90TH CONGRESS
1st Session

SENATE

REPORT
No. 744

SOCIAL SECURITY AMENDMENTS OF 1967

REPORT

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

TOGETHER WITH MINORITY VIEWS

TO ACCOMPANY

H.R. 12080

TO AMEND THE SOCIAL SECURITY ACT TO PROVIDE AN INCREASE IN BENEFITS UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, TO PROVIDE BENEFITS FOR ADDITIONAL CATEGORIES OF INDIVIDUALS, TO IMPROVE THE PUBLIC ASSISTANCE PROGRAM AND PROGRAMS RELATING TO THE WELFARE AND HEALTH OF CHILDREN, AND FOR OTHER PURPOSES

NOVEMBER 14, 1967.—Ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE
85-999 O WASHINGTON : 1967

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price $1.00

CONTENTS

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

REPORT

TOGETHER WITH MINORITY VIEWS

[To accompany H.R. 12080]

The Committee on Finance, to which was referred the bill (H.R. 12080) to provide an increase in benefits under the old-age, survivors, and disability insurance system, to provide benefits for additional categories of individuals, to improve the public assistance program and programs relating to the welfare and health of children, and for other purposes, having considered the same, reports favorably thereon with amendments and recommends that the bill do pass.

I. BRIEF SUMMARY OF THE BILL

The proposals embodied in H.R. 12080 as reported by the committee would make major improvements in the provisions of the Social Security Act relating to the old-age, survivors, and disability insurance program, the hospital and medical insurance programs, the medical assistance program, the aid to families with dependent children, and other public assistance programs and the child welfare and child health programs.

Old-Age, Survivors, and Disability Insurance

The bill would increase social security benefits of the 23.8 million elderly and disabled people, widows and orphans receiving benefits and would improve the protection of the old-age, survivors, and disability insurance provisions of the social security program, by providing—

(1) An across-the-board benefit increase of 15 percent for people on the rolls, with a minimum monthly primary insurance amount of $70;

(2) An increase in the earnings base from $6,600 to $8,000 in 1968, $8,800 in 1969, and $10,800 in 1972.

(3) An increase from $35 to $50 in the special payments now provided for certain people age 72 and older who have not worked long enough to qualify for regular cash benefits;

(4) An increase from $1,500 a year to $1,680 in 1968, and to $2,000 in 1969 and thereafter, in the amount that an individual may earn in a year and still get full benefits;

(5) Actuarially reduced benefits at age 60 for both men and women;

(6) Liberalized insured-status requirements and a liberalized definition of disability for disability insurance benefits for the blind;

(7) New guidelines for determining when a disabled worker cannot engage in substantial gainful activity;

(8) An alternative insured-status requirement for workers disabled before age 31;

(9) Monthly cash benefits for disabled widows and disabled dependent widowers;

(10) A new definition of dependency for children of women workers;

(11) Additional wage credits for military service; and

(12) Other improvements in the social security cash benefits program.

Health Insurance

The bill would improve the health insurance benefits now provided to the aged under the medicare legislation of 1965, would extend the

protection of health insurance, and would simplify administration, by providing—

(1) Coverage of additional days of hospital care;

(2) For coordination of hospital insurance reimbursement with planning by States under the Partnership for Health Act;

(3) Authority for experiments to achieve greater economy without reduction in quality of care, through various alternatives for reimbursement of hospitals, physicians, and other providers of health services;

(4) Retroactive payment to patients of a percentage of the charges for services rendered by nonparticipating hospitals with respect to admissions occurring before 1968;

(5) Payment to patients of a percentage of the charges for emergency hospital services, and redefinition of hospitals eligible to provide covered emergency services;

(6) For the inclusion under the medical insurance plan of certain services of podiatrists, chiropractors, and optometrists;

(7) Elimination of the requirement that a physician certify to the medical necessity of admissions to general hospitals and of outpatient hospital services;

(8) A procedure for paying the patient supplementary medical insurance benefits on the basis of an itemized, non-receipted bill;

(9) Extension of medical insurance coverage through elimination of the deductible and coinsurance provisions applicable to inpatients for pathology and radiology services, and simplification of hospital billing by transferring coverage of outpatient hospital diagnostic services to the supplementary medical insurance program and by permitting hospitals to collect charges from outpatients for relatively inexpensive services;

(10) Modification of the medical insurance enrollment periods;

(11) For a study by the Secretary of Health, Education, and Welfare of certain legislative proposals which would (1) cover prescription drugs under medicare, and (2) establish, through a formulary committee, quality and cost control standards for drugs provided under the various Federal-State assistance programs and the hospital insurance part of medicare; and

(12) Other miscellaneous improvements.

Financing the Social Insurance Program

The cost of the changes would be met through the existing financing and through an increase in the earnings base from $6,600 to $8,000 in 1968, $8,800 in 1969, and $10,800 in 1972 and through an increase in the tax rates. In the future there would be increases in the tax rates. As a result, the system would be in close actuarial balance.

Aid to Families With Dependent Children

The bill would make the following reforms in the aid to families with dependent children programs:

(1) For the purpose of providing greater incentives for appropriate members of families drawing aid to families with dependent

children (AFDC) payments to obtain employment so that they need no longer be dependent on the welfare rolls the bill would—

(*a*) exempt a portion of earned income for members of the family who can work;

(*b*) establish a new work incentive and training program for individuals to be administered by the Department of Labor upon referral by the State welfare agency;

(*c*) require State welfare agencies to assure adequate child care arrangements for the children of working mothers;

(*d*) require the State welfare agencies to establish a social service plan for each AFDC family; and

(*e*) modify the optional unemployed fathers program to provide for a uniform definition of unemployment throughout the United States.

In order to enable the States to implement these requirements, the Federal Government would supply Federal matching for services (including child welfare and day care) which the States would be required to furnish. Federal matching would also be provided for training, supervision, materials, and other items and services needed in the work incentive program.

(2) To aid in the reduction of births out of wedlock, and to prevent the neglect, abuse, and exploitation of children, the bill would require the States—

(*a*) To provide family planning services which would be offered on a voluntary basis in all appropriate cases;

(*b*) To institute protective payments to an interested person to assure that the child rather than an incompetent or irresponsible parent or relative receives the benefit of assistance, or to provide direct vendor payments, where it is determined the cash payments to the parent or relative would be detrimental to the welfare of the child;

(*c*) To bring unsuitable home conditions of children to the attention of the courts or law-enforcement agencies; to develop a program through a single organizational unit to establish paternity of needy children (in order to get support payments from the fathers); to utilize reciprocal support arrangements with other States to enforce court support orders for deserted children; and to enter into cooperative arrangements with the court to carry out these arrangements. Also, to assist in the runaway fathers problem, the services and powers of the Federal tax collector would be used to locate fathers and to require them to make payments to their abandoned children in compliance with support orders of local courts or incur a liability to the U.S. Government.

The bill provides more favorable Federal matching and broadens eligibility for foster care for children removed from an unsuitable home by court order. Moreover, certain requirements that have restricted the use of protective payments would be removed and vendor payments would be authorized for the first time in the cash program. Finally, a new program optional with the States would authorize dollar-for-dollar Federal matching to provide temporary assistance to meet the great variety of situations faced by needy children in families with emergencies.

Public Assistance

To expand and improve the operation of the public assistance programs, the bill would—

(1) Require the States to guarantee that old-age, blind, and disabled recipients will receive, on an average, an additional $7.50 a month in total income (either assistance or social security payments);

(2) Require the States by July 1, 1969, to provide a more liberal earnings exemption under public assistance programs;

(3) Extend and expand the public assistance demonstration grant program;

(4) Initiate a program of grants to educational institutions to expand undergraduate and graduate social work training; and

(5) Provide Federal matching for essential home repairs of a limited nature for homes owned by public assistance recipients.

Child Welfare Services

To expand and improve the operation of the child welfare programs, the bill would—

(1) Increase the authorization for child welfare services to provide more foster care and day care services; and

(2) Combine child welfare services administratively within State agencies so as to coordinate welfare services under the AFDC program.

Medical Assistance (Medicaid)

To modify the program of medical assistance by establishing certain limits on Federal participation in the program and to add flexibility in administration, the bill would—

(1) (a) Impose an outside limitation on the individuals for whom medical expenses would be subject to Federal matching at an income level related to 150 percent of the old-age assistance standard and (b) substantially reduce the Federal matching share for assistance provided the medically indigent;

(2) Allow States, as to the medically indigent, (a) a broader choice of required health services under the program; (b) the option of imposing deductibles or cost-sharing requirements as to inpatient hospital care;

(3) Exempt from the requirement of "comparability" for all recipients the benefits "bought-in" for the aged under the medicare supplementary medical insurance program;

(4) Allow recipients free choice of qualified providers of health services;

(5) Allow, at the option of the States, direct payments to recipients to meet the cost of physicians' and dentists' services;

(6) Extend assistance to certain spouses of assistance recipients who are essential to their welfare;

(7) Require the States, as a condition of participation in the program, to have a professional medical audit program and to license only nursing homes which meet certain conditions; and

(8) Establish an Advisory Council on Medical Assistance to advise on administration of the program.

Child Health

To improve programs relating to the health of mothers and children, the bill would—

(1) Consolidate earmarked authorizations, now in separate sections of the law, into three broad categories under one authorization: formula grants to States, project grants, and grants for research and training, with project authority to be assumed by the States in their formula grants and eliminated as a separate category in fiscal year 1973;

(2) Increase total authorizations by steps, with such increases directed particularly to expanded screening and treatment of children with disabling conditions, family planning, and dental health of children and earmark a portion of funds, ultimately 20 percent of all child health funds, for family planning purposes;

(3) Amend the research and training authority to emphasize improved methods of delivering health care through the use of new types of personnel with varying levels of training in order to give added emphasis to the training of medical assistants and health aides and the strengthening of training at the undergraduate level; and

(4) Provide for administration of the crippled children's program by the Children's Bureau.

Employment and Income Tax

The bill also added a few amendments which are related to the social security program, but in provisions dealing with employment taxes and income taxes. The more important of these amendments would—

(1) Permit a taxpayer or his spouse if either is over age 65 (and certain dependents over 65) to claim a medical expense deduction in computing their Federal income tax without regard to the 3-percent limitation (and 1-percent limitation on drug expenses), but this is only available, if the individual involved has permanently waived all rights to medicare benefits;

(2) Grant income tax exemption for joint hospital service facilities operated on a cooperative basis and extend deductible status for charitable contributions to these joint entities;

(3) Extend the time for filing for exemption from self-employment tax by the Amish; and

(4) Provide employee status for certain fishermen and truck loaders and unloaders and thereby assure social security coverage and income tax withholding for these individuals.

II. SUMMARY OF PRINCIPAL PROVISIONS OF THE BILL

A. Old-Age, Survivors, and Disability Insurance

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

There are several provisions in the Committee's bill that affect the amount of benefits to be paid out. Overall, the increase in benefit payments for the first full year of operation, as compared with what payments would be under present law, would be 25 percent. This figure includes increases arising from the benefit formula change, a change in the retirement test, the addition of benefits for disabled widows, the payment of benefits on an actuarially reduced basis at age 60 and certain other, less important changes.

Increase in Social Security Benefits

By far the most important change proposed by the Committee is an across-the-board increase in benefit payments with a guaranteed increase in monthly cash benefits of 15 percent for all beneficiaries on the social security rolls and with a minimum primary insurance amount of $70.

The increased benefits would be first payable for March 1968. It is estimated that 23.8 million people would be paid increased benefits beginning early in April. As a result of the benefit increase, $4.3 billion in additional benefits would be paid out in the first 12 months.

The benefit increases proposed by the committee are the same as those recommended by the Administration and exceed those adopted by the House. The House bill would have provided for an increase in cash benefits of 12½ percent, with a minimum primary insurance amount of $50 per month. Under the provisions adopted by the committee, the average monthly benefit paid to retired workers and their wives now on the rolls would increase from $145 to $171 ($164 under the House bill). Monthly benefits would range from a new minimum of $70 to $163.30, for retired workers now on the social security rolls who began to draw benefits at age 65 or later, compared with $50 to $159.80 under the House bill. Under existing law, the benefit range for such retired people now receiving old-age benefits is $44 to $142 a month.

The amount of earnings which would be subject to tax and could be used in the computation of benefits would be increased from $6,600 to $8,000 in 1968, to $8,800 in 1969, and to $10,800 in 1972. The House bill provided for one increase in the base—to $7,600 a year, effective January 1, 1968.

The increase in the amount of earnings that can be used in the benefit computation would result in a maximum benefit of $288 (based on average monthly earnings of $900—$10,800 a year) in the future; the maximum benefit under the House bill would be $212 (based on average monthly earnings of $633—$7,600 a year). Under present law,

the maximum benefit is $168 (based on maximum average monthly earnings of $550—$6,600 a year). Under the committee bill, the maximum benefits payable to a family on a single earnings record would be $540 ($423.60 under the House bill) rather than $368 as under present law.

These higher maximum retirement benefits just outlined will be payable to workers who are now young and who consequently will be paying contributions on these higher amounts of earnings over a considerable period of time before they retire. But because of the higher earnings base, benefit amounts would be increased significantly over those that would be payable under present law and under the House bill for workers who are much older now and who consequently pay on these higher amounts for a much shorter period. A man age 50 in 1968, for example, who earns $8,800 a year until he is 65 will get a benefit of $204 at age 65—31.6 percent higher than he could get under present law, and 9.9 percent higher than he would get under the House bill. If he earns $10,800 a year or more, his benefit will be $223—43.9 percent higher than he would get under present law, and 20.1 percent higher than under the House bill.

The special payments made to individuals aged 72 and over would be increased by the committee bill from $35 to $50 a month for a single person and from $52.50 to $75 a month for a couple. Under the House bill these payments would be increased to $40 and $60, respectively.

Reduced Benefits at Age 60

Under present law, full-rate widow's, widower's, and parent's insurance benefits are payable at age 62; and reduced old-age, wife's and dependent husband's benefits are payable at age 62; only widow's insurance benefits are payable as early as age 60 at a reduced rate.

Under the committee bill, the age of eligibility would be lowered to 60 for all categories of aged beneficiaries, with the benefits payable before age 62 reduced according to the principle which is applied under present law. The reduction rate in present law for a wife's (or a husband's) benefit is twenty-five thirty-sixths of 1 percent, and for an old-age or widow's benefit it is five-ninths of 1 percent, for each month that the beneficiary is under age 65 (age 62 for a widow) when he begins to get benefits. Thus, a worker coming on the rolls at age 60 would receive two-thirds of his full benefit.

H.R. 12080, as passed by the House of Representatives, contained no comparable provision.

Monthly benefits would be payable under this provision beginning with the month of December 1968. An estimated 775,000 additional people are expected to claim benefits for December, and benefits amounting to $555 million would be paid during the first 12 months of operation. Because the benefit amount payable at age 60 would be reduced to take account of the longer period over which benefits would be paid, payment of these benefits would not result in any increase in the long-range cost of the program.

Retirement Test

The committee modified the provision of the House bill which would have increased from $1,500 a year to $1,680 the amount a person may earn without having some social security benefits withheld. The

committee bill, like the House bill, provides an increase from $1,500 to $1,680 in the amount a person may earn in a year without having any social security benefits withheld for taxable years ending in 1968. The committee bill modifies the House bill by providing for an additional increase in this amount to $2,000 for taxable years ending in 1969 and later. The amounts to which the $1-for-$2 reduction would apply would range from $1,680 to $2,880 (as in the House bill) for taxable years ending in 1968. For taxable years ending in 1969 and later the $1-for-$2 reduction would apply from $2,000 to $3,200. The amount a person may earn in a month and still get full benefits for that month (regardless of how much he earns in a year) would be increased to $140 (as in the House bill) for taxable years ending in 1968 and would increase to $166⅔ (one-twelfth of $2,000) for taxable years ending in 1969 and later. About $175 million would be paid out in additional benefits with respect to calendar year 1968 to 760,000 people in calendar year 1968, and about $500 million would be paid out in additional benefits with respect to calendar year 1969 to 840,000 people in calendar year 1969.

Disabled Widows and Widowers

The committee bill would provide full-rate benefits for many totally disabled widows and widowers—the benefits equaling 82½ percent of the deceased spouse's primary insurance amount. Under the House bill, reduced benefits—ranging from 50 percent to 82½ percent of the spouse's primary insurance amount—would have been provided for disabled widows and widowers age 50 and over. The committee's bill would not only increase the benefit amounts provided by the House but would also eliminate the requirement that the disabled widow or widower be at least age 50. As in the House bill, benefits would be payable only to a widow or widower who became totally disabled not later than 7 years after the spouse's death, or in the case of a widowed mother, before her mother's benefits end or within 7 years thereafter. About 70,000 disabled widows and widowers would be eligible for benefits and about $71 million in benefits would be paid during the first 12 months of operation.

Benefits for the Blind

The committee added to the House bill a provision which would make blind people with at least six quarters of social security coverage eligible for disability insurance benefits without regard to their ability to work. In order to qualify for benefits a person would have to have vision of 20/200 or less, rather than 5/200 as in present law.

Child's Benefits for those Disabled Before Age 22

The committee added to the House bill a provision which would provide child's insurance benefits for an otherwise qualified disabled child if his 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.

Extension of Retroactivity of Disability Applications

The committee added a provision to the House bill to allow a longer period of time after termination of disability for the filing of a disability freeze application by an individual whose mental or physical condition interfered with his filing a timely application. This would enable workers who are totally disabled over an extended period but fail to file timely applications to nevertheless have the period of disability frozen, and thus not counted against them in subsequent determinations as to whether they are insured for social security benefits or the amount of such benefits.

Family Employment

The committee added a provision to the House bill to extend social security coverage to domestic employment performed in an employer-employee relationship by a parent for his son or daughter where there is a need for the parent to perform the work. The employment would be covered if the son or daughter is (*a*) a widow or widower with a child under age 18 or a disabled child or (*b*) a person with such a child who either is divorced or has a disabled spouse.

Policemen and Firemen

The committee added a provision to the House bill to permit Nebraska and Puerto Rico, if they desire, to provide social security coverage for policemen and firemen who are now covered only under a State or local retirement system. Present Federal law prohibits social security coverage for policemen and firemen who are under retirement systems but excepts 19 specified States from this prohibition; the addition of Puerto Rico and Nebraska would raise the number of excepted jurisdictions to 21.

In addition, as part of any coverage extension, the State of Nebraska would be permitted to validate the coverage of firemen, in the group being covered, for whom social security contributions have been erroneously paid.

Coverage of Firemen

The committee added to the House bill a provision under which social security coverage could be extended under specified conditions to firemen under a State or local retirement system in States not permitted, under the present provisions of the Social Security Act, to cover policemen and firemen. Such coverage could be extended only by means of the referendum provisions in present law, and only if the Governor of the State certifies that the overall benefit protection of the group of firemen which would be brought under the social security program would be improved by reason of the extension of social security coverage to the group.

Employees of the Massachusetts Turnpike Authority

The committee added to the House bill a provision to permit the State of Massachusetts to remove from social security coverage employees of the Massachusetts Turnpike Authority.

State and Local Employees Receiving Fees

The committee added a provision to the House bill to modify the social security coverage provisions applying to State and local government employees who are compensated solely on a fee basis (such as constables and justices of the peace). Under present law, fee-basis employees, like other State and local government employees, may be covered only under a State coverage agreement. Under the provision approved by the committee, in the case of employees who are compensated solely on a fee basis, fees received after 1967 which are not covered under a State agreement would be compulsorily covered under the self-employment provisions of law, except that people in fee-basis positions in 1968 could elect not to have their fees covered under the self-employment provisions. Under the committee bill, a State could, as under present law, modify its coverage agreement to provide coverage for fee-basis employees as employees. However, unlike present law, the committee bill would permit States to remove from coverage under its agreement persons who are compensated solely on a fee basis.

State and Local Divided Retirement Systems

The committee added a provision to the House bill to grant an additional opportunity, through 1969, for election of social security coverage by employees of States and localities who did not elect coverage when they previously had the opportunity to do so under the provision of present law permitting specified States to cover only those current members of a retirement system who desire coverage.

Coverage of Erroneously Reported Wages for Former State or Local Government Employees

The committee added a provision to the House bill to permit a State, when it provides retroactive coverage for a coverage group under a modification of the State's agreement, to provide the retroactive coverage for former employees of the coverage group whose earnings had been erroneously reported, if no refund has been made of the taxes paid on the erroneously reported earnings.

Exclusion of Prisoners From Coverage Under Certain Programs

The committee added to the House bill a provision to provide that any employment by an inmate of a prison would not be creditable for purposes of establishing entitlement to unemployment insurance compensation, or for purposes of the Federal civil service retirement system and certain other Federal programs. The bill would also broaden the present exclusion from social security coverage of most Federal employment to exclude all employment performed by a prison inmate for a Federal agency.

Coverage of Ministers

The committee bill would modify the House-passed bill by deleting the provision providing coverage for members of religious orders who have taken a vow of poverty (thus retaining present law for this group). It would also permit a clergyman to elect not to be covered

if he opposes such coverage on grounds of religious principle or conscience.

Benefits Paid on Basis of Erroneous Reports of Death in Military Service

The committee added a provision to the House bill which would make benefits paid on the basis of official reports of death issued by the Department of Defense lawful payments even though it is later determined that the person who was reported dead is still alive.

Special Saving Provision in the Case of Certain Children

The House bill provided that benefits payable to certain children who became entitled to benefits under the 1965 amendments could not exceed the difference between the total amounts payable to other persons on the same earnings record and the family maximum amount. As a substitute, the committee bill would provide that the benefits payable to a person on the effective date of the 1965 amendments, which were reduced because a child became entitled to benefits under the 1965 amendments, will not be reduced in the future. For people who became entitled after the effective date of the 1965 amendments or become entitled in the future, the provisions of present law would apply.

Recovery of Overpayments

The committee bill added a provision which would authorize the Secretary of Health, Education, and Welfare to recover overpaid benefits where the overpaid beneficiary is alive by withholding the benefits payable to him, or to any other person entitled to benefits on the same earnings record. (Under present law, overpayments may be recovered from the overpaid person while he is getting benefits; recovery may not be made from any other person getting benefits on the same account. There is no specific provision for recovering an overpayment while the beneficiary is alive if he is not getting benefits.)

Underpayments

The committee modified the House-passed provision relating to benefits due after a person has died. The committee's bill would provide that amounts due under supplementary medical insurance (part B of medicare) after the beneficiary's death be paid first to the person who paid for the services or the person who provided the services. (If the person who paid for the services is the decedent, the payment would be made to the legal representative of his estate, if there is one.) Then it would provide the following uniform order of payment for both cash benefits and part B benefits:

1. Spouse living with the deceased individual at time of his death or the spouse not living with him but entitled to benefits on the same earnings record.
2. Child entitled to benefits on the same earnings record.
3. Parent entitled to benefits on the same earnings record.
4. Spouse who was neither entitled to benefits on the same earnings record nor living with the deceased individual.
5. Child not entitled to benefits on the same earnings record.
6. Parent not entitled to benefits on the same earnings record.

7. Legal representative of the deceased individual's estate, if any.

8. Person related to the deceased individual by blood, marriage, or adoption and determined by the Secretary to be the proper person to receive the payment due.

Marriage of Child in School

Under present law a child's benefits generally stop when the child marries. The committee bill adds a provision to the House bill which would provide that a child's benefits would not stop when the child married if the child was under age 22 and a full-time student and, in the case of a girl, if her husband was also a full-time student.

U.S. Treaty Obligations—5-Year Residence Requirement

The bill adds a provision to the House bill which would provide that the present 5-year residence requirements that uninsured people must meet in order to qualify for hospital insurance, or for special age-72 payments, or for benefits under the supplementary medical insurance program would not apply when they would be contrary to present treaty obligations of the United States.

Payments to Aliens Outside the United States

The committee bill modifies the effective date of the provisions in the House bill which would (a) restrict benefit payments to an alien while outside the United States, and (b) prohibit payment of more than 12 months of accumulated benefits, and all future benefits, to an alien who is living in a Communist-controlled country. Under the committee's change the effect of these House provisions would be delayed until after December 31, 1968.

Separate Authorization for Social Security Research Programs

The committee added to the House bill a provision under which there would be specific authorizations for cooperative research and demonstration grant programs for both the Social Security Administration and the Social and Rehabilitation Service. (As under present law, there would be a single authorization and the amendment would not increase the funds available for these research programs.)

Expedited Benefit Payments

The committee added to the House bill a provision which would provide for expedited payment of benefits on the basis of a written request. The provision would not apply to disability benefits or negotiated checks. Also, the provision would not limit the Secretary's authority to make earlier payments in appropriate cases.

Advisory Councils on Social Security

The committee's bill would modify the House-passed provision relating to the time when the Advisory Councils would be appointed and issue reports, by providing that an Advisory Council be appointed at any time after January 31 (rather than in February as in the House

bill) in 1969 and every 4 years thereafter. As in present law, each Council would report to the Secretary not later than the first day of the second year following the year in which it is appointed, and the report would include any interim reports the Council may have issued.

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

The Dependency of a Child on His Mother

The bill would provide that a child be deemed dependent on his mother under the conditions of present law which provide for deeming a child dependent on his father. As a result, a child could become entitled to benefits if at the time his mother dies, or retires, or becomes disabled, she is either fully or currently insured. Under present law, currently insured status (coverage in six out of the last 13 quarters ending with death, retirement or disability) is required unless the mother was actually supporting the child.

Eligibility of Adopted Child for Monthly Benefits

The bill would permit a child adopted by a surviving spouse to get benefits even though the adoption is not completed within 2 years after the worker's death if adoption proceedings had begun before the worker died.

Additional Wage Credits for Servicemen

The bill would provide that, for social security benefit purposes, the pay of a person in the uniformed services would be deemed to be $100 a month more than his basic pay. The additional cost of paying the benefits resulting from this provision would be paid out of general revenues.

Definition of "Widow," "Widower," and "Stepchild"

The bill would provide that a widow, widower, or stepchild would be considered as such for social security purposes if the marriage existed for 9 months, or, in case of death in line of duty in the uniformed services and in case of accidental death, if the marriage existed for 3 months (unless it is determined that the deceased individual could not have reasonably been expected to live for 9 months at the time the marriage occured). Under present law a marriage must have existed for 12 months.

Disability Benefits Affected by the Receipt of Workmen's Compensation

The bill would modify one of the provisions in present law for determining the amount of combined social security and workmen's compensation benefits that can be paid when a disabled worker is eligible under both programs. In these cases, the computation of average earnings could include earnings in excess of the annual amount taxable under social security.

Definition of "Disability"

The bill would provide a more detailed definition of "disability." New guidelines would be provided in the law under which a person could be determined to be disabled only if he is unable to engage in any kind of substantial gainful work which exists in the national economy even though such work does not exist in the general area in which he lives.

Insured Status for Workers Disabled While Young

The bill would allow a worker who becomes disabled before the age of 31 to qualify for disability insurance benefits if he worked in one-half of the quarters between the time he is 21 and the time he is disabled, with a minimum of six quarters of coverage. This requirement would be an alternative to the present requirement that the worker must have had a total of 5 years out of the last 10 years in covered employment.

Limitation on Wife's Benefit

The bill contains a provision which establishes a maximum limit of $105 a month for wife's benefits. The effect of this provision will not be felt for many years.

Requirements for Husband's and Widower's Insurance Benefits

The bill would repeal the requirement in present law that a dependent husband or widower may become entitled to social security benefits on his wife's earnings only if his wife is currently insured at the time she died, became disabled, or retired.

Retirement Income of Retired Partners

The committee bill provides that certain partnership income of retired partners would be neither taxed nor credited for social security purposes.

Coverage of State and Local Employees Ineligible for Membership in a State Retirement System

The bill would facilitate social security coverage for workers in positions under a State or local government retirement system who are not eligible to join the system. Under present law, these workers cannot be covered under social security in connection with the procedure for extending coverage to members of a retirement system by means of the provision permitting specified States to cover only those current members of a retirement system who desire coverage. The provision in the bill would permit these ineligible workers to be covered under this procedure.

Exclusion of Emergency Services by State and Local Employees

The bill would exclude mandatorily from social security coverage services performed for a State or local government by workers hired on a temporary basis in emergencies such as fire, storm, flood, or earthquake.

Simplification of Benefit Computation

Where wages earned before 1951 are used in the benefit computation, the committee bill would allow certain assumptions to be made so that the benefit could be computed by electronic data processing equipment.

Extension of Time for Filing Reports of Earnings

Under the bill the Secretary of Health, Education, and Welfare would be authorized to grant an extension of the time in which a person may file his report of earnings for earnings test purposes if there is a valid reason for his not filing it on time. Permission to file a late report may be given in advance of the date on which the report is to be filed.

Penalties for Failure To File Timely Reports of Earnings and Certain Other Events

Under the present law, it is possible for a person to be penalized because of his failure to file a timely report of earnings under the retirement test, in an amount in excess of the benefit that must be withheld. The committee bill contains a provision which would eliminate the possibility of this occurring in the future, and also would reduce the penalty for failure to file timely reports of certain other events.

Election Officials and Election Workers

The bill would permit a State to exclude from social security coverage future services performed by election workers and election officials who are paid less than $50 in a calendar quarter for such services. The exclusion could be taken for the election officials and workers of the State or any of its political subsivisions either at the time coverage is extended to employees of the State or the subdivision or at a later date. Under present law these services may be excluded only at the time coverage is extended to the employees of the State or the subdivision.

State and Local Coverage in Illinois

The bill would add Illinois to the list of States (19 under present law) which are permitted to extend social security coverage to those current members of a State or local retirement system who desire coverage, with all future employees being compulsorily covered.

Reports of Boards of Trustees

Under the bill the date on which the annual reports of the trustees of the social security trust funds is due would be changed from March 1 to April 1, The report would contain a separate actuarial analysis of the benefit disbursements made from the old-age and survivors insurance trust fund with respect to disabled beneficiaries.

General Saving Provision

The bill would provide that, where a person becomes entitled to benefits as a result of the Social Security Amendments of 1967, the benefit paid to any other person on the same account would not be reduced by the family maximum provision because the new person became entitled to benefits.

Disability Insurance Trust Fund

The bill would increase the percentage of taxable wages appropriated to the disability insurance trust fund (now 0.70 of 1 percent) to 0.95 of 1 percent and would increase the percentage of self-employment income (now 0.525 of 1 percent) to 0.7125 of 1 percent.

B. Health Insurance Benefits

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

Additional Days of Hospital Care

The committee bill modified the provision of the House bill which would extend the number of inpatient hospital days covered during a "spell of illness" from 90 to 120 days, with a $20 coinsurance requirement from the 91st day through the 120th day. Instead, each medicare beneficiary would be provided with a lifetime reserve of 60 days of added coverage of hospital care after the 90 days covered in a "spell of illness" have been exhausted. Coinsurance of $10 for each day would be applicable to such added days of coverage. Under the House bill persons who are more or less permanently institutionalized, and who therefore have only one spell of illness during their lifetime would have qualified for only 30 additional days of hospital care. Under the committee provision they would qualify for up to 60 additional days of care during their lifetime.

Payment of Physician Bills Under the Supplementary Medical Insurance Program

The committee bill modifies the provision in the House bill which provides for physician payment under the medical insurance program. Under present law, payment may be made only to the physician upon assignment or to the patient upon presentation of a receipted bill. The House bill provided for retention of present law provisions and added new alternatives for payment to the physician or patient on the basis of an unpaid bill. As modified and simplified by the committee, only two methods of payment would be provided: Payment either directly to the patient on the basis of an itemized bill (which could be either receipted or unpaid) or directly to the physician as under the present assignment method.

Payment for Services in Nonparticipating Hospitals

The committee added a provision to the House bill which would permit payment for services received in certain nonparticipating hospitals. At present, payments can be made to participating hospitals

and, in an emergency case, to a nonparticipating hospital which meets certain standards only if the nonparticipating hospital agrees to accept reasonable cost reimbursement as full payment for the services rendered.

