to in subsection (a)(1), means the difference between (A) the total expenditures for such quarter under such plan as, respectively, old-age assistance, aid to the blind, aid to the disabled, and aid to the aged, blind, or disabled, and (B) the amounts determined for such quarter for such State with rsepect to such expenditures under, respectively, seciions 3, 1003, 1403, and 1603 of such Act and (in the case of the plan approved under title I or X) under section 9 of the Act of April 19, 1950.".

FEDERAL CHILD CARE CORPORATION

SEC. 510. (a) This section may be cited as the "Federal Child Care Corporation Act".

(b) The Social Security Act is amended by adding after title XX the following new title:

"TITLE XXI—FEDERAL CHILD CARE CORPORATION

"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 agency or organization, public or private, which can assume 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 Federal

Child Care Corporation which shall have the responsibility and authority to meet the Nation's 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 individuals receiving such services.

"ESTABLISHMENT AND ORGANIZATION OF CORPORATION

"SEC. 2102. (a) In order to carry out the purposes of this title, there is hereby created a body corporate to be known as the Federal Child Care Corporation (hereinafter in this title referred to as the 'Corporation')

"(b)(1) The powers and duties of the Corporation shall be vested in a Board of Directors (hereinafter in this title referred to as the 'Board').

"(2) The Board shall consist of three members, to be appointed by the President, by and with the advice and consent of the Senate. One member of the Board shall, at the time of his appointment, be designated by the President as Chairman of the Board.

"(3) Not more than two members of the Board shall be members of the same political party.

"(4) 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, 1972, one on June 30, 1973, and one on June 30, 1974.

"(c) Vacancies in the Board shall not impair the powers of the remaining members of the Board to exercise the powers vested in, and carry out the duties imposed upon the Corporation.

"(d) Each member of the Board shall, during his tenure in office, devote himself to the work of the Corporation and shall not during such tenure, engage in any other business or employment.

"(e)(1) The Board shall have the power to appoint (in accordance with the provisions of title 5, United States Code, governing appointments in the competitive service) and fix the compensation (in accordance with the provisions of chapter 51 and subchapter III of chapter 53 of such title, relating to classification and General Schedule pay rates) such personnel as it deems necessary to enable the Corporation to carry out its functions under this title.

"(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 for individuals not to exceed the per diem equivalent of the rate authorized for GS–18 by section 5332 of such title.

"DUTIES OF CORPORATION

"SEC. 2103. (a) It shall be the duty and function of the Corporation to meet, 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 Corporation 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 include 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 Corporation 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 any public agency) which agrees to pay such fee or a part thereof.

"(3) The Corporation shall not enter into any arrangement with any person under which the facilities or services of such person will be utilized by the Corporation to provide child care services unless such person agrees 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 Corporation shall accord first priority 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 IV 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.

"STANDARDS FOR CHILD CARE

"SEC. 2104. (a) The Corporation 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 providing such care shall not normally be greater 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.

"(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 Board 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 Corporation provides child care (whether directly or through arrangements with others) must—

"(A) 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 Corporation 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 Corporation 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;

"(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; and must have separate rooms or areas for cooking, toilets, and other purposes;

"(C) have floors and walls of a type which can be thoroughly 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 comfort of each child receiving care therein;

"(E) provide safe and comfortable facilities for naps for young children receiving care therein;

"(F) provide special 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 Board, in determining whether any particular facility meets minimum requirements imposed by paragraph (1) of this subsection, shall evaluate 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 Corporation 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 Board 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, immuniza-

tion, 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 periodic assessments of their physical and mental competence to provide child care (except, that any rules or regulations involving medical examination, immunization, or physical evaluation of staff members of such facility shall include appropriate exemptions, with due consideration to the protection of the public from

epidemics of contagious diseases, for those who object thereto on religious grounds);

"(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.

"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 Board, in selecting the location of any facility to provide child care under this title, shall, to the maximum extent feasible, approve only a site which—

"(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 travel time (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

"SEC. 2106. Any facility in which child care services are provided by the Corporation (whether directly or through arrangements with other persons) shall not be subject to any licensing or similar requirements imposed by any State (or political subdivision 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.

"GENERAL POWERS OF CORPORATION

"SEC. 2107. (a) The Corporation shall have 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 the duties and functions imposed on it by this title;

"(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 Corporation or against the Corporation with respect to its property;

"(4) to conduct its business in any State of the United States and in the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam;

"(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, the District of Columbia, the Commonwealth of Puerto

Rico, the Virgin Islands, or Guam (for any agency, instrumentality, or political subdivision thereof), or (iii) any 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, including but not limited to a facility for child care, 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 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;

"(10) to provide child care services for the public directly or by agreement or lease with any person, agency, or organization, through and in the facilities

for child care of the Corporation 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;

"(11) to provide advice and technical assistance to persons desiring to enter into an arrangement with the Corporation for the provision of child care services to assist them in developing their capabilities to provide such services under such an arrangement;

"(12) 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 Corporation provides child care directly;

"(13) to construct and equip, or by contract cause to be constructed and equipped, facilites (other than home child care facilities) for child care services;

"(14) to invest any funds held in reserves or sinking funds, or any funds not required for immediate use or disbursement, at the discretion of the Board, in obligations of the United States or obligations the principal and interest on which are guaranteed by the United States;

"(15) to procure insurance, or obtain indemnifica-

tion, against any loss in connection with the assets of the Corporation or any liability in connection with the activities of the Corporation, such insurance or indemnification to be procured or obtained in such amounts, and from such sources, as the Board deems to be appropriate;

"(16) to cooperate with any organization, public or private, the objectives of which are similar to the purposes of this title; and

"(17) 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 Corporation in this title.

"(b) Funds of the Corporation shall not be invested in any obligation or security other than obligations of the United States or obligations the principal and interest on which are guaranteed by the United States; and any obligations or securities (other than obligations of the United States or obligations the principal and interest on which are guaranteed by the United States) acquired by the Corporation by way of gift or otherwise shall be sold at the earliest practicable date after they are so acquired.

"REVOLVING FUND

"SEC. 2108. (a) There is hereby established in the Treasury a revolving fund to be known as the 'Federal Child

Care Corporation Fund" (hereinafter in this title referred to as the 'fund'), which shall be available to the Corporation without fiscal year limitation to carry out the purposes, functions, and powers of the Corporation under this title.

"(b) There shall be deposited in the fund—

"(1) funds loaned to the Corporation by the Treasury pursuant to subsection (d); and

"(2) the proceeds of all fees, rentals, charges, interest, or other receipts (including gifts) received by the Corporation.

"(c) Except for expenditures from the Federal child care corporation capital fund (established by section 2109 (d)) and expenditures from appropriated funds, all expenses of the Corporation (including salaries and other personnel expenses) shall be paid from the fund.

"(d) The Secretary of the Treasury shall, from time to time, in accordance with requests submitted to him by the Board, deposit, as a loan to the Corporation, in the fund such amounts (the aggregate of which shall not exceed $50,000,000). Beginning with the fiscal year ending June 30, 1975, the principal on such loan shall be repaid by the Corporation in annual installments of $2,000,000. The Corporation shall pay interest on any moneys so deposited in the fund for periods, during any fiscal year, that such moneys have been in such fund. Interest on such moneys for any

fiscal year shall be paid on July 1 following the close of such fiscal year and shall be paid at a rate equal to the average rate of interest paid by the Treasury on long-term obligations during such fiscal year.

"(e) If the Corporation determines that the moneys in the fund are in excess of current needs, 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 CORPORATION

"SEC. 2109. (a) The Corporation is authorized (after consultation with the Secretary of the Treasury) to issue and sell bonds, notes, and other evidences of indebtedness (hereinafter in this section collectively referred to as 'bonds') whenever the Board determines that the proceeds of such bonds are necessary, together with other moneys available to the Corporation from the Federal Child Care Corporation Fund, to provide funds sufficient to enable the Corporation 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, 1973, (2) not 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 Corporation, including, but not limited to, fees, rentals, or other charges which the Corporation receives for the use of any facility for child care which the Corporation owns or in which the Corporation 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 Board may prescribe.

"(d)(1) There is hereby established in the Treasury a fund to be known as the 'Federal Child Care Corporation Capital Fund' (hereinafter in this title referred to as the 'Capital Fund'), which shall be available to the Corporation without fiscal year limitation to carry out the purposes and functions of the Corporation 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 pur-

suant 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.

"CORPORATE OFFICES

"SEC. 2110. (a) The principal office of the Corporation shall be in the District of Columbia. For purposes of venue in civil actions, the Corporation shall be deemed to be a resident of the District of Columbia.

"(b) The Corporation shall establish offices in such areas as it deems necessary to carry out its duties as set forth in section 2103.

"TAXATION

"SEC. 2111. The Corporation, its property, assets, and income shall be exempt from taxation in any manner or form by the United States, a State (or political subdivision thereof).

"REPORTS TO CONGRESS

"SEC. 2112. The Corporation shall not later than January 30 following the close of the second session of each Congress (commencing with January 30, 1973), submit to the Congress a written report on its activities 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 Corporation has taken to improve the quality of child care services, together with a statement regarding the future plans (if any) of the Corporation to improve the quality of such services.

"APPLICABILITY OF OTHER LAWS

"SEC. 2113. (a) Except as otherwise provided by this title, the Corporation, 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 Corporation.

"(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 Corporation.

"(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 Corporation, 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 Corporation.

"(e) 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 Corporation or to the acquisition of any site for any such building.

"(f) All general Federal penal statutes relating to the larceny, embezzlement, conversion, or to the improper handling, retention, use, or disposal of moneys or property of the United States shall apply to the moneys and property of the Corporation.

"COLLECTION AND PUBLICATION OF STATISTICAL DATA

"SEC. 2114. The Corporation shall collect, classify, and publish, on a monthly and annual basis, statistical data relating to its operations and child care provided (directly or indirectly) by the Corporation together with such other data as may be relevant to the purposes and functions of the Corporation.

"RESEARCH AND TRAINING

"SEC. 2115. (a) The Secretary, in the administration of section 426, shall consult with and cooperate with the Corporation with a view to providing for the conduct of research and training which will be applicable to child care services.

"(b) The Secretary of Labor, in the administration of

part C of title IV, shall consult with and cooperate with the Corporation with a view to providing for the conduct of training which will be applicable to child care services.

"(c) The Corporation shall have the authority to conduct directly or by way of contract programs of in-service training in day 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 Board in matters of general policy in carrying out the purposes and functions of the Corporation, and with respect to improvements in the administration by the Corporation 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 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) 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 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 either a recipient of public assistance or 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 3 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 Board at the time of appointment, four on June 30, 1972, four on June 30, 1973, and four on June 30, 1974.

"(c) The Council is authorized to engage such technical assistance as may be required to carry out its functions, and the Board shall, in addition, make available to the Council such secretarial, clerical, and other assistance and such pertinent data prepared by the Corporation 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 travel-

time; 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.

"(e) There are hereby authorized to be appropriated for each fiscal year such sums as may be necessary to carry out the provisions of this section.

"COOPERATION WITH OTHER AGENCIES

"SEC. 2117. (a) The Corporation is authorized to enter into agreements with public and other nonprofit agencies or organizations whereby children receiving child care provided by the Corporation (whether directly or through arrangements with other persons) will be provided other services conducive to their health, education, recreation, or development.

"(b) Any such agreement with any such agency or organization shall provide that such agency or organization shall pay the Corporation in advance or by way of reimbursement, for any expenses incurred by it in providing any services pursuant to such agreement.

"DEFINITIONS

"SEC. 2118. For purposes of this title—

"(a) The term 'Corporation' means the Federal Child Care Corporation 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 fa-

cility 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 home) which provides child 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, a 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 pri-

marily 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 14 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."

(c)(1) Section 422(a)(1) of such Act is amended by striking out subparagraph (C) thereof.

(2) Section 425 of such Act is amended by striking out "or day-care" and by adding "other than those defined in sec. 2118(c)" after "child-care facilities".

(3) The amendments made by this subsection shall take effect July 1, 1972.

(d) Section 1101(a)(1) of the Social Security Act is amended by striking out "and XIX" and inserting in lieu thereof "XIX, XX, and XXI".

(e)(1) Section 5316 of title 5, United States Code (relating to Executive Schedule pay rates at level V), is amended by adding at the end thereof:

"(130) Chairman of the Board of Directors of the Federal Child Care Corporation.

"(131) Member of the Board of Directors of the Federal Child Care Corporation."

AMENDMENTS TO IMPROVE THE WORK INCENTIVE PROGRAM ESTABLISHED UNDER PART C OF TITLE IV OF THE SOCIAL SECURITY ACT

SEC. 520. (a)(1) Section 402(a)(15) of the Social Security Act is amended to read as follows:

"(15) provide (A) for the development of a program, for appropriate members of such families and such other individuals, 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 establishment of a single organization unit in such State or local agency, as the case may be, responsible for the furnishing of such services;".

(2) Section 402(a)(19)(A) of such Act is amended to read as follows:

"(A) effective July 1, 1971, provide 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—

"(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; or

"(v) a mother or other relative of a child under the age of six who is caring for the child;

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;".

(3) Section 402(a)(19)(C) of such Act is amended effective July 1, 1971, by striking out "20 per centum" and inserting in lieu thereof "10 per centum".

(4) Section 402(a)(19)(D) of such Act is amended effective July 1, 1971, to read as follows:

"(D) that training incentives and other allowances authorized under section 434 shall be disregarded in determining the needs of an individual under section 402(a)(7);".

(5) Section 402(a)(19) of such Act is further amended by striking out subparagraph (E).

(6) The parenthetical clause in section 402(a)(19)(F) of such Act is amended by striking out "pursuant to subparagraph (A) (i) and (ii) and section 407(b)(2)" and inserting in lieu thereof "pursuant to subparagraph (G)".

(7) Section 402(a)(19) of such Act is amended by adding at the end thereof the following new subparagraph:

"(G) that the State agency, effective July 1, 1971, 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 (through utilization of the services of the Federal Child Care Corporation, or otherwise), 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 such individuals are prepared to accept employment or receive manpower training, refer such individuals to the Secretary of Labor for employment or training under part C, and (iii) will participate in the development of operational and employability plans under section 433(b); if more than one kind of child care is available, the mother may choose the type,

but she may not refuse to accept child services if they are available;".

(8) Section 403 of such Act is amended by adding at the end thereof the following new subsection:

"(e) 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 by one percentage point for each percentage point by which the number of individuals referred, 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 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)."

(9) Section 403 of such Act is amended by adding after subsection (e) the following new subsection:

"(f) Notwithstanding subparagraph (A) of subsection (a)(3) the rate specified in such subparagraph shall be—

"(1) 100 per centum (rather than 75 per centum) with respect to family planning services provided pursuant to clause (15) of section 402(a),

"(2) 90 per centum (rather than 75 per centum) with respect to child care services provided pursuant to clause (14) of section 402(a) or section 402(a) (19)

(G) but only, in the case of any quarter, if the total amount of non-Federal expenditures during such quarter under the State plan for child care services is not less than the amount of the average quarterly amount of non-Federal expenditures under such plan for child care services for the 4-quarter period ending December 31, 1970; except that the Secretary is authorized, for a temporary period of not to exceed 6 months, to increase such rate to 100 per centum in a political subdivision of a State or portion thereof if and only if he determines that such services would not be made available during such period in the absence of such increased rate of payment, and

"(3) 90 per centum (rather than 75 per centum) with respect to social and supportive services (other than family planning services and child care services) provided pursuant to section 402(a)(19)(G)."

(b)(1) The first sentence of section 430 of the Social Security Act is amended by striking out "special work projects" and inserting in lieu thereof "public service employment".

(2) Section 431 of such Act is amended (1) by inserting "(a)" immediately after "SEC. 431.", and (2) by adding at the end thereof the following new subsections:

"(b) Of the amounts expended from funds appropriated

pursuant to subsection (a) for any fiscal year (commencing with the fiscal year ending June 30, 1972), not less than 40 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)(1) For the purpose of carrying out the provisions of this part in any State for any fiscal year (commencing with the fiscal year ending June 30, 1972), there shall be available (from the sums appropriated pursuant to subsection (a) for such fiscal year) for expenditure in such State an amount equal to the allotment of such State for such year (as determined pursuant to paragraph (2) of this subsection).

"(2) Sums appropriated pursuant to subsection (a) for the fiscal year ending June 30, 1972, or for any fiscal year thereafter, shall be allotted among the States as follows: Each State shall be allotted from such sums an amount which bears the same ratio to the total of such sums as—

"(A) in the case of the fiscal year ending June 30, 1972, 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

"(B) in the case of the fiscal year ending June

30, 1973, 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."

(3)(A)(i) Clause (1) of section 432(b) of such Act is amended—

(I) by inserting "(A)" immediately after "(1)"; and

(II) by striking out "and utilizing" and inserting in lieu thereof "and (B) a program utilizing".

(ii) Clause (3) of section 432(b) of such Act is amended by striking out "special work projects" and inserting in lieu thereof "public service employment".

(B) Section 432(d) of such Act is amended to read as follows:

"(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 non-reimbursable basis."

(C) Section 432 of such Act is further amended by adding at the end thereof the following new subsection:

"(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."

(4)(A) Section 433(a) of such Act is amended—

(i) by striking out "section 402" and inserting in lieu thereof "section 402(a)(19)(G)"; and

(ii) by adding at the end thereof the following new sentence: "The Secretary, in carrying out such program for individuals so referred to him by a State, shall accord priority to such individuals in the following order, taking into account employability potential: first, unemployed fathers; second, dependent children and relatives who have attained age 16 and who are not in school, or engaged in work or manpower training; third, mothers, whether or not required to register pursuant to section 402(a)(19)(A), who volunteer for participation under a work incentive program; fourth, all other individuals so referred to him."

(B) Section 433(b) of such Act is amended to read as follows:

"(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) In carrying out any such statewide operational plan of any State, there shall be developed jointly by the Secretary and the administrative unit of the State administering the special program referred to in section 402(a)(19)(G) in each area of the State an employability plan for

each individual residing in such area who is participating in the work incentive program established by this part. Such employability plan for any such individual shall (i) conform with the statewide operational plan of such State, (ii) provide that the separate administrative unit referred to in section 402(a)(19)(G)(ii) will provide the services referred to in section 402(a)(19)(G) (ii), and (iii) provide that the Secretary shall be responsible for providing the training, placement, and related services authorized under this part."

(C)(i) Section 433(e)(1) of such Act is amended by striking out "special work projects" and inserting in lieu thereof "public service employment".

(ii) Section 433(e)(2)(A) of such Act is amended by striking out "a portion" and inserting in lieu thereof "100 per centum (in the case of the first year that such agreement is in effect, if such agreement is in effect at least three years) and 90 per centum (if such agreement is in effect less than three years; or, if such agreement is in effect at least three years, in the case of any year after the first year that such agreement is in effect)".

(iii) Section 433(e)(2)(B) of such Act is amended by striking out "on special work projects of" and inserting in lieu thereof "in public service employment for".

(iv) Section 433(e)(3) of such Act is hereby repealed.

(D) Section 433(f) of such Act is amended by striking

out "any of the programs established by this part" and inserting in lieu thereof "section 432(b)(3)".

(E) Section 433(g) of such Act is amended by striking out "section 402(a)(19)(A) (i) and (ii)" and inserting in lieu thereof "section 402(a)(19)(G)".

(F) Section 433(h) of such Act is amended by striking out "special work projects" and inserting in lieu thereof "public service employment".

(G) Section 434 of such Act is amended—

(i) by inserting "(a)" immediately after "SEC. 434."; and

(ii) by adding at the end thereof the following new subsection:

"(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 relating to the participation by such member in such training."

(5)(A) Section 435(a) of such Act is amended, effective July 1, 1971, by striking out "80 per centum" and inserting in lieu thereof "90 per centum".

(B) Section 435(b) of such Act is amended by striking out "; except that with respect to special work projects under the program established by section 432(b)(3), the costs of

carrying out this part shall include only the costs of administration".

(6) Section 436(b) of such Act is amended by striking out "by the Secretary after consultation with" and inserting in lieu thereof "jointly by him and".

(7) Section 437 of such Act is amended to read as follows:

"SEC. 437. The Secretary is authorized to provide to an individual who is registered pursuant to section 402(a)(19)(A) and who is unemployed relocation assistance (including grants, loans, and the furnishing of such services as will aid an involuntarily unemployed individual who desires to relocate to do so in an area where there is assurance of regular suitable employment, offered through the public employment offices of the State in such area, which will lead to the earning of income sufficient to make such individual and his family ineligible for benefits under part A)."

(8) Section 438 of such Act is amended by striking out "projects under".

(9) Section 439 of such Act is amended to read as follows:

"SEC. 439. The Secretary and the Secretary of Health, Education, and Welfare shall, not later than six months after the date of enactment of the Social Security Amendments of 1970, issue regulations to carry out the purposes of this part,

as amended by the Social Security Amendments of 1970. 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 uniform reporting and similar require-
duty of which sall 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)."