For a temporary period, almost all of which has already expired, the committee bill would permit direct reimbursement to be made to an individual who was furnished hospital services during the temporary transitional period in a nonparticipating hospital. This coverage would not extend to admissions to hospitals which occur after 1967. Payment would be limited to 60 percent of the room and board charges and 80 percent of the hospital ancillary charges, for up to 20 days in each spell of illness (subject to the $40 deductible and other statutory payment limitations in present law) if the hospital did not formally participate in medicare before January 1, 1969. If it did participate in medicare before that date and if it applied its utilization review plan to the services for which medicare benefits are being claimed and which it provided before its regular participation started, the full 90 days of coverage could be provided. Thus, there would be an incentive over and above existing incentives for presently nonparticipating hospitals to participate because participation is a condition for covering past services beyond 20 days as well as a condition for future coverage.

A similar provision relating only to emergency services would apply beginning with respect to admissions taking place on or after January 1, 1968, but only as an alternative to present coverage of emergency care. Hospitals could apply for payment on a reasonable-cost basis as under present law, or if the hospital did not apply, the patient could obtain payment directly under the new provisions on the basis of 60 percent of room and board charges and 80 percent of ancillary service charges.

A new definition would be used for hospitals eligible under these transitional and emergency care provisions. Under it, a qualifying hospital must have a full-time nursing service, be licensed as a hospital, and be primarily engaged in providing medical care under the supervision of a doctor of medicine or osteopathy. This definition would apply retroactive to July 1, 1966, so that some hospitals which today would be ineligible to receive payment for emergency services may receive such payments on behalf of beneficiaries back to the beginning of the program provided they apply for such payments. If they do not apply for reimbursement, the patient would be paid directly under the new payment provisions.

Coordination of Reimbursement With Health Facility Planning

The committee added to the House bill a provision under which the Secretary of Health, Education, and Welfare would take into account the specific disapproval by State agencies carrying on planning under the Partnership for Health Act, of certain expenditures by hospitals or other health facilities for substantial capital items. Depreciation and interest attributable to substantial capital items which are found not in accordance with a State's overall plan would not be includable as a part of the "reasonable cost" of the facilities covered services provided to individuals under title V, XVIII, and XIX. The provision would be effective with respect to capital expenditures made after June 30, 1970, or earlier at the request of a State.

Incentives for Economy while Maintaining or Improving Quality in the Provision of Health Services

The committee modified the House provision which would authorize the Secretary of Health, Education, and Welfare to experiment with various methods of reimbursement to organizations and institutions participating under medicare, medicaid, and the child health programs which would provide incentives for limiting costs of the program while maintaining quality care. Under the committee bill, the authorization would also cover similar experiments with respect to physicians' services, but only with respect to those physicians volunteering to participate in such experiments.

Services of Podiatrists, Chiropractors, and Optometrists

The House bill modified the definition of a physician to include a doctor of podiatry. The committee would also include within the expanded definition of physician a licensed chiropractor and a doctor of optometry but only with respect to functions the practitioner is authorized to perform by the State in which he practices. With respect to coverage of podiatry services, no payment would be made for routine foot care whether performed by a podiatrist or a medical doctor; with respect to optometric services, no payment would be made for services involving the diagnosis or detection of eye diseases unless the optometrist is legally authorized to treat the disease or for an optometrist's diagnostic services where the optometrist provides no treatment. In addition, no payment would be made for expenses for eye refraction procedures (other than procedures performed in connection with furnishing prosthetic lenses) whether performed by an optometrist, a medical doctor, or other physician.

Physical Therapy

The committee extended the provisions of the House bill which would cover physicial therapy when provided in a patient's home under the supervision of a hospital to also cover outpatient physicial therapy services furnished by physical therapists employed by or under an agreement with and under the supervision of hospitals and other providers of services as well as approved clinics, rehabilitation centers and local public health agencies. The patient would not have to be homebound for the physical therapy services to be covered.

Supplementary Medical Insurance Enrollment Periods

The committee added to the House bill a provision effective January 1, 1969, under which the general enrollment periods of the supplementary medical insurance program would be placed on an annual basis rather than biennial and run from January 1 through March 31, rather than October 1 through December 31 as under present law. The Secretary would determine and promulgate during December of each year the premium rate which would be applicable for a 12-month period to begin the following July 1. When the Secretary promulgated a rate change for part B, he would also be required to issue a public statement setting forth the actuarial assumptions and bases upon which he arrived at the new rate. Persons wishing

to disenroll could do so at any time, but such disenrollment would not take effect until the close of the calendar quarter following the quarter in which the notice of disenrollment was filed. The bill would also make other minor changes in the late enrollment provisions of present law.

Payment Under the Medical Insurance Program for Noncovered Hospital Ancillary Services

The committee added a provision to the House bill which would permit payment under the medical insurance program for presently noncovered ancillary hospital and extended care facility services, principally X-ray and laboratory services, furnished after the patient has exhausted his eligibility under the hospital insurance program. Under current law if a person is in a hospital or extended care facility qualified to participate under medicare, payment may not be made for services which could be paid for under part B if not received in a qualified hospital or extended care facility. As a result, sometimes the services are not covered under either part B or part A. The committee bill would allow payment to be made for hospital or extended care inpatients for services ordinarily paid for under part B if provided in a doctor's office, wherever part A payments could not be made, if the appropriate hospital or independent laboratory standards are met. Payment would be made for these services under the usual part B provisions applying to the $50 deductible and 20-percent coinsurance.

Limitation on Special Reduction in Allowable Days of Inpatient Hospital Services

Under the House bill the limitation on payment of hospital insurance benefits during the first spell of illness for an individual who is an inpatient of a psychiatric or tuberculosis hospital at the time he first becomes eligible for benefits under the hospital insurance program would be made inapplicable to benefits for services in a general hospital if the services are not primarily for the diagnosis or treatment of mental illness or tuberculosis. The committee accepted the change in the House bill with respect to psychiatric hospitals, but modified that part relating to tuberculosis hospitals. The committee would remove such hospitals from the provision in present law under which days in a tuberculosis institution immediately before entitlement to hospital insurance are counted against the days of coverage an individual would otherwise have. In effect, the committee's change would make an individual's entitlement to hospital insurance benefits the same if he received hospital services in a tuberculosis hospital as it would be if he received services in a general hospital.

Payment for Blood

The committee modified the provision in the House bill which provides that the patient would have to replace 2 pints of blood for the first pint of blood received for purposes of the 3-pint deductible. (In effect, 4 pints would have to be replaced for the 3 pints used.) Under the committee's bill, replacement would be on a pint-for-pint basis, as under present law. The committee accepted the provisions of the House bill that would broaden the definition of "blood" to

include packed red blood cells as well as whole blood and would add a 3-pint deductible provision to the supplementary medical insurance program as well as to the hospital insurance program.

Payment for Certain Hospital Services Furnished Outside the United States

The committee added to the House bill a provision which would permit direct payment of hospital insurance benefits to a resident of the United States for up to 20 days of inpatient hospital services furnished in a country contiguous to the United States by a hospital which is not more than 50 miles from the border of the continental United States. In the case of nonemergency care, the hospital would have to be the one nearest to the patient's residence suitable to treat his illness. The committee bill also provides that payment may be made for emergency inpatient hospital services furnished outside the United States in a hospital within 50 miles of the border if the hospital was the closest one suitable for treatment and the emergency occurred no more than 50 miles outside the United States (present law provides emergency coverage outside the United States only if the emergency occurs in the United States). Benefits would be payable for the services covered under this provision only on the basis of an application for reimbursement filed by the medicare beneficiary and only if the hospital met standards which are essentially comparable to those required of hospitals participating under the program in the United States.

Hospital Insurance Benefits for State and Local Employees

The committee added to the House bill a provision which would permit the States, at their option, to contract with the Secretary of Health, Education, and Welfare for hospital insurance coverage for State and local governmental employees, retired or active (and their dependents and survivors), age 65 or over who do not otherwise qualify for medicare hospital insurance protection. The States would reimburse the medicare program for the actual costs of benefits paid and administrative expenses incurred with respect to these people.

Study of Drug Proposals

The committee added to the House bill a provision which would require the Secretary to study and report to the Congress, prior to January 1, 1969, the savings which might accrue to the Government and the effects on the health professions and on all elements of the drug industry which might result from enactment of two proposals relating to drugs: (1) a proposal to cover prescription drugs under medicare, and (2) a proposal to establish, utilizing a formulary committee, quality and cost control standards for drugs provided under the various Federal-State assistance programs and the hospital insurance part (part A) of the medicare program.

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

Physician Certification

The committee adopted the provision under which physician certification of the medical necessity for hospital outpatient services and admissions to general hospitals would be eliminated.

Transfer of Hospital Outpatient Services to the Supplementary Medical Insurance Program

The committee adopted the provision which would transfer hospital outpatient diagnostic services from the hospital insurance program to the supplementary medical insurance program. The effect of the change would be that all hospital outpatient benefits would be covered under the supplementary medical insurance program and thus subject to the deductible ($50 a year) and coinsurance (20 percent) provisions of that program.

Hospital Billing for Outpatient Services

The committee adopted the provision which permits hospitals, as an alternative to the present procedure, to collect small charges (less than $50) for hospital outpatient services from the beneficiary without submitting a cost-reimbursement bill to medicare. (The amounts collected would be counted as expenses reimbursable to the beneficiary under the medical insurance plan.) The payments due the hospitals would be adjusted at intervals to assure that the hospital received its final reimbursement on a cost basis.

Radiologists' and Pathologists' Services

The committee adopted the provision which would permit the payment of full reasonable charges for radiological or pathological services furnished by physicians to hospital inpatients. Under existing law, the $50 deductible and 20-percent coinsurance are applicable to such services.

Payment for Portable X-ray Services

The committee adopted the provision which would permit payment for diagnostic X-rays taken in a patient's home or in a nursing home. These services would be covered under the supplementary medical insurance program if they are provided under the supervision of a physician and if they meet health and safety regulations.

Payment for Purchase of Durable Medical Equipment

The committee adopted the provision which would permit payment to be made for durable medical equipment that has been purchased by the individual. Payment would be made periodically in the same amount as would be the case under present law if the equipment were rented, but payment would be made only for the period the equipment was needed, and not more than the purchase price could be covered.

Reimbursement for Civil Service Retirement Annuitants for Premium Payments Under the Supplementary Medical Insurance Program

The committee adopted the provision under which the Federal employee health benefit plans would be permitted to reimburse certain civil service retirement annuitants who are members of group health plans for the premium payments they make to the supplementary medical insurance program.

Date of Attainment of Age 65 of Persons Enrolling in SMI Program

The committee adopted the provision under which a person who is over 65, but believes, on the basis of documentary evidence, that he has just reached age 65, would be allowed to enroll in the supplementary medical insurance program as if he had attained age 65 on the date shown in the evidence.

Use of State Agencies To Assist Health Facilities To Participate in the Various Health Programs Under the Social Security Act

The committee adopted the provisions whereby States could receive 75-percent Federal matching for the services which State health agencies perform in helping health facilities to qualify for participation in the various health programs under the Social Security Act (including medicare, medicaid, and the child health programs) and to improve their fiscal records for payment purposes. Similar provisions in the medicare program (which finances such services on a 100-percent basis from the Federal Hospital Insurance Trust Fund) would be repealed effective July 1, 1969, when this provision would go into effect.

Transitional Provisions for Uninsured Individuals Under the Hospital Insurance Program

The committee adopted the provision under which a person who attains age 65 in 1968 could become entitled to hospital insurance benefits if he has a minimum of three quarters of coverage (existing law requires six), with the number of quarters of coverage needed by persons who reach age 65 in later years increasing by three in each year until the regular insured status requirement is met.

Appropriation to Supplementary Medical Insurance Trust Fund

The Committee adopted the provision which would provide that whenever the transfer of general revenue funds to the supplementary medical insurance trust fund, after June 30, 1967, is not made at the time the enrollee contribution is made, the general fund of the Treasury would pay, in addition to the Government share, an amount equal to the interest that would have been earned had the transfer been made on time. Also, the contingency reserve now provided for 1966 and 1967 would be made available through 1969.

Health Insurance Benefits Advisory Council

The Committee adopted the provision whereby the Health Insurance Benefits Advisory Council established under present law would assume the duties of the National Medical Review Committee called

for under present law. The National Medical Review Committee has not yet been appointed. The Health Insurance Benefits Advisory Council's membership would be increased from 16 to 19 persons.

Study of Coverage of Services of Health Practitioners

The Committee adopted the provision which would require the Secretary of Health, Education, and Welfare to study the need for, and to make recommendations concerning, the extension of coverage under the supplementary medical insurance program to the services of additional types of personnel who engage in the independent practice of furnishing health services.

Creation of an Advisory Council To Make Recommendations Concerning Health Insurance for Disability Beneficiaries

The Committee adopted the provision which would require the Secretary of Health, Education, and Welfare to establish an Advisory Council to study the problems relative to including the disabled under the health insurance program, and also any special problems with regard to the costs which would be involved in such coverage. The Council is to make its report by January 1, 1969.

C. Financing of Social Security Program

Social Security tax rates and the maximum taxes payable under present law and under H.R. 12080 as passed by the House of Representatives and under the committee bill are shown in tables 1 and 2. Income and outgo data for the programs that are financed by payroll taxes are shown in table 3.

TABLE 1.—TAX RATES UNDER PRESENT LAW AND H.R. 12080

(In percent)

Period	OASDI			HI			Total		
	Present law	House bill	Committee bill	Present law	House bill	Committee bill	Present law	House bill	Committee bill
	Employer-employee, each								
1967	3.9	3.9	3.9	0.5	0.5	0.5	4.4	4.4	4.4
1968	3.9	3.9	3.8	.5	.5	.6	4.4	4.4	4.4
1969–70	4.4	4.2	4.2	.5	.6	.6	4.9	4.8	4.8
1971–72	4.4	4.6	4.6	.5	.6	.6	4.9	5.2	5.2
1973–75	4.85	5.0	5.0	.55	.65	.65	5.4	5.65	5.65
1976–79	4.85	5.0	5.05	.6	.7	.65	5.45	5.7	5.7
1980–86	4.85	5.0	5.05	.7	.8	.75	5.55	5.8	5.8
1987 and after	4.85	5.0	5.05	.8	.9	.75	5.65	5.9	5.8
	Self-employed								
1967	5.9	5.9	5.9	0.5	0.5	0.5	6.4	6.4	6.4
1968	5.9	5.9	5.8	.5	.5	.6	6.4	6.4	6.4
1969–70	6.6	6.3	6.3	.5	.6	.6	7.1	6.9	6.9
1971–72	6.6	6.9	6.9	.5	.6	.6	7.1	7.5	7.5
1973–75	7.0	7.0	7.0	.55	.65	.65	7.55	7.65	7.65
1976–79	7.0	7.0	7.0	.6	.7	.65	7.6	7.7	7.65
1980–86	7.0	7.0	7.0	.7	.8	.75	7.7	7.8	7.75
1987 and after	7.0	7.0	7.0	.8	.9	.75	7.8	7.9	7.75

Note: Maximum taxable earnings base under present law is $6,600. Maximum taxable earnings base under House bill is $7,600, beginning in 1968. Maximum taxable earnings base under committee bill is $8,000 in 1968, $8,800 in 1969–71, and $10,800 in 1972 and after.

TABLE 2.—MAXIMUM TAX CONTRIBUTIONS UNDER PRESENT LAW AND UNDER H.R. 12080

Period	OASDI			HI			Total		
	Present law	House bill	Committee bill	Present law	House bill	Committee bill	Present law	House bill	Committee bill
By employee:									
1967	$257.40	$257.40	$257.40	$33.00	$33.00	$33.00	$290.40	$290.40	$290.40
1968	257.40	296.40	304.00	33.00	38.00	48.00	290.40	334.40	352.00
1969–70	290.40	319.20	369.60	33.00	45.60	52.80	323.40	364.80	422.40
1971	290.40	349.60	404.80	33.00	45.60	52.80	323.40	395.20	457.60
1972	290.40	349.60	496.80	33.00	45.60	64.80	323.40	395.20	561.60
1973–75	320.10	380.00	540.00	36.30	49.40	70.20	356.40	429.40	610.20
1987 and after	320.10	380.00	545.40	52.80	68.40	81.00	372.90	448.40	626.40
By self-employed:									
1967	389.40	389.40	389.40	33.00	33.00	33.00	422.40	422.40	422.40
1968	389.40	448.40	464.00	33.00	38.00	48.00	422.40	486.40	512.00
1969–70	435.60	478.80	554.40	33.00	45.60	52.80	468.60	524.40	607.20
1971	435.60	524.40	607.20	33.00	45.60	52.80	468.60	570.00	660.00
1972	435.60	524.40	745.20	33.00	45.60	64.80	468.60	570.00	810.00
1973–75	462.00	532.00	756.00	36.30	49.40	70.20	498.30	581.40	826.20
1987 and after	462.00	532.00	756.00	52.80	68.40	81.00	514.80	600.40	837.00

TABLE 3.—COMPARISON OF CONTRIBUTION INCOME AND BENEFIT OUTGO UNDER PRESENT LAW, HOUSE BILL AND FINANCE COMMITTEE BILL, 1967–72

[In billions of dollars]

Calendar year	Present law	House bill	Finance committee bill
	Contribution income		
1967	28.5		
1968	29.6	30.8	31.2
1969	33.7	34.9	36.3
1970	35.2	36.5	38.3
1971	36.2	40.3	42.5
1972	37.2	42.0	46.0
	Benefit outgo		
1967	24.2		
1968	25.5	[1] 28.7	[2] 29.0
1969	26.9	30.3	32.7
1970	28.2	31.7	34.4
1971	29.4	33.1	35.9
1972	30.8	34.6	37.4
	Excess of contributions over benefits		
1967	4.3		
1968	4.1	2.1	2.2
1969	6.8	4.6	3.6
1970	7.0	4.8	3.9
1971	6.8	7.2	6.6
1972	6.4	7.4	8.6

[1] Assumes that increased benefits will be payable for all 12 months of 1968 (as would have been the case if bill had been enacted when it passed the House).
[2] Based on effective date of March (payable at beginning of April) for increased benefits.

Note: Benefit outgo data include increase in HI benefit-cost estimates made following passage of the House bill.

D. Public Assistance

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

Limitation on Federal Matching in AFDC Program

The House bill sets a limitation on Federal financial participation in the AFDC program related to the proportion of the child population that could be aided because of the absence from the home of a parent. Federal financial participation would not be available for any excess above the percentage of children of absent parents who received aid to the child population in the State as of January 1, 1967.

This limitation is not retained in the committee bill.

Work Incentive Program for AFDC Families

The committee modified the provisions of the House bill by establishing a new work incentive program for families receiving AFDC payments to be administered by the Department of Labor, and by defining more precisely than in the House bill those AFDC recipients who would be referred to the program. The State welfare agencies would decide who was appropriate for such referral but would not include (1) children who are under age 16 or going to school; (2) any person with illness, incapacity, advanced age or remoteness from a project that precludes effective participation in work or training; (3) persons whose substantially continuous presence in the home is required because of the illness or incapacity of another member of the household; (4) a mother who is in fact caring for one or more children of preschool age, if such mother's presence in the home is necessary and in the best interest of the children; (5) persons whose participation in the program would not (as determined by the State agency) be in their best interest and in the interest of the program. For all those referred the welfare agency would be required to assure necessary child care arrangements for the children involved. An individual who desires to participate in work or training would be considered for assignment and, unless the request was specifically disapproved, would be referred to the program.

People referred by the State welfare agency to the Department of Labor would be handled under three priorities of operations. Under priority I, the Secretary of Labor, through the over 2,000 U.S. employment offices, would establish an employability plan for each person and make arrangements for as many as possible to move into regular employment.

Under priority II all those found suitable would receive training appropriate to their needs and a weekly incentive payment of up to $20. After training, as many as possible would be referred to regular employment.

Under priority III, the employment office would make arrangements for special work projects to employ those who are found to be unsuitable for the training and those for whom no jobs in the regular economy can be found at the time. These special projects would be set up by agreement between the employment office and public agencies or nonprofit agencies organized for a public service purpose.

It would be required that workers receive at least the minimum wage (Federal or State) if the work they perform is covered under a minimum wage statute.

Moreover, the work performed under such projects could not result in the displacement of regularly employed workers and would have to be of a type which, under the circumstances in the local situation, would not otherwise be performed by regular employees.

The special work projects would work like this: The State welfare agency would make payments to the employment office equal to:

(1) The welfare benefit the family would have been entitled to if the relative did not work in the project, or, if smaller,

(2) That part of the welfare benefit equal to 80 percent of the wages which the individual receives on the special project.

The Secretary of Labor would arrange for the participants to work in a special work project. The amount of the funds paid by him into the project would depend on the terms he negotiates with the agency sponsoring the project. The amount of funds put into the projects by the Secretary of Labor could not be larger than the funds sent to the Secretary by the State welfare agency.

The extent to which the State welfare expenditures might be reduced would depend upon the negotiating efforts of the Secretary of Labor. If he is successful in placing these workers in work projects where the pay is relatively good, the contribution the State must make into the employment pool would be less.

Employees who work under these agreements would have their situations reevaluated by the employment office at regular intervals (at least every 6 months) for the purpose of making it possible for as many such employees as possible to move into regular employment or training.

An important facet of this suggested work program is that in most instances the recipient would no longer receive a check from the welfare agency. Instead, he would receive a payment from an employer for services performed. The entire check would be subject to income, social security, and unemployment compensation taxes, thus assuring that the individual would be accruing rights and responsibilities as he would in regular employment. In those cases where an employee receives wages which are insufficient to raise his income to a level equal to the grant he would have received had he not been in the project plus 20 percent of his wages, a welfare check equal to the difference would be paid. In these instances the supplemental check would be issued by the welfare agency and sent to the worker.

A refusal to accept work or undertake training without good cause by a person who has been referred would be reported back to the State agency by the Labor Department; and, unless such person returns to the program within 60 days (during which he would receive counseling), his welfare payment would be terminated. Protective and vendor payments would be provided to protect dependent children from the faults of others. Under the House bill, such payments would be optional with the States, but under the committee proposal the children must be given this protection.

Earnings Exemption

Under the present AFDC program, the States, at their option, may disregard not more than $50 per month of earned income of each de-

pendent child under age 18 but not more than $150 per month in the same home in computing a family's income for public welfare purposes. The States also have the option of disregarding $5 of income from any source before applying the child's earned income exemption.

Under the House bill, all earned income of each child recipient under age 16, and of each child age 16 to 21 who is a full-time student attending school, would be excluded in determining need for assistance. In the case of a child over 16 who is not in school or an adult relative the first $30 of earned income of the group plus ⅓ of the remainder of such income for the month would also be exempt. The option of the States to disregard $5 a month of any type of income would be continued. The provision exempting $50 a month of a child's income would be superseded by these provisions.

Under the committee bill, the earnings exemption provision would be enlarged to require States to exempt the first $50 and one-half of family income over $50 rather than $30 and one-third of family earnings above $30. After July 1, 1969, the same earnings exemption would be extended to the old-age assistance program and the aid to the permanently and totally disabled program.

The exemption of all earnings would not be available to any child whether above or below age 16 unless he was attending school full time.

Unemployed Fathers Program

The committee bill removes certain provisions contained in the House bill which affect eligibility of children on AFDC when their father is unemployed. Specifically, the requirement that the father have six calendar quarters of work or have been entitled to unemployment compensation would be removed. In addition, the committee bill would restore present provisions of existing law under which a State may at its option make payments for a month in which the father received unemployment compensation. Under the House bill, receipt of any unemployment compensation would bar assistance for the month.

Runaway Parents Location and Liability

In an attempt to compel a parent who deserts or abandons his dependent child to comply with a child-support court order, the House bill required disclosure of the address of the parent or his employer to the court issuing the order and provided for Federal participation in the cost of a State agency entering into an agreement with law-enforcement personnel to press collection of the support payment.

The committee added a provision to give the State agency making payments to the family with a dependent child in which a parent has deserted and failed to make support payments, the assistance of the Department of Health, Education, and Welfare, and the Treasury Department in locating the parent. If the runaway parent is located outside the State where his dependent children reside and if he refuses to comply with the court order for their support, the Internal Revenue Service is to collect by levy or distraint an amount equal to the court-ordered support payment or the Federal share of the welfare payments to his family, whichever is lower.

The committee amendment also makes information regarding the runaway parent's whereabouts available to both courts in interstate support proceedings.

Increasing Income of Old-Age, Blind, and Disabled Assistance Recipients

Under the committee bill, the States would be required to adjust their standards of need and maximum payment provisions to guarantee that assistance recipients, both those eligible for social security benefits (about 1 million) and those who are not (also about 1 million) will receive, on the average, an increase in total income equal to $7.50 a month. Any increases the States have made in payments since January 1, 1967, would count toward this requirement. The effect of this requirement is that adult assistance recipients as a group will share in the savings which the States will realize because of reduction in assistance payments for those recipients who are also eligible for the social security benefit increase.

Federal Matching for Assistance Recipients in Intermediate Care Facilities

Under current law, vendor payments may be made with Federal sharing only in behalf of persons in medical facilities, such as skilled nursing homes. There is no Federal vendor-payments matching for people who need institutional care in the range above room and board, and below that of skilled nursing homes.

The committee bill would provide for a vendor payment in behalf of persons who qualify for OAA, AB, or APTD, and who are living in facilities which are more than boarding houses but which are less than skilled nursing homes. The rate of Federal sharing for payments for care in those institutions would be at the same rate as for medical assistance under title XIX. Such homes would have to meet standards of safety and sanitation comparable to those required for nursing homes in a given State.

This provision should result in a reduction in the cost of title XIX by allowing States to move substantial numbers of welfare recipients from skilled nursing homes to lower cost institutions.

Maintenance of State Effort

Present law contains certain provisions which in effect require that the additional Federal dollars States received as a result of the Social Security Amendments of 1965 are passed on to recipients or are otherwise used in the State's welfare program, for a period ending July 1, 1969. The House approved bill modifies the provisions describing the kinds of expenditures States may count toward meeting this provision to broaden the scope of expenditures which may be counted. Under the committee bill, the House provisions are retained, but the expiration date is advanced to July 1, 1968, and the effective date changed from January 1, 1966, to July 1, 1966.

Purchase of Social Services

The House bill permits the purchase by welfare agencies of child care and other services under title IV of the act, aid to families with

dependent children. Such services may now be provided by welfare agency staff but existing law does not permit their purchase.

The committee bill makes a similar change in titles I, X, XIV, and XVI under which Federal participation in payments to aged, blind, and disabled persons is authorized, thereby permitting the purchase of such services as homemaker or rehabilitation services under programs authorized under those titles.

Provision of Family Service State Plan Requirement

There is a provision in present law requiring State welfare agencies to make a plan for providing welfare service for each child in an AFDC family. Under the committee bill, the plan would also have to include the adults in the family.

Payment for Home Repairs

The House bill amended the cash public assistance programs, other than the AFDC program, to allow 50 percent Federal matching for home repairs (up to $500) if to do so would be more economical from the standpoint of the program. The committee bill would extend this provision to the AFDC program.

Repatriation Extension

The committee bill would extend for 1 year, until July 1, 1969, the temporary legislation which authorizes assistance to Americans who have been repatriated to the United States by the Department of State from foreign countries.

Demonstration Projects

Two million dollars annually is currently available to encourage the States to develop demonstrations in improved methods of providing service to recipients or in improved methods of administration. The House approved bill increased this amount to $4 million annually. The committee amendment provides for $10 million a year.

Study of Services Given to Recipients

The committee bill directs the Secretary to study and report to the Congress, by July 1, 1969, the extent to which staff of welfare agencies are serving the needs of assistance recipients in securing the full benefits and protection of local, State, and Federal laws relating to health, housing, and related laws and the degree to which assistance recipients are helped to take advantage of the public welfare and other related programs in the community. The report is to contain the Secretary's recommendations on how these services might be made more effective. The study is to include the Secretary's findings and recommendations on the extent to which public assistance programs may be used as a means of enforcing State, local, and Federal law in the field of health, housing, and related laws.

Use of Subprofessional and Volunteer Staff

The committee bill requires the States, effective July 1, 1969, to train and use subprofessional staff, with particular emphasis on the

use of welfare recipients and other persons of low income, as community service aides for the kinds of jobs appropriate for them in the public assistance, child welfare, and health programs under the Social Security Act. The committee amendment would also direct the States to make use of volunteers in the program both for the provision of service to recipients, and to serve as members of advisory committees.

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

Social Work Manpower and Training

The committee adopts the House bill provision which authorizes $5 million for the fiscal year ending June 30, 1969, and $5 million for each of the 3 succeeding fiscal years for grants to public or nonprofit private college and universities and to accredited graduate schools of social work, or an association of such schools, to meet part of the costs of development, expansion, or improvement of undergraduate programs in social work and programs for the graduate training of professional social work personnel. Not less than one-half of the amount appropriated would have to be used for grants for undergraduate programs.

Federal Payments for Foster Home Care of Dependent Children

Under the House bill, effective July 1, 1969, States would have to provide AFDC payments for children who are placed in a foster home if in the 6 months before proceedings started in the court they would have been eligible for AFDC if they had lived in the home of a relative. Provision of such care would be optional with the States before July 1, 1969. Under present law, children in foster care are eligible for AFDC payments only if they actually received such payments in the month they were placed in foster care. Federal matching would be available for grants up to an average of $100 a month per child. The committee adopted this provision.

Limitation on Federal Matching for Puerto Rico, Guam, and Virgin Islands

Under the House bill, the dollar limit for Federal financial participation in public assistance for Puerto Rico would be raised from the present $9.8 million to $12.5 million for 1968, $15 million for 1969, $18 million for 1970, $21 million for 1971 and $24 million for 1972 and thereafter. Up to an additional $2 million could be certified for family planning services and expenses to support the work incentive program.

Under medicaid an overall dollar limit of $20 million would apply in the case of Puerto Rico (in lieu of the limitation made applicable to the States by the bill) and the ratio of Federal matching would be changed from 55 percent to 50 percent.

Proportionate increases in the dollar maximums for Guam and the Virgin Islands would be made.

The committee adopts these decisions.

E. Child Welfare Services

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

Increased Authorizations for Child Welfare Services

The House bill increased child welfare authorizations from $55 million for fiscal year 1969 to $100 million, and from $60 million for later years to $110 million. The committee bill would further increase these authorizations to $125 million and $160 million respectively. The increases are designed to meet the day care costs of working women who are not AFDC recipients.

Parent Involvement in Day Care—Day Care Standards

The committee bill adds a State plan requirement to the child welfare day-care provisions for development of arrangements for the more effective involvement of parents in day care programs. Also, the day care standards in the child welfare services programs will be made applicable to day care provided to AFDC children.

F. Medical Assistance (Medicaid)

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

Limitation on Federal Participation in Medical Assistance

Under the House bill, States would be limited in setting income levels for Federal matching purposes to the lower of (1) 133⅓ percent of the AFDC payment level, or (2) 133⅓ percent of the States per capita income applied to a family of four.

In lieu of the House provisions the committee bill would apply *both* of the following provisions:

(1) Beginning July 1, 1968, the Federal Government would not participate in matching any of the cost of medical assistance to persons whose income exceeds 150 percent of the old-age assistance standards in a given state; *and*

(2) Beginning July 1, 1969, Federal participation will be at the rate of—

(a) The Federal medical assistance percentage (which varies according to State per capita income from 50 percent to 83 percent) applicable with respect to all cash assistance recipients and persons in medical institutions whose incomes are less than the applicable cash assistance standard in a State; *and*

(b) The square of the Federal medical assistance percentage (which gives a result which varies between 25 percent and 69 percent) with respect to the medically needy (subject to the limitation in (1) above)

This formula results in a reduction in short-term costs to the Federal Government estimated as follows:

Fiscal Year:	*Amount (in millions)*
1969	$45
1970	701
1971	998
1972	1,294

After the squaring rule becomes effective in 1969 the long-term savings under the House bill and the committee amendment are approximately the same. The lower savings under the committee amendment estimated for 1969 results in large part from the fact that part (2) of the limitation would not go into effect until fiscal year 1970.

Skilled Nursing Home Standards Under Medicaid

The bill would require the States, as a condition to participation in the medicaid program, to place public assistance receipients only in those nursing homes which are licensed as meeting certain conditions. The conditions include requirements which relate to environment, sanitation, and housekeeping now applicable to extended care facilities under medicare, as well as the fire and safety standards of the Life Safety Code of the National Fire Protection Association (unless the Secretary finds that a State's existing fire code is adequate).

The committee amendment would also require the States to have a professional medical audit program under which periodic medical evaluations of the appropriateness of the kind and level of care provided title XIX patients in nursing homes, mental hospitals, and other institutions will be made.

Effective July 1, 1970, States which provide skilled nursing home care under medicaid will also be expected to provide home health care services.

Hospital Deductibles and Copayment for Medically Indigent

Under present law, States may not impose any deductibles or cost sharing with respect to hospital care provided under the medicaid program. Under the committee bill, the costs of hospital care received by the medically needy could be subject to deductibles or other cost sharing if a State desired to have such provisions in its program. As under existing law such deductible or cost sharing could not be imposed with respect to the money payment recipients.

Essential Person—Medicaid

The committee bill would extend medical assistance to certain "essential persons." At present there is no provision in title XIX which permits a State to receive Federal matching for medical assistance provided to "essential persons." An "essential person" is defined as the spouse of a cash public assistance recipient who is living with him, who is essential or necessary to his welfare, and whose needs are taken into account in determining the amount of his cash payment. The wife of an OAA recipient, for example, who herself is not eligible for cash assistance because she is under age 65 could be eligible for medical assistance if the State plan so provided.

Licensing of Nursing Home Administrators

The committee bill includes an amendment which would require States to license administrators of nursing homes. Administrators currently operating a home who do not qualify initially would have until July 1, 1972, to qualify. In the meantime, the States would be required to offer programs of training to assist administrators to qualify.

Direct Billing

Under present law, the States are required to pay for health services provided under medical assistance programs directly to the provider of the services. The House bill would permit States to make payment directly to the recipient for physicians' services with respect to those medical assistance recipients who are not also receiving cash assistance. Under the committee bill, the provision is broadened to include dentists as well as physicians and to apply also to those recipients who are receiving cash assistance. The Secretary would establish safeguards to assure that charges by physicians to the recipients are reasonable, and that the State agency has methods and procedures to safeguard against the possibility of unnecessary utilization of care, and to assure the reasonableness of any charges paid by any recipient.

General Accounting Office and Department of Health, Education, and Welfare Audit Authority

Under the committee bill, it would be made clear that auditors of the General Accounting Office and Department of Health, Education, and Welfare would be authorized, on a spot check basis or in cases where there is good cause to believe fraud may be present, to review records and examine the premises of providers of services who receive funds under medical assistance programs in which there is Federal financial participation.

Required Services Under Medicaid

Under current law, States must provide, as a minimum, five basic services: inpatient hospital services, outpatient hospital services, other laboratory and X-ray services, skilled nursing home services, and physician's services. States may select a number of other items from an additional list in the law. The House bill provided that a State, as an alternative to the basic five items of services, may select any seven of the first 14 services listed in the law. In addition to the basic five, the services from among which States can make their selection are: (1) Medical care or any type of remedial care recognized under State law, furnished by a licensed practitioner within the scope of his practice as defined under State law; (2) home health care services; (3) private duty nurse services; (4) clinic services; (5) dental services; (6) physical therapy and related services; (7) prescribed drugs, dentures and prosthetic devices and eyeglasses; (8) other diagnostic, screening, preventive and rehabilitative services; and (9) inpatient hospital services and skilled nursing home services for individuals age 65 or older in an institution for mental diseases.

Under the committee bill, States would be required to continue to provide the basic five services for all money payment recipients, the most needy receiving help under the program. With respect to the medically indigent, States would be allowed to select either the first five, or at least seven out of 14, services authorized under present law, except that if nursing home or hospital care services are selected, a State must also provide physician's services in those institutions. Subsequent to July 1, 1970, a State would be required to also provide home health services for its assistance recipients who are eligible for skilled nursing home care.

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

Free Choice for Persons Eligible for Medicaid

Effective July 1, 1969 (July 1, 1972, for Puerto Rico, the Virgin Islands, and Guam), people covered under the medicaid program would have free choice of qualified medical facilities and practitioners.

Use of State Agencies To Assist Health Facilities To Participate in the Various Health Programs Under the Social Security Act

States could receive 75-percent Federal matching for the services which State health agencies perform in helping health facilities to qualify for participation in the various health programs under the Social Security Act (including medicare, medicaid, and the child health programs) and to improve their fiscal records for payment purposes. Similar provisions in the medicare program (which finances such services on a 100-percent basis from the Federal hospital insurance trust fund) would be repealed effective July 1, 1969, when this provision would go into effect.

Payments for Services and Care by a Third Party

States would have to take steps to assure that the medical expenses of a person covered under the medicaid program, which a third party had a legal obligation to pay, would not be paid, or if liability is later determined, that steps will be taken to secure reimbursement in order to reduce program costs.

Coordination of Title XIX and the Supplementary Medical Insurance Program

Under the House bill, States would have until January 1, 1970 (rather than Jan. 1, 1968, as under present law), to buy-in title XVIII supplementary medical insurance for aged persons eligible for medicaid. Also, the bill would allow people who are eligible for medicaid but who do not receive cash assistance to be included in the group for which a State can purchase such coverage and would make persons who first go on the medicaid rolls after 1967 eligible for the buy-in. There would be no Federal matching toward the State's share of the premium costs for the non-cash assistance recipients. The bill would provide that Federal matching amounts would not be available to States toward the cost of services which could have been covered under the supplementary medical insurance programs but were not. The committee adopts these provisions.

Modification of Comparability Provisions

States would not have to include in medicaid coverage for recipients under age 65 the same items which the aged receive under the supplementary medical insurance program which is furnished to them under the buy-in provisions discussed above. The committee concurs in these House bill provisions.

Extent of Federal Financial Participation in State Administrative Expenses

Under the House bill, States would be able to get the same 75-percent Federal matching for the costs of physicians and other professional medical personnel working on the medicaid program in the State health agencies which they now get when such personnel work in the "single State agency," usually the public assistance agency. Under present law, the matching is 50 percent in such cases. The committee concurs in the House bill provision.

Advisory Council on Medical Assistance

An Advisory Council on Medical Assistance, consisting of 21 persons from outside the Government, would be established to advise the Secretary of Health, Education, and Welfare in matters of administration of the medicaid program.

G. Child Health

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

Family Planning

Family planning expenditures are now made under the maternal and child health program in title V and through medical assistance under title XIX, as a medical services expenditure. States are free to offer family planning services to AFDC recipients under title IV, but there are no Federal requirements. Under the House-approved bill, the States would be required to offer family planning services to all appropriate AFDC recipients. Federal matching of these expenditures would be provided. Under the House bill, authorization for the maternal and child health programs would be increased and, though funds are not earmarked for family planning, an estimated $15 million would be spent for that purpose under the 1969 authorization, with some increases thereafter. Demonstration projects would need to be developed for the provision of family planning services for mothers in needy areas.

Under the committee bill, the House provisions in the AFDC program are retained with language added to clarify that the acceptance of family planning services would be voluntary and not a requisite for the receipt of assistance. The House-approved amounts for the maternal and child health program would be raised by $30 million in 1970, and $60 million for later years, with an eventual 20 percent of all maternal and child health funds earmarked for family planning purposes.

Optometric Services Under Child Health Programs

The committee bill includes a provision to insure that persons receiving health services under child health programs are free to utilize the services of optometrists when appropriate. The provision recognizes that when health services are provided through a clinic or similar basis that the inclusion of optometric services may not always be feasible.

Administration of the Program for Services for Crippled Children

The House bill combined maternal and child health services and crippled children's services into one program and consolidated the authorizations. The committee bill goes further and assures administration of the crippled children's program by the Children's Bureau.

Training of Personnel for Health Care and Related Services for Mothers and Children

The committee has modified the House language to direct the Secretary of Health, Education, and Welfare "to give special attention to" rather than "priority to" programs providing training at the undergraduate level in making grants for training of such personnel.

Christian Scientists—Welfare Health Programs

The committee added a provision to the House bill under medical assistance (title XIX) and the child health programs (title V), to make clear that no provision in such titles would require an individual to undergo medical screening, diagnosis, or treatment except in cases involving infection, contagious disease or environmental health.

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

Consolidation of Earmarked Authorizations

In place of a number of separate earmarked authorizations in present law, the House bill consolidates all authorizations into one single authorization with three broad categories. The committee concurs.

Additional Requirements on the States Under the Formula Grant Program

The House bill requires that State plans provide for the early identification and treatment of crippled children. Title XIX is amended to conform to this requirement. The States must also devote special attention to family planning services and dental care for children in the development of demonstration services. The committee bill retains this provision.

Project Grants

Until July 1972, the House bill authorizes project grants (1) to help reduce the incidence of mental retardation and other handicapping conditions caused by complications associated with childbearing, and to help reduce infant and maternal mortality; (2) to promote the health of children and youth of school and preschool age; and (3) to provide dental care and services to children. Beginning July 1972, responsibility for these projects will be transferred to the States.

The fiscal year 1968 authorization for maternity and infant care special projects grants would be increased from $30 to $35 million. The committee adopted those amendments.

H. Employment and Income Tax

I. NEW PROVISIONS ADDED TO THE HOUSE BILL BY THE COMMITTEE

Medical Expense Tax Deduction for Aged

The committee added a provision restoring, with a qualification, the Federal income tax treatment of medical care and drug expenses applicable for persons 65 years of age and over prior to changes made by the Social Security Amendments of 1965. Before the 1965 change, an income tax deduction was permitted without application of the 3-percent floor (or 1-percent floor for drug expenses) for medical and drug expenses of a taxpayer and his spouse if either was age 65 or over. This unlimited medical expense deduction was also allowed for dependent parents age 65 and over. However, the 1965 amendments provided, effective in 1967, that medical expense deductions for persons age 65 and over would be limited in the same manner as already generally applied in the case of taxpayers under age 65; that is, medical expense deductions would be limited to those in excess of 3 percent of the taxpayer's adjusted gross income and the cost of medicines and drugs would be treated as a deductible medical expense only to the extent that they exceed 1 percent of his adjusted gross income.

The committee has restored the full medical expense and drug expense deductions for persons age 65 or over, without regard to the 3-percent and 1-percent floors, to the extent available under pre-1967 law but only if the person involved permanently waives all future entitlement to medicare benefits—both those providing hospitalization insurance and those providing supplementary medical care benefits. A waiver will be effective for a taxable year, if it is filed during a taxable year, or on or before the due date for filing an income tax return for such year. In addition, for years beginning in 1967, a waiver is effective if filed on or before June 30, 1968 (regardless of due date for filing the income tax return for the taxable year beginning in 1967).

Tax-Exempt Status for Entities Servicing a Group of Tax-Exempt Hospitals

The committee added a provision according tax-exempt status to entities providing joint services for hospitals where certain conditions are met. Gifts to such entities also are to qualify as deductible charitable contributions. To qualify for this treatment, the joint entity must be organized and operated to provide services of a type which if provided by a tax-exempt hospital would be considered an integral part of its exempt activities, the hospital members must be exempt organizations, and the joint entity must be organized and operated on a cooperative basis.

Time for Filing Applications for Exemption from Self-Employment Tax by the Amish

The committee added a provision extending the time for filing for exemption from the self-employment tax by members of religious sects conscientiously objecting to insurance. For those who have received self-employment income in 1966 or earlier years, the provision would

extend the time for filing the application for exemption until December 31, 1968. For those first receiving self-employment income after 1966, if the individual does not file for the exemption by the due date for his income tax return, he would nevertheless have until 3 months following the month in which he is notified in writing by the Internal Revenue Service that a timely application has not been filed.

Employee Status for Fishermen and Truck Loaders and Unloaders

The committee added a provision providing employee status for fishermen and truck loaders and unloaders. The effect of this is to assure social security coverage and income tax withholding for these individuals. Generally the owner of a fishing boat is to be classified as the employer of the boat's crew members although in certain cases the person leasing the boat will be considered their employer. In the case of truck loaders and unloaders, the driver of the truck will generally be considered the employer unless he, too, is an employee, in which event his employer will be considered the "employer" of the truck loaders and unloaders. An exception is provided where other persons are recognized as the employer.

Refund of Certain Overpayments by Employees of Hospital Insurance Tax

The committee added a provision dealing with the situation where an employee (or self-employed person) is paying both Federal Insurance Contributions Act taxes and Railroad Retirement Act taxes with respect to hospital insurance where he works for two employers or for one employer and is self-employed. In this case the individual is to be able to receive a refund of tax paid with respect to amounts in excess of the maximum wage base ($6,600 under present law and $8,000 in 1968, $8,800 in 1969, and $10,800 in 1972 and thereafter under the committee amendments), taking into account his earnings for both employers or his earnings for one employer and self-employment income.

Joint Employees of Certain Tax-Exempt Organizations

The committee added a provision dealing with situations where an individual is an employee of two or more tax-exempt organizations providing hospital or medical insurance where one of the organizations pays all of the wages to the employee for his work for both organizations. In this case the organization which pays the wages (with the consent of the other organization) is to be treated as the employer of the individual with respect to his joint employment.

III. GENERAL DISCUSSION OF THE BILL

A. General Discussion of Old-Age, Survivors, Disability, and Health Insurance Provisions

1. Increase in OASDI Benefits

The committee has carefully considered the need for increased social security benefits and has concluded that the present level of benefits is so low that a greater increase than the 12½-percent increase provided in the House-passed bill is required. In its deliberations the committee considered the fact that the cash-benefit increase as well as the hospital and health insurance benefits enacted in 1965 did much to improve the economic situation of social security beneficiaries. However, cash benefits are still insufficient for the vast number of people who must rely on social security benefits for a very significant part of their support. Therefore, the committee's bill would provide a guaranteed increase in cash benefits of 15 percent for all beneficiaries now on the social security rolls. This increase is needed not just to bring the benefits for the aged, the disabled, the widowed, and the orphaned up to date in terms of increases in the level of living since the last benefit increase, but also to provide some improvement in the adequacy of benefits. The earnings levels of all wage earners covered under the social security program have risen by about 14 percent and the Consumer Price Index has risen by about 8 percent since the level of benefits was last adjusted in 1965.

In keeping with the decision to increase benefits above the level of the House bill and to improve the income of the beneficiaries in the lower part of the benefit scale, the committee recommends that the minimum worker's benefit for retirement at or after age 65 be increased to $70, rather than to $50 as in the House bill.

In considering the level of benefits under the social security program a number of facts are pertinent. According to Social Security Administration studies, social security benefits are virtually the sole reliance of about half the beneficiaries and the major reliance for most beneficiaries. Because 82 percent of the people age 65 and over are getting social security benefits and 92 percent of the people currently reaching age 65 are eligible to get social security benefits, the level at which social security benefits are set determines in large measure the basic economic well-being of the majority of the Nation's older people.

Monthly benefits for retired workers now on the social security rolls who began to draw benefits at age 65 or later now range from $44 to $142, and the benefits for disabled workers now on the social security rolls range from $44 to $152; under the bill, these benefits would range from $70 to $163.30 for retired workers, and from $70 to $174.80 for disabled workers. The benefit amount payable to workers with average monthly earnings of $550 ($6,600 earnings base), the highest possible under present law, would be increased from $168 to $193.20. For a

survivor family consisting of a widow and two or more children getting benefits on the basis of $550 of average monthly earnings (maximum wages under a $6,600 earnings base) total monthly benefits of $400.40 would be payable rather than the $368 now payable.

In the future, the higher creditable earnings resulting from the increase in the earnings base (to $8,000 in 1968, $8,800 in 1969, and $10,800 in 1972) would 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. Such a static situation might eventually mean that the program would provide a flat benefit unrelated to total earnings because almost everyone would have earnings at the maximum creditable amount. In 1968, with the present $6,600 base, about one-half of all regularly employed men would get social security credit for their full earnings; under the proposed $8,000 base, it is estimated that about two-thirds of all regularly employed men would have their full earnings counted toward benefits. It is estimated that in 1972 the $6,600 base would cover the full earnings of about 38 percent of all regularly employed men, while the recommended $10,800 base would cover the full earnings of nearly four-fifths of all regularly employed men.

While the ultimate maximum benefit would not be payable to a man retiring at age 65 until the year 2010, survivorship and disability protection would be more quickly increased for all those earning above $6,600. For example, if a worker aged 35 in 1968 with annual earnings of $8,800 died in 1970, his widow and child would receive a monthly benefit of $267.60 or $44.00 (20 percent) more than is provided now. And his widow at age 62 would get a monthly benefit of $147.10 or $24.10 (20 percent) a month more than under present law. If the worker became disabled in 1970, he would get a monthly disability benefit of $178.30, an increase of $29.30 (20 percent) a month over the amount he would get under present law.

Illustrative monthly benefits payable under present law, under the House bill, and under the committee bill are shown in the following tables:

TABLE 1.—RETIREMENT BENEFITS PAYABLE AT SELECTED AVERAGE MONTHLY EARNINGS LEVELS UNDER PRESENT LAW, THE HOUSE BILL, AND THE COMMITTEE BILL

Average monthly earnings	Worker's [1] benefit			Couple's [1] benefit		
	Present law	House bill	Committee bill	Present law	House bill	Committee bill
$67	$44.00	$50.00	$70.00	$66.00	$75.00	$105.00
150	78.20	88.00	90.00	117.30	132.00	135.00
250	101.70	114.50	117.00	152.60	171.80	175.50
350	124.20	139.80	142.90	186.30	209.70	214.40
450	146.00	164.30	167.90	219.00	246.50	251.90
550	168.00	189.00	193.20	252.00	283.50	289.80
633	168.00	212.00	216.00	252.00	[2] 317.00	[2] 321.00
666	168.00	212.00	226.00	252.00	[2] 317.00	[2] 331.00
733	168.00	212.00	244.00	252.00	[2] 317.00	[2] 349.00
900	168.00	212.00	288.00	252.00	[2] 317.00	[2] 393.00

[1] For a worker who is disabled or is age 65 or older at the time of retirement and a wife age 65 or older when she comes on the rolls.
[2] Wife's benefit limited to $105.

TABLE 2.—SURVIVOR BENEFITS PAYABLE AT SELECTED AVERAGE MONTHLY EARNINGS LEVELS UNDER PRESENT LAW, THE HOUSE BILL, AND THE COMMITTEE BILL

Average monthly earnings	Widow age 62, widower, or parent			Widow and 2 children		
	Present law	House bill	Committee bill	Present law	House bill	Committee bill
$67	$44.00	$50.00	$70.00	$66.00	$75.00	$105.00
150	64.60	72.60	74.30	120.00	132.00	135.00
250	84.00	94.50	96.60	202.40	202.40	202.40
350	102.50	115.40	117.90	279.60	280.80	280.80
450	120.50	135.60	138.60	328.00	350.40	360.00
550	138.60	156.00	159.40	368.00	391.20	400.40
633	138.60	174.90	178.20	368.00	423.60	433.20
666	138.60	174.90	186.50	368.00	423.60	447.60
733	138.60	174.90	201.30	368.00	423.60	474.00
900	138.60	174.90	237.60	368.00	423.60	540.00

The committee did not change the provision in the House bill under which the wife's insurance benefit would ultimately be limited to $105 a month. However, it should be pointed out that this provision will generally have no practical effect at this time. It would not apply to anyone now on the rolls, but it could apply in the case of a young worker who becomes disabled in 1970 and in the case of a man who retires at age 65 in 1979. The following table compares the relationship of wages to a couple's benefit under existing law and your committee's bill:

BENEFITS PAYABLE TO A COUPLE BOTH OF WHOM ARE AGE 65 OR OLDER AT SELECTED AVERAGE MONTHLY EARNINGS LEVELS UNDER PRESENT LAW, UNDER THE HOUSE BILL, AND UNDER THE COMMITTEE BILL

Average monthly earnings	Couple's benefit			Percent of average monthly earnings		
	Present law	House bill	Committee bill	Present law	House bill	Committee bill
$67	$66.00	$75.00	$105.00	98.5	(1)	(1)
150	117.30	132.00	135.00	78.2	88.0	90.0
250	152.60	171.80	175.50	61.0	68.7	70.2
350	186.30	209.70	214.40	53.2	59.9	61.3
450	219.00	246.50	251.90	48.7	54.8	56.0
550	252.00	283.50	289.80	45.8	51.5	52.7
633	252.00	[2] 317.00	[2] 321.00	39.8	50.1	50.7
666	252.00	[2] 317.00	[2] 331.00	37.8	47.6	49.7
733	252.00	[2] 317.00	[2] 349.00	34.4	43.2	47.6
900	252.00	[2] 317.00	[2] 393.00	28.0	35.2	43.7

[1] Over 100 percent.
[2] Wife's benefit limited to $105.

The benefit increase would be effective beginning with benefits for March 1968 and would apply to lump-sum death payments in the case of deaths in or after March 1968.

An estimated 23 million people would be paid increased benefits early in April 1968, and $4.1 billion in additional benefits would be paid in the first 12 months as a result of the general benefit increase.

2. Increase in Special Payments to Certain Individuals Age 72 and Older

Under the 1965 amendments to the social security law special monthly payments ($35 a month for a worker or a widow, $17.50 for a wife) were provided for certain people who attained 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 in the same amount were also provided, under an amendment to the law enacted in 1966, for certain people

who attain age 72 before 1972 and who have not earned sufficient credit under the social security program to 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. In addition, the special payment is suspended for any month for which the beneficiary gets payments under a federally aided public assistance program. The cost of the payments under this provision is met out of general revenues.

Under the bill, the payments under both of these special transitional provisions would be increased from $35 to $50, rather than the $40 provided under the House bill (from $52.50 to $75 for an eligible couple). As a result, about 235,000 people who do not now get the special payments under this provision would qualify for some payments in March 1968 and about 817,000 would qualify for higher payments under this provision. An estimated $200 million in additional payments would be paid out in the first 12 months; about $178 million of this amount would be paid from general revenues.

3. Reduce eligibility age to 60

Social security benefits are payable under present law at age 62 (age 60 for widows), with the benefits payable to workers and their wives (or husbands) who start getting them before age 65 (and to widows who start getting them before age 62) reduced to an amount that will on the average give the same total lifetime benefits that would have been paid if the benefits had not begun until age 65 (age 62 for widows). The committee bill adds a new provision to the House bill under which the age of eligibility would be lowered to 60 for all aged beneficiaries, with the benefits payable before age 62 reduced according to the same principle as that applied under present law.

The reduction rate in present law for a wife's (or a husband's) benefit is twenty-five thirty-sixths of 1 percent, and for a worker's (and a widow's) benefit it is five-ninths of 1 percent, for each month that the beneficiary is under age 65 (62 for a widow) when he begins to get benefits.

Under present law, widow's, widower's, and parent's benefits are not reduced if the beneficiary is between the ages of 62 and 65 when he begins to get his benefits, and no change would be made under the committee's bill. The benefits for widowers and parents would be reduced, as is now done for widows, only if they take their benefits between ages 60 and 62. A worker who takes his benefits at age 60 would get a benefit equal to two-thirds of the amount he would have been paid if he had stopped working at that age and waited until he reached age 65 to claim his benefits; a wife's benefit would be 58⅓ percent of what she would have been paid at age 65; a widower's or parent's benefit (as well as a widow's benefit) would be 86⅔ percent of what would have been paid at age 62.

Providing benefits at age 60 would lessen to some extent the financial hardships faced by workers who, because of ill health, technological unemployment, or other reasons, find it impossible to continue working until they reach age 62. The committee believes that these people would rather have reduced social security benefits than no regular income at all, and that such benefits should be made available to them.

Monthly benefits would be payable under this provision beginning with the month of December 1968. An estimated 775,000 people are expected to claim benefits for December, and benefits amounting to $555 million would be paid during the first 12 months of operation. Since 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.

The bill also makes two technical changes. The first would provide that a divorced wife age 62–64 (age 60–64 under the committee bill) cannot get full benefits, as is possible under present law, if she has an eligible child in her care. Under present law, a divorced wife under age 62 cannot get any benefits at all by reason of having an eligible child in her care, and there is no reason why she should become eligible for full benefits before age 65, rather than for reduced benefits, just because of having a child in her care.

The second technical change would provide that social security disability benefits may be reduced because of concurrent entitlement to workmen's compensation payments only prior to the month in which the beneficiary attains age 60 instead of age 62 as under present law. This second change would maintain the effect of present law.

4. The Retirement Test

Under present law if a beneficiary earns more than $1,500 in a year benefits are withheld on a sliding scale—$1 less in benefits is payable for each $2 of earnings between $1,500 and $2,700, and for each $1 of earnings above $2,700. Full benefits are payable, though, regardless of annual earnings, for any month in which the beneficiary neither works for wages of more than $125 nor renders substantial services in self-employment. The committee bill retains for 1968 the provisions of the House bill which would increase the annual amount to $1,680 and the monthly amount to $140. However, under the committee bill a beneficiary would receive the full amount of his benefits for years after 1968 if he had annual earnings of no more than $2,000, rather than $1,680 as provided in the House bill. As under present law, his benefit would be reduced by $1 for each $2 of earnings for the first $1,200 above the exempt amount (between $2,000 and $3,200 rather than between $1,680 and $2,880 as in the House bill), and for each $1 of wages thereafter. The bill would increase from $125 to $166.66⅔ ($140 in the House bill) the amount of earnings that a beneficiary can have in a given month and still get full benefits for that month.

About $175 million would be paid out in additional benefits to 760,000 people with respect to benefits payable for 1968.

5. Amendments to Disability Program

(a) Benefits for disabled widows and widowers

The committee's bill modifies the provision of the House bill which would provide social security benefits for certain totally disabled widows (including surviving divorced wives) and totally disabled dependent widowers. (Present law does not provide social security benefits for widows and widowers on the basis of disability.) The committee believes that there is a need to provide monthly benefits

for the severely disabled widow and dependent widower who are unable to support themselves by working.

The bill, therefore, would provide monthly benefits for widows and dependent widowers who become totally disabled before or within 7 years after the spouse's death or, in the case of a widow, before or within 7 years after the end of her entitlement to mother's benefits. It is thought that providing benefits for disabilities which occur before the end of this 7-year period would protect widows and widowers until they have a reasonable opportunity to meet the insured status requirements for disability benefits based on their own work, including the requirement of a minimum of about 5 years of covered work out of the 10 years preceding disablement.

The committee bill removes the provisions of the House bill which would limit the payment of these benefits.

Under the House bill, a disabled widow or widower entitled to benefits beginning at age 50 would receive a monthly benefit amounting to 50 percent of the deceased spouse's primary insurance amount. Where entitlement to disabled widow's or widower's benefits begins at a later age the monthly benefit amount would range from 50 percent to 82½ percent of the primary insurance amount, depending on the age at which the widow or widower became entitled. The committee believes that disabled widows and widowers have no less need for benefits than aged widows and widowers. Therefore, the committee bill would provide disabled widows and widowers with benefits equal to the benefit that would be payable at age 62. These benefits would be available to qualified disabled widows and widowers regardless of age.

The committee's bill makes a minor change in the test of disability (which is more strict than the definition which applies to workers) for purposes of widow's and widower's benefits. This new test is discussed in the statement on "The Definition of Disability."

The provision for benefits for disabled widows and widowers 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 March 1968. About 70,000 totally disabled widows and widowers under age 62 would immediately become eligible for cash benefits. About $71 million in additional benefits would be paid out during the first 12 months of operation.

(*b*) *Alternative disability insured-status requirement for workers disabled before age 31*

The committee's bill would extend social security disability protection to additional totally disabled young workers and their families by providing an alternative to the present requirements that such workers must meet in order to be insured for social security disability protection. Under present law, a disabled worker (other than certain blind people) must have at least 20 quarters of coverage (about 5 years of covered work) out of the 40 calendar quarters preceding disablement, in addition to meeting a requirement of previous covered work that is comparable to the insured-status requirement for old-age insurance benefits. The 20-out-of-40 requirement—a test of substantial recent covered employment—provides some assurance that social security disability protection will be related to loss of earnings on

account of disability. The requirement thus serves an important purpose and is reasonable as a general test of substantial recent employment.

The committee believes, however, that a less restrictive employment test is necessary in the case of a worker disabled early in his working life who may not have had an adequate opportunity to earn 20 quarters of coverage.

Under the bill, a disabled worker would be insured for social security disability protection if (1) he has quarters of coverage in at least half of the calendar quarters elapsing after he attains age 21, and up to and including the quarter in which he becomes disabled, with a minimum of six quarters of coverage, or (2) if disabled before age 24, he has quarters of coverage in half of the 12 quarters ending with the quarter of disablement. If disability begins after age 31, the generally applicable employment test in present law would remain applicable.

This amendment, which would be effective with respect to benefits for March 1968, would provide social security disability protection for the significant number of younger workers, and their families, who may become disabled before they are old enough to have worked long enough to meet the work requirements in present law. It would be applicable not only prospectively but also to workers who have in the past become totally disabled before age 31, and on enactment would provide monthly payments to about 100,000 people—disabled workers and their dependents. About $72 million in additional benefits would be paid out in the first 12 months of operation.

(c) Increase in allocation to the disability insurance trust fund

The bill would provide for an increase in the allocation of contribution income to the disability insurance trust fund. Beginning in 1968 an additional 0.25 percent of taxable wages and 0.1875 percent of self-employment income would be allocated to the trust fund, bringing the total allocation to 0.95 percent of taxable wages and 0.7125 percent of taxable self-employment income. (Under present law, 0.70 percent of taxable wages and 0.525 percent of taxable self-employment income are allocated to the disability insurance trust fund.)

This increase would take into account not only the increased cost of the disability insurance provisions due to the benefit increases provided by the bill and to the additional disabled workers and their dependents who would be eligible for benefits under the bill, but also the larger than anticipated numbers of disabled people who have become entitled to benefits in the past 4 years.

(d) The definition of disability

The present law defines disability (except for certain cases of blindness) as the "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." The committee recognizes and shares the concern expressed by the Committee on Ways and Means regarding the way this definition has been interpreted by the courts and the effects their interpretations have had and might have in the future on the administration of the

disability program by the Social Security Administration. The allocation to the disability trust fund has increased from 0.50 percent of payroll in 1956 to 0.70 percent today, and will be increased to 0.95 percent by the committee's bill. In 1965 the Congress adopted an increase in the social security taxes allocated to the disability insurance trust fund; a large part of which was needed to meet an actuarial deficiency of 0.13 percent in the system. Again this year the Administration has come to the Congress asking for an increase in the taxes allocated to that fund to meet an even larger actuarial deficiency, which has reduced the 0.03 percent surplus, estimated after the 1965 amendments, to a 0.15 percent deficiency. The studies of the Committee on Ways and Means indicate that over the past few years the rising cost of the disability insurance program is related, along with other factors, to the way in which the definition of disability has been interpreted. The committee therefore includes in its bill more precise guidelines that are to be used in determining the degree of disability which must exist in order to qualify for disability insurance benefits.

In arriving at the conclusion that the definition of disability has been eroded over a period of time, the committee observed that the last long-range projection prepared by the Social Security Administration showed a significant increase in the proportion of the population becoming disabled within the definition. Moreover, it appears that the increase was not due to changes in actuarial methods or to changes in the actuarial interpretation of past experience; rather it was the experience itself that changed. Over the last 4 years the number of disability allowances was larger than the number estimated. Because there is no evidence to indicate that the proportion of the disabled in the country is greater now than 4 years ago, the committee is forced to conclude that over a period of years a number of subtle changes may have occurred in the concept of the "disabled worker."