(10) Section 441 of such Act is amended—

(A) by inserting "(a)" immediately after "SEC. 441.";

(B) by adding immediately after the last sentence thereof the following sentence: "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."; and

(C) by adding after and below such section the following new subsection:

"(b) The Secretary shall collect and publish monthly, by State, by age group, and by sex, the following information

with respect to individuals registered pursuant to section 402 (a)(19)(A)—

"(1) the number of individuals so registered, the number of individuals receiving each particular type of work training services, and the number of individuals receiving no such services;

"(2) the number of individuals placed in jobs by the Secretary under section 432(b)(1)(A), and the average wages of the individuals so placed;

"(3) the number of individuals who begin but fail to complete training, and the reasons for the failure of such individuals to complete training; and the number of individuals who register voluntarily but do not receive training or placement;

"(4) the number of individuals who obtain employment following the completion of training, and the number of such individuals whose employment is in fields related to the particular type of training received;

"(5) of the individuals who obtain employment following the completion of training, the average wages of such individuals, and the number retaining such employment three months, six months, and twelve months, following the date of completion of such training;

"(6) the number of individuals in public service

employment, by type of employment, and the average wages of such individuals; and

"(7) the amount of savings, under Part A of this title, realized by reason of the operation of each of the programs established pursuant to this part."

(11) Section 442 is amended to read as follows:

"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)."

(12) Section 443 is amended by striking out "20 per centum" wherever it appears therein and inserting in lieu thereof "10 per centum".

(13)(A) Section 402(a)(8)(A)(ii) of the Social Security Act is amended by striking out everything that follows "determination," and inserting in lieu thereof the following: "(I) the first $60 of earned income for individuals who are employed at least 40 hours per week, or at least 35 hours per week and are earning at least $64 per week, and (II) the first $30 of earned income for other individuals, plus in each case, one-third of up to $300 of additional earnings, and one-fifth of such additional earnings in excess

of $300, except that in each case reasonable child care expenses (subject to such limitations as the Secretary may prescribe in regulations) shall first be deducted before computing such individual's earned income; and".

(B) Except as provided in section 570, clause (A) shall be effective July 1, 1971, except that any State may elect to modify its plan so as to provide for an earlier effective date.

(C) The amendments made by this section shall, except as otherwise specified herein, take effect on January 1, 1971.

EMERGENCY ASSISTANCE TO NEEDY MIGRANT WORKERS WITH CHILDREN

SEC. 530. (a) Section 402(a) of the Social Security Act is amended by striking out "and" at the end of clause (22), and by inserting immediately before the period at the end of clause (23) the following: "; and (24) effective July 1, 1971, provide that emergency assistance to needy families, as defined in section 406(e)(1), be furnished on a Statewide basis to needy migrant workers with children in the State."

(b) Section 406(e) of such Act is amended by striking out paragraph (2).

(c) Section 403(a)(3)(A) of such Act is amended (A) by striking out "or" at the end of clause (ii), (B) by striking out "; plus" at the end of clause (iii) and inserting in lieu thereof ", or", and (C) by inserting after clause (iii) the following:

"(iv) emergency assistance to needy families, as defined in section 406(e)(1) which is furnished to needy migrant workers with families pursuant to section 402(a)(24); plus"

(d) Except as provided in section 570, the amendments made by this section shall be effective on July 1, 1971.

OBLIGATION OF DESERTING FATHER

SEC. 540. (a) Title IV of the Social Security Act is amended by adding after section 410 the following new section:

"PENALTY FOR CROSSING STATE LINES TO AVOID PARENTAL RESPONSIBILITIES

"SEC. 411. Whoever, knowingly goes from one place to another in interstate or foreign commerce for the purpose of avoiding any responsibility imposed upon him under the common law or under statutory law of any State pertaining to the obligations of a parent to his child, shall be guilty of a misdemeanor and upon conviction thereof shall be imprisoned for not more than one year.

(b) Title IV of such Act is further amended by adding after section 411 (as added by subsection (a) of this section) the following new section:

"FINANCIAL OBLIGATION OF DESERTING PARENT

"SEC. 412. (a) Except as provided in subsection (b), any individual who has deserted his spouse, child, or chil-

dren, with the result that such spouse, child, or children, because of financial need, obtained aid under this title, shall be obligated to the United States in an amount equal to the Federal share of such aid.

"(b) If a court of any State has issued a support order against any individual described in subsection (a), the obligation of such individual under this section shall be limited to the amount specified in such court order less any amounts actually paid by such individual pursuant to such court order. The Attorney General of the United States is authorized, in accordance with procedures applicable to the recovery of obligations due to the United States, to enforce such court order in any appropriate court and to distribute the proceeds to the beneficiaries of such court order after deducting the amount paid as aid under this title. He shall refund to any State that portion of the amount so recovered which constitutes the State's share of such aid.

"(c) If a State court has not issued a support order against an individual described in subsection (a) the Attorney General of the United States is authorized to recover from such individual an amount equal to the Federal share of the aid furnished under this title to the spouse and child or children of such individual.

"(d) If the Attorney General of the United States (or any other officer of the United States) obtains information

with respect to address or location of any individual described in subsection (b) such officer is authorized to furnish, upon request, such information to the deserted spouse, guardian, or custodian of the child or children deserted, or their counsel."

(c) The amendments made by this section shall be effective upon enactment of this Act.

DENIAL OF AID TO FAMILIES WITH DEPENDENT CHILDREN WHERE THERE IS A CONTINUING PARENT-CHILD RELATIONSHIP

SEC. 541. (a) Section 406(a) of the Social Security Act is amended by adding at the end thereof the following new sentences: "If the State plan of any State so provides, a child shall be deemed not to have been deprived of parental support or care by reason of the continued absence from the home of a parent if there exists a continuing child-parent type relationship between such child and an adult individual who is not the father, mother, grandfather, grandmother, adult brother, adult sister, adult stepbrother, adult stepsister, adult uncle, adult aunt, adult first cousin, adult nephew, or adult niece, of such child. For purposes of determining whether such a relationship exists between a child and such an adult individual, only the following factors may be taken into account: (A) the frequency with which such child and such individual appear together in public, (B)

whether such individual is the parent of a half brother or half sister of such child, (C) whether such individual exercises parental control over such child, (D) whether substantial gifts are made by such individual to such child or to members of the family of such child, (E) whether such individual claims such child as a dependent for income tax purposes, (F) 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, (G) 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, (H) 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, (I) whether such individual makes frequent visits to such household, (J) 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 between an adult individual and a child may be determined to exist in any case only after an evaluation of the factors referred to in the preceding sentence, as well as any evidence which may refute any inference supported by evidence related to such factors."

(b) The amendments made by this section shall be effective January 1, 1971.

DURATION OF RESIDENCE REQUIREMENTS UNDER PUBLIC ASSISTANCE PROGRAMS

SEC. 542. (a)(1) Section 2(a)(10) of the Social Security Act is amended (A) by striking out "and" at the end of subparagraph (B), and (B) by adding at the end thereof the following new subparagraphs:

"(D) except as provided in subparagraph (E), provide that assistance shall not be furnished to any individual unless such individual (i) is a resident of the State, and (ii) has resided in the State continuously for one year immediately preceding the application for assistance; and".

"(E) provide that assistance shall be furnished under the State plan for a period not to exceed one year to any individual who (i) has moved out of such State, (ii) was receiving assistance under such State plan in the month before the month in which he moved out of such State, (iii) continues to meet the eligibility requirements of such State plan except for residency, and (iv) does not meet the duration of residency requirements (if any) imposed under the old-age assistance plan of the State in which he is living;"

(2) Section 2(b) of such Act is amended by adding at the end thereof the following new sentence: "For purposes of the preceding sentence, the requirement of subsection (a)(10)(D) shall not apply, if compliance with such requirement would be inconsistent with State law, or any rule or regulation made pursuant to State law."

(3) Section 4(2) of such Act is amended by inserting "(other than the provision contained in section 2(a)(10)(D)" immediately after "section 2(a)".

(b)(1) Section 402 of such Act (as amended by section 530 of this Act) is amended further by (A) striking out "and" at the end of paragraph (23), and (B) by inserting immediately before the period at the end of paragraph (24) the following: "; (25) except as provided in paragraph (26), provide that aid will not be furnished with respect to any child unless such child (A) is a resident of the State, and (B)(i) has resided in the State for one year immediately preceding the application for such aid, or (ii) was born within one year immediately preceding the application for such aid, and the parent or other relative with whom the child is living has resided in the State for one year immediately preceding the birth of such child; and (26) provide that aid shall be furnished under the State plan for a period not to exceed one year to any individual who (A) has moved out of 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) does not meet the duration of residency requirements (if any) imposed under the plan for aid to families with dependent children of the State in which he is living."

(2) Section 402(b) of such Act is amended by adding at the end thereof the following new sentence: "For purposes of the preceding sentence, the requirement of subsection (a)(25) shall not apply, if compliance with such requirement would be inconsistent with State law, or any rule or regulation made pursuant to State law."

(3) Section 404(a)(2) of such Act is amended by inserting "(other than the provision contained in section 402(a)(25))" immediately after "section 402(a)".

(c)(1) Section 1002(a) of such Act (as amended by section 505 of this Act) is further amended (A) by striking out "and" at the end of paragraph (13), and (B) by inserting immediately before the period at the end of paragraph (14) the following: "; (15) except as provided in paragraph (16), provide that aid will 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 one year immediately preceding the application for aid; and (16) provide that aid shall be furnished under the State plan

for a period not to exceed one year to any individual who (A) has moved out of 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) does not meet the duration of residency requirements (if any) imposed under the plan for aid to the blind of the State in which he is living.".

(2) Section 1002(b) of such Act is amended by adding at the end thereof the following new sentence: "For purposes of the first sentence of this subsection, the requirement of subsection (a)(15) shall not apply, if compliance with such requirement would be inconsistent with State law, or any rule or regulation made pursuant to State law.".

(3) Section 1004(2) of such Act is amended by inserting "(other than the provision contained in section 1002 (a)(15))" immediately after "section 1002(a)".

(d)(1) Section 1402(a) of such Act is amended (A) by striking out "and" at the end of paragraph (11), and (B) by inserting immediately before the period at the end of paragraph (12) the following: "; (13) except as provided in paragraph (14), provide that aid will 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 one year immediately preceding the application for aid; and

(14) provide that aid shall be furnished under the State plan for a period not to exceed one year to any individual who (A) has moved out of 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) does not meet the duration of residency requirements (if any) imposed under the plan for aid to the disabled of the State in which he is living."