The Social Security Administration has indicated that in large part the reasons why a larger number of people than anticipated have become entitled to disability benefits are:

(1) Greater knowledge of the protection available under the program leading to increased numbers of qualified people applying for benefits;

(2) Improved methods of developing evidence of disability; and

(3) More effective ways of assessing the total impact of an individual's impairment on his ability to work.

The committee has also learned that there is a growing body of court interpretations of the statute which, if followed in the administration of the disability provisions, could result in substantial further increases in costs in the future.

The idea that the concept of the disabled worker has changed over time is given substance by a reading of some of the court decisions on the subject. As one court pointed out, by quoting another court, "once the claimant has shown inability to perform his usual vocation, the burden falls upon the Secretary to show the reasonable availability of suitable positions." In another case the court observed that "disability includes physical or mental impairment which not only prevents one from obtaining a job, but from even being considered for it

by reason of hiring practices and policies," In summing up its interpretation of the statute and the case law, one court said:

> The standard which emerges from these decisions in our circuit and elsewhere is a practical one: Whether there is a reasonably firm basis for thinking that this particular claimant can obtain a job within a reasonably circumscribed labor market.

When asked about the court decisions, the Social Security Administration summarized developments in the courts in some jurisdictions as—

> (1) An increasing tendency to put the burden of proof on the Government to identify jobs for which the individual might have a reasonable opportunity to be hired, rather than ascertaining whether jobs exist in the economy which he can do. Claims are sometimes allowed by the courts where the reason a claimant has not been able to get a job is that employers having jobs he can do, prefer to avoid what they view as a risk in hiring a person having an impairment even though the impairment is not such as to render the person incapable of doing the job available.
>
> (2) A narrowing of the geographic area in which the jobs the person can do must exist, by reversing the Department's denial in cases in which it has not been shown that jobs the claimant can do exist within a reasonable commuting distance of his home, rather than in the economy in general.
>
> (3) The question of the kind of medical evidence necessary to establish the existence and severity of an impairment, and how conflicting medical opinions and evidence are to be resolved.
>
> (4) While there have heretofore been no major differences by or among the courts on the issue of disability when the claimant was performing work at a level which the Secretary under the regulations had determined to be substantial gainful activity, this issue was recently highlighted and publicized in the case of *Leftwich* v. *Gardner*. The Fourth Circuit Court of Appeals in this case held that the claimant was under a disability despite his demonstrated work performance considered by the Secretary to be substantial gainful activity.

The committee concurs with the statement of the Committee on Ways and Means instructing the Social Security Administration to report immediately to the Congress on future trends of judicial interpretation of this nature. As a remedy for the situation which has developed, the committee's bill would provide guidelines to reemphasize the predominant importance of medical factors in the disability determination.

The original provision was designed to provide disability insurance benefits to workers who are so severely disabled that they are unable to engage in any substantial gainful activity. The bill would provide that such an individual would be disabled only if it is shown that he has a severe medically determinable physical or mental impairment or impairments; that if, despite his impairment or impairments, an individual still can do his previous work, he is not under a disability; and that if, considering the severity of his impairment together with his age, education, and experience, he has the ability to engage in some other type of substantial gainful work that exists in the national

economy even though he can no longer do his previous work, he also is not under a disability regardless of whether or not such work exists in the general area in which he lives or whether he would be hired to do such work. It is not intended, however, that a type of job which exists only in very limited numbers or in relatively few geographic locations would be considered as existing in the national economy. While such factors as whether the work he could do exists in his local area, or whether there are job openings, or whether he would or would not actually be hired may be pertinent in relation to other forms of protection, they may not be used as a basis for finding an individual to be disabled under this definition. It is, and has been, the intent of the statute to provide a definition of disability which can be applied with uniformity and consistency throughout the Nation, without regard to where a particular individual may reside, to local hiring practices or employer preferences, or to the state of the local or national economy.

The impairment which is the basis for the disability must result from anatomical, physiological, or psychological abnormalities which can be shown to exist through the use of medically acceptable clinical and laboratory diagnostic techniques. Statements of the applicant or conclusions by others with respect to the nature or extent of impairment or disability do not establish the existence of disability for purposes of social security benefits based on disability unless they are supported by clinical or laboratory findings or other medically acceptable evidence confirming such statements or conclusions. In most cases the decision that an individual is disabled can be made solely on the basis of an impairment, or impairments, which are of a level of severity presumed (under administrative rules) to be sufficient so that, in the absence of an actual demonstration of ability to engage in substantial gainful activity, it may be presumed that the person is unable to so engage because of the impairment or impairments. The language which would be added by the bill specifies the requirements which must be met in order to establish inability to engage in substantial gainful activity for those people with impairments to which the presumption mentioned above does not apply.

The committee also believes it is necessary to reaffirm that an individual who does substantial gainful work despite an impairment or impairments that otherwise might be considered disabling is not disabled for purposes of establishing a period of disability or for social security benefits based on disability during any period in which such work is performed. The language in the committee's bill, therefore, specifically provides that where the work or earnings of an impaired individual demonstrate ability to engage in substantial gainful activity under criteria prescribed by the Secretary, the individual is not disabled within the meaning of title II of the Social Security Act.

Finally, the bill would provide that the individual must submit such medical and other evidence that he meets the preceding requirements as the Secretary may require; if he fails to do so, he may be found not to be under a disability.

The bill would also provide benefits (as discussed in the statement on benefits for disabled widows and widowers) for certain disabled widows (including surviving divorced wives) and disabled dependent widowers under a test of disability that is somewhat more restrictive than that for disabled workers and childhood disability beneficiaries. The de-

termination of disability in the case of a widow or widower would be based solely on the level of severity of the impairment. Determinations in disabled widow and widower cases would be made without regard to nonmedical factors such as age, education, and work experience, which are considered in disabled worker cases. Under this test, the Secretary of Health, Education, and Welfare would by regulation establish the severity of impairment which may be deemed to preclude an individual from engaging in any "substantial gainful activity" (as opposed to "gainful activity" as provided in the House bill). An individual whose impairments meet the level of severity established by the regulations of the Secretary would generally be found to be disabled, although, of course, if other evidence establishes ability to engage in substantial gainful activity despite such impairments, he would not be found disabled; and individuals whose impairments do not meet this level of severity may not in any case be found disabled.

(e) Workmen's compensation offset provisions

Under present law, if a disabled worker under age 62 qualifies for periodic 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, by which 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 considered to equal the larger of (a) the average monthly wage used for computing his social security benefits, or (b) his average monthly earnings during his 5 consecutive years of highest covered earnings after 1950. Under present law the covered earnings referred to in (b) do not include that part of the earnings in covered work in excess of the maximum annual amount that is creditable for social security purposes.

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 disablement. The committee believes that the present provisions go beyond this objective in cases where a worker's actual previous earnings in covered employment are higher than the maximum amount that is creditable under the social security program. For example, a disabled worker whose actual earnings in covered work during his highest 5-year period are double the amount counted for social security purposes may be restricted to combined benefits of 40 percent, instead of 80 percent, of his previous pay. The committee's bill would rectify this situation by specifying that average current earnings—and the amount of combined benefits that can be paid—may be computed without regard to the limitations established for annual creditable earnings. However, the records of the Social Security Administration do not show the workers' earnings above the creditable limit. Therefore, the bill would provide that certain assumptions may be made on the basis of the information contained in the records; under regulations, the Secretary may estimate the amount of earnings above the creditable limit on the basis of the information available to him. This change would provide more reasonable and equitable treatment for many workers who earn more than the annual amounts that may be counted for social security purposes.

Under the House bill these provisions would become effective with the first month after the month of the bill's enactment. The committee's bill modifies the House bill to make the effective date of these provisions consistent with that of the general benefit increase; i.e., March 1968.

(*f*) *Benefits for children disabled before reaching age 22*

The committee's bill would add a new provision to provide 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 is considered dependent and can qualify for 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. The committee's bill would permit the payment of these benefits to a son or daughter who becomes totally disabled before age 22.

When total disability arises between ages 18 and 22—for example, a 19-year-old student who is disabled in an automobile or athletic accident—the disabled son or daughter generally continues to be dependent on his parents. The 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 first benefits payable by reason of this change in the law would be paid for the month of March 1968. The amendment would be applicable to those who become totally disabled between ages 18 and 22 in the future and also to such disablement occurring in the past.

About 10,000 people—disabled children and their mothers—would immediately become eligible for benefits. Benefit payments under these provisions would total $8 million in the first 12 months of operation.

(*g*) *Retroactivity of applications for closed periods of disability*

Under present law, disability benefits can be paid no earlier than the 12th month before an application is filed. A period of disability ("disability freeze") can be established beginning as early as the actual onset of an insured worker's disability, if he files an application before or within 12 months after the end of his period of disability. Under the disability freeze provisions of the law, a period during which a worker is totally disabled is not counted against him in determining whether he is insured for social security benefits or in computing his average earnings, which determine the amount of his benefits. Under the present law, disabled workers, in general, have adequate time—the period of disability plus 12 months—to apply for the disability freeze protection available to them. However, in some cases, the physical or mental impairment that results in disability is so severe that the disabled person is unable to file an application on his own behalf. Such an individual must rely on another person to file for him and thus protect his rights. Where no one files an application on

behalf of such a person, the disabled individual may not become aware of the need to file an application until many months after recovery.

The person who is physically or mentally unable to exercise his rights during a significant part of the filing period (the period of disability if such period ended before July 1, 1965, or the period of disability plus 12 months if such period ended on or after July 1, 1965) may not have sufficient opportunity for filing an application. In such a case, there may be not only a loss of benefits for the previous disablement but also a loss of future protection under the program.

The committee has therefore included in the bill provisions under which the time provided for filing an effective application to establish a closed period of disability would be extended for an additional 24 months—to a total of 36 months—in cases where it is shown to the satisfaction of the Secretary that the disabled individual's failure to file within the prescribed period is due to his mental or physical incapacity to execute such an application. An application filed in such a case within the extended period would permit establishment of a disability freeze for a past period of disability ending after the month of enactment, although the retroactive payment of benefits would not be extended beyond the 12 months provided in present law.

In recognition of the possible loss of protection that may have occurred in the past in situations such as would be covered under these new provisions, the committee bill also would provide for a 12-month period after the month of enactment during which a new valid application could be filed for a period of disability ending in or before the month of enactment in the case of a disabled worker who has previously filed an application within 36 months after a closed period of disability but failed to file timely within the requirements of the law at the time because of physical or mental incapacity.

(h) *Payment of disability benefits to industrially blind persons with six quarters of coverage earned at any time*

The committee's bill adds a new provision which would modify the disability insurance provisions to improve cash benefit protection for the blind.

Under present law, a person who meets the insured status requirements and the definition of blindness—essentially total blindness—may become entitled to a disability freeze. To qualify for disability benefits the totally blind person must meet the definition of disability in present law: (*a*) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that has lasted or is expected to last for 12 months or to end in death, or if aged 55 or over, (*b*) inability to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he had previously engaged with some regularity and over a substantial period of time. (An older blind worker found to be disabled under the alternative definition, however, cannot receive disability benefits for any month in which he engages in substantial gainful activity regardless of whether or not it involves his usual skills or abilities.)

In recognition of the economic hardships faced by blind persons, the bill would change the definition of disability to permit persons with "industrial blindness" (that is visual acuity of 20/200 or less)

to meet the definition regardless of their capacity to work, and to receive disability benefits for any month in which they do not engage in substantial gainful activity. This definition of blindness is the definition in the Internal Revenue Code and is used by a number of governmental and private agencies.

This provision would also modify the disability insured status requirements so that industrially blind persons could qualify for a period of disability and for disability benefits on the basis of a relatively small amount of covered employment. 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. There is one exception to the 20-out-of-40 requirement: the worker who becomes disabled before age 31 because of blindness as defined in present law is insured for disability protection 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. (Another provision of the committee bill would extend this alternative requirement to all workers disabled before age 31.)

While the disability insured status requirements of present law (as modified for young workers) are, generally speaking, reasonable tests designed to provide some assurance that the protection afforded by the disability provisions of the law will be related to loss of covered earnings on account of disability, they do not seem appropriate for the blind person, who faces employment problems not encountered by sighted persons.

Many blind persons can secure only temporary jobs, jobs being automated out of existence, and jobs requiring very little skill. Blind persons may be the last hired and the first to lose their jobs. These factors make it very difficult for blind persons to meet the 20 out of 40 quarters rule. The bill, therefore, provides that persons who are industrially blind will be insured if they have as few as six quarters of coverage, earned at any time.

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 permits industrially blind persons who have six quarters of coverage to continue to receive disability insurance benefits beyond age 65, and since these benefits are disability rather than retirement benefits they will not be subject to deductions under the retirement test. On the other hand no benefits can be paid for any month in which a blind person engages in substantial gainful activity. The bill would also exclude these 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.

This provision would be effective for December 1968. About 205,000 persons—blind workers and their dependents—would become immediately eligible for monthly benefits. Benefit payments in the first 12 months of operations under this provision are estimated to total $165 million.

6. Coverage Changes

(a) Coverage of ministers

Under present law, the services which a clergyman (including a Christian Science practitioner or member of a religious order who has not taken a vow of poverty) performs in the exercise of his ministry are excluded from social security coverage unless he elects coverage. If a clergyman elects coverage, his services in the ministry are covered under the provisions of law applicable to self-employed persons. For a clergyman to elect coverage, the law requires that he must file a waiver certificate by the due date of his income tax return for the second year in which he has had net earnings of $400 or more, any part of which was derived from the ministry. Services which a member of a religious order who has taken a vow of poverty performs in the exercise of his duties required by the order are compulsorily excluded from coverage.

An individual clergyman can decide on a completely voluntary basis whether he will be covered under social security. The committee was informed that many clergymen, who can never become covered under the social security program because they did not file the waiver certificate within the prescribed time, now wish to become covered. On several occasions, in the past, the Congress has extended the time in which clergymen could elect coverage. The committee recommends that the coverage provisions for clergymen be changed. Under the House bill, all clergymen would be covered under social security, under the self-employment provisions, except those who on religious grounds are conscientiously opposed to the acceptance of social security benefits based on their services as clergymen. Clergymen who are conscientiously opposed to social security could have their ministerial services excluded from coverage by filing an irrevocable statement to that effect.

Under the committee's bill, a clergyman could be exempted from coverage not only on the basis of his being conscientiously opposed to coverage, as provided in the House bill, but also if he is opposed to coverage on the basis of religious principle. This change is intended to permit a clergyman to accept the discipline of his church as well as his individual conscience in deciding whether or not to seek exemption; it is not intended, however, to permit an exemption that is not based on religious considerations. In effect coverage is still voluntary on the part of the individual, because he can elect not to be covered.

Under the bill, a clergyman in the ministry in 1966 or 1967 whose time for electing coverage under present law has not expired would retain the rights he has under present law to elect coverage for these years. Clergymen electing coverage under present law would continue to be covered for all future periods. Clergymen not electing coverage under present law nevertheless would be covered beginning January 1, 1968, except those who obtain exclusion from social security coverage on the basis of the provisions of the committee bill. Clergymen who are in the ministry in 1968 or before and who have not elected coverage under the present provisions of law would have until April 15, 1970, in which to obtain exclusion from coverage on the basis of conscience or religious principle; clergymen first entering the ministry in 1969 or later would have until the due date of the tax return for their second year in the ministry in which to obtain exclusion. These

effective dates and deadlines would be somewhat different for those relatively few ministers who do not file tax returns on a calendar-year basis.

Also, under the House bill, members of religious orders, whether or not they have taken a vow of poverty, would be covered or exempted under the same provisions that would be applicable to clergymen. The committee has been advised that the religious orders need more time to evaluate the effects of the provision in the House-approved bill, which would extend social security coverage to members who have taken a vow of poverty. The committee believes that the present status of members who have taken a vow of poverty should not be changed until the orders have had an opportunity to determine how such coverage would affect them.

(b) Coverage provisions applying to employees of States and localities

The committee's bill would facilitate the operation, at both State and Federal levels, of the provisions under which the States may bring groups of State and local government employees under social security.

(1) COVERAGE FOR CERTAIN PERSONS INELIGIBLE TO JOIN RETIREMENT SYSTEMS

The bill would facilitate social security coverage for certain workers who are in positions under a State or local government retirement system but are not eligible to join the system due to personal disqualification, such as those based on age or length of service. Under existing law, such workers can be covered under social security in certain circumstances but they cannot be covered in connection with the extension of coverage to members of their retirement system by means of a procedure known as the divided retirement system procedure. Under this procedure (now available to 19 specified States and to all interstate instrumentalities), coverage is extended to all those current members of a retirement system who want it, with all future members of the system being covered mandatorily. For purposes of this coverage extension procedure, the term "members" does not include any person who is ineligible to join the system; people in this situation can be brought under social security only if coverage is extended to the employees of the State or political subdivision who are not in positions subject to the retirement system. In some cases this avenue to social security coverage is closed because the State has not brought the nonretirement system group under social security. The bill would permit a State to modify its social security coverage agreement with the Secretary of Health, Education, and Welfare (either at the time coverage is extended under the divided retirement system procedure or at any time subsequent to such action) to bring under social security, as a group, those workers who are in positions under the retirement system but are ineligible to join the system. This amendment would not be applicable to policemen or firemen.

(2) ADDITION OF ILLINOIS TO THE STATES WHICH MAY USE THE DIVIDED RETIREMENT SYSTEM PROVISIONS

The bill would add Illinois to the list of States which may use the divided retirement system coverage procedure. The 19 States which

are now permitted to extend coverage under this provision are Alaska, California, Connecticut, Florida, Georgia, Hawaii, Massachusetts, Minnesota, Nevada, New Mexico, New York, North Dakota, Pennsylvania, Rhode Island, Tennessee, Texas, Vermont, Washington, and Wisconsin.

(3) PERMISSIVE EXCLUSION FROM COVERAGE OF CERTAIN ELECTION OFFICIALS AND WORKERS AND MANDATORY EXCLUSION FROM COVERAGE OF CERTAIN EMERGENCY SERVICES

Other changes that would be made by the committee's bill in the provisions for social security coverage of State and local government workers relate to services performed by certain temporary employees.

Under present law, the States have the option, at the time they bring a group of workers under social security, of excluding from coverage certain types of services; for example, those in part-time positions and those of an emergency nature, such as service performed in case of fire, storm, earthquake, or similar emergency. The State may extend coverage at a later date to services which were excluded under one of these options at the time coverage was provided for any coverage group. However, if the State does not exercise the option of excluding the services at the time coverage is provided for the coverage group, the services cannot thereafter be excluded. The coverage of some types of these optionally excluded services has been accidental, particularly in the case of emergency services, and services performed by election officials and workers who are paid small amounts at infrequent intervals

The bill would permit States to exclude from social security coverage election officials and election workers who are paid less than $50 in a calendar quarter. This change would be applicable to most services performed by election officials and workers, because they usually work for no more than a day or two at a time. Actions taken by States to effectuate the exclusion could be taken in regard to any particular group of workers either at the time coverage is provided for the group, or at a later date. States would be permitted to modify their agreements on or after January 1, 1968, to prospectively exclude these services.

Also, the bill would provide for the mandatory exclusion of emergency services such as those which are rendered during forest fires, floods, and similar emergencies. Because emergency situations arise infrequently and different workers may be involved each time, the mandatory exclusion of their services is unlikely to have adverse effects on the social security protection of the workers who perform emergency services. The provision would be effective with respect to services performed on or after January 1, 1968.

(4) POLICEMEN AND FIREMEN IN NEBRASKA AND PUERTO RICO

The committee bill contains a new provision adding Nebraska and Puerto Rico to the list of States which may provide social security coverage for policemen and firemen in positions under retirement systems. The States (now 19) which are permitted to provide coverage for such policemen and firemen 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 addition, the bill would permit Nebraska to modify its agreement at any time before 1970 to validate certain erroneous reporting of services performed by individuals in firemen's positions, if the State agreement covers the future services of firemen in the same coverage group. Some erroneous reporting resulted because of a misunderstanding on the part of certain cities in Nebraska. Nebraska law requires that cities of a certain size establish a retirement system for their firemen, and the positions of firemen in these cities have been held by the State of Nebraska to be under a retirement system regardless of whether the city has actually established a system; several cities in Nebraska which did not establish the required retirement system did not understand and erroneously reported their firemen as a part of the coverage group made up of city employees not under a retirement system. The erroneous reporting was in good faith, and making the validation of the erroneous reports contingent upon future coverage should assure that the validation will take place only where the original understanding as to future coverage is carried out.

(5) FACILITATE COVERAGE UNDER THE PROVISIONS FOR DIVISION OF STATE AND LOCAL GOVERNMENT RETIREMENT SYSTEMS

The bill also would provide a further opportunity for election of social security coverage by employees of States and localities who did not elect coverage when they previously had the opportunity to do so under the provision of law permitting specified States to cover only those members of a retirement system who desire coverage. Under the present provision, the specified States may, during the 2-year period after coverage of a group is approved, cover additional employees who request coverage. (Employees hired after coverage of the group is originally approved are covered on a compulsory basis.) Under the bill, those employees who had not elected coverage before the expiration of the 2-year period following approval of the coverage of their group would be given an opportunity to elect coverage through December 31, 1969.

The committee recognizes that employees who initially failed to elect coverage under the divided retirement system provision were provided three subsequent opportunities for election of coverage under amendments made to the Social Security Act in 1958, 1961, and 1965. The committee has been informed that some employees not choosing coverage under previous opportunities now desire coverage because, as a result of changes made in some State or local retirement system benefits with respect to employees also covered under social security, employees now coming under social security are treated more favorably under the retirement system than was formerly the case. Thus, the choice presented the employee is a different choice than the one he formerly had.

The committee's bill will reopen coverage until the end of 1969. This should provide ample time for the States to bring under social security coverage any employees who formerly did not choose coverage but who now desire it.

(6) RETROACTIVE COVERAGE OF CERTAIN FORMER EMPLOYEES

The committee's bill adds to the House bill a provision which would permit social security credit to be given for some past earnings that were erroneously reported for certain former State and local government employees who were not covered under a State agreement. Situations have arisen in which an employer, such as a library or hospital, has mistakenly thought it was a nonprofit organization or a private employer, rather than a unit of a State or local government, and has reported its employees under the coverage provisions applicable to nonprofit or private employment. When the error is discovered, the employer, in some cases, asks the State to provide coverage for the coverage group under the State agreement. Under the committee's bill, if the State modifies its coverage agreement to make it applicable to the group involved, the State would be permitted to specify that whatever retroactive coverage is provided for a group of current employees, under the present generally applicable provisions of law, would also be provided for all former employees of the group whose earnings were erroneously reported. The retroactive coverage provided for the former employees would be limited to those for whom no refund of the employer and employee taxes had been made.

(7) COVERAGE OF PERSONS IN POSITIONS COMPENSATED ENTIRELY ON A FEE BASIS

The committee added a provision to the House bill which would modify provisions applying to coverage of State and local government employees who are compensated solely on a fee basis. Under present law, fee-basis employees, like other State and local government employees, may be covered only under a State coverage agreement. Services in positions the compensation for which is on a fee basis are one of the types of services which the States have the option of excluding from coverage at the time they bring a group of workers under social security; if so excluded, they may later be covered, but if covered, they may not later be excluded.

Because of the difficulties involved States and localities have chosen not to provide coverage for most fee-basis employees. The amounts received as fees are often relatively small, and in view of administrative problems, the States and localities sometimes regard the reporting of such amounts as a nuisance. Many of the fee-basis employees not covered under State agreements need and would like to have their fees covered under social security.

The committee's provision would apply only to State and local government employees who are compensated solely on a fee basis; the coverage provisions applying to persons in positions compensated partly by fees and partly by salaries would not be changed. For employees who are compensated solely on a fee basis, fees received after 1967 which are not covered under a State agreement would be covered under the self-employment provisions of law, except that people in fee-basis positions in 1968 could elect not to have their fees covered under the self-employment provisions. Under the provision, a State could, as under present law, modify its coverage agreement to provide coverage for fee-basis employees as employees. However, unlike present law, the committee bill would permit States to remove

from future coverage persons who are compensated solely on a fee basis. The coverage of certain fee-basis employees under the self-employment provisions of law is not intended to affect in any way the social security coverage, or the status under State or local law, of other persons who may be working in the same office with or who may be under the supervision of the fee-basis employees.

The committee recognizes that it is not generally desirable to cover employees under the self-employment coverage provisions of the law, or to give persons an individual choice as to having their services covered under social security. However, it was felt that the provisions of the committee's bill were justifiable in the case of employees compensated entirely by fees because of the unusual problems involved in providing coverage for these persons under the employee provisions.

(8) EMPLOYEES OF THE MASSACHUSETTS TURNPIKE AUTHORITY

The committee has added a provision to the House bill, applicable only to employees of the Massachusetts Turnpike Authority, which would permit the removal from social security coverage of Turnpike Authority employees. The committee has been informed that the positions involved have been under social security for many years, with no coverage under a staff system. Now, however, the positions in question are being covered under a system established under provisions of Massachusetts State law. It is believed that it would not be feasible for the Turnpike Authority and the employees involved to pay full contributions under both social security and the State-established system.

(9) COVERAGE OF STATE AND LOCAL GOVERNMENT FIREMEN

The committee added a provision under which the States not named in the Social Security Act as States which may extend social security coverage to policemen and firemen may nonetheless cover firemen who are under a retirement system, but only under the referendum procedure, and only if the Governor of the State certifies that the overall benefit protection of the firemen to be brought under social security would be improved by the extension of social security coverage to the group. Under the referendum procedure, all members of a retirement system group are covered upon a favorable majority vote of the group.

There would be no change in the coverage of firemen (or policemen) in the States listed in the law as States permitted to cover policemen and firemen. (There are now 19 such States, and Nebraska and Puerto Rico would be added by other provisions of the bill.) All of these States can now use the referendum provision, without the type of Governor's certification the amendment would provide, and 10 of the States now authorized to cover policemen and firemen who are under retirement systems are on the list of States which may use the divided retirement system provision, under which coverage may be provided for only those current retirement system members who desire coverage, with all future employees being covered compulsorily. The committee's amendment, however, would not extend the divided retirement system provisions to any new State.

(c) Additional wage credits for those in the uniformed service

The committee's bill would provide additional social security protection for those serving in the uniformed services of the United States. Under present law, servicemen are covered under social security on a contributory basis similar to that applicable to other covered employment. A serviceman's coverage, however, is limited to his basic pay, and does not include certain cash increments which many receive or the substantial value of pay in kind, such as food, shelter, and medical services, the cash value of which is generally counted as wages in case of other jobs covered under social security. Thus the social security protection of a worker may be impaired during a period when he is in military service, because of the relatively low earnings covered under social security, on which benefit amounts are based. The committee's bill would take account of this situation by providing that, when social security benefits for a serviceman or veteran, or his family, are computed, there would be included an additional wage credit of $100 for each $100, or fraction thereof, of active duty pay, up to $300 a quarter (i.e., up to $100 a month), for service performed in the uniformed services after December 31, 1967, subject to the general limitation on the maximum earnings creditable in a year for benefit and tax purposes. The committee believes that it would be unfair to many servicemen, particularly those whose cash pay is relatively small, to require that they pay social security employee contributions on these additional wage credits. Accordingly, the bill provides for reimbursing the social security trust funds from general revenues on a current basis for the added cost of benefits which would result from the enactment of this provision. The committee expects that the Defense Department appropriation will carry these funds.

(d) Retirement payments made to retired partners

Retirement payments (whether received by an employee or a self-employed person) are, in general, not covered under social security for purposes of contributions, benefit computations, and the retirement test. However, retirement payments made by a partnership to a retired partner from the current earnings of the partnership are generally treated as earnings from self-employment and are covered under social security. This is true even though the retired partner performs no services in any trade or business which the partnership conducts and even though the retirement payments represent the individual's only relationship to the partnership. The committee believes that partnership payments which are clearly retirement income should be excluded for all social security purposes.

Under the bill, payments received by a retired partner from the partnership would be excluded under conditions which assure that the payments are bona fide retirement income. The exclusion would apply where the payments received by the retired partner are made pursuant to a written plan of the partnership which provides for lifelong periodic retirement payments to the partner. It would only apply if the retired partner no longer had any interest in the partnership except for the right to the retirement payments. The exclusion would not apply to retirement payments made in a year in which the partner performed any services for the partnership. It would apply to taxable years ending on or after December 31, 1967.

(e) *Coverage of Federal employees*

The committee is aware of the gaps which exist in the protection of the Federal workers who do not have survivorship, disability, or retirement protection based on that employment.

A particular hardship exists in many instances when an individual dies during his first 5 years of Government service, when he is not yet entitled to survivorship protection under his Federal staff retirement system but he has lost his social security protection. A similar situation occurs when an individual dies shortly after leaving Federal service and before he has worked under social security long enough to be covered for survivorship benefits.

Additionally, an inequity may possibly exist in the relationship of the medicare program to Federal employees. Approximately 50 percent of our retired Federal employees are entitled to hospital insurance benefits under medicare on the basis of coverage acquired while serving in the armed services or working in private employment. If the retiree elects to pay the premium for coverage under the voluntary supplementary medical plan open to all of our citizens, he will enjoy health insurance protection approaching that afforded by the high option plans offered by the Federal Employees Health Benefit Act. In that case, the Federal Government is relieved of any obligation to contribute to his health care as an employee distinct from a member of the general public.

Those Federal retirees not entitled to hospital insurance protection under medicare cannot benefit from the voluntary supplementary plan toward which the Government currently contributes $3 per month on behalf of each participant. Since the retiree must retain the health insurance plan he selected as an employee in order to have hospital insurance protection, the voluntary supplementary plan will duplicate coverage he already has. As he is not permitted to collect duplicate benefits, the voluntary supplementary plan is not worth the $3 per month the individual would be required to pay.

The administration's bill, H.R. 5710, contained a proposal under which credits for work subject to a Federal staff-retirement system would be transferred to social security in all cases where the worker or his survivors do not become eligible for staff-system benefits based on that work. The committee also considered the possibility of extending social security hospital insurance coverage to Federal civilian employment, on the contributory basis that is applicable to such coverage of almost all other kinds of work. Although each of these ideas has some merit, the committee believes there should be further and more comprehensive study of the possible ways of including Federal employees in the program before any recommendation for change is made.

The committee, like the Committee on Ways and Means, is concerned about a situation that can occur when Government employees, either active or retired, work in employment covered under the social security program and qualify for the minimum or low benefits. This situation occurs when the Government worker with a substantial Government salary works part time under social security or enters covered employment after retirement; in such cases he can become entitled to social security benefits (perhaps the minimum benefit) which will be heavily weighted in his favor, receiving a higher percentage of wage replacement on his social security earnings. The

social security weighted benefit formula is designed for the worker who has low earnings from all sources all his working life.

The committee concurs with the House committee in directing the Social Security Administration to make a thorough study of all of the various problems which up to now have precluded the coverage of governmental employees under social security. The study is to be made in close and constant cooperation with employee groups and with appropriate Federal agencies with a view to resolving the problems in a manner that is fair to both the governmental employees and the other members of the labor force who support the social security system. The report of the study, including positive recommendations for covering of Government employees on a basis that is fair to both Government employees and all other workers, is to be submitted to the Congress prior to January 1, 1969.

(*f*) *Modification of coverage provisions relating to family employment*

Under present law, employment performed in the private home of the employer by a parent in the employ of his son or daughter is not covered under social security. Usually when a parent performs domestic service in the home of a son or daughter there is no employer-employee relationship between them. Sometimes, however, there is such a relationship and a need for an employee to perform domestic services. Under the committee's bill, coverage would be provided for employment by a parent performed in the home of his son or daughter if the employer has a child (including an adopted child) or stepchild in his home who is under age 18 or who has a mental or physical condition which requires the personal care and supervision of an adult for at least 4 continuous weeks in the calendar quarter in which the service is rendered, and the employer is a widow, widower, or a divorced person who is not married or if he has a spouse who has a mental or physical condition which results in such spouse being incapable of caring for such child for at least 4 continuous weeks in the calendar quarter in which the services are rendered. In these situations, there is generally a definite need for a person to render services in the home to care for the child (or children). A written statement by a doctor of the existence of the mental or physical condition of the child or spouse would usually be sufficient evidence to establish the condition. The committee's bill would continue to exclude from coverage under the family employment exclusion employment performed in a private home by a parent of the employer when the specified conditions are not met.