(2) Section 1402(b) of such Act is amended by adding at the end thereof the following new sentence: "For purposes of the preceding sentence, the requirement of subsection (a)(13) shall not apply, if compliance with such requirement would be inconsistent with State law, or any rule or regulation made pursuant to State law."

(3) Section 1404(2) of such Act is amended by inserting "(other than the provision contained in section 1402(a)(13))" immediately after "section 1402(a)".

(e)(1) Section 1602(a) of such Act (as amended by section 505 of this Act) is further amended (A) by striking out "and" at the end of paragraph (17), (B) by striking out the period at the end of paragraph (18) and inserting a semicolon in lieu of such period, and (C) by adding after paragraph (18) the following new paragraphs:

"(19) provide that aid to the aged, blind, or dis-

abled 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 one year immediately preceding the application for such aid; and

"(20) provide that aid to the aged, blind, or disabled shall be furnished under the State plan for a period not to exceed one year to any individual who (A) has moved out of 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) does not meet the duration of residency requirements (if any) imposed under the plan for aid to the aged, blind, or disabled of the State in which he is living."

(2) Section 1602(b) of such Act is amended by adding at the end thereof the following new sentence: "For purposes of the first sentence of this subsection, the requirement of subsection (a)(19) shall not apply, if compliance with such requirement would be inconsistent with State law, or any rule or regulation made pursuant to State law.".

(3) Section 1604 of such Act is amended by inserting "(other than the provision contained in section 1602(a)(19))" immediately after "section 1602" and immediately after "any such provision".

(f) Except as provided in section 570, the amendments made by this section shall be effective as of July 1, 1971.

LIMITATION ON DURATION OF APPEALS PROCESS

SEC. 543. (a) Section 2(a)(4) of the Social Security Act is amended by—

(1) striking out "(4) provide" and inserting in lieu thereof "(4) provide (A)"; and

(2) inserting before the semicolon at the end thereof the following: ", (B) that any hearing held before the State agency at the request of any individual to determine the matter of whether the assistance provided to such individual under the State plan should be terminated or the amount thereof reduced shall be completed, and the State agency shall make a final decision 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 assistance, and (C) that if any individual is determined under any such final decision to have received (prior to such decision) as assistance under the State plan any amount to which he was not entitled, such amount shall be repaid by such individual to the State agency, and if such amount is not so repaid it shall be withheld from any future payments to which such individual would otherwise be entitled under the State plan".

(b) Section 402(a)(4) of such Act is amended by—

(1) striking out "(4) provide" and inserting in lieu thereof "(4) provide (A)"; and

(2) inserting before the semicolon at the end thereof the following: ", (B) that any hearing held before the State agency 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 completed, and the State agency shall make a final decision 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, and (C) that if any individual (or family) is determined under any such final decision to have received (prior to such decision) as aid under the State plan any amount to which he (or his family) was not entitled, such amount shall be repaid by such individual (or his family) to the State agency, and if such amount is not so repaid it shall be withheld from any future payments to which such individual (or his family) would otherwise be entitled under the State plan".

(c) Section 1002(a)(4) of such Act is amended by—

(1) striking out "(4) provide" and inserting in lieu thereof "(4) provide (A)"; and

(2) inserting before the semicolon at the end thereof the following: ", (B) that any hearing held before the State agency at the request of any individual to determine the matter of whether the aid provided to such individual under the State plan should be terminated or reduced shall be completed, and the State agency shall make a final decision 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, and (C) that if any individual is determined under any such final decision to have received (prior to such decision) as aid under the State plan any amount to which he was not entitled, such amount shall be repaid by such individual to the State agency, and if such amount is not so repaid it shall be withheld from any future payments to which such individual would otherwise be entitled under the State plan".

(d) Section 1402 (a) (4) of such Act is amended by—

(1) striking out "(4) provide" and inserting in lieu thereof "(4) provide (A)"; and

(2) inserting before the semicolon at the end thereof the following: ", (B) that any hearing held before the State agency at the request of any individual to determine the matter of whether the aid provided to such individual under the State plan should be terminated or reduced

shall be completed, and the State agency shall make a final decision with respect to such matter, not later than 30 days after the date such individual is notified of the intention of such agency to terminate or reduce the amount of such aid, and (C) that if any individual is determined under any such final decision to have received (prior to such decision) as aid under the State plan any amount to which he was not entitled, such amount shall be repaid by such individual to the State agency, and if such amount is not so repaid it shall be withheld from any future payments to which such individual would otherwise be entitled under the State "plan".

(e) Section 1602(a)(4) of such Act is amended by—

(1) striking out "(4) provide" and inserting in lieu thereof "(4) provide (A)"; and

(2) inserting before the semicolon at the end thereof the following: ", (B) that any hearing held before the State agency at the request of any individual to determine the matter of whether the aid provided to such individual under the State plan should be terminated or reduced shall be completed, and the State agency shall make a final decision 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, and (C) that if any individual is determined under any such final decision to have received (prior to such decision) as aid under the State plan any amount to which he was not entitled, such amount shall be repaid by such individual to the State agency, and if such amount is not so repaid it shall be withheld from any future payments to which such individual would otherwise be entitled under the State plan".

(f) The amendments made by this section shall take effect July 1, 1971.

REFUSAL TO NAME PUTATIVE FATHER OF CHILD

SEC. 544. Section 402(a)(10) of the Social Security Act is amended by inserting immediately before the semicolon at the end thereof the following: "(except that nothing in this clause shall be construed to preclude the State agency from seeking the assistance of the mother of a child born out of wedlock, who is an applicant for or recipient of aid under the State plan, in identifying the father of such child)".

DENIAL OF WELFARE FOR REFUSAL TO ALLOW CASEWORKER IN HOME

SEC. 545. Title XI of the Social Security Act is amended by adding after section 1127 (as added by section 506 of this Act) and before section 1151 (as added by section 245 of this Act) the following new section:

"AUTHORITY TO REQUIRE INSPECTION OF HOME IN ADMINISTRATION OF STATE WELFARE PLANS

"SEC. 1128. Any State which has in effect a plan approved under title I, X, XIV, XVI, or part A or title IV may require that any applicant for (or any individual presently receiving) aid or assistance under any such plan agree, as a condition of eligibility for such aid or assistance, 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."

PROHIBITION AGAINST USE OF FEDERAL FUNDS TO UNDERMINE PUBLIC ASSISTANCE PROGRAMS

SEC. 546. Title XI of the Social Security Act is amended by adding after section 1128 (as added by section 545 of this Act) and before section 1151 (as added by section 245 of this Act) the following new section:

"PROHIBITION AGAINST USE OF FEDERAL FUNDS TO UNDERMINE PROGRAMS UNDER THE SOCIAL SECURITY ACT

"SEC. 1129. (a) 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 con-

tractual arrangement with the executive branch, 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.

"(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."

REGULATIONS REQUIRING USE OF DECLARATION METHOD IN DETERMINING ELIGIBILITY FOR PUBLIC ASSISTANCE

SEC. 550. Section 1102 of the Social Security Act is amended (1) by inserting "(a)" immediately after "SEC. 1102." and (2) by adding at the end thereof the following new subsection:

"(b) Nothing contained in subsection (a) or any other provision of law 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 I, part A of title IV, title X, title XIV, or title XVI, to utilize a simplified or declaration method in determining eligibility for aid or assistance under such plan."

DEPENDENT CHILDREN OF UNEMPLOYED FATHERS; DEFINITION OF UNEMPLOYMENT

SEC. 551. (a) Section 407 of the Social Security Act is amended by—

(1) striking out "(as determined in accordance with standards prescribed by the Secretary)" in subsection (a) and in subsection (b)(1)(A);

(2) striking out "and" at the end of paragraph (2) of subsection (d);

(3) striking out the period at the end of paragraph (3) of subsection (d) and inserting in lieu thereof "; and"; and

(4) inserting after such paragraph (3) the following new paragraph:

"(4) An individual shall be considered to be unemployed if—

"(A) he worked less than ten hours in the last week prior to application for aid under a State plan approved under section 402, or

"(B) he worked less than eighty hours in the thirty days prior to application."

(b) The amendments made by this section shall be effective as of July 1, 1971.

ADVISORY COUNCILS FOR STATE PROGRAMS OF AID TO FAMILIES WITH DEPENDENT CHILDREN NOT TO BE REQUIRED UNDER REGULATIONS OF THE SECRETARY

SEC. 552. Section 1102 of the Social Security Act (as amended by section 550 of this Act) is further amended by adding at the end thereof the following new subsection:

"(c) Nothing contained in subsection (a) or any other provision of law 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, to establish or pay the expenses of any advisory council to advise the State with respect to the programs under such title in such State."

USE OF SOCIAL SECURITY NUMBERS

SEC. 560. (a) Section 2(a) of the Social Security Act (as amended by section 542 of this Act) is further amended (A) by striking out "and" at the end of paragraph (12), (B) by striking out the period at the end of paragraph (13) and inserting in lieu of such period "; and", and (C) by adding after paragraph (13) the following new paragraph:

"(14) effective January 1, 1972, provide (A) that, as a condition of eligibility under the plan, each applicant for or recipient of assistance shall furnish to the State agency his social security account number; and (B) that such State agency shall utilize such account numbers in the administration of such plan."

(b) Section 402(a) of such Act (as amended by section 542 of this Act) is further amended (A) by striking out "and" at the end of paragraph (25), and (B) by inserting immediately before the period at the end of paragraph (26), the following: "; and (27) effective January 1, 1972, provide (A) 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; and (B) that such State agency shall utilize such account numbers in the administration of such plan."

(c) Section 1002(a) of such Act (as amended by section 542 of this Act) is further amended (A) by striking out "and" at the end of paragraph (15), and (B) by inserting immediately before the period at the end of paragraph (16) the following: "; and (17) effective January 1, 1972, provide (A) 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; and (B)

that such State agency shall utilize such account numbers in the administration of such plan."

(d) Section 1402(a) of such Act (as amended by section 542 of this Act) is further amended (A) by striking out "and" at the end of paragraph (13), and (B) by inserting immediately before the period at the end of paragraph (14) the following: "; and (15) effective January 1, 1972, provide (A) 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; and (B) that such State agency shall utilize such account numbers in the administration of such plan."

(e) Section 1602(a) of such Act (as amended by section 542 of this Act) is further amended (A) by striking out "and" at the end of paragraph (19), (B) by striking out the period at the end of paragraph (20) and inserting in lieu of such period "; and", and (C) by adding after paragraph (20) the following new paragraph:

(21) effective January 1, 1972, provide (A) 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; and (B) that such State agency shall utilize such account numbers in the administration of such plan."

TESTING OF ALTERNATIVES TO PROGRAM OF AID TO FAMILIES WITH DEPENDENT CHILDREN

SEC. 561. (a) For purposes of this section—

(1) The term "family assistance test program" means a program which contemplates that—

(A) the assets and resources of families will (except to the extent otherwise prescribed by the Secretary) be taken into account in determining eligibility for or amount of payments under the program;

(B) there will be established minimum income levels for families of various sizes;

(C) money payments will be made (periodically) to families whose income is less than the applicable minimum income level so established;

(D) such money payments will be denied to any adult member of a family (other than such a member who is ill, aged, or disabled, is caring for another member of such family who is ill or disabled, or is caring for another member of such family who is a child of preschool age) who refuses without good cause to accept employment or participate in a vocational training or similar training program which is designed to prepare such member to engage in employment;

(E) incentives for members of families to engage in employment will be provided by disregarding a por-

tion of the earnings of such family for purposes of determining eligibility for and the amounts of the money payments payable to such family under the program; and

(F) there will be provided to the families participating in such program (in appropriate cases) (i) placement and employment training services, (ii) child care services when needed to facilitate participation, by adult members of such families, in employment or a vocational training or similar training program, (iii) family planning services, and (iv) other appropriate supportive services.

(2) The term "workfare test program" means a program which contemplates that—

(A) the assets and resources of families will (except to the extent otherwise prescribed by the Secretary) be taken into account in determining eligibility to participate in the program;

(B) families headed by an adult, who (by reason of advanced age, illness, or disability, caring for another member of the family who is ill or disabled, or caring for a member of such family who is a child of pre-school age) is presumed to be unable to engage in employment, will be entitled to receive welfare assistance in the form of money payments the amount of which shall be based

on standards of need developed for families of various sizes, with provision for disregarding a portion of the earnings of such family for purposes of determining eligibility for and the amounts of the money payments payable to such family under the program;

(C) adult individuals who are heads of families and who are unemployed (or underemployed) will be eligible to register to participate in employment or in a training program designed to qualify them for specific jobs available in the locality in which they live;

(D) all registrants will be placed in employment (including subsidized public service employment) or such a training program;

(E) registrants placed in employment for wages at less than the rate of the minimum wage would receive wage supplement payments (in amounts which shall not be greater than the difference between any registrant's hourly wage and the minimum wage) for hours (not in excess of 40 hours for any week) during which work is performed by them in such employment;

(F) training allowances would be paid to registrants with appropriate reductions in the amount of such allowances in cases where registrants participate in training on less than a full-time basis; and

(G) there will be provided to the families partic-

ipating in such program (i) child care services when needed to facilitate participation, by any registrant, in employment or a vocational training or similar training program, (ii) family planning services, and (iii) other appropriate supportive services.

(3) The term "family" means a family with children.

(b)(1) The Secretary of Health, Education, and Welfare (hereinafter in this section referred to as the "Secretary") is authorized, effective January 1, 1971, to plan for and conduct, in accordance with the provisions of this section, not more than four test programs. One-half of such programs shall be family assistance test programs and one-half of such programs shall be workfare test programs.

(2) Whenever a family assistance test program is commenced, there shall commence, on the same date as such program, a workfare test program, and both such programs shall (except as may otherwise be authorized by the Congress) terminate on the same date. Except as may otherwise be authorized by the Congress, no test program under this section shall be conducted for a period of less than 24 months.

(3) Any such test program shall be conducted only in and with respect to an area which consists of a State, one or more political subdivisions of a State, or part of a political subdivision of a State, and shall be applicable to all the individuals who are residents of the State or the area of the

State in and with respect to which such program is conducted.

(4) During any period for which any such test program is in effect in any State or in any area of a State, individuals residing in such State or the area of the State in which such program is in effect shall not be eligible for aid or assistance under any State plan or program for which the State receives Federal financial assistance under part A of title IV of the Social Security Act.

(5) The Secretary, in determining the areas in which test programs under this section shall be conducted, shall select areas with a view to assuring—

(A) that the number of participants in any such program will (to the maximum extent practicable) be equal to the number of participants in any other such program; and

(B) that the area in which any family assistance test program is conducted shall be comparable (in terms of size and composition of population, of average per capita income, rate of unemployment, and other relevant criteria) to an area in which a workfare test program is conducted.

(c)(1) No test program under this section shall be conducted in any State (or any area thereof) unless such State

shall have entered into an agreement with the Secretary under which the State agrees—

(A) to participate in the costs of such test program; and

(B) to cooperate with the Secretary in the conduct of such program.

(2) Under any such agreement, no State shall be required to expend, with respect to any test program conducted within such State (or any area thereof), amounts greater than the amounts which would have been expended with respect to such State or area thereof (as the case may be), during the period that such test program is in effect, under the State plan of such State approved under part A of title IV of the Social Security Act. For purposes of determining the amount any State would have expended under such a plan during the period that any such test program is in effect within such State (or any area thereof), it shall be assumed that the rate of State expenditure (from non-Federal funds) under such plan would be equal to the average rate of State expenditure (from non-Federal funds) under such plan for the 12-month period immediately preceding the commencement of such test program.

(d)(1) The Secretary shall, upon completion of any plans for and prior to the commencement of any test pro-

gram under this section, submit to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives a complete and detailed description of such program and shall invite and give consideration to the comments and suggestions of such committees with respect to such program.

(2) During the period that test programs are in operation under this section, the Secretary shall from time to time (but not less frequently than once during any 12-month period) submit to the Congress a report on such programs which shall contain full and complete information and data with respect to such programs and the operation thereof, together with such recommendations and comments of the Secretary with respect to such programs as he deems desirable.

(3) At the earliest practicable date after the termination of all test programs authorized to be conducted by this section, the Secretary shall submit to the Congress a full and complete report on such programs and their operation together with the Secretary's evaluation of such programs and such comments or recommendations of the Secretary with respect to such programs as he deems desirable.

(e)(1) The Secretary shall—

(A) in the planning of any test program under this section; or

(B) in assembling information, statistics, or other

materials, to be contained in any report to Congress under this section;

consult with, and seek the advice and assistance of, the General Accounting Office and the General Accounting Office shall consult with the Secretary and furnish such advice and assistance to him upon request of the Secretary or at such times as the Comptroller General deems desirable.

(2) The operations of any test program conducted under this section shall be reviewed by the General Accounting Office, and the books, records, and other documents pertaining to any such program or its operation shall be available to the General Accounting Office at all reasonable times for purposes of audit, review, or inspection. The books, records, and documents of each such program shall be audited by the General Accounting Office from time to time (but not less frequently than once each year).

(3) During the period that test programs are in operation under this section, the Comptroller General shall from time to time (but not less frequently than once during any 12-month period) submit to the Congress a report on such programs which shall contain full and complete information and data with respect to such programs and the operation thereof, together with such recommendations and comments of the Comptroller General with respect to such programs as he deems desirable.

(4) At the earliest practicable date after the termination of all test programs authorized to be conducted by this section, the Comptroller General shall submit to the Congress a full and complete report on such programs and their operation together with his evaluation of, and comments and recommendations (if any) with respect to, such programs.

(f) In the administration of test programs under this section, the Secretary shall provide safeguards which restrict the use or disclosure of information identifying participants in such programs to purposes directly connected with the administration of such programs (except that nothing in this subsection shall be construed to prohibit the furnishing of records or information concerning participants in such programs to the Committee on Finance of the Senate or the Committee on Ways and Means of the House of Representatives).

(g) For the purpose of enabling the Secretary to formulate operational plans and to conduct test programs under this section, there are authorized to be appropriated for each fiscal year such sums as may be necessary.

PILOT PROJECT TO BE ADMINISTERED BY REHABILITATION SERVICES ADMINISTRATION

SEC. 562. (a)(1) The Secretary of Health, Education, and Welfare is authorized to utilize the personnel and facilities of the Rehabilitation Services Administration to con-

duct in one location a pilot project of a welfare program for needy families with children (including families where the head of the family is employed but whose earnings are insufficient adequately to meet family needs) headed by individuals who are able (or when provided with needed counseling, rehabilitative services, and vocational training, have a potential for becoming able) to work.

(2)(A) The pilot project authorized by this section shall commence on the same date as the commencement of the first family assistance test program to be commenced under section 561 and such project shall terminate on the date of termination of such test program.

(B) The Secretary, in determing the area in which such pilot project shall be conducted, shall select an area which is comparable (in terms of size and composition of population, of acreage per capita income, rate of unemployment, and other relevant criteria) to the area in which such family assistance test program is to be conducted.

(b)(1) It shall be the purpose and objective of such project to encourage and assist adult individuals who are able to work (or have a potential for becoming able to work) to prepare for and obtain employment.

(2) Such individuals shall be provided with such coun-

seling, rehabilitative, social, and other services (including child care services), such as vocational training as may be necessary or appropriate to prepare them for and enable them to accept employment.

(3) To the maximum extent feasible, such individuals shall be prepared for and assisted in obtaining employment the remuneration from which will be sufficient adequately to meet family needs.

(c) Individuals who are residents of the area wherein such pilot project is conducted shall not, during the period that such project is in effect, be eligible for aid or assistance under any State plan or program for which the State receives Federal financial assistance under part A of title IV of the Social Security Act; but, such pilot project shall be administered in such manner that such individuals who would, except for such pilot project, be eligible for aid or assistance under any such plan or program, shall receive benefits equal to those which would have been provided to them under such plan or program.

(d) The Secretary may consult with the Secretary of Labor concerning training or other manpower services to be provided under any pilot project conducted under this sec-

tion, and may with the consent of the Secretary of Labor utilize, on a reimbursable basis, the personnel and facilities of the Department of Labor in providing such services under any such pilot project.

(e) The provisions of subsections (c), (d), (e), and (f) or section 561 of this Act shall be applicable to the pilot project authorized under this section in like manner as if such project were a test program under such section 561.

(f) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

CERTAIN EFFECTIVE DATES POSTPONED IF STATE LEGISLATURE DOES NOT CONVENE BEFORE 1972

SEC. 570. The requirements imposed by sections 520 (b)(14), 530, and 542 of this Act shall not be requirements for the State plan of any State prior to July 1, 1972, if the legislature of such State does not meet in a regular session which closes before July 1, 1971.

TITLE ~~III~~ *VI*—MISCELLANEOUS PROVISIONS

MEANING OF TERM "SECRETARY"

SEC. ~~301~~ *601*. As used in *titles I, II, IV, and V of* this Act, and in the provisions of the Social Security Act amended by this Act, the term "Secretary," unless the context other-

wise requires, means the Secretary of Health, Education, and Welfare.