(*g*) *Exclusion of prisoners from coverage under certain programs*

Under present law, some convicts can, solely as the result of their work while serving a prison sentence, establish eligibility for unemployment benefits, earn credits under the Federal civil service retirement system, or obtain credits under social security. The committee believes that it is inappropriate to provide the same benefits for prison work as for other work.

The committee bill provides that any employment by an inmate of a prison would not be creditable for purposes of establishing entitlement to unemployment insurance compensation. The bill would

further provide that any employment of an inmate of a prison for the United States or any of its instrumentalities would not be creditable for the purposes of the Federal civil service retirement system or for qualifying under certain other programs established for the protection of Federal civilian employees and their families. The bill would also broaden the present exclusion from social security coverage of most Federal employment to exclude all employment performed by a prison inmate for a Federal agency. The provisions relating to unemployment compensation based on private employment would be effective January 1, 1969, with respect to Federal approval of State laws and would apply to services performed after December 31, 1968. The provisions relating to Federal employment and social security coverage would apply to service performed after the month following the month of enactment.

7. Health Insurance Provisions

(a) Extending health insurance protection to disabled beneficiaries

The committee gave extensive consideration to a proposal to extend health insurance protection under title XVIII to persons entitled to monthly cash benefits under the social security and railroad retirement programs because they are disabled. While the committee believes that there is much to say for extending the protection of medicare to disability beneficiaries, it has regretfully concluded that it cannot recommend this extension of protection at the present time.

A major factor in the committee's decision was that data which first became available while the proposal was being considered by the House indicated that the per capita cost of providing health insurance for the disabled under medicare would be considerably higher than is the cost of providing the same coverage for the aged. As a result of the new data, the chief actuary of the Social Security Administration increased his estimates of the cost of the proposal significantly; this increase in the cost estimates, together with the revised estimates for the overall cost of the hospital insurance program discussed elsewhere in this report, raised serious problems with respect to the financing of the proposal.

The estimated difference between the cost of medicare for the disabled and for the aged also raised questions as to what would be the most equitable way of financing medicare coverage—especially medical insurance coverage, half of the total cost of which is met by the beneficiaries themselves.

The committee has, therefore, deferred recommending extension of medicare to the disabled, but has agreed with the provision of the House bill under which an advisory council will be appointed in 1968 to study the question of extending medicare to the disabled, including 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 submit a report of its findings to the Secretary of Health, Education, and Welfare not later than January 1, 1969. The Council would also be required to make recommendations on how this protection should be financed and on the extent to which the cost of this protection could appropriately be borne 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.

(*b*) *Elimination of requirement of physician certification in case of certain hospital services*

Under present law, payment under the hospital insurance program may be made for services furnished by a hospital only if a physician certifies that the services are medically necessary. In addition, when the patient has received inpatient hospital services for an extended period, the physician must recertify to the continuing need for the services.

The committee's bill would, upon enactment, eliminate the outpatient hospital services certification requirement and the requirement for a physician's initial certification of the medical necessity for inpatient services furnished by hospitals other than tuberculosis and mental institutions. Outpatient hospital services and admissions to general hospitals are almost always medically necessary and the requirement for a physician's certification of this fact results in largely unnecessary paperwork. The committee is hopeful that elimination of the certification requirement in these cases will be accompanied by a greater emphasis by hospitals on utilization review and on those certifications which will continue to be required.

The requirement for a physician's certification after inpatient hospital services have been furnished over a period of time, which is now met through a recertification requirement, would be retained. Since special conditions, in addition to need for some of the services they provide, are attached to payment for services furnished by psychiatric and tuberculosis hospitals, extended care facilities, and home health agencies, the physician certifications with respect to these services are important and meaningful and would be retained.

(*c*) *Method of payment to physicians under the supplementary medical insurance program*

Present law provides two methods for the payment of charges by physicians (and others whose services are covered under the medicare program on a reasonable charge basis). Payment may be made directly to the beneficiary on the basis of a receipted bill submitted by him following his payment of the physician's fees; or the beneficiary may assign his right to reimbursement to the physician, who then submits the bill and receives payment on his patient's behalf. Under the assignment method the physician must agree that his total bill will not exceed the reasonable charges used as the basis of reimbursement under the medical insurance program.

Although many physicians are accepting assignments at least part of the time, there are instances where the physician prefers not to accept assignment even though the beneficiary may not be in a position to pay a sizable fee in advance of medicare reimbursement. In recognition of the financial hardships imposed on the medicare patient in such cases, the House-passed bill would provide for a new payment procedure under the medical insurance program to serve as an alternative to the present procedures. Under this procedure, payment could be made to the physician (or other individual providing covered services) on the basis of an itemized, unpaid bill without his having to agree, as under the assignment procedure, to accept the program's reasonable charges as payment in full, if he submits the bill in an acceptable

manner and if his charges do not—in fact—exceed the program's allowable charges. Conversely, where these conditions are not met or where the physician requests that the benefits be paid directly to the patient, the House-approved bill provides for payment, on the basis of an itemized bill, to be made to the patient.

The committee recognizes the problem that arises under present law because a beneficiary of limited means whose physician is unwilling to accept assignment must pay all (or, at least, a major portion) of the physician's fees out-of-pocket before he may receive the benefits of the program. Although the committee is in agreement with the objective of the House-passed proposal to resolve this problem by permitting medical insurance benefits to be paid, subject to certain preconditions, on the basis of an itemized, unpaid bill, there is concern that this proposal, under which there would be four alternative methods of payment, would be unnecessarily complex. Therefore, the committee has amended the House-approved bill to provide for a simpler modification which follows the pattern of reimbursement used by most private health insurers.

Under the committee's bill, the two methods of payment provided for under present law would be retained with but one change: the bill would delete the requirement that the patient must pay the physician's charges before he can be reimbursed under the program. Thus, the committee's bill would permit payment either to the patient on the basis of an itemized bill (which could be either paid or unpaid) or to the physician under the present assignment method. The new provision would apply to medical insurance claims on which a final determination has not been made on the date of enactment.

The committee believes that this amendment will not only benefit patients whose physicians are unwilling to accept assignments but will enable the patient to make a more informed evaluation of his physician's charges since he will have the benefit of his medical insurance intermediary's reasonable-charge determination at the time he pays his physician's bill.

In addition, the House-approved bill would establish a time limit on the period within which payment may be requested under the medical insurance program with respect to physicians' services and other services reimbursable on a charge basis. Although authority to establish a time limitation on the filing of claims by hospitals and other providers of service for cost reimbursement is provided under present law, no such limitation is provided for with respect to the filing of charge-related claims under the medical insurance program. Under the House bill, claims for the services in question would, in general, have to be filed no later than the end of the calendar year following the year in which the services were furnished. The committee recognizes the desirability of promoting efficient administration by avoiding the handling of claims which by reason of their age are not readily subject to verification. The committee, therefore, concurs in the House decision but postpones its effective date by making the time limitation applicable only to bills submitted and requests for payment made on or after April 1, 1968. The effect of this change is to provide an additional 3 months—January through March 1968—for individuals to claim benefits for services furnished during the first 3 months of the program.

(d) Simplification of reimbursement to hospitals for certain physicians' services and for outpatient hospital services

The committee's bill would simplify the procedures required for medicare reimbursement to hospitals and hospital patients. The simplification would be accomplished by: (1) providing that the full reasonable charges will be paid under the medical insurance program for covered radiological and pathological services furnished by physicians to hospital inpatients; (2) consolidating all coverage of outpatient hospital services under the medical insurance program, and (3) allowing hospitals to collect small outpatient charges from medicare outpatients. The result of these changes would be to facilitate beneficiary understanding and simplify hospital and intermediary handling of medicare claims by bringing the requirements of the medicare program more closely into line with the usual billing practices of hospitals and the payment methods of private insurance organizations. The amendments would become effective on April 1, 1968.

(1) RADIOLOGICAL AND PATHOLOGICAL SERVICES FURNISHED TO HOSPITAL INPATIENTS

Physicians' charges for services to individual medicare patients are covered under the medical insurance program. On the other hand, the compensation that some physicians receive from or through a hospital for services which benefit patients generally (for example, administrative services, committee work, teaching, research, and general supervision) as well as the other costs the hospital incurs in providing covered services (for example, salaries of technicians employed by the hospital, overhead, and equipment) are reimbursable under the hospital insurance program. A major difficulty has arisen for hospitals in preparing bills for reimbursement under medicare because it is very common for hospitals, for other reimbursement purposes, to give their patients bills for pathological and radiological procedures that cover both the specialist's services to the patient and the supporting hospital services. Therefore, it is necessary under present law, where such consolidated bills are presented, for the hospital and physician to establish a breakdown of the combined bill into two parts, one for each of these two categories of services, in order to determine the patient's liability under the medical insurance program for deductible and coinsurance amounts and to compute the respective liabilities of the two parts of the medicare program. The additional work for hospitals and physicians which results from this required division is an administrative burden for which medicare is entirely responsible. The required division of charges and split billing serves no purpose other than medicare reimbursement and the deductible and coinsurance payments, which are often very small, are a cause of confusion, annoyance, and misunderstanding among beneficiaries.

The committee's bill would not modify the decision, embodied in the original medicare enactment, that physicians' services to the patient be reimbursed under part B, the medical insurance program, and that the cost of hospital services be reimbursed under part A, the hospital insurance program. The bill would, however, improve medical insurance coverage somewhat by providing full coverage under

medicare for pathology and radiology services furnished to hospital inpatients by physicians specializing in pathology and radiology. This change would provide reimbursement for the services in question in a manner that is comparable to the inhospital coverage of pathology and radiology procedures employed by many other health benefit plans thereby simplifying beneficiary understanding of the program and greatly facilitating medicare reimbursement by making it possible to pay for the services in question in a manner that is more consistent with the usual billing procedures of the hospital.

Under the bill, where the hospital customarily bills for the hospital's services and the services of the pathologist or radiologist in combination, the absence of the medical insurance deductible and coinsurance would make it unnecessary to break down the bill on a patient-by-patient basis into the parts covered under the hospital insurance and medical insurance programs where the patient is entitled to benefits under both programs and has met the hospital insurance deductible. It is anticipated that in combined billing situations, a single intermediary would make all the required benefit determinations and that the respective liabilities of the two medicare trust funds would be determined periodically on the basis of the compensation the physician receives for services to patients and the costs incurred by the hospital in making its covered services available. From time to time throughout the year, adjustments would be made on an aggregate basis between the two funds of the amounts for which each fund is estimated to be liable, and final settlements of the respective liabilities of the two funds would be made on the basis of the annual audited cost finding required in connection with hospital reimbursement.

There would generally be no patient liability for inpatient pathology or radiology services either with respect to the hospital insurance component (since the inpatient hospital deductible will ordinarily have been met through charges for other services) or the medical insurance component. Therefore, the committee would expect that the proposed change would provide opportunities for the development of procedures which would eliminate paperwork and facilitate administration where the services in question are customarily billed through the hospital.

Pathologists and radiologists whose billings for their services to hospital inpatients are independent of the hospital's billing would also benefit from the committee's amendment. Since no deductible or coinsurance would be applicable to these services, the physician could, if he chooses to do so, submit a single bill to the program for his full reasonable charge; in such cases, the physician would not have to look to the patient for additional payment. Under the committee's bill, as under present law, the hospital and physician would be left free to decide whether charges for the physician's services are to be billed for by the hospital or by the physician, as well as to determine the additional elements of the parties' financial or other arrangements with each other.

(2) SERVICES TO HOSPITAL OUTPATIENTS

The committee's bill would consolidate the coverage of outpatient hospital services under the medical insurance program so that such services would be subject to the same deductible and coinsurance

provisions as physicians' services. Under present law, reimbursement for hospital services to outpatients is made under whichever of the following sets of provisions is applicable: (1) Services provided by the hospital (including hospital-based physicians' services which benefit patients generally) are covered under the hospital insurance program, subject to a $20 deductible, where the services are diagnostic in nature and (2) coverage of hospital services is provided under the medical insurance program, subject to the $50 annual deductible and where the services are not diagnostic. In both cases a 20-percent coinsurance amount is applicable after the appropriate deductible is met. Expenses incurred in meeting the $20 deductible under the hospital insurance program are covered under the medical insurance program.

By transferring coverage of outpatient hospital diagnostic services to the medical insurance program, the committee's bill would simplify the procedure for paying benefits for services to hospital outpatients by making such payments subject to a single set of rules for determining patient eligibility, patient and medicare liability, and trust fund accountability. The bill would also remove any differential in benefits that could result under present law between hospital outpatient coverage and physician's office coverage because a patient's liability for the deductible with respect to diagnostic services furnished in a physician's office may be different from the patient's liability if the tests are furnished in a hospital outpatient department. Moreover, since all hospital services to outpatients and the related services of hospital-based physicians would be covered under the same program, there would be no reason not to permit combined billing for these services under medicare where this would be consistent with the usual practices of the hospital and physician. In these cases, a single intermediary could make all the required payments on the basis of the remuneration of the hospital-based physicians and the nonphysician costs the hospital incurs in making outpatient services available. The status under medicare of the physician who bills patients directly would not be affected.

(3) SIMPLIFIED REIMBURSEMENT OF HOSPITAL OUTPATIENT SERVICES

Under present law, providers of health services claim reimbursement for covered services from their hospital insurance intermediary. They may charge the medicare patient only for applicable deductible and coinsurance amounts and noncovered services. This procedure is consistent with the inpatient billing practices of other hospital insurance programs and has proved to be generally satisfactory under medicare. It has, however, placed an unaccustomed administrative burden on hospitals in claiming reimbursement for low-cost services to outpatients.

In many cases the operation of the $20 deductible for diagnostic services and the $50 deductible for therapeutic services makes the patient liable for the total charge and no payment, or a very small payment, is made by the program. Experience indicates that the hospital's administrative costs in billing the program and the patient, in the case of the small bills involved, have sometimes been disproportionate in relation to the size of the bills and the amounts that have been collected. Another problem is that the hospital is often unable to accu-

rately determine at the time outpatient hospital services are furnished how much the medicare patient has already paid toward the deductible. Where a check of the central medicare records after the patient has left the hospital premises indicates that the hospital collected less than the patient owed, it is often difficult for the hospital to collect the additional amounts from the patient. In the case of nonmedicare outpatients, the hospital can often collect the entire bill from the patient on the spot, where small charges are involved.

The committee's bill would simplify billing for outpatient hospital services by permitting hospitals, as an alternative to the present reimbursement procedure, to collect small charges (in no case charges of more than $50) for covered services from the medicare beneficiary outpatient without submitting a cost-reimbursement bill to medicare. Under this new procedure, a hospital could bill the patient its customary charges for outpatient services rendered and the patient would be reimbursed for 80 percent (less any applicable deductible amount) of the hospital outpatient charges as he would be reimbursed for other services that are reimbursed under the medical insurance program. The Secretary would determine the situations in which collection from the outpatient by the hospital was an advantageous procedure and would issue regulations limiting the application of the procedure to these cases. The Secretary would establish procedures designed to make it as easy as possible for beneficiaries who pay their hospital outpatient bills to claim reimbursement. Furthermore, since claims for hospital reimbursement will not be submitted for all outpatients under the proposed change as they are under present law, the Secretary will limit the applicability of the procedure to cases where the hospital can provide an adequate record of amounts collected from medicare patients and related information. As noted previously, since the hospital services to outpatients and the related hospital-based physicians' services to outpatients would both be covered under the medical insurance program, the program or the patient, whichever is billed, would receive a combined billing for these services where this would be consistent with the hospital's usual practice.

Hospital collections from outpatients would be taken into account to assure that a hospital's total reimbursement from the program and medicare patients for the services in question would not exceed the hospital's cost of providing the covered services plus the appropriate charges to patients for noncovered services. In other words, the proposal would make no change in hospital income in the aggregate, in the program's liability or in the amounts that patients would be required to pay.

(*e*) *Additional days of hospital care*

The committee's bill would provide a lifetime reserve of 60 days of inpatient hospital benefits to be available to the beneficiary whenever he has used up the 90 days of hospital benefits in a spell of illness provided under present law. The beneficiary could draw upon any or all of these additional days whenever he has exhausted his 90 days of hospital benefits in any spell of illness, but such additional days could not exceed a maximum of 60 days during his lifetime. Each of these additional days would be subject to the coinsurance amount

(now $10) equal to one-fourth the inpatient hospital deductible (now $40). The proposal would in effect guarantee to a beneficiary that no less than 150 days of inpatient hospital benefits would be available to him during his lifetime.

The House bill would provide for an additional 30 days of coverage of inpatient hospital services in a spell of illness (up to 120 days in total in any spell of illness) with a coinsurance amount ($20 initially) equal to one-half the inpatient hospital deductible applicable to each of such 30 days.

The proposed increases in the number of days of inpatient hospital benefits provided under both the House bill and the committee bill are intended to help meet the problem faced by a beneficiary who requires long term care in an extended care facility or nursing home and whose spell of illness continues through his stay in the facility because he has not been out of a hospital or any institution that is primarily engaged in providing skilled nursing care and related services for 60 consecutive days. The committee believes that the provision of an additional 60 days of inpatient hospital benefits during a beneficiary's lifetime will be of greater help to those beneficiaries who are more or less permanently institutionalized and who therefore have, in effect, only one spell of illness during their lifetime. Under the House bill these persons would qualify for only an additional 30 days of inpatient hospital benefits, while under the committee bill they would qualify for up to 60 additional days of benefits. The additional coverage provided under the committee bill would also be of greater value to those persons who have several spells of illness during their lifetime and who may require more than 120 days of hospital care in any one of these spells of illness. The lifetime maximum of 60 such additional days provided under the committee bill, together with the imposition of the coinsurance amount for each of these additional days, provides safeguards against any possible excessive use of hospital care in these cases. Also, the committee expects that the Secretary of Health, Education, and Welfare would establish appropriate regulations under present provisions of the law for appropriate verification of the medical necessity of the additional days of hospital care for which payment would be made. The amendment would become effective January 1, 1968.

(*f*) *Study of coverage of preventive care under medicare*

Preventive health care, including periodic health examinations and disease detection services, can assist in reducing the incidence of serious illness. The committee believes that health insurance coverage of some of the costs of such examinations and services would reduce financial barriers to using preventive medicine and to early detection of disease and thereby might help to increase the use of such services. The result might then be to reduce serious and disabling illness as well as the need for more intensive and costly health care.

The committee also believes that older people might profit greatly by being better informed concerning steps that they can take to prevent and treat illness. Many steps to improve health can be taken by the person himself if he were aware of their importance. Moreover, older people with health problems may not know of the health resources and treatment methods which are available to them.

The committee, therefore, instructs the Secretary of Health, Education, and Welfare to conduct a study of the possible coverage under medicare of the cost of comprehensive health screening services and other preventive services designed to contribute to the early detection and prevention of disease in old age, and the feasibility of instituting and conducting informational or educational programs designed to reduce illness among medicare beneficiaries and to aid them in obtaining needed treatment. The Secretary will report to the Congress, prior to January 1, 1969, his findings and recommendations resulting from these studies.

(g) Incentives for economy while maintaining or improving quality in the provision of health services

Under present law, medicare payments are made either on the basis of the reasonable cost of, or the reasonable charge for, covered services. Participating providers of services and, in certain cases, group practice prepayment plans are reimbursed on the basis of the reasonable costs they incur in providing covered services to medicare beneficiaries. Payment for services furnished by persons other than providers of services are made on the basis of the reasonable charge for the services; in general, a physician's charge is considered to be reasonable if it is his customary charge and if it does not exceed the charge prevailing in the community for the same service. Title V (maternal and child health) and title XIX (medicaid) of the Social Security Act also provide that hospitals will be reimbursed on a reasonable cost basis for the inpatient services they furnish recipients; the State determines the basis of reimbursement for the other health services financed under those titles.

Under the House-passed bill, the Secretary would be authorized to enter into agreements with a limited number of individual providers of health services, community groups, and group practice prepayment plans under which these organizations would engage in experiments with reimbursement systems other than those based on cost where these alternative systems provide incentives to lower the cost of providing services while maintaining or improving their quality. Group practice prepayment plans which provide both physicians' services and hospital services to their membership could engage in experiments under which a combined system of reimbursement could be developed for both physician and hospital services.

This provision grew out of the concern, which is shared by the committee, that rigid commitment to a cost basis of reimbursement may provide insufficient incentive for participating providers of services to furnish health care economically and efficiently. The organization which is reimbursed at cost may see no advantage in lowering its cost. Moreover, patients may not take the same interest in the cost of health services they receive when it is paid from insurance or Government funds as when they pay it out-of-pocket. The committee agrees that bases of reimbursement other than the cost method should be explored which may, through experimentation, be demonstrated to be effective in increasing the efficiency and economy of providing institutional health services without adversely affecting the quality of such services.

The committee also believes, however, that many of the considerations which suggest a need to experiment with reimbursement for providers of services apply equally to reimbursement of physicians' services. The committee is concerned that the forthcoming increase in part B premiums under medicare not be followed by increases of similar magnitude in subsequent years (except, of course, where there is a statutory change in the benefits provided). Therefore, the committee's bill would also give the Secretary authority to enter into agreements with physicians to experiment with payment for their services on bases other than charges, such as fee schedules, fees related to physician-time, or retainer or per capita arrangements. The Secretary will be expected to develop the experiments authorized under the bill and establish procedures for the selection of participants which are likely to be able to carry them out properly. The Secretary will approve only those experiments which can reasonably be expected to result in greater efficiency, lower costs, and maintenance or improvement in the quality of the services being provided. Under the bill, the Secretary would be authorized to reimburse States for any additional costs they incur under their title V or title XIX program which result from these experiments. The participation of physicians in such experiments or demonstrations will be purely voluntary on their part.

Since the success of the experiments will be measured by improvement in efficiency and increase in output of health services per dollar of expenditure, effective measures of efficiency and quality are essential elements to the experiments and in many cases appropriate means of measurement will have to be developed before experimentation can begin. The committee believes that the Secretary may find it helpful to contract with research organizations, under existing authority, for the conduct of research designed to establish better methods of determining health care efficiency and output.

Under the bill, the Secretary would be required to report annually to the Congress on the experience in carrying out these provisions of the bill.

(*h*) *Transitional provision on eligibility of presently uninsured individuals for hospital insurance benefits*

Under present law, persons who attain age 65 in 1967 or earlier are eligible for hospital insurance protection even though they have not earned any quarters of coverage under the social security or railroad retirement programs. However, persons who attain age 65 in 1968 must have earned at least six quarters of coverage or be eligible for social security or railroad retirement benefits. The committee believes that this initial increase to six quarters of coverage is too great, and the bill provides that the minimum number of quarters of coverage required for entitlement under this special provision of persons attaining age 65 in 1968 would be three quarters of coverage, with the required number of quarters of coverage increasing by three quarters for each subsequent year in which the individual attains age 65. The transitional provision will phase out so that by 1975 (1974 for women) the same number of quarters of coverage will be required for entitlement to cash benefits and hospital insurance benefits. The cost of hospital insurance protection provided under this provision will continue to be financed from general revenues rather than from

the Federal Hospital Insurance Trust Fund. The committee concurs with the House on this amendment. The following table shows both the present and the new requirements for entitlement under the transitional insured status provision:

COVERAGE REQUIREMENTS UNDER THE INSURED STATUS PROVISION OF PRESENT LAW AND UNDER THE COMMITTEE BILL

Year attains age 65	Men			Women		
	Present law		Committee bill	Present law		Committee bill
	OASI	HI	HI	OASI	HI	HI
1967 or earlier	16	0	0	13	0	0
1968	17	6	3	14	6	3
1969	18	9	6	15	9	6
1970	19	12	9	16	12	9
1971	20	15	12	17	15	12
1972	21	18	15	18	18	15
1973	22	21	18	19	19	18
1974	23	23	21	20	20	20
1975	24	24	24			

(i) Coverage of the services of podiatrists, chiropractors, and optometrists under supplementary medical insurance program and exclusion of routine foot care and of certain procedures performed during eye examinations

Under the House bill, the definition of the term "physician" in title XVIII of the Social Security Act would be amended to include a doctor of podiatry or surgical chiropody. The committee bill would further amend the definition of "physician" to include a chiropractor and a doctor of optometry.

The committee bill would cover the nonroutine services of doctors of podiatry or surgical chiropody, in the same fashion as these services would be covered if performed by doctors of medicine and osteopathy, as well as the services of licensed chiropractors and certain services of doctors of optometry. The bill would provide this coverage by broadening the definition of the term "physician" in title XVIII to include a doctor of podiatry or surgical chiropody, a licensed chiropractor, and a doctor of optometry so that the services they provide which are covered under the supplementary medical insurance program would be covered under that program as "physicians' services." Under present law, a "physician" is defined as a doctor of medicine or osteopathy or, in certain limited circumstances, a doctor of dentistry or of dental or oral surgery. Physicians' services to individual beneficiaries are covered under the supplementary medical insurance part (part B) of the medicare program.

In line with the exclusion in present law of such services as routine physical checkups, most dental services, eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, examinations for hearing aids, immunizations, and so forth, the bill would exclude certain types of foot care whether provided by a podiatrist or by a medical doctor. Payment would not be made for the treatment of flat feet and the prescription of supportive devices therefor; treatment of subluxations of the foot; and routine foot care, including the cutting or removal of corns, warts, or calluses, the trimming of nails, and other routine hygienic care. Although the exclusion of certain types of foot

care would apply whether the care was provided by a podiatrist or a medical doctor, as a matter of fact, medical doctors seldom provide such care. Thus, the exclusion would not be a significant reduction in the coverage of present law of foot ills and would result in making the coverage of treatment of foot problems equivalent for medical doctors and doctors of podiatry where the two types of doctors are equally qualified to provide the required care.

The committee bill would cover the services of a licensed chiropractor but only with respect to services which he is legally authorized to perform by the State where he is working. Of course, present law excludes from coverage under the health insurance program expenses incurred for such health items and services as routine physical checkups and personal comfort items. Payment for the services of chiropractors would be limited, as are payments for the services of medical doctors, to covered health items and services.

With respect to a doctor of optometry, the committee bill would cover those services which he is legally authorized to perform by the State in which he is working, exclusive of services involving the diagnosis or detection of eye diseases (and referral charges therefor) where he would not be qualified to treat the disease if found. Where such treatment consists of eye training or eye exercises, the services would not be covered unless they were prescribed by a doctor of medicine or a doctor of osteopathy.

Present law excludes from coverage expenses incurred for eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses. One of the routine procedures performed in connection with eye examinations is an eye refraction. The committee bill would make clear that expenses for such refraction procedures would be excluded from coverage under the health insurance program when performed by an optometrist or when performed by an ophthalmologist or any other physician even when the refraction is part of an examination performed in relation to an illness not entirely related to the possible need for eyeglasses. Unlike the House bill, however, the committee bill would permit payment to be made for refraction procedures performed in connection with furnishing prosthetic lenses.

The amendments would become effective April 1, 1968, with respect to optometrists and chiropractors, and effective January 1, 1968 (as under the House bill) with respect to podiatrists.

(j) Payment for the purchase of durable medical equipment

Present law provides reimbursement under the supplementary medical insurance program for expenses incurred for the rental of durable medical equipment. There are, however, instances where the patient purchases the equipment or where he would wish to purchase the equipment because he believes it would be more economical or more practical than rental—for example, where a patient's treatment will require the use of an item of durable medical equipment for a period of time over which the customary rental fees would exceed the usual purchase price.

The committee's bill would make benefits covering durable medical equipment more responsive to the needs of the patient by including a provision which would permit medical insurance benefits to be paid in situations where an individual chooses to purchase rather than to

rent the equipment. However, this provision would operate only as an economical alternative to the present coverage. To avoid paying the full purchase price of costly equipment used only a short time and, thereby, allowing the patient or his estate to profit upon its disposition, the bill would provide that benefits for the purchase of relatively expensive items of durable medical equipment would be paid in monthly installments that are equivalent to the payments that would have been made had the patient chosen to rent the equipment. Moreover, benefits would be paid only for that period of time during which the equipment was certified to be medically necessary or until the purchase price of the equipment had been fully reimbursed, whichever came first. The patient would wish to make the purchase under these circumstances if the purchase was less costly than rental because through the purchase his coinsurance payments would be reduced.

With respect to the purchase of inexpensive equipment, on the other hand, the committee's bill would permit a lump-sum payment of benefits where the carrier determines a single payment to be more practical than periodic payments.

(k) Payment for outpatient physical therapy services

Under present law, health insurance payments may generally be made for physical therapy services when provided to an inpatient in a hospital or extended care facility which is participating in the health insurance program, when furnished in a homebound patient's home by a participating home health agency, or when provided as an incident to the services of a physician who personally supervises the therapy. Because in some instances a hospital may have the personnel and be organized to provide physical therapy services in the patient's home similar to those provided by a home health agency and under circumstances which would not pose substantial problems of administration, the House-passed bill extended supplementary medical insurance coverage to physical therapy services which are not directly incident to a physician's service if furnished by a hospital, or by others under arrangements with the hospital, to outpatients in a place of residence used as the outpatient's home.

The committee bill would extend medical insurance coverage to physical therapy services which are provided under organized arrangements to an outpatient regardless of whether such services are provided in a place of residence used as the outpatient's home, in a hospital or an extended care facility, or elsewhere. Payments would be made for outpatient physical therapy services only when furnished in accordance with a plan established and periodically reviewed by a physician. The plan would prescribe the type of physical therapy services that would be provided and the amount and duration of such services.

The proposed outpatient physical therapy payments would meet the cost of skilled physical therapy and rehabilitation services furnished by providers of services—hospitals, extended care facilities, and home health agencies—and by approved clinics, rehabilitation agencies, or public health agencies to beneficiaries on an outpatient basis. The services could be furnished either directly by the providers of services or by approved clinics or agencies or by other parties under arrangements with them.

The requirements that clinics and rehabilitation agencies must meet in order to be eligible for payments are intended to assure that only quality health care will be paid for. The clinic or rehabilitation agency would be required to satisfy conditions specified in the bill relating to medical records, policies governing the services provided, and State or applicable local licensing requirements. The clinic or rehabilitation agency would also have to be organized so as to provide an adequate outpatient physicial therapy program. This would include a requirement that they have adequate physician and other participation to provide and oversee the furnishing of skilled physicial therapy and rehabilitation services and to assure that the services provided are both efficient and properly related to the total medical needs of the patient. In addition, the clinic or rehabilitation agency would have to meet such other conditions relating to health and safety as the Secretary may find necessary. It is not intended that organizations which are primarily engaged in providing mineral or warm spring baths, often as an incident to vacation and travel plans and which serve many visitors as pleasure resorts, would be able to participate in the program as approved clinics or agencies.

The committee bill does not specifically require providers of services—hospitals, extended care facilities, and home health agencies—to meet the requirements that clinics and rehabilitation agencies must meet in order to be eligible for payments for outpatient physical therapy services. The committee believes that the provisions of present law with respect to conditions for participation by such providers permit the establishment of needed standards for outpatient physical therapy services furnished by or under arrangement with a provider of service. The committee expects that the Secretary of Health, Education, and Welfare would develop standards for providers of services furnishing outpatient physical therapy services which would be similar to those for clinics or rehabilitation agencies providing such services. The committee expects that local public health agencies will be particularly helpful in rural areas in arranging for or directly providing physical therapy services to beneficiaries. In many rural areas, the public health agency may very well be the only agency available to arrange for and supervise such services. It is expected, therefore, that the Secretary will allow greater latitude and flexibility to public health agencies in their arrangements for physical therapy than is the case with other providers or nonpublic agencies.