DEDUCTIBILITY OF ILLEGAL MEDICAL REFERRAL PAYMENTS, ETC.

SEC. 602. (a) Section 162(c) of the Internal Revenue Code of 1954 (relating to bribes and illegal kickbacks) is amended—

(1) by striking out paragraphs (2) and (3) and inserting in lieu thereof the following new paragraph:

"(2) OTHER ILLEGAL PAYMENTS.—No deduction shall be allowed under subsection (a) for any payment (other than a payment described in paragraph (1)) made, directly or indirectly, to any person, if the payment constitutes an illegal bribe or kickback under any law of the United States, or under any law of a State (but only if such State law is generally enforced), which subjects the payor to a criminal or civil penalty (including the loss of license or privilege to engage in a trade or business). For purposes of this paragraph, a bribe or kickback includes a payment in consideration of the referral of a client, patient, or customer."; and

(2) by striking out "BRIBES AND ILLEGAL KICKBACKS." in the heading of such section and inserting in lieu thereof "ILLEGAL BRIBES, KICKBACKS, ETC.".

(b) The amendments made by subsection (a) shall apply with respect to payments made after December 30, 1969.

REQUIRED INFORMATION RELATING TO EXCESS MEDICARE TAX PAYMENTS BY RAILROAD EMPLOYEES

SEC. 603. (a) Section 6051(a) of the Internal Revenue Code of 1954 (relating to requirement of receipts for employees) is amended—

(1) by striking out "section 3101, 3201, or 3402" in the matter preceding paragraph (1) and inserting in lieu thereof "section 3101 or 3402";

(2) by inserting "and" at the end of paragraph (5), and by striking out "; and" at the end of paragraph (6) and inserting in lieu thereof a period; and

(3) by striking out paragraphs (7) and (8).

(b) Section 6051(c) of such Code (relating to additional requirements) is amended by striking out "sections 3101 and 3201" in the second sentence and inserting in lieu thereof "section 3101".

(c) Section 6051 of such Code (relating to receipts for employees) is amended by adding at the end thereof the following new subsection:

"(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."

(d) The amendments made by this section shall apply in respect of remuneration paid after December 31, 1969.

REPORTING OF MEDICAL PAYMENTS

SEC. 604. (a) Subpart B of part III of subchapter A of chapter 61 of the Internal Revenue Code of 1954 (relating to information concerning transactions with other persons) is amended by adding at the end thereof the following new section:

"SEC. 6050A. RETURNS REGARDING PAYMENTS TO PROVIDERS OF HEALTH CARE SERVICES.

"(a) REQUIREMENT OF REPORTING.—

"(1) PAYMENTS TO PROVIDERS.—Every person who during any calendar year (beginning with calendar year 1971) makes payments aggregating $600 or more to a provider of health care services for health care services furnished by such provider or by another such provider shall make a return according to the forms or regulations prescribed by the Secretary or his delegate setting forth the total amount of such payments made to such provider during the calendar year, and the name and address of such provider.

"(2) PAYMENTS IN REIMBURSEMENT OF CERTAIN AMOUNTS PAID OR PAYABLE TO PROVIDERS UNDER GOVERNMENT PROGRAMS.—Every person who during

any calendar year (beginning with calendar year 1972) makes payments to one or more persons in reimbursement of amounts aggregating $600 or more paid or payable to a provider of health care services for health care services furnished by such provider or by another such provider under a Government health care program shall make a return according to the forms or regulations prescribed by the Secretary or his delegate setting forth the total amount paid or payable to such provider during the calendar year with respect to which such reimbursements were made, and the name and address of such provider.

"(b) EXCEPTIONS.—

"(1) EXEMPT ORGANIZATIONS.—Subsections (a) (1) and (2) shall not apply to any payment to, or amount paid or payable to, an organization—

"(A) which is described in section 501(c)(3) and is exempt from taxation under section 501(a), or

"(B) which is an agency or instrumentality of the United States or of any State or political subdivision thereof.

"(2) CERTAIN DIRECT PAYMENTS.—Subsection (a)(1) shall not apply to—

"(A) any payment by an individual for health

care services furnished to himself or any other individual (other than any such payment made in the course of a trade or business), or

"(B) any payment of wages (as defined in section 3401(a)) with respect to which a statement is made under section 6051.

"(3) PAYMENTS SPECIFIED IN REGULATIONS.—The Secretary or his delegate may by regulations specify payments to which subsection (a)(1) shall not apply and amounts paid or payable to which subsection (a)(2) shall not apply.

"(c) DEFINITIONS.—For purposes of this section—

"(1) HEALTH CARE SERVICES.—The term 'health care services' means—

"(A) services described in paragraphs (1) through (9) of section 1861(s) of the Social Security Act, or (to the extent not described therein) in paragraphs (1) through (15) of section 1905(a) of such Act, and

"(B) such other services (similar or related to the services described in subparagraph (A)) as the Secretary or his delegate may prescribe by regulations.

"(2) PROVIDERS OF SERVICES.—The term 'provider of health care services' means any person who furnishes health care services, except any such person whose services are principally the selling or leasing of items of personal property.

"(3) GOVERNMENT HEALTH CARE PROGRAMS.—The term 'Government health care program' means any program for providing health care services which is administered by any department, agency, or instrumentality of the Government of the United States or is funded to a substantial extent by the United States, and includes (but is not limited to) the programs provided under—

"(A) titles V, XVIII, and XIX of the Social Security Act,

"(B) chapter 89 of title 5, United States Code, and the Retired Federal Employees Health Benefits Act,

"(C) chapter 55 of title 10, United States Code, and

"(D) chapter 17 of title 38, United States Code.

"(d) RETURNS BY GOVERNMENT OFFICERS.—Any return required under subsection (a) with respect to payments or reimbursements made by the United States, any

State or political subdivision thereof, or any agency or instrumentality of the foregoing, shall be made by the officers or employees having information as to such payments or reimbursements.

"(e) STATEMENTS TO BE FURNISHED TO PROVIDERS WITH RESPECT TO WHOM INFORMATION IS FURNISHED.—Every person making a return under subsection (a) shall furnish to each provider of health care services whose name is set forth in such return a written statement showing—

"(1) the name and address of the person making such return, and

"(2) the total amount of payments described in subsection (a)(1) made to the provider as shown on such return, and the total amounts paid or payable to the provider with respect to which reimbursements described in subsection (a)(2) were made as shown on such return.

The written statement required under the preceding sentence shall be furnished to the provider on or before January 31 of the year following the calendar year for which the return under subsection (a) was made.

"(f) RECIPIENT TO FURNISH REQUIRED INFORMATION.—Upon demand of a person making payments to, or in

reimbursement of amounts paid or payable to, a provider of health care services, there shall be furnished to such person by such provider—

"(1) his name and address, and (if different) the address used for purposes of filing his income tax return, and

"(2) such identifying number as may be prescribed for securing proper identification of such provider.

"(g) RETENTION OF RECORDS.—Every person making a return under subsection (a) shall—

"(1) retain the records and other documents relating to the payments and reimbursements with respect to which such return is made for such time as the Secretary or his delegate prescribes by regulations, and

"(2) make such records and documents available to the Secretary or his delegate whenever in the judgment of the Secretary or his delegate such records and documents are necessary to the determination of the tax imposed on any person under subtitle A.

"(h) STUDY OF PRACTICES IN COLLECTING PAYMENTS FOR HEALTH CARE SERVICES.—

"(1) JOINT STUDY BY SECRETARIES OF TREASURY AND HEALTH, EDUCATION, AND WELFARE.—The Secretary and the Secretary of Health, Education, and Welfare shall make a joint continuing study of the practices

of providers of health care services in collecting payments for health care services (A) from insurance companies which provide health care insurance coverage for individuals and (B) from the individuals for whom such services are furnished.

"(2) REPORTS TO CONGRESSIONAL COMMITTEES.—The Secretary and the Secretary of Health, Education, and Welfare shall, on or before June 30 of each year (beginning with 1971), report the results of their study under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives."

(b)(1) The table of sections for subpart B of part III of subchapter A of chapter 61 of the Internal Revenue Code of 1954 is amended by adding at the end thereof the following new item:

"Sec. 6050A. Returns regarding payments to providers of health care services."

(2) Section 6041 (a) of such Code (relating to information at source) is amended by striking out "or 6049 (a) (1)" and inserting in lieu thereof "6049 (a) (1), or 6050A (a)".

(3) Section 6652 (a) of such Code (relating to failure to file certain information returns) is amended—

(A) by striking out "or" at the end of paragraph (2);

(B) by inserting "or" at the end of paragraph (3);

(C) by inserting after paragraph (3) the following new paragraph:

"(4) to make a return required by section 6050A (a) (relating to reporting payments made to providers of health care services, etc.) with respect to payments to a provider of health care services and amounts paid or payable to such a provider for which reimbursements were made,"; and

(D) by striking out "(2) or (3)" and inserting in lieu thereof "(2), (3), or (4)".

(4) Section 6678 of such Code (relating to failure to furnish certain statements) is amended—

(A) by inserting "6050A (e)," before "or 6052 (b)"; and

(B) by inserting "6050A (a)," before "or 6052 (a)".

(c) Title XI of the Social Security Act is amended by adding after section 1129 (as added by section 546 of this Act) and before section 1151 (as added by section 245 of this Act) the following new section:

"RECORDS WITH RESPECT TO MEDICAL AND HEALTH CARE ITEMS AND SERVICES

"SEC. 1130. (a) It shall be the duty of the Secretary to compile, keep, and maintain, for each calendar year (be-

ginning with the calendar year 1970), such records as may be necessary accurately to indicate—

"(1) the identity (by name, address, medical or health care specialty, and such other identifying criteria as may be appropriate) of each person who, during the calendar year, furnishes medical or health care items or services to any individual, the number of individuals to whom such items or services were furnished by such person during such year, and the items and services furnished to such individuals by such person during such year, if all or any part of the cost or charge attributable to the provision of such items or services is payable under a program established by title XVIII or under any program or project under or established pursuant to this title, title V, or title XIX; and

"(2) with respect to each person referred to in paragraph (1), the aggregate of the amounts of the costs or charges attributable, under each program or project referred to in such paragraph, to medical or health care items or services furnished, during the calendar year, by such person to individuals under such programs and projects (including, in the aggregate amount of costs or charges so attributable, the amounts paid to individuals by reason or on account of the furnishing by such person of such items or services to such individuals).