The committee bill provides that payment to approved clinics, rehabilitation agencies, and public health agencies shall be equal to the cost of the services provided. Such payment is made under present law for services furnished by participating hospitals, extended care facilities, and home health agencies whether reimbursed under part A or part B of the health insurance program. For purposes of administration, it is expected that payment for outpatient physical therapy services provided by approved clinics and agencies, or by others under arrangements with them, would be handled by organizations serving as fiscal intermediaries under part A of the program. In effect, approved clinics and agencies would be treated as "providers of services" for purposes of facilitating payment for outpatient physical therapy services and as such would have to agree not to charge any beneficiary for covered services for which payment would be made under the program and to make adequate provision for refund of erroneous charges.

The committee bill would extend the provisions of present law under which State agencies, operating under agreements with the Secretary, determine whether a provider of services meets the conditions for participation in the health insurance program, to provide that State agencies would also determine whether a clinic or rehabilitation agency, meets the appropriate requirements.

Benefits would be payable for covered outpatient physical therapy services furnished beginning July 1, 1968. Although other benefit provisions in the committee bill generally have an effective date of April 1, 1968, a later date is provided for outpatient physical therapy services to allow time for the clinics and agencies to make any changes necessary to meet the requirements for participation and for State agencies to inspect such clinics or rehabilitation agencies and make determinations with respect to whether they are eligible to participate.

(l) Payments for certain portable X-ray services

Under present law, diagnostic X-ray tests furnished outside the hospital and extended care facility are covered under the supplementary medical insurance program if rendered under the direct supervision of a physician.

There are instances, however, where technicians take X-rays in the patient's home in accordance with the written authorization and under the general direction of a physician but without his immediate supervision and where the films are read by a radiologist. Making benefits available for portable X-ray services provided in the patient's home would facilitate diagnosis in some cases where, because the patient is bedridden or unable to obtain transportation, it is difficult for him to receive X-rays outside his home. The committee's bill would provide coverage under the supplementary program for the services in question, but to avoid supporting services which are inadequate or hazardous to the patient, benefits would be paid only where the tests are performed under the supervision of a physician and meet such conditions relating to health and safety, with respect to both the equipment used and the operators thereof, as the Secretary may find necessary. Because of potential hazards to a patient's health and because of the professional education required to determine the nature of the services required and the meaning of the results, diagnostic X-ray services would have to be provided under very careful skilled supervision to be adequate. The effective date for this benefit is January 1, 1968.

(m) Payment for blood

The committee has modified the provision of the House bill which amended the blood deductible provisions of present law with respect to replacement of blood. Under present law a deductible, equal to the cost of the first 3 pints of blood furnished a beneficiary in a spell of illness, is applied with respect to whole blood provided under the hospital insurance program (part A). There is no deductible with respect to blood derivatives and no special deductible is applied with respect to blood furnished under the supplementary medical insurance program (part B).

Under the House bill, the "blood" with respect to which the 3-pint deductible under part A applies would be broadened to include

packed red blood cells in addition to whole blood. The supply of either of these forms of blood requires continual donations of fresh whole blood. The deductible would be modified so that a beneficiary could be considered to have replaced the blood, and not be charged for the 3 pints, only if he supplied 2 pints of blood in replacement of the first pint of blood received. The second and third pints furnished a beneficiary would be replaced on a pint-for-pint basis as under present law. The House bill also establishes a separate deductible under the supplementary medical insurance program (part B) for the first 3 pints of whole blood or packed red blood cells furnished a beneficiary in a calendar year and covered under that program. The replacement policy would be the same as under part A. The blood deductibles under parts A and B would be applied separately, without respect to whether one or the other had been met.

The committee recognizes that the deductible with respect to blood furnished is designed to encourage donations of blood to replace that furnished medicare beneficiaries. Data, in large part provided by the American Red Cross, indicate that older people have unusual difficulties replacing blood and the committee believes that these difficulties should not be increased through requiring 2-for-1 replacement of the first pint of blood received. For this reason the committee has deleted this provision of the bill.

The committee has, however, retained the House bill's provisions relating to including packed red blood cells in the blood deductible, and adding a blood deductible to the supplementary medical insurance program.

(n) Appropriations to supplementary medical insurance trust fund

The Social Security Act authorizes the appropriation to the supplementary medical insurance trust fund of a contribution from general revenues equal to the aggregate premiums payable by persons enrolled under the medical insurance plan. The Congress intended that the Government contribution should be paid into the trust fund at the time that the premiums being matched by this contribution were deposited. When the matching funds are deposited subsequent to the time the premiums are paid, the delay in making the Government contribution results in a loss of interest to the trust fund and a gain in interest to the general funds of the Treasury. The committee believes that no such loss to the trust fund should be allowed to occur. However, while it has included in the bill a provision for making up for interest lost to the trust fund, the committee intends that Government payments due the trust fund should be appropriated promptly as due and deposited in the fund; the bill merely assures that, if there should nevertheless be a delay in appropriation or deposit, no interest loss to the trust fund and no gain to general funds should result.

The bill would authorize the appropriation from general revenues of amounts sufficient to cover any loss of interest incurred by the trust fund in a fiscal year (beginning with fiscal year 1968) as a result of delays in the deposit of the Government contribution. The bill would also authorize the appropriation of amounts sufficient to cover any Government contributions due the trust fund for fiscal year 1967 but not appropriated during that year, as well as interest on such amounts,

the interest to be computed as if such amounts had been appropriated on June 30, 1967.

In addition, present law authorized the appropriation from general revenues of a contingency reserve which will remain available to the medical insurance program until the end of calendar year 1967. This reserve was considered to be necessary at the beginning of the program when there was no experience with benefit costs for the program and when contingency reserve funds would only gradually be accumulated. In view of the fact that sufficient operating data have not been available to permit an analysis upon which to base a conclusive judgment of whether present funds are sufficient, the committee believes that it would be desirable to extend authorization for this contingency reserve to the end of calendar year 1969. It is hoped that during this period reasonably adequate information on benefit costs, derived from experience with the present program, will become available, and on the basis of this experience, accurate estimates of future costs made. Furthermore, during this period it is expected that an adequate fund for contingencies will be accumulated from the excess of premiums over benefits. If no contingency reserve is made available to provide an additional safety factor, the premium rate over the next several years would have to be set at a higher level than is expected to be needed for the cost of benefits and administration, in order to provide funds which might be needed should the estimates of cost prove to be substantially below experience. The contingency reserve would not, even if used, be a permanent charge to general revenues from which it was authorized to be appropriated since any advances from this reserve are to be repaid from future income to the supplementary medical insurance trust fund.

(o) *Enrollment under supplementary medical insurance program based on alleged date of attaining age 65*

Under present law, a person is eligible to enroll in the supplementary medical insurance program when he attains age 65. However, the law includes several restrictions on his enrollment after age 65 because of concern that in the absence of these restrictions persons might delay enrolling until they foresee that they will have covered medical expenses. If a person does not enroll during his initial 7-month enrollment period, beginning with the third month before the month in which he attains age 65, he cannot enroll until the next general enrollment period. If he does enroll after his initial enrollment period, he may be required to make additional payments and coverage cannot begin until the July 1 following a general enrollment period. Also, he cannot enroll in the program for the first time more than 3 years after his initial enrollment period. Present law makes no provision for excusing individuals who first seek to enroll some time after they reach age 65 because they are mistaken about their age. Thus, although a person who files for benefits some time after he is first eligible is able to get cash benefits and hospital insurance benefits retroactively for up to 12 months, he may have to wait for a substantial period before his medical insurance coverage could begin.

The committee believes that where documentary evidence indicates the individual delayed filing because he was mistaken about his age, he should not be penalized by having to wait until a general

enrollment period to enroll in the medical insurance program and by having to make additional payments because of the delay. The bill would, upon enactment, provide that where an individual who has attained age 65 has failed to enroll in the medical insurance program because he relied on documentary evidence which indicated that he was younger than he actually was, he would be allowed to enroll, using, for the purpose of determining his initial enrollment period and coverage period, the date of attainment of age 65 shown in the documentary evidence.

(p) Limitation on special reduction in allowable days of inpatient hospital services

Present law requires that when an individual is an inpatient of a psychiatric hospital or a tuberculosis hospital when he becomes eligible for hospital insurance benefits, the number of days on which he was an inpatient in such an institution in the 90 days (150 days under the bill) before his first eligibility be deducted from the 90 days of inpatient hospital services for which payment could otherwise be made during the spell of illness which begins with his entitlement. This so-called carryover provision was included in the law along with other provisions related to psychiatric and tuberculosis hospital care to seek to assure that the hospital insurance plan will cover only the active phase of psychiatric or tuberculosis treatment. The carryover provision excludes payment for psychiatric or tuberculosis hospital services beginning with age 65 on behalf of a patient who had been receiving care in such a hospital for an extended period previous to attaining age 65.

Under the House bill the limitation on payment of hospital insurance benefits during the first spell of illness for an individual who is an inpatient of a psychiatric or tuberculosis hospital at the time he becomes entitled to benefits under the hospital insurance program would not apply to benefits for services in a general hospital if the services are not primarily for the diagnosis or treatment of mental illness or tuberculosis. The committee accepted the change in the House bill with respect to psychiatric hospitals, but modified that part relating to tuberculosis hospitals. The committee would remove such hospitals from the provision in present law under which days in a tuberculosis institution immediately before entitlement to hospital insurance are counted against the days of coverage an individual would otherwise have. In effect, the committee's change would make an individual's entitlement to hospital insurance benefits the same if he received hospital services in a tuberculosis hospital as it would be if he received services in a general hospital.

The committee believes that the changing nature of services in tuberculosis hospitals supports this change in the law. Such hospitals are to an increasing extent providing care for patients who require short-term care, often for diseases other than tuberculosis, so that the distinction between general hospitals and tuberculosis hospitals is diminishing. Under the House bill the person who enters a tuberculosis hospital before his 65th birthday and who must remain there for further treatment after he reaches age 65 might not be entitled to the hospital insurance benefits to which he would have been entitled had he first entered and remained in a general hospital, even though the treatment

in the tuberculosis hospital is the same as the treatment he would have received in the general hospital. The committee has therefore concluded that the carryover provision as it applies to care in tuberculosis hospitals should be eliminated.

The committee was also concerned that the retention of the carryover provision for psychiatric hospitals bars payment for general hospital services for long term psychiatric hospital inpatients when the patient suffers some illness, other than a psychiatric condition, which requires general hospital care, for example, where a mental patient suffers appendicitis or a heart attack. Therefore, the committee accepted the House bill's modification of the provision in question so that the reduction of coverage which applies when an inpatient was in a psychiatric hospital before entitlement to medicare would not be applicable to inpatient hospital services furnished outside a psychiatric institution when these services are not primarily for the diagnosis or treatment of the patient's mental illness. For example, consider an individual who had been a psychiatric hospital patient when he became entitled under the hospital insurance program and had been in the institution for all of the preceding 150-day period. This individual would, beginning with services furnished after December 1967, the effective date of the change, be eligible for payments for up to 150 days of inpatient hospital services in his initial spell of illness, (including his lifetime reserve of 60 days of inpatient hospital services), but only if they are furnished by hospitals that are not psychiatric hospitals and only if the services are primarily for a condition other than a mental condition. The bill would also change the coverage in the case where the individual had fewer than 150 days in such an institution prior to his entitlement. For example, an individual who had been in a psychiatric hospital for 60 days before reaching age 65 in August 1966, when he became entitled, would under present law, have been covered for the next 30 days of care in that hospital. If he were still in the same hospital on January 1, 1968, he would be eligible for an additional 60 days of coverage, provided under the lifetime reserve provision of the bill, in a psychiatric institution. At the end of those 60 days he would remain eligible for 60 days of coverage in a general hospital for treatment of a disorder other than a mental disorder.

(q) *Study to determine feasibility of inclusion of certain additional services under part B of title XVIII of the Social Security Act*

The committee's bill would require the Secretary of Health, Education, and Welfare to study the question of adding to the services now covered under the supplementary medical insurance program the services of additional types of licensed practitioners performing health services in independent practice. The Secretary would be required to report to the Congress, prior to January 1, 1969, his finding with respect to the need for covering under the medical insurance program the various types of services performed by such practitioners and the costs of such coverage. The Secretary would also be required to make recommendations as to the priority of covering these services, the methods of the coverage, and the safeguards that should be included in the law if any such coverage is provided.

(r) Payment for certain hospital services furnished outside the United States

Under present law, hospital and medical services furnished outside the United States are generally excluded from coverage under the medicare program. The only exception is that benefits are payable for emergency inpatient hospital services furnished in nearby foreign hospitals if the beneficiary is physically present within the United States when the emergency arises and the foreign hospital is more accessible than the nearest hospital within the United States which is adequately equipped to deal with, and available for the treatment of, the beneficiary's illness or injury. Under regulations, if the hospital does not provide actual cost data, payments on claims submitted by nonparticipating hospitals are made on the basis of 90 percent of the hospital's average per diem cost for all patients or 85 percent of the hospital's regular charges for the services rendered to the beneficiary, whichever is lower.

Although the decision to exclude services provided by foreign hospitals from coverage under the medicare program was made in consideration of the difficulties which would be involved in enforcing the standards of the medicare law in other countries, the committee recognizes that this restriction imposes a hardship on the medicare beneficiary who, residing in an area of the United States that is directly adjacent to the continental border, finds that the nearest hospital suited to his care is located outside the United States. Moreover, the committee recognizes the financial problem to beneficiaries created by the present law restriction of payment for emergency inpatient hospital services to cases where the individual is physically present within the United States when the emergency arises. Therefore, the committee has amended the House approved bill to provide for payment of benefits to the individual if he is a resident of the United States (and if he would have been eligible for payment with respect to such services had they been furnished by a hospital participating in the medicare program) for up to 20 days of inpatient hospital services furnished in a country contiguous to the United States by a hospital located in a city or municipality (any part of which is not more than 50 miles from the border of the continental United States). In the case of nonemergency services, the provision would require that the hospital providing care be the one nearest to the beneficiary's residence which is suitable to treat his illness. In the case of emergency inpatient hospital services furnished outside the United States, the provision would eliminate the restriction in present law that benefits may be paid only if the individual is physically present within the United States at the time the emergency arises, and would, instead, permit payment to be made if the emergency occurs within 50 miles of the U.S. border.

Benefits for the services covered under the provision would be payable only on the basis of an application for reimbursement filed by the individual and only if the hospital has been accredited by the Joint Commission on Accreditation of Hospitals or under a hospital approval program having standards essentially comparable to those of the Joint Commission on Accreditation of Hospitals. The amount payable under this provision would be the same as that which the committee has provided for certain nonparticipating hospitals in the

United States—60 percent of the hospital's reasonable charges for "routine services" in the room occupied by the individual or in semiprivate accommodations, whichever is less, plus 80 percent of the hospital's reasonable charges for "ancillary services" (subject, of course, to appropriate deductibles and coinsurance), or, if separate charges for routine and ancillary services are not made by the hospital, two-thirds of the hospitals' charges (again, subject to the appropriate deductibles and coinsurance).

This amendment would apply to services furnished with respect to admissions occurring after March 31, 1968.

(s) Payment for services furnished by nonparticipating hospitals

Under present law, payment may be made for hospital services furnished in hospitals which have entered into agreements to participate in the program. To participate a hospital must meet a number of specific statutory requirements as well as health and safety requirements established by regulations. The law also authorizes payments to be made to hospitals without agreements when a medicare beneficiary must enter such an institution in an emergency. However, such emergency hospital services may not be paid for except in institutions which meet certain statutory requirements and which apply to receive medicare reimbursement and only when such hospitals agree to accept medicare reimbursement as essentially full payment of a patient's liability.

The committee is concerned that some older people who have received hospital care since the beginning of the medicare program and have expected to have their hospital bills paid by medicare have found no payments are possible because the hospitals have not met the requirements of law, or have refused to accept medicare payments. Certainly, such situations are not in accord with medicare's commitment to older citizens that they would be helped in meeting the costs of necessary hospital care. To relieve these patients of the resultant financial difficulties they have faced, the committee's bill provides for payments to beneficiaries admitted to certain nonparticipating hospitals during the period on or before December 31, 1967. The provision is temporary because the problem is one of confusion about the coverage of the program which occurred at its outset and has gradually diminished. The patient would be reimbursed for 60 percent of the hospital's reasonable charges for "routine services" in the room occupied or in semiprivate accommodations, whichever is less, plus 80 percent of the hospital's reasonable charges for covered "ancillary services," after applying the deductible and coinsurance provisions of present law. Because cost data could not be expected to be provided by nonparticipating hospitals, payment would be made on the basis of charges, but only the specified percent of charges to assure that no more would be paid in the case of nonparticipating hospital services than for participating hospitals. If separate charges for routine and ancillary services, as defined, are not made by the hospital, reimbursement, subject to the appropriate deductibles and coinsurance, would be based on two-thirds of the hospital's charges.

The term "routine services" would include the regular room, dietary and nursing services, minor medical and surgical supplies and the use of equipment and facilities for which a separate charge is not cus-

tomarily made. The term "ancillary services" would include those covered special services (such as X-ray and laboratory) for which charges are customarily made over and above those for routine services.

Payment under this provision would be limited to up to 20 days of inpatient hospital services in a spell of illness if furnished in a hospital that did not participate in medicare before January 1, 1969. The 20-day limit is included because nonparticipating hospitals might not apply required reviews of the need for the services provided. If the hospital did participate before January 1, 1969, and if it applied its utilization review plan to the services in the past, up to the full 90 days of coverage could be provided. This provision would create an incentive for these hospitals to participate in order to provide coverage for the full 90 days before 1968, as well as normal incentives to provide future full coverage for their patients.

When a nonparticipating hospital provides emergency services which may be covered by the program, payment may be made only to the hospital upon its application and agreement not to also charge the patient. Some nonparticipating hospitals have been unwilling to request medicare payment for these services thereby working a financial hardship upon those who were supposed to have been relieved of such hardships under the program. The committee has included a provision in its bill under which, if the hospital does not request medicare payment, the patient may be reimbursed directly on the basis of charges. The amount payable for such services where the patient bills the program would be the same as under the temporary provision for nonparticipating hospitals—60 percent of the hospital's reasonable charges for "routine services" in the room occupied or semiprivate accommodations, whichever is less, plus 80 percent of the hospital's reasonable charges for "ancillary services" after application of regular deductibles and coinsurance as well as the other provisions previously described. Before a beneficiary is reimbursed directly with respect to services furnished in a calendar year, the hospital would be given an opportunity to elect to bill the medicare program for all covered emergency services it furnished during such year. In the absence of such an election, payment with respect to services furnished during such calendar year would be made only directly to the patient. The annual election is provided so that a hospital might not require some emergency patients to pay the full charge and only request medicare payment for a patient whose bill was uncollectible. The annual election would prevent a nonparticipating hospital from always selecting the most favorable of the two alternatives.

The committee bill also includes a new definition which would be used for emergency hospitals and for hospitals eligible under the temporary provisions applicable before 1969. Under it a qualifying hospital must have a full-time nursing service, be licensed as a hospital, and be primarily engaged in providing medical care under the supervision of a doctor of medicine or osteopathy. This definition would apply back to July 1, 1966, so that some hospitals previously ineligible for coverage of emergency services may receive such payments on behalf of beneficiaries back to the beginning of the program, provided such hospitals apply for such payments. If the hospital does not apply, the patient would be paid under the provisions described above for reimbursement to the patient.

(t) Payment under the medical insurance program for noncovered hospital ancillary services

Under present law, payment cannot be made under the medical insurance program for medical and other health services (e.g., diagnostic tests, prosthetic devices, braces, drugs which cannot be self-administered, X-ray therapy, and other ancillary services which are ordinarily covered under part B) if they are inpatient hospital services, posthospital extended care services or home health services. When furnished to a patient of a qualified health-care institution, these services can be paid for only under the hospital insurance portion of the program. As a result of this provision, patients in participating hospitals or extended care facilities who are ineligible for hospital insurance payments because they have exhausted their eligibility, and patients in extended care facilities who have not met the requirement for coverage that their care be for an illness which previously required hospitalization for at least 3 days are left without protection against the cost of these services under either part of the medicare program.

To deny benefits under the medical insurance program for such services when payment cannot be made under the hospital insurance program not only imposes a hardship on the patient but is inequitable since benefits are paid for under part B for these and similar services furnished to people living in their own homes or in residential facilities.

The services which would be covered under part B under this provision consist of services which are now covered under part A of present law when furnished by a participating provider of services to a beneficiary before his part A eligibility expires. The committee bill would merely add to the benefits available to extended care and hospital patients who have enrolled in medical insurance and who have exhausted their benefit rights under the hospital insurance program or whose care is not covered by hospital insurance. These services, rendered after March 1968, would be covered under part B and they would be paid for on a cost basis.

In instances where any of these ancillary services would be furnished by a facility meeting the definition of a hospital for emergency purposes, the standards applied by medicare related to these services in participating hospitals would have to be met. If the services are laboratory services and are not furnished by such a facility, the present law provisions, and applicable standards, for independent laboratories would apply.

(u) Changes in SMI enrollment period

Under present law, the general enrollment periods for the supplementary medical insurance program begin October 1 and end December 31 of each odd-numbered year. The Secretary is required, between July 1 and October 1 of each such year, to determine and promulgate the supplementary medical insurance premium rate for the succeeding 2-year period. This premium rate is effective beginning the following January 1. An individual may terminate his coverage under supplementary medical insurance only during a general enrollment period effective December 31 of that year.

Effective with the year 1969, the committee's bill would change the dates for the general enrollment period from October 1 through December 31 to January 1 through March 31, and would change the

scheduling of the general enrollment periods from every odd-numbered year to every year. An individual who is enrolled in the supplementary medical insurance program could file a notice that he wishes to disenroll at any time during the year. His coverage would cease at the close of the calendar quarter following the quarter in which he filed such notice, provided it was not terminated at an earlier date for nonpayment of premiums.

The committee bill would also change the provision in present law which requires the Secretary, in each odd-numbered year, to determine and promulgate the dollar amount of premiums to be applicable for the 2 succeeding years. The committee bill would provide for more flexibility by authorizing the Secretary to establish premium rates annually during December of each year rather than every 2 years. In some years, of course, no change might be necessary. The Secretary would announce in December the premium effective beginning with the following July. Whenever the Secretary announces the premium rate he would be required at that time to issue a public statement setting forth the actuarial assumptions and bases he has used in arriving at the premium rate.

The committee adopted these changes in view of current experience in establishing a new premium and applying the general enrollment provisions. Since consideration of social security legislation which might affect the supplementary medical insurance premium rate and the beginning of the general enrollment period overlapped, Public Law 90–97 was enacted to extend the 1967 general enrollment period through March 31, 1968, and postpone the deadline for promulgating the premium rate to December 31, 1967. Under Public Law 90–97 the higher premium announced in December of this year would become effective with April 1968. For subsequent years, as already pointed out, the new premium would become effective with respect to the following July.

The committee believes that permanent changes should be made in the enrollment provisions of the law in order to prevent the need for such special legislation in future years. In the absence of a change in the October–December enrollment period, the late enactment of social security legislation could mean there would be only a relatively brief period in which persons could act to enroll or terminate their coverage in the light of the changes in law. Further, if time was short, it might not be possible to prepare and distribute informational materials about the new legislation needed by potential enrollees to make an informed choice. An enrollment period of January–March, however, with the announcement of the new premium rate in the preceding December, would avoid the confusion that would result if the enrollment process were to be initially based on current law and people had to be informed of the effects of a new law enacted sometime thereafter. Providing for a July 1 effective date for any premium changes found necessary would make the change effective simultaneously with the beginning of coverage for individuals who enroll during the open enrollment periods and would allow people who decide to terminate their enrollment after a premium increase to do so without paying the higher amount in any month.

Under present law, coverage of a person who is enrolled in the supplementary medical insurance program may be terminated in one of two ways: through nonpayment of premiums or through the filing of

a notice during a general enrollment period. People who are receiving monthly social security, railroad retirement, or civil service retirement benefits are unable to terminate their coverage by not paying premiums because such premiums are automatically deducted from their monthly cash benefits. On the other hand, people who are not receiving such monthly benefits may terminate their coverage by not paying their premiums when they are due. The committee believes that people who are receiving monthly cash benefits and who wish to terminate their medical insurance coverage should, like those who are not receiving such benefits, be permitted to withdraw from coverage before a general enrollment period. The committee's bill would, therefore, allow an individual who wishes to disenroll to file a notice to this effect at any time and would provide that the termination of such individual's coverage take place at the close of the calendar quarter following the quarter in which he filed such notice.

Present law also provides that an individual who enrolls in the supplementary medical insurance program more than 12 months after the close of his initial enrollment period will have his premium rate increased by 10 percent for each such 12-month period. The committee's bill would substitute for the provisions increasing the premium by 10 percent for each 12 months of delayed enrollment, a one-time "late enrollment charge" which would be equal to the sum of 2 months' premiums for each full 12 months in which he could have been but was not enrolled. However, in no case could the late enrollment charge exceed the sum of 3 months' premiums.

Under present law a person may not enroll in the supplementary medical insurance program more than 3 years after the close of the first enrollment period during which he could have enrolled, even if the 3-year period ends during a general enrollment period. Under the committee bill, if the 3-year period ends during a general enrollment period (January through March under the bill) his eligibility period would be extended to the end of that enrollment period. The committee bill would thus provide to these persons the full 3-month period following the announcement of a new premium rate to decide about enrolling in the program.

(v) Study of proposed drug legislation

On the basis of the testimony received during public hearings and further discussion in executive session, the committee has agreed to direct the Secretary of Health, Education, and Welfare to investigate, and report to the Congress by January 1, 1969, the effects of proposals for (1) the inclusion of certain prescribed drugs under the supplementary medicare insurance program established by part B, title XVIII, of the Social Security Act; and (2) the establishment of Federal standards of quality and cost of drugs provided to certain individuals under other titles of the act.

Consideration would be specifically given by the Secretary, under the bill, to the following factors:

(1) Price savings which might accrue to the U.S. Government from the enactment of such legislation.

(2) Effects upon all segments of the health professions.

(3) Effects upon all elements of the pharmaceutical industry, including large and small manufacturers of drugs, wholesalers, and retailers of drugs.

(4) Such other medical, economic and social factors as the Secretary determines to be material.

The legislative proposals that would be the subject of study are (1) S. 17, or amendment No. 265 to H.R. 12080, the proposed Social Security Amendments of 1967, with respect to drug benefits under the supplementary medical insurance program and associated quality and cost controls; and (2) S. 2299, or amendment No. 266 to H.R. 12080, with respect to quality and cost controls for drugs provided under other social security programs.

During hearings on these proposals, testimony was presented by officials of the Department of Health, Education, and Welfare, including the Commissioner of the Food and Drug Administration as well as from the Comptroller General of the United States. Witnesses from the professions of medicine and pharmacy, and from the pharmaceutical industry and labor organizations also appeared.

Under this committee amendment, the Secretary would report his findings and conclusions to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives, prior to January 1, 1969.

(*w*) *Evaluation of reimbursement under medicare*

This committee is aware of what may very well be inequities in the formula under which hospitals and extended care facilities are reimbursed under title XVIII. Certainly, it was the intent of the Congress to reimburse such facilities equitably for the actual costs of the care provided to beneficiaries on a basis which takes into account other Federal programs and financial assistance to hospitals and extended care facilities.

In May 1966, the committee held an executive hearing which explored some of the problems and opportunities involved in the reimbursement formula which was initially proposed for the medicare program. The committee was able, with the cooperation of the Secretary, to develop some changes in the reimbursement formula which were designed to protect the public interest as well as that of the various providers of services.

The committee intends to devote early attention to a review of the actual experience with the reimbursement procedures in medicare. Hard data are just starting to come in only now because of the fact that most hospitals are on a fiscal year basis—usually ending on September 30. When this actual experience has been compiled, summarized and analyzed the committee will be in a position to intelligently and constructively evaluate the situation.

The committee is also concerned over reports of alleged abuses including overpayments and overcharges under the medicare and medicaid programs. The committee intends to request the cooperation of appropriate governmental agencies with a view toward determining the extent and nature of any abuse in the two health care programs.

(*x*) *Reimbursement for the services of unpaid hospital workers*

In enacting the medicare law the Congress did not intend that hospitals participating in the medicare program should be reimbursed directly or indirectly for the value of services rendered gratis by volunteers such as those affiliated with the American National Red

Cross, hospital guilds, auxiliaries, and similar organizations. Such services have traditionally been rendered on a purely volunteer basis without expectation of any form of reimbursement being made to the person rendering the service and third parties that reimburse hospitals on the basis of incurred costs have not made any payment to the hospitals for the value of such services.

On the other hand, the value of services traditionally provided by sisters and other members of religious orders under arrangements whereby the hospital actually makes payment to the religious order has generally been reimbursed by third parties which pay hospitals on a cost basis. Such services are properly reimbursable under the medicare program (but not in excess of the prevailing rate for similar services performed by compensated employees) where the volunteer services are performed by individuals whose maintenance is provided for by the religious order which arranged for their services and who regularly work more than 20 hours per week in full-time positions of kinds that are normally occupied by paid personnel in hospitals not operated by or related to religious orders.

While constitutional questions would be raised if considerations of religious sponsorship were to determine which volunteer services to hospitals are reimbursable, such factors as the circumstances under which the volunteers are employed and the financial arrangements existing between the unpaid workers, the sponsoring organization and the hospital should be considered in deciding whether the volunteer services rendered are of a kind that have traditionally been furnished to hospitals on a purely volunteer basis and traditionally been reimbursable by other third parties. The purpose of the medicare program is to follow the usual and customary methods of third parties in compensating or not compensating for such volunteer services.

(y) Qualified health personnel

Pursuant to present law, the Secretary of Health, Education, and Welfare establishes various health and safety criteria as conditions for the participation of providers of services and independent laboratories in the medicare program. In setting these standards, it was necessary to establish criteria for judging the professional competency and the qualifications of key professional personnel in these health facilities. Membership in or registration or certification by certain specialty or professional organizations is the principal accepted means of establishing professional qualifications in health fields. Medicare regulations go beyond these usual tests of qualifications by providing that individuals meeting alternative training and experience requirements may be found to be qualified personnel.

While the committee agrees that the Secretary's health and safety requirements are intended to safeguard the welfare of patients, it is concerned that the reliance placed on specific formal education, training, or membership in private professional organizations might sometimes serve to disqualify people whose work experience and training may make them equally or better qualified than those who meet the existing requirements. Failure to make possible the fullest use of properly trained health personnel is of particular concern because of the shortage of skilled health personnel in several fields.

While the committee recognizes the difficulties involved in determining the qualifications of persons in some of these health professions, it

also believes and expects that the Secretary should engage in consultation with appropriate professional health organizations and State health agencies and, to the extent feasible, explore, develop, and apply appropriate means of determining the proficiency of health personnel disqualified under the present regulations. Moreover, the Secretary should encourage and assist programs designed to upgrade the capabilities of those who are not now sufficiently skilled to qualify in health occupations now in short supply, but who could perform adaquately with relatively little additional training.

(z) *Hospital insurance protection for State and local government employees*

The committee has added to the House bill a provision permitting States and interstate instrumentalities to enter into agreements with the Secretary of Health, Education, and Welfare to purchase hospital insurance protection beginning April 1, 1968, for retirement system members (retired or active) and their wives, husbands, widows, or widowers age 65 or over who do not qualify for the protection under present law.

Social security hospital insurance protection under present law is based upon entitlement to cash benefits: All persons age 65 or over who are entitled to cash benefits under the social security or railroad retirement programs have hospital insurance protection. In addition, many persons who are now near or past retirement age and who are not entitled to such cash benefits (including many State and local government employees and annuitants under State and local retirement systems, and their dependents or survivors) are eligible for hospital insurance protection under a special temporary transitional provision that is financed from general revenues.

Social security coverage is available for employees of the States and their political subdivisions through agreements between the Secretary of Health, Education, and Welfare and the various States. Since about one-fourth of State and local government jobs are covered only under staff retirement systems and not under social security, there are, under present law, a significant number of State and local employees and retired employees, and their dependents or survivors, who will not qualify for hospital insurance protection. Public employees in a number of States have expressed an interest in legislation which would make social security hospital insurance protection available to them even though their work is not covered under social security.