"(b)(1) In order to carry out the provisions of subsection (a), the Secretary shall require persons, agencies, or agents (including carriers and intermediaries utilized under title XVIII and fiscal agents and insurers utilized under any program established under or pursuant to title V or XIX) administering, or assisting in the administration of, any program or project referred to in subsection (a)(1) to collect, and submit to the Secretary at such time or times as the Secretary may require, such data and information as the Secretary may deem necessary or appropriate. Such persons, agents, carriers, intermediaries, fiscal agents, and insurers shall utilize, in supplying the data and information provided for in the preceding sentence, the identifying numbers required under paragraph (2) as the basic means of identifying persons referred to in subsection (a)(1).

"(2) The Secretary shall require, for purposes of identifying the persons referred to in subsection (a)(1), the employment of the identifying numbers utilized on returns required with respect to payments to such persons pursuant to section 6050A of the Internal Revenue Code of 1954.

"(c)(1) The Secretary shall submit to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives with respect to each calendar year, beginning with the calendar year 1970, a

report indicating the name, address, and medical or health care specialty of each person who, during such year, furnished medical or health care items or services to individuals the costs of or charges for which give rise to payments under one or more of the programs or projects referred to in subsection (a)(1) of $25,000 or more. Such report shall indicate the amount of payments under each of such programs or projects attributable to such items or services furnished during such year by each such person, the number of different individuals to whom such items or services were furnished by such person during such year, and the items and services furnished to such individuals by such person during such year.

"(2) Such report for the calendar year 1970 shall be submitted not later than June 30, 1971, and such report for each succeeding calendar year shall be submitted not later than June 30 of the following calendar year."

APPOINTMENT AND CONFIRMATION OF ADMINISTRATOR OF SOCIAL AND REHABILITATION SERVICES

SEC. 605. Appointments made on or after the date of enactment of this Act to the office of the Administrator of the Social and Rehabilitation Service, within the Department of Health, Education, and Welfare, shall be made by the President, by and with the advice and consent of the Senate.

ADVISORY COUNCIL ON SOCIAL SECURITY; CHANGE IN REPORTING DATE

SEC. 606. So much of section 706(d) of the Social Security Act as precedes paragraph (1) is amended by inserting immediately after "appointed," the following: "(except that the Council appointed in 1969 shall submit its reports to the Secretary not later than March 1, 1971)".

VETERANS' PENSIONS

SEC. 607. (a)(1) The table in subsection (b) of section 521 of title 38, United States Code, is amended to appear as follows:

"Column I		Column II
Annual income		
More than— but	Equal to or less than—	
	$400	$120
$400	500	117
500	600	114
600	700	110
700	800	106
800	900	102
900	1,000	98
1,000	1,100	94
1,100	1,200	90
1,200	1,300	86
1,300	1,400	81
1,400	1,500	76
1,500	1,600	70
1,600	1,700	64
1,700	1,800	58
1,800	1,900	52
1,900	2,000	46
2,000	2,100	38
2,100	2,200	34
2,200	2,300	30".

(2) The table in subsection (c) of such section 521 is amended to appear as follows:

"Column I		Column II	Column III	Column IV
Annual income				
More than—	but Equal to or less than—	One dependent	Two dependents	Three or more dependents
	$600	$130	$135	$140
$600	700	128	133	137
700	800	126	131	134
800	900	124	129	131
900	1,000	122	127	128
1,000	1,100	120	125	125
1,100	1,200	118	122	122
1,200	1,300	116	119	119
1,300	1,400	114	116	116
1,400	1,500	112	113	113
1,500	1,600	110	110	110
1,600	1,700	107	107	107
1,700	1,800	104	104	104
1,800	1,900	101	101	101
1,900	2,000	98	98	98
2,000	2,100	95	95	95
2,100	2,200	92	92	92
2,200	2,300	89	89	89
2,300	2,400	86	86	86
2,400	2,500	83	83	83
2,500	2,600	80	80	80
2,600	2,700	77	77	77
2,700	2,800	74	74	74
2,800	2,900	71	71	71
2,900	3,000	68	68	68
3,000	3,100	64	64	64
3,100	3,200	60	60	60
3,200	3,300	56	56	56
3,300	3,400	51	51	51
3,400	3,500	43	43	43
3,500	3,600	35	35	35"

(3) The table in subsection (b) of section 541 of title 38, United States Code, is amended to appear as follows:

"Column I		Column II
Annual income		
More than— but	Equal to or less than—	
	$400	$80
$400	500	78
500	600	76
600	700	74
700	800	72
800	900	69
900	1,000	66
1,000	1,100	63
1,100	1,200	60
1,200	1,300	57
1,300	1,400	54
1,400	1,500	51
1,500	1,600	47
1,600	1,700	43
1,700	1,800	39
1,800	1,900	35
1,900	2,000	30
2,000	2,100	24
2,100	2,200	21
2,200	2,300	18"

(4) The table in subsection (c) of such section 541 is amended to appear as follows:

"Column I		Column II
Annual income		
More than— but	Equal to or less than—	
	$600	$97
$600	700	96
700	800	95
800	900	94
900	1,000	93
1,000	1,100	92
1,100	1,200	91
1,200	1,300	89
1,300	1,400	87
1,400	1,500	85
1,500	1,600	83
1,600	1,700	81
1,700	1,800	79
1,800	1,900	77
1,900	2,000	75
2,000	2,100	73
2,100	2,200	71
2,200	2,300	69
2,300	2,400	67
2,400	2,500	65
2,500	2,600	63
2,600	2,700	61
2,700	2,800	59
2,800	2,900	57
2,900	3,000	55
3,000	3,100	53
3,100	3,200	51
3,200	3,300	49
3,300	3,400	47
3,400	3,500	45
3,500	3,600	42"

(5) Subsection (d) of such section 541 is amended by striking out "$16" and inserting in lieu thereof "$17".

(6) Section 542(a) of title 38, United States Code, is amended by striking out "$40" and "$16" and inserting in lieu thereof "$43" and "$17", respectively.

(b)(1) The table in subsection (b)(1) of section 415 of title 38, United States Code, is amended to appear as follows:

"Column I		Column II
Total annual income		
More than—	but Equal to or less than—	
	$800	$94
$800	900	90
900	1,000	86
1,000	1,100	82
1,100	1,200	76
1,200	1,300	69
1,300	1,400	62
1,400	1,500	55
1,500	1,600	48
1,600	1,700	41
1,700	1,800	34
1,800	1,900	28
1,900	2,000	22
2,000	2,100	16
2,100	2,200	14
2,200	2,300	12"

(2) The table in subsection (c) of such section 415 is amended to appear as follows:

"Column I		Column II
Total annual income		
More than—	but Equal to or less than—	
	$800	$63
$800	900	61
900	1,000	58
1,000	1,100	54
1,100	1,200	51
1,200	1,300	47
1,300	1,400	42
1,400	1,500	37
1,500	1,600	32
1,600	1,700	28
1,700	1,800	24
1,800	1,900	21
1,900	2,000	18
2,000	2,100	15
2,100	2,200	13
2,200	2,300	12"

(3) The table in subsection (d) of such section 415 is amended to appear as follows:

"Column I		Column II
Total combined annual income		
More than— but	Equal to or less than—	
	$1,000	$63
$1,000	1,100	62
1,100	1,200	60
1,200	1,300	58
1,300	1,400	56
1,400	1,500	54
1,500	1,600	52
1,600	1,700	50
1,700	1,800	48
1,800	1,900	46
1,900	2,000	44
2,000	2,100	42
2,100	2,200	40
2,200	2,300	38
2,300	2,400	36
2,400	2,500	34
2,500	2,600	32
2,600	2,700	30
2,700	2,800	28
2,800	2,900	26
2,900	3,000	24
3,000	3,100	22
3,100	3,200	20
3,200	3,300	18
3,300	3,400	16
3,400	3,500	14
3,500	3,600	12"

(c) Clause (G) of section 415(g)(1) of title 38, United States Code, and clause (6) of section 503 of such title are hereby repealed.

(d) The amendments made by this section shall become effective January 1, 1971.

DISREGARDING OF SOCIAL SECURITY INCREASES UNDER WELFARE PROGRAMS

SEC. 608. (a) Section 1007 of the Social Security Amendments of 1969, as amended by section 2(b) of Public Law 91-306, is amended to read as follows:

"SEC. 1007. In addition to the requirements imposed by law as a condition of approval of a State plan to provide aid to individuals under title I, X, XIV, or XVI of the Social Security Act, there is hereby imposed the requirement (and the plan shall be deemed to require) that, in the case of any individual found eligible (as a result of the requirement imposed by this section or otherwise), for aid for any month after March 1970 and before January 1972 who also receives in such month—

"(1) a monthly insurance benefit under title II of such Act, the sum of the aid received by him for such month, plus the monthly insurance benefit received by him in such month, shall not be less than the sum of the aid which would have been received by him for such month under the State plan as in effect for March 1970, plus either

"(A) the monthly insurance benefit which was or would have been received by him in March 1970 without regard to the other provisions of this title plus $4, or

"(B) the monthly insurance benefit which was or would have been received by him in March 1970 under the provisions of this title,

whichever is less (whether this requirement is satisfied

by disregarding a portion of his monthly insurance benefit or otherwise), or

"(2) a monthly payment of annuity or pension under the Railroad Retirement Act of 1937 or the Railroad Retirement Act of 1935, the sum of the aid received by him in such month, plus the monthly payment of such annuity or pension received by him in such month (not including any part of such annuity or pension which is disregarded under section 1006), shall (except as otherwise provided in the succeeding sentence) not be less than the sum of the aid which would have been received by him for such month under such plan as in effect for March 1970, plus either

"(A) the monthly payment of annuity or pension which was or would have been received by him in March 1970 without regard to the provisions of any Act enacted after May 30, 1970, and before December 31, 1970, which provides general increases in the amount of such monthly payment of annuity or pension plus $4, or

"(B) the monthly payment of annuity or pension which was or would have been received by him in March 1970, taking into account the provisions of such Act (if any),

whichever is less (whether this requirement is satisfied by disregarding a portion of his monthly payment of annuity or pension or otherwise)."

(b) Notwithstanding the provisions of sections 2(a)(10), 1002(a)(8), 1402(a)(8), and 1602(a)(13) and (14) of the Social Security Act, each State, in determining need for aid or assistance under a State plan approved under title I, X, XIV, or XVI, of such Act, shall disregard (and the plan shall be deemed to require the State to disregard), in addition to any other amounts which the State is required or permitted to disregard in determining such need, any amount paid to an individual under title II of such Act (or under the Railroad Retirement Act of 1937 by reason of the first proviso in section 3(e) thereof), in any month after December 1970, to the extent that (1) such payment is attributable to the increase in monthly benefits under the old-age, survivors, and disability insurance system for January or February 1971 resulting from the enactment of this Act, and (2) the amount of such increase is paid separately from the rest of the monthly benefit of such individual for January or February 1971.