The committee believes that the best way to provide this protection is by the basic method provided under present law—that is, through entitlement to cash benefits based upon contributory social security coverage. However, in view of the fact that this method has failed to provide hospital insurance protection for a fairly large number of State and local government employees, the committee believes that an alternative method of providing it is needed for this group. Under the committee's bill the States and localities could make sure that all persons under a State or local government retirement system and their qualified dependents will have hospital insurance protection by purchasing this protection on a coverage group basis.

For the purpose of providing social security hospital insurance protection, the term "coverage group" would include all individuals who

are annuitants under a State or local retirement system, or all individuals who are members but not annuitants, or the wives, husbands, widows, or widowers of such annuitants or members. Groups other than annuitants could be covered only if annuitants are covered; the wives, husbands, widows, or widowers of members or annuitants could be brought under an agreement only if the members or annuitants are under the agreement. A determination by the State as to whether an individual is an annuitant or member of a retirement system or the wife, husband, widow, or widower of such an annuitant or member would, for purposes of the agreement to provide hospital insurance protection, be final and conclusive upon the Secretary.

The committee bill provides that each State which enters into an agreement with the Secretary of Health, Education, and Welfare to purchase hospital insurance protection will reimburse the Federal Hospital Insurance Trust Fund, at such time or times as the Secretary specifies, for the payments made from the Fund for the services furnished to those persons covered under the hospital insurance program through the State's agreement with the Secretary, 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 payments for other persons entitled to benefits under the hospital insurance program.

The committee bill provides that, upon giving at least 6 months' notice to the Secretary, a State may terminate its agreement either in its entirety or with respect to a coverage group. Terminations would be effective at the end of the calendar quarter specified in the notice. If the Secretary should find that the State has failed or is no longer legally able to comply with any provision of the agreement to provide hospital insurance protection, he would notify the State that the agreement will be terminated in its entirety, or with respect to any one or more coverage groups designated by him.

(*aa*) *Coordination of reimbursement under titles V, XVIII and XIX with States' health facility planning*

Health costs have been rising rapidly during the past several years, and are expected to continue that accelerated rise at least for the next several years. Hospital costs, in particular, have increased at a rate greater than that of any other category of health services. Unnecessary duplication of facilities and investment in excess equipment and plant size are responsible in part for the higher costs—apart from the avoidable demands such unnecessary duplication makes upon scarce health personnel. The work of various State and local planning groups, private health insurance organizations, and others has shown that there is real promise for reducing costs and increasing efficiency through improved health facility planning. Federal legislation—the Partnership for Health Act (Public Law 89–749)—designed to encourage and to increase support for health service planning was enacted by the last Congress. That law includes in its "Findings and declaration of purpose" a statement of public policy:

> The Congress finds that comprehensive planning for health services, health manpower, and health facilities is essential at every level of government * * *

In order to avoid having the medicare and medicaid programs undercut these health planning measures through indiscriminate reimbursement of capital expenditures, which were made contrary to a State's overall health facility plan, provisions have been included in the committee's bill to coordinate reimbursement under the medicare and medicaid programs with State health facility planning under the Partnership for Health Act.

Under the provisions of the bill, the Secretary of Health, Education, and Welfare would utilize the services of State agencies carrying on planning under the Partnership for Health Act, to determine whether substantial capital items purchased or otherwise acquired by a provider of service are in accordance with the overall plan of the State agency. In the case of facilities which are reimbursed on the basis of reasonable costs or reasonable charges or on a basis comparable to such costs or charges, depreciation and interest attributable to substantial capital items found by the State agency not to be in accordance with a State's overall plan would not be includable as a part of the "reasonable cost" or "reasonable charges" of covered services provided to individuals under titles V, XVIII, and XIX. It is intended that a capital item will be considered substantial only if (1) it involves aggregate expenditures of $50,000 or more, or (2) changes the bed capacity of the facility, or (3) significantly changes the services of the facility. It is expected that States will take the steps necessary to assure that the State agencies are informed by health care institutions of proposed substantial capital expenditures in time to determine whether they conform to the overall State plan and make any necessary notification of a finding of nonconformance to the facilities before the expenditures are actually made. In determining whether expenditures of $50,000 or more are involved, expenditures for studies, surveys, designs, plans, working drawings, specifications, and other actions essential to the construction or acquisition of a capital item would be included. Rental and leasing of facilities and equipment would be subject to the planning requirements to prevent the use of such arrangements to avoid the planning requirements.

Existing local and areawide planning agencies would in all likelihood be used extensively by the State agency, and the findings of such agencies could, in many cases, provide the basis for determinations for program purposes. However, such areawide or local planning agencies should be used only where they are determined to be properly representative of the various types of providers affected by their decisions as well as where they provide for appropriate consumer representation. Notwithstanding usage of local planning agencies, final responsibility for approval of capital expenditures affected by this provision of the bill resides with the Partnership for Health agency. The State agency would provide for health-care facility planning in all political subdivisions of the State, assist health care facilities in the State with their programs of planning, and establish proper and orderly procedures for reconsideration of its determinations at the request of a dissatisfied facility. Where a State agency does not specifically disapprove a capital item, the health facility would be free to proceed as it does now.

The planning provisions would be effective with respect to depreciation and interest attributable to items purchased or otherwise acquired after June 30, 1970, or earlier if a State so requested.

8. Other Provisions Relating to the Cash and Health Insurance Programs

(a) Eligibility of adopted child for monthly benefits

The committee bill would provide an alternative to the requirements of present law relating to benefits for a child adopted by the surviving spouse of a worker after the worker died. Under present law a child can get benefits based on the earnings record of a deceased worker who is not his parent only if the child is adopted by the worker's surviving spouse within 2 years after the worker's death. Under the bill benefits could be paid to such child if before his death the worker had initiated proceedings to adopt the child or the child had been placed in the worker's home for adoption.

In some cases, a surviving spouse, due to circumstances beyond her control, is unable to complete within 2 years of the worker's death an adoption started before his death. The committee believes it is reasonable to presume that where the worker initiated adoption proceedings, or the child was placed in the home by an adoption agency, prior to the worker's death, the child lost a source of support on the death of the worker.

The change would be effective beginning in March 1968.

(b) Eligibility of a child for benefits based on his mother's earnings record

Under the present law a child is always considered dependent on his mother if the mother is currently insured (that is if she has approximately 1½ years of covered work in the 3-year period immediately prior to her becoming disabled, reaching retirement age, or dying). If the mother is not currently insured, the child is dependent on her only if: (A) she is contributing at least one-half of the child's support; or (B) she is living with the child or is making regular contributions to the child's support and the child's father is neither living with the child nor making regular contributions to the child's support.

The committee believes that even where a fully insured mother was not gainfully employed immediately before her retirement, disability, or death the family generally suffers a substantial economic loss. In many cases the loss of the mother's earnings that occurs as a result of her retirement, disability or death may have much the same effect on future family income as the loss of the father's income. Therefore, the same general presumptions of dependency ought to be applied for the purpose of paying child's benefits based on the mother's earnings as are now applied for the purpose of paying benefits based on the father's earnings.

Thus, the committee's bill would provide that a child would be deemed dependent on his mother on the same basis as that on which a child is deemed dependent on his father under present law. As a result, the child would always be deemed dependent on his mother if she were fully or currently insured unless the child was legally adopted by another person.

Dependency on a stepmother would be established on the same basis as it is on stepfathers under present law—a child would be dependent on his stepmother if the child is living with the stepmother or if the child is receiving at least one-half of his support from the stepmother.

Where a child is eligible for benefits on the earnings records of two parents, he would be paid the higher of the two benefits, as under present law.

An estimated 175,000 children would be eligible for benefits beginning in March 1968 as a result of this change, and an estimated $85 million would be payable in additional benefits in the first 12 months of operation under the amendment.

(c) *Special saving provision for certain children*

Under present law, because of the provision of the 1965 amendments to the Social Security Act enabling certain illegitimate children to become entitled to benefits, the benefits that were already being paid to a worker's wife or widow and legitimate children have been reduced in some cases.

Under the House bill this situation would have been corrected by providing that the benefits payable to children under the 1965 amendment (sec. 216(h)(3) of present law) would be residual; that is, the benefits payable to such children could not exceed the difference between the sum of all other benefits being paid on the worker's earnings record and the maximum amount payable on that record.

The committee's bill would correct this situation through a saving clause for those beneficiaries who were eligible for benefits before the 1965 amendments. The saving clause would provide that each beneficiary whose benefit was reduced because of the entitlement of one or more children by virtue of the 1965 amendments would receive, for months after February 1968, the benefit to which he would have been entitled had no child become entitled under the 1965 provision. The Senate passed a similar amendment in 1966.

(d) *Overpayments and underpayments*

(1) OVERPAYMENTS

Recovery of overpayments.—Under present law, when a person who has been overpaid is alive the overpayment can be recovered only by withholding subsequent benefits payable to him. If he dies before the overpayment has been recovered, the overpayment can be recovered by withholding subsequent benefits to others getting benefits on the same earnings record. The committee concurs with the recommendation of the General Accounting Office, made in a report to the Congress dated July 25, 1961, that the Secretary of Health, Education, and Welfare should have the authority to recover overpayments of social security benefits to a living person by withholding benefits of other people getting benefits on the same earnings record. Such a provision would put people who are getting benefits on the same earnings record as the overpaid living beneficiary on the same basis as people who are getting benefits on the same earnings record as an overpaid deceased beneficiary. Under the bill the Secretary would have authority, in any case where there has been an overpayment of cash benefits, to recover the overpayment by requiring a refund or by withholding the cash social security benefits of the overpaid person or of other people who are getting benefits on the same earnings record, whether or not the overpaid person is alive.

Waiver of recovery.—Under present law, a beneficiary who is liable for repayment of an overpayment made to another person is denied the opportunity for waiver of recovery of the overpaid amount if the overpaid person was at fault, even though he himself is without fault and otherwise meets all the conditions prescribed in the law for having recovery waived. Under the bill, any beneficiary who is liable for repayment of an overpayment, whether the overpayment was made to him or to another person, would be able to qualify for waiver of recovery of the overpaid amount if he is without fault and if he meets the other conditions prescribed in the law.

These provisions are similar to provisions adopted by the Senate in 1965 but not included in the bill enacted.

(2) UNDERPAYMENTS

The bill would change the provisions of present law governing the payment of cash benefits due a beneficiary who has died and would establish in the law a method of settling claims in similar situations under the supplementary medical insurance program.

Cash benefits.—Under present law, if the amount of cash benefits due a beneficiary at the time he dies is 1 month's benefit or less, it is paid to the surviving spouse who was living in the same household with the deceased beneficiary at the time of his death; where the amount due is greater than 1 month's benefit, or if there is no surviving spouse, payment can be made only to a legal representative of the estate.

The committee recognizes that the present provision gives rise to unnecessary difficulties, particularly where the amount of the unpaid benefits is small. State law governs the procedures for appointing a legal representative of a deceased person's estate, and very few States, even where small-estate statutes are in effect, provide a simple means by which a person can be appointed to act as the legal representative of an estate. The expense of appointing an administrator (for an estate whose only asset may be the unpaid check) may be larger than the amount of the check, and, even where an administrator is appointed and the underpayment is paid, the amount that the claimant finally gets may be severely reduced by the cost of setting up the estate. At the end of September 1967 there were about 152,000 cases in which claims for underpayments had not been paid under the present provision for settling claims for benefits due a beneficiary who has died.

Under the provisions recommended by the committee, these difficulties would be largely avoided by listing in the law an order of priority for settling claims for such underpayments. The order of priority under the committee bill, provides a single uniform rule to replace the two-track priority system recommended by the House. It would apply as follows:

1. Spouse living with the deceased individual at time of his death or spouse not living with the deceased individual but entitled to benefits on the same earnings record.
2. Child entitled to benefits on the same earnings record.
3. Parent entitled to benefits on the same earnings record.
4. Spouse who was neither entitled to benefits on the same earnings record nor living with the deceased individual.
5. Child not entitled to benefits on the same earnings record.

6. Parent not entitled to benefits on the same earnings record.
7. Legal representative of the deceased individual's estate, if any.
8. Person related to the deceased individual by blood, marriage, or adoption and determined by the Secretary to be the proper person to receive the payment due.

Unpaid medical insurance benefits.—Present law provides no direction on how claims for medical insurance benefits should be settled in cases where the beneficiary dies after receiving covered services for which reimbursement is due but before reimbursement has been made to the beneficiary and before an assignment of the benefits has been effected. In the absence of a specific provision in the law, the Social Security Administration has been making payments, in agreement with the provisions of applicable State law, to the legal representative of the deceased beneficiary's estate; in cases where no legal representative has been appointed, the Administration has been making payments to alternative payees provided under administrative procedures. The committee's bill would provide in the law specific directions for settling claims for unpaid medical insurance benefits in these cases.

Under the committee's recommendations, in cases where a beneficiary who has received services for which payment is due him dies, and the bill for such services has been paid (but reimbursement under the medical insurance program has not been made) payment of the medical insurance benefits to the person who paid the bill would be authorized. If the deceased beneficiary is the person who paid the bill, payment would be made to the legal representative of the deceased beneficiary's estate, if any. If payment could not be made to the person who paid bill or if there is no legal representative, payment would be made to relatives of the deceased individual under the same order of priority provided for monthly cash-benefit underpayments. (The House bill provided a different order of priority for making these payments from that provided for paying cash benefit underpayments.)

The bill would also authorize the Secretary to settle claims for unpaid medical insurance benefits in cases where the bill for covered services had not been paid by making payment to the physician (or other supplier of services) who provided the services, but only if the physician (or other provider of health services) agrees to accept the reasonable charge for the services as his full charge.

The changes relating to underpayments and overpayments would be effective on enactment.

(e) *Simplification of computation of primary insurance amount and quarters of coverage in case of 1937–50 wages*

The bill would provide a solution to specific administrative problems that have developed in the social security program by revising the method of computing benefits and determining quarters of coverage based on wages in years prior to 1951 so that electronic data processing, rather than manual, procedures could be used.

Because an annual breakdown of wages earned during the period 1937–50 has not been transferred to magnetic tape (it is now on microfilm) whenever such wages must be considered in figuring a benefit amount a manual examination of the microfilm earnings record for

that period is necessary; this procedure is expensive and time consuming. In order to eliminate the manual processing now required, the bill would modify the benefit computation using pre-1951 wages so that electronic data processing equipment could be used. Under the provisions of the bill, a worker would be deemed to have been paid all the wages credited to his social security account (including military service credits and creditable compensation under the Railroad Retirement Act) for the years 1937 through 1950 in 9 years before 1951 (distributed evenly over the 9 years) if his total wages for those years do not exceed $27,000; if the total pre-1951 earnings exceed $27,000, the earnings would be allocated to the pre-1951 years at the rate of $3,000 a year (the maximum then creditable toward benefits). A formula giving roughly the same effect as the present-law formula of computing benefits plus 14 "increments" would be provided for computations where the period used is the one beginning with 1937. (Under present law the word "increment" describes the 1-percent increase in the basic benefit amount that is given for each year prior to 1951 in which the worker was paid wages of $200 or more.)

The reason for distributing the worker's pre-1951 wages over a minimum of 9 years and for allowing 14 increment years in each case is that with these provisions there would be no deliberalizations of present law and liberalizations would be small in both number and amount. If all of the pre-1951 earnings were allocated over fewer than 9 years and 14 increment years were given in each case, liberalizations could be quite large. If, on the other hand, in such cases earnings were allocated to more than 9 years and increment years in some number less than 14 were given substantial deliberalizations could occur.

In order to further assure that no deliberalizations or excessive liberalizations would occur when the new method of computation is used, the provisions of present law would continue to apply where: (1) the primary insurance amount is figured using the computation provisions in effect before the Social Security Amendments of 1960 (where a period of years shorter than the period required under present law can be used in computations); (2) a worker attained age 21 after 1936 and before 1951 (where less than 9 years of pre-1951 earnings can be used); or (3) years in a period of disability which began before 1951 are excluded in computing the primary insurance amount (where, again, less than 9 years of pre-1951 earnings can be used).

The provision would apply to all computations and recomputations made after enactment. However, it would not apply to benefits payable before 1967 and benefits for people on the benefit rolls generally would not be recomputed under this amendment unless the worker had covered earnings after 1965.

Alternative Method of Determining Quarters of Coverage.—In order to qualify for social security cash benefits, a person must have credit for a specific amount of work under social security.

As in the case where pre-1951 wages must be considered in figuring a benefit amount, whenever a worker's insured status depends on his quarters of coverage in the period 1937–50, a manual examination of the microfilm earnings record is necessary to determine the number of quarters of coverage he has credited in that period. Under the bill, quarters of coverage for that period would be determined on the basis of the worker's total wages in the period, for which information is recorded on magnetic tape; one quarter of coverage would be allotted

for each $400 of total wages before 1951. (No change would be made in the provisions of present law for determining quarters of coverage earned after 1950.)

Use of the alternative method of counting quarters of coverage would be limited to people who need seven or more quarters of coverage in order to be fully insured (men born after 1892 and women born after 1895). The reason for this limitation is to prevent, as much as possible, giving a fully insured status to people not fully insured under present law.

This provision would be effective on enactment.

(f) Definitions of "widow," "widower," and "stepchild"

Under present law the relationship of widow, widower, or stepchild must have existed for at least 1 year if social security benefits based on the spouse's or stepparent's earnings are to be paid. (The 1-year requirement does not apply to the surviving spouse if there are natural or adopted children of the marriage or if the survivor is potentially entitled to benefits on the earnings record of a previous spouse.) The committee's bill would reduce the duration-of-relationship requirements for widows, widowers, and stepchildren of deceased workers from 1 year to 9 months.

The present law contains a 1-year duration-of-relationship requirement which was adopted as a safeguard against the payment of benefits where a relationship was entered into in order to secure benefit rights. While the present requirements have generally worked out satisfactorily, situations have been called to the committee's attention in which benefits were not payable because the required relationship had existed for somewhat less than 1 year. Although some duration-of-relationship requirement is appropriate, a less stringent requirement would be adequate.

The committee's bill would further modify the duration-of-relationship requirements for widows, widowers, and stepchildren of deceased workers to provide an exception to the 9-month requirement applicable to deaths among members of the uniformed services and accidental deaths. Thus, under the bill, the duration-of-marriage requirement would be reduced to 3 months where the insured person was a member of a uniformed service on active duty, or where the worker's death was accidental, unless the Secretary determines that at the time of the marriage the individual could not reasonably have been expected to live for 9 months.

Under the bill, a person suffers accidental death if he receives bodily injuries through "violent, external, and accidental means and, as a direct result of the bodily injuries and independently of all other causes" and dies within 3 months of receiving the bodily injuries. This definition follows those used in private insurance contracts.

The change would be effective for benefits beginning in March 1968.

(g) Elimination of the currently insured requirement for entitlement to husband's and widower's benefits

Under present law, husband's and widower's benefits can be paid only if the husband or widower was actually dependent on his wife at the time she retired, became disabled, or died. It is also required that she be currently insured (that is, if she had at least 1½ years of

covered work within the 3-year period before her retirement, disability or death). A wife, on the other hand, is always able to qualify for benefits based on her husband's earnings.

Because men are not ordinarily dependent on their wives, it seems reasonable to retain the requirement that a husband must show that he was dependent on his wife. If the requirement were removed, the cost of the program would be substantially increased and the additional benefits would be paid chiefly to people, such as retired Government employees, who are getting other public pensions. However, the committee knows of no compelling reason for retaining the currently insured requirement. The fact that a woman supported her husband should be sufficient grounds for paying monthly benefits to him.

An estimated 5,000 husbands and widowers would qualify for benefits beginning in March 1968 under this provision. Benefit payments would be about $3 million in the first 12 months of operation.

(h) *Extension of time for filing reports of annual earnings for the retirement test*

The Social Security Act requires a person whose earnings in a year were large enough to cause him to lose some or all of his benefits to file a report of his earnings not later than the 15th day of the fourth month following the close of the taxable year in which he had the earnings. For most people the report is due on April 15. The law does not provide any way in which the due date may be extended for an individual and requires a penalty for late filing unless the individual can show good cause for the late filing.

In some circumstances an individual knows that he will be unable to file his report on time and he could be expected to ask for an extension of time if there were a provision in the law authorizing it. The committee believes that when a valid reason exists a beneficiary should be allowed a brief extension of time within which to make the required report of his earnings.

This change would be effective upon enactment of the bill.

(i) *Reduced penalties for failure to file timely reports of earnings and certain other events*

Failure to file timely reports of earnings.—Under present law, the first time a beneficiary under age 72 fails to report (for purposes of the retirement test) annual earnings above $1,500, the law imposes a penalty equal to 1 month's benefit. This penalty was established when 1 month's benefit was the smallest amount that could be withheld under the retirement test. Under the provisions of present law, the amount of benefits that can be withheld may be less than 1 month's benefit. The bill would reduce this penalty for the first failure to report such earnings within the specified time to an amount equal to the amount to be withheld but not less than $10.

Failure to file timely reports of other events requiring the withholding of benefits.—The bill would also reduce penalties for failure to report within the required time employment or self-employment outside the United States on 7 or more days in a month by a beneficiary under age 72, and, for a woman getting wife's or mother's benefits because

she is caring for a child, any month in which she does not have the child in her care.

Under present law, failure to report these events results in a penalty of 1 month's benefits for the first offense. For all subsequent offenses the penalty is 1 month's benefits for each month for which benefits are to be withheld. This penalty provision for offenses after the first can produce unduly harsh results.

It is proposed that the penalties for second and subsequent offenses be similar to the penalties for second and subsequent failures to report earnings for purposes of the retirement test—that is, the penalty for a second failure to report would generally be 2 months' benefits, and the penalty for a third or subsequent failure would generally be 3 months' benefits. However, as under the provisions for second and subsequent failures to report earnings, in no case would the amount of the penalty exceed the amount of benefits withheld on account of work or failure to have a child in one's care. Thus, where only 1 month's benefit is to be withheld, the penalty for a second or subsequent failure would be 1 month's benefit, and where only 2 months' benefits are to be withheld, the penalty for a third or subsequent failure would be 2 months' benefits. Generally, the penalty for a second offense would be more stringent than the penalty for a first offense and the penalty for a third offense would be more stringent than the penalty for a second offense.

These changes would be effective upon enactment of the bill.

(j) Limitation on payment of benefits to aliens outside the United States

Under present law, benefits may not be paid to certain aliens after they have been outside the United States for 6 consecutive calendar months. The bill would provide that an alien who has been outside the United States for 30 consecutive days would be considered to be outside the United States until he has been in the United States for 30 consecutive days. Thus, once an alien has been out of the United States for 30 days his benefits would stop 6 months after he left the United States unless he returns to the United States for 30 consecutive days. Under present law, an alien's benefit payments are continued if he returns to the United States for 1 day before the end of the 6-month period.

Under present law, however, benefit payments to aliens who are outside the United States for more than 6 months are not stopped if they have 40 quarters of coverage or if they have resided in the United States for 10 years or more. The committee bill, like the House bill, would provide that these exceptions would not apply to aliens who are citizens of a country that has a social insurance or pension system of general applicability under which benefit payments are not paid to otherwise eligible Americans while they are outside of that country. Also, the exceptions would not apply to citizens of foreign countries that do not have a social insurance or pension system of general applicability if at any time within 5 years prior to the month of enactment or the first month thereafter his benefits are withheld because he is outside the United States and benefits to individuals in that country cannot be paid because of the Treasury ban on payments to Communist-controlled countries discussed below. Under the committee bill this provision would become effective after 1968, rather than 6 months after enactment as under the House bill.

Under present law, the Department of the Treasury is authorized to withhold checks drawn against funds of the United States for delivery in a foreign country if that Department determines that there is no reasonable assurance that the payee will receive the check and will be able to negotiate it for full value. Under this authorization, social security benefit payments have been withheld from beneficiaries in certain Communist-controlled countries. When the beneficiary leaves the country in question, or when conditions in the country change so that the Treasury ban on payments in that country is lifted, retroactive payments covering the period are made to the beneficiary or, if he is dead, to his estate.

The committee bill would provide that if an alien's benefits for months after December 1968 would otherwise be withheld by the Department of the Treasury, the benefits would not be payable, and that any past benefits that are being withheld from aliens for months through December 1968 would not be paid, in the event that payments are resumed, in excess of the last 12 months' benefits or to anyone other than the person from whom they have been withheld or a survivor who is entitled to benefits on the same earnings record. Under the House bill, this provision would have become effective with enactment, rather than the end of 1968.

The committee has been advised that the application of these provisions might create difficulties within the application of certain treaties which were fully consistent with the Social Security Act in effect at the time the treaties were signed and that the provisions might adversely affect foreign relations between the United States and the other countries concerned. Accordingly, the committee bill changes the effective dates, as described above, to permit further study of the proposals and the enactment of further legislation if it is found desirable.

(*k*) *Transfer to Health Insurance Benefits Advisory Council of the functions of the National Medical Review Committee; increase in Council's membership*

Four months after the enactment of the Social Security Amendments of 1965 the Secretary appointed, in accordance with the law, a 16-member Health Insurance Benefits Advisory Council to advise him on general administrative policy and the formulation of regulations. The Council consists of leaders from the health field, not otherwise employed by the Federal Government, and the general public; a majority of the members are physicians. The Department informs the Committee that the Council has been of substantial assistance in the policy development which had to occur with the enactment of the program.

Present law also provides for the Secretary to appoint a nine member National Medical Review Committee to study the utilization of hospital services and other health and medical services covered by the program with a view toward recommending changes in the way in which health services are used and modifications in the administration of the program or in the provisions of law relevant to the utilization of services. This Committee has not been established primarily because its effective operation requires the availability of experience under the new program to serve as a basis for study. The

program has been in operation for not quite 1½ years and significant data on experience under it are only now beginning to emerge.

The committee believes that the functions of the two advisory groups are quite closely related and that it would be desirable to combine them in a single body by transferring the Committee's duties to the Health Insurance Benefits Advisory Council and by repealing the provisions for a National Medical Review Committee. The committee's bill would also increase the membership of the Advisory Council from 16 to 19 members to provide the Council a broader base of experience for meeting its enlarged responsibilities.

(l) Advisory council on social security and timing of reports

Under the committee's bill, an Advisory Council on Social Security would be appointed in 1969 and every fourth year thereafter. Councils would be appointed at any time after the end of January of the specified year, rather than in February, as provided in the House-passed bill, and would be required to report no later than January 1 of the second year after appointment, as under present law, rather than January 1 of the year after appointment as under the House-passed bill. The committee believes that the longer period provided under present law is needed in view of the legislative requirement that the Councils review all aspects of the social security program; it would not be reasonable to expect these councils to make a thorough review and comprehensive recommendations in a period of only 11 months as provided under the House bill.

During the committee's deliberations on the bill, suggestions for improving the investment income of the social security trust funds were brought to the attention of the committee and the committee recommends that the next Council study methods of increasing the interest income to the trust funds including (1) the desirability of continuing to invest trust fund money in participation certificates issued under the Participations Sales Act of 1966, (2) whether adequate statutory authority exists for such investments, (3) whether the trust funds should have priority in the opportunity to make such investments, (4) whether present obligations held by the trust funds which bear interest of less than 4 percent should be redeemed at par and reinvested in securities bearing higher interest rates, and (5) whether decisions about trust fund investments should be guided by the interests of the trust funds or the public interest. Although the committee's bill would not require the next Advisory Council to report until January 1971, any recommendation of the Council that should be brought to the attention of the Congress before that date should be in an interim report to the 91st Congress.

The bill would also provide for the appointment of the Chairman of the Advisory Council by the Secretary of Health, Education, and Welfare. Under present law, the Secretary of Health, Education, and Welfare appoints the 12 members of the Advisory Council on Social Security and the Commissioner of Social Security serves as the Chairman of the Council. During the course of the consideration of the bill in the House, the Commissioner of Social Security suggested that it might be desirable for the Chairman of the Council, like the Council members, to be a person from outside the Government. The committee agrees, and under the bill the Secretary would appoint the

Chairman in addition to appointing the other 12 members of the Council.

(m) Reimbursement of civil service retirement annuitants for certain premium payments under supplementary medical insurance program

The committee's bill, like the House bill, would, upon enactment, permit plans approved under the Federal Employees Health Benefits Act of 1959 to reimburse civil service retirement annuitants for amounts equal to the premiums paid under the supplementary medical insurance program, provided such reimbursement is financed from funds other than the contributions made by the Federal Government and the Federal employees toward the health benefit plan. Under most private insurance plans that have been modified to take account of the medical insurance protection available under medicare, the beneficiary pays an adjusted premium rate that reflects the modified protection he receives. In contrast, annuitants who have enrolled in a Federal employee health benefits plan and who enroll also in the supplementary medical insurance program are not likely to receive additional protection which is equivalent to the additional premiums they must pay. Since the Government plans, unlike private plans, are unable under the Federal Employees Health Benefits Act of 1959 to develop provisions for coordination of their coverage with that provided by the supplementary medical insurance program, annuitants, unlike almost all other aged persons, receive little advantage from the supplementary medical insurance program. By permitting reimbursement of amounts equivalent to the supplementary medical insurance premiums, the bill would remedy these problems and would have the effect of encouraging such annuitants to enroll in the supplementary medical insurance program.

(n) Disclosure to courts of whereabouts of certain individuals

Under present law and regulations the Secretary furnishes, at the request of a State or local public assistance agency, the most recent address in the social security records of a parent (or his most recent employer, or both) who has failed to provide support for his destitute child or children if they are eligible for aid under a public assistance program.

Like the House bill, the committee's bill includes an additional provision under which the Secretary would be required to furnish the most recent address of a deserting parent (or his most recent employer, or both), on request, to a court having appropriate jurisdiction to issue orders against the parent for the support and maintenance of his children, if the court certifies that the information is requested for its own use in issuing, or determining whether to issue, such an order. In addition, the committee's bill would provide that such information could be used by appropriate courts in proceedings under the Uniform Reciprocal Enforcement of Support Act. The information would be furnished to the court regardless of whether the children were applicants for or receiving assistance from a welfare agency. The committee believes that assisting the courts in locating such parents may result in securing from the parents support for their children which would insure that such children would not have to apply for assist-

ance under the Federal-State program of aid to families with dependent children. This provision is related to changes which the committee is recommending in the aid-to-families-with-dependent-children program discussed later in this report.

(o) Reports of the boards of trustees to Congress

Under the present law, the boards of trustees of the old-age and survivors insurance, disability insurance, hospital insurance, and supplementary medical insurance trust funds must submit their reports on the status of each fund for the preceding fiscal year to the Congress by the following March 1. It is becoming increasingly difficult for the boards of trustees to meet the March 1 deadline because information which formerly was available in December is now not available until January. Under the committee's bill, the trustees would have 1 additional month in which to prepare the report, as it would not be due until April 1.

As noted earlier, the committee has become concerned with the rising costs of the disability insurance program. In examining the costs of that program, the committee became aware of rising costs under the old-age and survivors insurance program due to payments made to people with childhood disabilities. Because of the rise in the cost of these benefits and because the benefits to disabled widows that would be provided under the bill would be paid out of the Federal old-age and survivors insurance trust fund, the Congress needs to be kept informed of the cost trends as they develop. Accordingly, the bill would require a separate actuarial analysis of all benefit expenditures made on account of disability payments.

(p) Payments based on erroneous reports of death

Under present law where members of the Armed Forces initially reported to have been killed in action are later discovered to have been captured, any social security benefits paid to their wives and children on the basis of the incorrect report of death issued by the Department of Defense must be considered erroneous payments and are subject to recovery. The committee believes this situation is unduly harsh, not only because it may present serious problems to the family at a time of great stress, but also because under other programs, such as those of the Veterans' Administration, payments made in such circumstances are not subject to adjustment or recovery.