(c) In addition to the requirements imposed by law as a condition of approval of a State plan to provide aid or assistance to individuals under title I, X, XIV, or XVI of the Social Security Act, there is hereby imposed the requirement (and the plan shall be deemed to require) that, for

months after March 1971, and before January 1972, the amount of aid or assistance payable to any individual under any such plan shall be computed in such manner as the Secretary of Health, Education, and Welfare shall by regulations prescribe to assure that any increase in the amount of such aid or assistance which is required by reason of the provisions of section 502 of this Act shall be in addition to, and not in lieu of, any increase in the amount of such aid or assistance which is or would be required by section 1007 of the Social Security Amendments of 1969, as amended.

ACCEPTANCE OF MONEY GIFTS MADE UNCONDITIONALLY TO THE SOCIAL SECURITY ADMINISTRATION

SEC. 609. (a) The second sentence of section 201(a) of the Social Security Act is amended by inserting after "in addition," and before "such amounts" the following: "such gifts and bequests as may be made thereto, and".

(b) The second sentence of section 201(b) of such Act is amended by inserting after "consist of" and before "such amounts" the following: "such gifts and bequests as may be made thereto, and".

(c) Section 201 of such Act is further amended by adding after subsection (h) the following new subsection:

"(i)(1) The Managing Trustee of the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insur-

ance Trust Fund, and the Federal Supplementary Medical Insurance Trust Fund is authorized to accept on behalf of the United States gifts and bequests made unconditionally to such Trust Funds or to the Social Security Administration.

"(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, to the Federal Old-Age and Survivors Insurance Trust Fund."

(d) The second sentence of section 1817(a) of such Act is amended by inserting after "consist of" and before "such amounts" the following: "such gifts and bequests as may be made thereto, and".

(e) The second sentence of section 1841(a) of such Act is amended by inserting after "consist of" and before "such amounts" the following: "such gifts and bequests as may be made thereto, and".

(f) The amendments made by this section shall apply with respect to gifts received after the date of enactment of this Act.

(g) For the purpose of Federal income, estate, and gift

taxes, any gift or bequest to the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, or the Federal Supplementary Medical Insurance Trust Fund, or the Social Security Administration, which is accepted by the Managing Trustee of such Trust Funds under the authority of section 201(i) of the Social Security Act, shall be considered as a gift or bequest to or for the use of the United States and as made for exclusively public purposes.

LOANS TO ENABLE CERTAIN FACILITIES TO MEET REQUIREMENTS OF LIFE SAFETY CODE

SEC. 610. (a) It is the purpose of this section to provide assistance in the form of loans to hospitals and extended care facilities, which are providers of service participating in the health insurance program established by title XVIII of the Social Security Act, in meeting requirements of the Life Safety Code of the National Fire Protection Association.

(b) The Secretary of Health, Education, and Welfare (hereinafter referred to as the "Secretary") is authorized for a period of five years commencing January 1, 1971, to lend to any hospital or extended care facility described in subsection (a) a sum sufficient to enable such hospital or extended care facility to install sprinkler systems and such as are necessary to meet the requirements of the Life Safety Code of the National Fire Protection Association, but only

if a State planning agency described in section 314(a), section 314(b), or section 604(a) of the Public Health Service Act (or such other appropriate planning agency as may be designated by the Secretary) determines that the proposed expenditure should be made to permit the continued participation of such hospital or extended care facility in the program established by title XVIII of the Social Security Act, and that the proposed investment is not inconsistent with, or inappropriate in terms of area needs for the facility concerned.

(c)(1) Loans under this section shall be made only upon application therefor and shall be made by the Secretary in such amounts as the Secretary determines to be appropriate to carry out the purposes of this section and protect the financial interests of the United States.

(2) The rate of interest to be charged for any loan under this section shall be the average of the rates of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund as determined at the time such loan is made.

(3) Such loans shall be repaid over a period of not to exceed 10 years, in equal periodic installments to be made not less frequently than annually.

(4) Such loans shall become due and payable in full at once if the Secretary determines (A) that the funds in question were not used for the purpose specified in the loan

application, or (B) that the facility has ceased to make its services available to a reasonable proportion of persons entitled to benefits under title XVIII of the Social Security Act in the area served by such facility and who require such services.

(d) No hospital or extended care facility shall be eligible for a loan under this section unless—

(1) it was in operation and participating as a provider of services under title XVIII of the Social Security Act on January 1, 1971,

(2) the building in which the sprinkler system is to be installed was constructed prior to January 1, 1971, and

(3) the Secretary is satisfied that the applicant is unable to secure such loan from other sources or is unable to secure such loan from other sources at a reasonable rate of interest and on reasonable terms and conditions.

(e) There are authorized to be appropriated for the fiscal year ending June 30, 1970, and for each of the next five fiscal years such sums as may be necessary to carry out this section.

RETIREMENT INCOME CREDIT

SEC. 611. (a) Section 37(d) of the Internal Revenue Code of 1954 (relating to limitation on retirement income) is amended—

(1) by striking out "$1,524" in the matter preceding paragraph (1) and inserting in lieu thereof "$1,872";

(2) by striking out "$1,200" in paragraph (2)(B) and inserting in lieu thereof "$1,680"; and

(3) by striking out "$1,700" each place it appears in paragraph (2)(B) and inserting in lieu thereof "$2,880".

(b) Section 37(i) of such Code (relating to special rules for married couples) is amended by striking out "$2,286" in paragraph (2)(B) and inserting in lieu thereof "$2,808".

(c) The amendments made by this section shall apply to taxable years beginning after December 31, 1970.

TAX CREDIT FOR CERTAIN EXPENSES INCURRED IN WORK INCENTIVE PROGRAMS

SEC. 612 (a) Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1954 (relating to credits allowable) is amended by renumbering section 40 as section 41, and by inserting after section 39 the following new section:

"SEC. 40. EXPENSES OF WORK INCENTIVE 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."

(b) Part IV of subchapter A of chapter 1 of such Code (relating to credits against tax) is amended by adding at the end thereof the following new subpart:

"Subpart C—Rules for Computing Credit for Expenses of Work Incentive Programs

"SEC. 50. 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 program expenses (as defined in section 50A(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 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 of 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), and

"(D) section 38 (relating to investment in certain depreciable property).

For purposes of this paragraph, any tax imposed for the taxable year by 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 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 controlled 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 program credit carryback to each of the 3 taxable years preceding the unused credit year, and

"(B) a work incentive 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, 1970. 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 PROGRAM EXPENSES.—If the taxpayer terminates the employment of any employee with respect to whom work incentive program expenses are taken into account under subsection (a) 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 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, or

"(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.

"(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 tax-

payer 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.

"SEC. 50A. DEFINITIONS; SPECIAL RULES.

"(a) WORK INCENTIVE PROGRAM EXPENSES.—For purposes of this subpart, the term 'work incentive program expenses' means the wages and salaries of employees who are certified by the Secretary of Labor as having been placed in employment under a work incentive program established under section 432(b)(1)(B) of the Social Security Act which are paid or incurred for services rendered by such employees during the first 12 months of such employment (whether or not consecutive).

"(b) LIMITATIONS.—

"(1) TRADE OR BUSINESS EXPENSES.—No item shall be taken into account under subsection (a) unless such item is allowable as a deduction under section 162 (relating to trade or business expenses).

"(2) REIMBURSED EXPENSES.—No item shall be taken into account under subsection (a) to the extent that the taxpayer is reimbursed for such item.

"(3) GEOGRAPHICAL LIMITATION.—No item shall be taken into account under subsection (a) with respect to any expense paid or incurred by the taxpayer for training conducted outside of the territory of the United States.

"(4) MAXIMUM PERIOD OF TRAINING OR INSTRUCTION.—No wages or salary of an 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) 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)), or

"(B) if the taxpayer is an estate or trust, is a grantor, beneficiary, or a 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.

"(c) SUBCHAPTER S CORPORATIONS.—In case of an electing small business corporation (as defined in section 1371)—

"(1) the work incentive 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.

"(d) ESTATES AND TRUSTS.—In the case of an estate or trust—

"(1) the work incentive 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 50(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 under paragraph (1) bears to the entire amount of such expenses.

"(e) 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.

"(f) CROSS REFERENCE.—

"For application of this subpart to certain acquiring corporations, see section 381(c)(24),"

(c)(1) The table of subparts for part IV of subchapter A of chapter 1 of such Code is amended by adding at the end thereof the following:

"Subpart C. Rules for computing credit for expenses of work incentive programs."

(2) The table of sections of subpart A of part IV of subchapter A of chapter 1 of such Code is amended by striking out the last item and inserting in lieu thereof the following:

"Sec. 40. Expenses of work incentive programs.
"Sec. 41. Overpayments of tax."

(3) Section 381(c) of such Code (relating to items taken into account in certain corporated acquisitions) is amended by adding at the end thereof the following new paragraph:

"(24) CREDIT UNDER SECTION 40 FOR WORK INCENTIVE 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) The amendments made by this section shall apply to taxable years beginning after December 31, 1970.

CHANGE IN EXECUTIVE SCHEDULE—COMMISSIONER OF SOCIAL SECURITY

SEC. 613. (a) Section 5316 of title 5, United States Code (relating to positions at level V of the Executive Schedule), is amended by striking out:

"(51) Commissioner of Social Security, Department of Health, Education, and Welfare.".

(b) Section 5315 of title 5, United States Code (relating to positions at level IV of the Executive Schedule), is amended by adding at the end thereof the following:

"(94) Commissioner of Social Security, Department of Health, Education, and Welfare.".

(c) The amendments made by the preceding provisions of this section shall take effect on the first day of the first pay period of the Commissioner of Social Security, Department of Health, Education, and Welfare, which commences on or after January 1, 1971.

Passed the House of Representatives May 21, 1970.

Attest: W. PAT JENNINGS,

Clerk.

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TITLE VI—MISCELLANEOUS PROVISIONS

Calendar No. 1443

91ST CONGRESS
2D SESSION

H. R. 17550

[Report No. 91–1431]

AN ACT

To amend the Social Security Act to provide increases in benefits, to improve computation methods, and to raise the earnings base under the old-age, survivors, and disability insurance system, to make improvements in the medicare, medicaid, and maternal and child health programs with emphasis upon improvements in the operating effectiveness of such programs, and for other purposes.

MAY 27, 1970
Read twice and referred to the Committee on Finance

DECEMBER 11, 1970
Reported with amendments