Under the committee's bill payments made on the basis of an erroneous report of death by the Department of Defense would not be considered to be erroneous payments.

This amendment would be effective with regard to people who are paid benefits in or after the month of enactment.

(q) Payment of child's insurance benefits to a full-time student who marries

Under present law, benefits payable to a child are generally terminated when that child marries. The committee believes that a child who is a full-time student and who marries continues to be just as dependent as a child who is an unmarried full-time student, and that to stop benefits just because the child marries is unrealistic. Thus, the

committee's bill would provide that a child's benefit would not be terminated because of marriage if the child is a full-time student. However, benefits payable to a female child who is a full-time student would be terminated if her husband is not also a full-time student, because generally she would be dependent on her husband.

Under the committee's bill, this provision would be effective for March 1968; for any individual who was not entitled to a child's benefit for the month of enactment, benefits under this provision would be paid only on the basis of an application filed in or after the month of enactment.

(r) *Modification of certain eligibility requirements as they apply to aliens so as not to conflict with treaty obligations*

Under present law, at age 65 a person is eligible for protection under the hospital insurance plan of the medicare program if he is entitled to cash social security or railroad retirement benefits. Under a special transitional provision, aged persons not eligible for cash benefits who are now 65 or over or who will attain age 65 prior to 1968 are eligible for such protection provided they are either citizens of the United States or are aliens lawfully admitted for permanent residence who have resided continuously in the United States for at least 5 years before filing an application for hospital insurance benefits. Aged persons are eligible to enroll in the supplementary medical insurance plan if they are eligible for hospital insurance protection or if they meet the same citizenship or residence requirements as apply with respect to eligibility of uninsured persons for hospital insurance.

The provision which restricts medicare protection for aliens who do not qualify on the basis of covered employment to those aliens who meet a 5-year residence requirement was included because the Congress did not intend to provide medicare benefits for persons who were merely visiting in this country or had come here solely to get medical treatment. This restriction, while having its desired effect, has in some instances produced a conflict with the Treaties of Friendship, Commerce, and Navigation which the United States has entered into with other countries; for example, the treaty with the Federal Republic of Germany. Such treaties were fully consistent with the Social Security Act when they were signed and accord reciprocal equal treatment for citizens of either country with regard to the application of laws establishing compulsory systems of social security in the case of sickness.

The committee bill provides exception to the alien residence requirement as it would pertain to citizens of countries with which the United States now has treaty arrangements. (The principle involved here is similar to that involved under title II of the Social Security Act (sec. 202(t)(3)) in the suspension of cash benefits of aliens outside the United States.)

The bill also provides exceptions to the requirement that an alien must be a resident of the United States for 5 years in order to qualify for the special age-72 payments provided in 1966 in cases where a treaty now in effect would otherwise be violated.

Hospital insurance coverage would be retroactive to July 1, 1966, for such nationals who were present in the United States but denied

coverage because they did not meet the residence requirement. On the other hand, coverage under the medical insurance plan would not be retroactive because such coverage is contingent upon factors other than residence; e.g., enrollment and payment of premiums. Coverage under the medical insurance plan could be effective for the month of enactment of the proposal and in accordance with provisions of existing law. The changes applicable to the special age-72 payments would be effective with the month of enactment.

(s) General saving provision

Under a saving clause provided in the bill, the benefit amounts payable to one or more members of a family who were on the benefit rolls in the month before the effective month of the benefit increase will not be reduced under the family maximum provisions of the law, if another family member (1) becomes entitled to benefits for the effective month of the benefit increase and (2) was made eligible for benefits by a provision of the bill. The newly entitled person will be entitled to a benefit equal to the benefit amount he would have gotten for the effective month of the benefit increase if there were no saving clause to protect the benefits of other members of the family—that is, he would get a benefit 15 percent higher than he would have gotten if he had been on the rolls in the previous month. Thus the provision would allow families now getting benefits limited by the family maximum provision to get additional benefits, which would not otherwise be payable, in cases where an additional member of the family qualifies for benefits as a result of a change made by the bill.

(t) Expedited benefit payments

The committee bill contains a provision (not in the House-passed bill) which would provide a formal method under which a person may file a special request for benefit payments which are due but have not been paid.

The committee believes that most beneficiaries are dependent on their social security payments to meet their everyday needs and that assurance of prompt payment is vital to their financial well-being.

The committee recognizes that there are situations in which delays may occur because the Social Security Administration is seeking definitive evidence of eligibility even though there is a prima facie case that a benefit is due the individual. The committee recognizes the desirability of holding erroneous benefit payments to a minimum. However, it believes that in such situations it is desirable for payments to be made, at least on a preliminary basis, with as little delay as possible. The committee bill contains a provision which specifically authorizes such a procedure.

It is important, however, that the Secretary should not be forced into making doubtful payments merely because of the passage of time; therefore, under the bill the individual must have supplied all evidence requested, and the Secretary must be confident of the validity of the claim, before an expedited payment can be made on the basis of a request for payment under the new provision.

Under the bill, in cases involving entitlement to monthly retirement and survivors insurance benefits or the resumption of benefits that have been suspended, a written request for expedited payment may be filed after 90 days have elapsed from the date when the claimant

submitted the last of the evidence requested to show that a payment was due. In a case involving an initially unexplained interruption in benefit payments or the transition from one type of benefit to another, from wife's to widow's benefits for example, a written request for expedited payment may be filed after 30 days have elapsed after the 15th of the month in which such benefit payment was due.

Under the bill, if payments were due they would begin within 15 days after the date of the request for special payment.

The bill would specifically exclude from the new expedited benefit payments procedure cases involving determinations as to whether a person meets the Social Security Act definition of disability for purposes of qualifying for benefits payable on account of disability. In the old-age and survivors insurance part of the program the issues involved are usually those that affect the amount of the benefit or the date for which payment is first due; in most cases, the basic question of entitlement is not at issue. Therefore, erroneous payments in the old-age and survivors insurance part of the program can usually be adjusted at a later point.

In the case of benefits based on a disability the usual issue is the basic question of whether or not the individual is sufficiently disabled to be entitled to a payment at all. The process of making disability determinations is significantly different from the retirement and survivors insurance claims process. In the disability process State vocational rehabilitation agencies are involved importantly in the making of the decision and in borderline cases lengthy and extensive development of facts of a medical nature is often required. Because the Secretary should be reluctant to make a favorable finding of basic eligibility in the disability area on the basis of partial evidence, the expedited payment procedure is not provided in disability cases.

Also excluded from the expedited benefit payment procedure are the cases where checks for the benefit involved have been negotiated. If this occurs it is necessary to consider the possibility of forgery or fraud.

This provision would be effective after June 30, 1968.

(u) Separate authorization for social security research programs

Under the present law, the cooperative research and demonstration grant programs carried on by the Social Security Administration and the Social and Rehabilitation Service of the Department of Health, Education, and Welfare are authorized as a single program. The committee has been informed that this has resulted in certain administrative difficulties. Therefore, the committee added to the House bill a provision under which there would be specific authorizations for cooperative research and demonstration grant programs for both the Social Security Administration and the Social and Rehabilitation Service. (As under present law, there would be a single authorization for appropriations and the amendment would not increase the funds available for these research programs.)

9. Financing Provisions

(a) Increase in the contribution and benefit base

The proposed increase in the contribution and benefit base would not only provide higher future benefits at higher earnings levels, but

would also help to finance the changes made by the bill. When the contribution and benefit base is raised, 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 income 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 contributions on earnings above the former maximum and up to the new maximum amount.

(b) Changes in the contribution rates

Consistent with the policy of maintaining the program on a financially sound basis that has always been followed in the past, the bill would make full provision for meeting the cost of the improvements it would make in the program. At the present time, the social security program as a whole has a significantly favorable actuarial balance although the disability insurance program has an actuarial deficiency; that is, it is expected that over the long-range future the income to the program will considerably exceed the costs of the program. It is possible to meet about half of the cost of the recommended cash benefit changes from the present favorable balance of that part of the program. The remainder of the cost of the proposed changes would be met through an increase in the contribution rates for the program, as well as in the maximum amount of annual earnings subject to the tax and used in computing benefits.

Under the schedule of old-age, survivors, and disability insurance contribution rates that the committee recommends (shown below), the employee-employer rate scheduled for 1968 would be decreased 0.1 percent, from 3.9 percent each to 3.8 percent each. The rate for 1969–70 would be 4.2 percent. The rate scheduled for 1971–72 would be increased 0.20 percent, from 4.4 percent each to 4.60 percent each. For 1973–75 the employee contribution rate would be 5.0 percent each instead of 4.85 percent each, as under present law. The rate for 1976 and after would be 5.05 percent.

The self-employed rate scheduled for 1968 for the cash benefit part of the program would be decreased 0.1 percent, from 5.9 percent to 5.8 percent, and the rate for 1969–70 would be 6.3 percent instead of 6.6 percent (as under present law. The rate scheduled for 1971–72 would be increased 0.3 percent, from 6.6 percent to 6.9 percent. For 1973 and after the rate would be 7 percent) as under present law.

The committee also recommends changes in the contribution rate schedule for the hospital insurance program resulting in a higher rate over the next few years and a lower ultimate rate than under present law. Under the bill, the contribution rate for 1968–72 would be increased to 0.6 percent and would then rise gradually to an ultimate rate of 0.75 percent in 1980 and thereafter. (The rate under present law for 1968–72 would be 0.5 percent and would rise to an ultimate rate of 0.8 for 1987 and thereafter.)

The contribution rate schedules under present law, under the House bill, and under the committee bill are as follows:

(In percent)

Period	OASDI			HI			Total		
	Present law	House bill	Committee bill	Present law	House bill	Committee bill	Present law	House bill	Committee bill
	Employer-employee, each								
1968	3.9	3.9	3.8	.5	.5	.6	4.4	4.4	4.4
1969–70	4.4	4.2	4.2	.5	.6	.6	4.9	4.8	4.8
1971–72	4.4	4.6	4.6	.5	.6	.6	4.9	5.2	5.2
1973–75	4.85	5.0	5.0	.55	.65	.65	5.4	5.65	5.65
1976–79	4.85	5.0	5.05	.6	.7	.65	5.45	5.7	5.7
1980–86	4.85	5.0	5.05	.7	.8	.75	5.55	5.8	5.8
1987 and after	4.85	5.0	5.05	.8	.9	.75	5.65	5.9	5.8
	Self-employed								
1968	5.9	5.9	5.8	.5	.5	.6	6.4	6.4	6.4
1969–70	6.6	6.3	6.3	.5	.6	.6	7.1	6.9	6.9
1971–72	6.6	6.9	6.9	.5	.6	.6	7.1	7.5	7.5
1973–75	7.0	7.0	7.0	.55	.65	.65	7.55	7.65	7.65
1976–79	7.0	7.0	7.0	.6	.7	.65	7.6	7.7	7.65
1980–86	7.0	7.0	7.0	.7	.8	.75	7.7	7.8	7.75
1987 and after	7.0	7.0	7.0	.8	.9	.75	7.8	7.9	7.75

Note: Maximum taxable earnings base under present law is $6,600. Maximum taxable earnings base under House bill is $7,600, beginning in 1968. Maximum taxable earnings base under committee bill is $8,000 in 1968, $8,800 in 1969–71, and $10,800 in 1972 and after.

10. Actuarial Cost Estimates for the Hospital Insurance System

(a) Summary of actuarial cost estimates

The hospital insurance system, as modified by the committee-approved bill, has an estimated cost for benefit payments and administrative expenses that is in long-range balance with contribution income. It is recognized that the preparation of cost estimates for hospital 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 newly established but also because of the greater number of variable factors involved in a service-benefit program than in a cash-benefit one. However, the committee believes that the present cost estimates are made under conservative assumptions with respect to all foreseeable factors.

The present cost estimates are based on considerably higher assumptions as to hospital costs than were the original estimates, which were prepared in 1965 at the time that the system was established. At that time, the sharp increases that have occurred in such costs in 1966–67 were not generally predicted by experts in the field. The current assumptions are based on the testimony of several experts, as will be discussed subsequently.

These cost estimates also contain revised assumptions as to the initial level of earnings in 1966 and as to future interest-rate trends. These assumptions are the same as those used in the revised cost estimates for the old-age, survivors, and disability insurance system, described elsewhere in this report. Also, the new cost estimates for the hospital insurance system are based on the revised estimates of beneficiaries aged 65 and over under the old-age, survivors, and disability insurance program. The latter show somewhat fewer aged beneficiaries relative to the covered population with respect to whom contributions are payable; accordingly, the cost of the hospital insurance

system is reduced on account of this factor (although only partly offsetting the effect of hospital-cost trend assumptions).

The new cost estimates contain the assumption that, in the intermediate-cost estimate, administrative expenses will be 3½ percent of the benefit payments, which is the anticipated experience in 1967–68 (as against the assumption of 3 percent in the original estimates). The administrative expenses for the low-cost and high-cost estimates are assumed to be the same proportion as in the intermediate-cost estimate.

The new cost estimates also take into account the small additional cost arising from the reimbursement bases for hospitals and extended care facilities that are now in effect being somewhat higher than was assumed in the original cost estimates.

The cost estimates presented here are developed on the same bases as those that were used in the committee report for the bill that was approved by the House of Representatives (H. Rept. 544), with one exception. At the hearings before the committee on August 24, 1967, in answer to a question put by Senator Williams of Delaware, the Chief Actuary of the Social Security Administration stated that the original estimate for the extended care facility benefit—$25 to $50 million for calendar 1967—was low since actual experience indicated that the figure would probably be of the magnitude of $250 to $300 million a year. (Hearings, page 371.)

Unlike the cost estimate presented in the House report, the estimates in this report (in the text and pertinent tables for present law, the House bill, and the committee bill) reflect the new cost assumptions based on the actual experience. The increased cost so included is about $250 million in 1967 for insured persons, and increasing amounts in later years. There would also be a proportionate increased cost for the uninsured. For more details on this change in actuarial cost assumption, see pp. 115–116.

(*b*) *Financing policy*

(1) FINANCING BASIS OF COMMITTEE-APPROVED BILL

The contribution schedule contained in the committee-approved bill for the hospital insurance program, under an $8,000 base in 1966, an $8,800 taxable earnings base in 1969–71, and $10,800 in 1972 and after, is as follows, as compared with that of present law (with an earnings base of $6,600) and with that of the House-approved bill (with an earnings base of $7,600 in 1968 and after):

[In percent]

Calendar year	Combined employer-employee rate			Self-employed rate		
	Present law	House-approved bill	Committee-approved bill	Present law	House-approved bill	Committee-approved bill
1967	1.0	1.0	1.0	0.50	0.50	0.50
1968	1.0	1.0	1.2	.50	.50	.60
1969–72	1.0	1.2	1.2	.50	.60	.60
1973–75	1.1	1.3	1.3	.55	.65	.65
1976–79	1.2	1.4	1.3	.60	.70	.65
1980–86	1.4	1.6	1.5	.70	.80	.75
1987 and after	1.6	1.8	1.5	.80	.90	.75

The combined employer-employee rate under the committee-approved bill would be 0.2 percent higher in 1968–75 than under present law, 0.1 percent higher in 1976–86, and 0.1 percent lower in 1987 and after. These increases, along with the additional income from the higher earnings bases, would finance the increased cost of the present program that results from the higher hospitalization-cost assumptions used in the current estimates, as compared with those used when the program was initiated in 1965. The lower ultimate rate is possible because of the higher earnings bases under the committee bill. Except in 1968, the committee-approved bill has the same or lower rates than the House-approved bill; this is primarily due to the financing effect of the higher earnings bases under the committee-approved bill.

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 wihholding 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).

(2) SELF-SUPPORTING NATURE OF SYSTEM

Just as has always been the case in connection with the old-age, survivors, and disability insurance system, the committee has very carefully considered the cost aspects of the 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.

(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 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 long-range trends of medical care costs and practices. For this reason, cost estimates for the hospital insurance program have been projected for only 25 years into the future, rather than 75 years as in the cost estimates for the old-age survivors, and disability insurance system.

In a new program such as hospital insurance, it seems desirable to the committee that the program should be completely in actuarial balance. In order to accomplish this result, the committee has 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 1954 and up through 1966.

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

[In percent]

Year	Increase over previous year	
	Average wages in covered employment [1]	Average daily hospitalization costs [2]
1955	3.8	6.3
1956	5.7	4.5
1957	5.5	7.7
1958	3.3	8.6
1959	3.3	6.8
1960	4.3	6.8
1961	3.1	8.5
1962	4.2	5.3
1963	2.4	5.6
Average for 1954–63 [3]	4.0	6.7
1964	3.1	6.9
1965	1.6	7.0
1966	4.4	8.3

[1] Data are for calendar years (based on experience in first quarter of year).
[2] Data are for fiscal years ending in September of year shown. When the data are adjusted on a calendar-year basis, the increase from 1965 to 1966 was determined to be 11.0 percent.
[3] Rate of increase compounded annually that is equivalent to total relative increase from 1954 to 1963.

The annual increases in earnings are based on those in covered employment under the old-age, survivors, and disability insurance system as indicated by first quarter taxable wages, which by and large are not affected by the maximum taxable earnings base. The data on increases in 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 10-year period up through 1963, although there were not very large deviations from the average annual rate of 4 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 6.7 percent.

During the period 1954–63, 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 2.7 percent.

In 1964–66, the increases in hospital costs as compared to the increase in wages resulted in differentials somewhat in excess of the 2.7 percent applicable in 1954–63. The 1967 experience to date shows a slightly higher rate of increase in hospital costs than did 1966.

The committee was advised by the Department of Health, Education, and Welfare that, in the future, earnings are estimated to increase at a rate of about 3 percent per year. It is much more difficult to predict what the corresponding increase in hospital costs will be.

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

For these reasons, the following cost estimates are based on the assumption that both hospital costs and wages will increase in the future for the entire 25-year period considered, while at the same time the earnings base will not change from the $8,000, $8,800, and $10,800 bases proposed in the committee bill. The fact that, under both present law and the committee bill, the cost-sharing provisions (the initial hospital deductible and coinsurance features) are on a dynamic basis, which automatically varies after 1968 in accordance with changes in hospital costs, results in lower estimated costs than if these provisions were on a static, unchanging basis.

(3) ASSUMPTIONS AS TO RELATIVE TRENDS OF HOSPITAL COSTS AND EARNINGS UNDERLYING COST ESTIMATE FOR COMMITTEE-APPROVED 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. 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 of hospital-utilization and medical-practice experience will be in the distant future.

Several estimates of the short-term future trend of hospital costs have been made by experts in this field. All of these are well above the rate of 5.7 percent per year until 1970 that was assumed in the initial cost estimates for the program made when it was enacted in 1965. The American Hospital Association has estimated an annual rate of increase of as much as 15 percent for the next 3 to 5 years. The Blue Cross Association has made a corresponding estimate of 9 percent per year in the period up to 1970.

Three sets of assumptions as to the short-term trend of hospital costs have been made for the cost estimates presented here. These are shown in table B. In each case, the annual rates of increase are assumed to merge with those used in the initial cost estimates for the program for 1971 for the low-cost and intermediate-cost assumptions and 1973 for the high-cost assumptions—namely, increases slightly above the increases in the earnings level from these dates until about 1975, and then the same increases. The low-cost set of assumptions

yields about the same result as the Blue Cross prediction, while the high-cost set corresponds to the highest American Hospital Association prediction. The intermediate-cost set is used to develop the financing provisions of the committee's bill.

TABLE B.—ASSUMPTIONS AS TO FUTURE RATES OF INCREASE IN HOSPITAL COSTS

(In percent)

Calendar year	Low cost	Intermediate cost	High cost
1967	12.0	15.0	15.0
1968	10.0	15.0	15.0
1969	8.0	10.0	15.0
1970	6.0	6.0	15.0
1971	5.2	5.2	15.0
1972	4.6	4.6	10.0
1973	4.1	4.1	4.1
1974	3.6	3.6	3.6
1975 and after	3.0	3.0	3.0

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

The hospital utilization rates used for the cost estimates for the committee-approved bill are the same as those used in the initial cost estimates for the program. Analysis of the actual experience for the first 6 months of operation (the last half of 1966) seems to indicate that it is close to the original assumptions.

(5) ASSUMPTIONS AS TO HOSPITAL PER DIEM RATES UNDERLYING COST ESTIMATES FOR COMMITTEE-APPROVED BILL

The average daily cost of hospitalization that is used in these cost estimates is computed on the same basis as the corresponding figures in the initial cost estimates that were prepared when the legislation was enacted in 1965. Specifically, an average of about $38.50 per day was used for 1966 and was projected for future years in the manner described previously. Analysis of the experience for 1966, for which complete data are not yet available, indicates that this assumption was close to what actually occurred.

(6) ASSUMPTIONS AS TO EXTENDED CARE FACILITY BENEFITS UNDERLYING COST ESTIMATES FOR COMMITTEE BILL

The limited experience that is available to date in regard to the extended care facility benefits indicates that their cost will be considerably in excess of the initial estimates. It now appears that these benefits will amount to about $250 to $300 million in the first year of operation (calendar year 1967) as against the estimate of $25 to $50 million. The apparent major reason for this difference is the much larger number

of facilities that qualified than had been expected according to the estimate. It should also be recognized that the original estimate was made on the basis of relatively little data, since this type of benefit had not been widely provided previously.

Accordingly, the cost estimates have been modified by increasing the estimated benefit outgo in 1967, as presented in previous cost estimates, by $250 million with respect to insured persons (and a proportionate amount for noninsured persons). This figure is increased in each future year up through 1975 by the assumed increases in hospitalization costs. After 1975, the same assumption as to hospitalization-cost increases is continued, but the resulting figure is gradually scaled down until it is taken as zero for 1990 (since the estimate for that year already includes the ultimate costs for extended care facility benefits). Appropriate corresponding assumptions are made for the noninsured group, taking into account its decreasing size (as well as its greater relative use of the extended care facility benefits).

(d) Results of cost estimates

(1) SUMMARY OF COST ESTIMATE FOR COMMITTEE-APPROVED BILL

Under the intermediate-cost assumptions as to the future trend of hospital costs, the level-cost of the benefits and administrative expenses under present law is estimated at 1.54 percent of taxable payroll. If the low-cost assumptions were used, the corresponding figure is 1.40 percent of taxable payroll, while under the high-cost estimate, it is 2.37 percent of taxable payroll. In each instance, the level-equivalent of the graded contribution schedule is 1.23 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 0.31 percent of taxable payroll for the intermediate-cost estimate. It may be noted that if the only change made in the program were to increase the earnings base to the $8,000 to $10,800 schedule in the committee bill, then the program would be in almost exact actuarial balance according to the intermediate-cost assumptions.

Under the committee-approved bill, there would be additional financing for the program, both through the increase in the earnings base, effective in 1968, and through increasing the rates in the contribution schedule in the period before 1987. The changes in the benefit provisions would have a relatively small effect on costs. Under the intermediate-cost estimate, the level-cost of the benefits and administrative expenses would be increased from 1.54 percent of taxable payroll under present law to 1.55 percent of taxable payroll under the committee-approved bill when measured on a $6,600 earnings base, but when measured against the earnings bases in the committee-approved bill, it would be brought back to 1.23 percent of taxable payroll. Thus, the new contribution schedule (which has a level-equivalent value of 1.34 percent of taxable payroll) would, under the intermediate-cost estimate, adequately finance the revised benefits and, in fact, would leave a small positive actuarial balance.

It should be noted that, under the revised assumptions with respect to the extended care facility benefts (described previously), the level-cost of the benefit payments and administrative expenses under the

House-passed bill became 1.41 percent of taxable payroll (increased from 1.35 percent). Since the level equivalent of the contribution schedule is estimated at 1.41 percent of taxable payroll, the system under the House-passed bill is in exact actuarial balance according to the revised assumptions.

(2) LEVEL-COSTS OF HOSPITAL AND RELATED BENEFITS

Table C shows changes in the actuarial balance of the hospital insurance system, expressed in terms of estimated level-costs as a percentage of taxable payroll (measured over the 25-year period, beginning January 1, 1966, which was the inception date of the program insofar as contribution collections are concerned), resulting from the changes made by the committee-approved bill. It should be recognized that the vast majority of the level-cost of the benefit payments relates to inpatient hospital benefits. Most of the remaining cost is attributable to extended care facility benefits, with home health service benefits representing only a small portion. Currently, inpatient hospital benefits account for about 90 percent of total benefit outgo. In later years, it seems quite possible that there will be much greater use of posthospital extended care services and posthospital home health services (particularly the former), thus tending to reduce the use of hospitals and, therefore, the cost of the inpatient hospital benefits.

The estimated level-cost of the system is reduced by 0.01 percent of taxable payroll as a result of transferring the outpatient diagnostic benefits to the supplementary medical insurance system. The estimated level-cost of providing a lifetime "reserve" of 60 additional days of inpatient hospital benefits with the same daily coinsurance as for the 61st to 90th days in a spell of illness is estimated at 0.01 percent of taxable payroll. The other changes in the benefit provisions of this program would not have any significant effect on the long-range costs.

TABLE C.—CHANGES IN ACTUARIAL BALANCE OF HOSPITAL INSURANCE SYSTEM, EXPRESSED IN TERMS OF ESTIMATED LEVEL-COST AS PERCENT OF TAXABLE PAYROLL, BY TYPE OF CHANGE, INTERMEDIATE-COST ESTIMATE, PRESENT LAW, AND COMMITTEE BILL, BASED ON 3.75 PERCENT INTEREST

[In percent]

Item	Level-cost
Level cost of benefit payments,[1] present law:	
Original estimate	1.23
Revised estimate	1.54
Increase in earnings base	−.31
Transfer of outpatient diagnostic benefits to SMI	−.01
Lifetime reserve of 60 additional inpatient hospital days	+.01
Revised contribution schedule	−.11
Total effect of changes in bill	−.42
Actuarial balance under present law, original estimate	.00
Actuarial balance under present law, revised estimate	−.31
Actuarial balance under committee bill	+.11
Net level cost of benefit payments[1] under committee bill	1.23
Net level equivalent of contributions under committee bill	1.34

[1] Including administrative expenses.

As indicated previously, one of the most important assumptions in the cost estimates presented herein is that the earnings base is assumed to remain unchanged after rising to $8,000 in 1968, to $8,800 in 1969, and then to $10,800 in 1972, even though for the remainder of the

period considered (up to 1990) the general earnings level is assumed to rise at a rate of 3 percent annually. If the earnings base does rise in the future to keep up to date with the general earnings level, then the contribution rates required would be lower than those scheduled in the committee-approved bill. In fact, if this were to occur, the steps in the contribution schedule beyond the combined employer-employee rate of 1.2 percent would not be needed.

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 or in the following discussions of the progress of the hospital insurance trust fund. A later portion of this section, however, discusses these costs for the blanketed-in group.

(3) FUTURE OPERATIONS OF HOSPITAL INSURANCE TRUST FUND

Table D shows the estimated operation of the hospital insurance trust fund under the committee-approved bill and under present law under the intermediate-cost estimate. According to this estimate, under the committee-approved bill, the balance in the trust fund would grow steadily in the future, increasing from about $1.1 billion at the end of 1966 to $3.9 billion 5 years later; over the long range, the trust fund would build up steadily, reaching $36 billion in 1990 (representing the disbursements for 3.3 years at the level of that time).

Under the intermediate-cost estimate for present law (including the financing on the basis of the $6,600 earnings base and the lower contribution rates than in the committee-approved bill), the hospital insurance trust fund reaches a peak of $1.3 billion in 1967; then, it decreases, being exhausted in 1970. This trend results from the assumption that hospital costs are now hypothesized to rise much more rapidly than in the initial cost estimates for the program that were made in 1965, which showed the system to be in exact actuarial balance.

TABLE D.—ESTIMATED PROGRESS OF HOSPITAL INSURANCE TRUST FUND INTERMEDIATE-COST ESTIMATE

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Interest on fund	Balance in fund at end of year
			Actual data		
1966	$1,911	$767	[1] $57	$34	$1,121
			Estimated data, committee-approved bill		
1967	$2,943	$2,683	$94	$45	$1,332
1968	4,051	3,208	112	68	2,129
1969	4,396	3,655	128	103	2,839
1970	4,604	4,003	140	129	3,422
1971	4,790	4,314	151	148	3,888
1972	5,263	4,626	162	167	4,523
1973	5,993	4,937	173	189	5,598
1974	6,245	5,244	184	207	6,644
1975	6,497	5,551	194	221	7,660
1980	9,009	6,978	244	400	13,957
1985	10,458	8,738	306	684	25,404
1990	11,968	10,905	382	998	36,026
			Estimated data, House-approved bill		
1967	$2,943	$2,683	$94	$45	$1,332
1968	3,332	3,190	112	48	1,413
1969	4,120	3,636	127	56	1,823
1970	4,348	3,982	139	69	2,119
1971	4,518	4,292	150	76	2,271
1972	4,680	4,602	161	76	2,263
1973	5,216	4,912	172	78	2,474
1974	5,442	5,216	183	81	2,598
1975	5,627	5,522	193	81	2,591
1980	7,982	6,940	243	121	4,271
1985	9,103	8,690	304	246	7,376
1990	11,441	10,843	380	363	10,693
			Estimated data, present law		
1967	$2,943	$2,683	$94	$45	$1,332
1968	3,150	3,208	112	43	1,205
1969	3,274	3,655	128	26	722
1970	3,394	4,003	140	[2]	[2]
1971	3,516	4,314	151	[2]	[2]
1972	3,637	4,626	162	[2]	[2]
1973	4,100	4,937	173	[2]	[2]
1974	4,270	5,244	184	[2]	[2]
1975	4,405	5,551	194	[2]	[2]
1980	6,379	6,978	244	[2]	[2]
1985	7,231	8,738	306	[2]	[2]
1990	9,172	10,905	382	[2]	[2]

[1] Including administrative expenses incurred in 1965.
[2] Fund exhausted in 1970.

Note: The transactions relating to the noninsured persons, the costs for whom is borne out of the general funds of the Treasury, are not included in the above figures. The actual disbursements in 1966, and the balance in the trust fund by the end of the year, have been adjusted by an estimated $174,000,000 on this account.

In calendar year 1968, benefit disbursements under the committee bill, according to the intermediate-cost estimate, would be about the same as under present law (because the transfer of the outpatient diagnostic benefits to the supplementary medical insurance program reduces outgo about the same amount as the changes increasing the cost of the program increase outgo). At the same time, as a result of the increase in the taxable earnings base to $8,000 and the increase in the contribution rate, contribution income under the committee bill would be about $900 million higher than under present law.

Table E shows the estimated operation of the hospital insurance trust fund under the committee bill under the low-cost and high-cost estimates. Under the low-cost estimate, the balance in the trust fund grows steadily, reaching $11 billion in 1975 and $57.4 billion in 1990 (at which time it represents the disbursements for 5.6 years). In actual practice, if the low-cost assumptions materialize, it would not be necessary to increase the contribution rates after 1975 as is done in the committee's bill.

Under the high-cost estimate, which represents probably the most extreme situation from a high-cost standpoint in regard to hospital costs, the balance in the trust fund under the committee bill reaches a maximum of $2.8 billion at the end of 1970 and then decreases until being exhausted in 1974. This estimate indicates that, despite very high assumptions as to the trend of hospital costs, the system would have sufficient funds to maintain operations for at least 5 years under these circumstances, without changing the financing provisions.

TABLE E.—ESTIMATED PROGRESS OF HOSPITAL INSURANCE TRUST FUND, UNDER SYSTEM AS MODIFIED BY COMMITTEE BILL, LOW-COST AND HIGH-COST ESTIMATES

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Interest on fund	Balance in fund at end of year
			Low-cost estimate		
1967	$2,943	$2,614	$92	$47	$1,405
1968	4,051	2,997	105	75	2,429
1969	4,396	3,354	117	120	3,474
1970	4,604	3,655	128	161	4,446
1971	4,790	3,953	138	197	5,342
1972	5,263	4,238	148	235	6,454
1973	5,993	4,522	158	286	8,053
1974	6,245	4,802	168	344	9,672
1975	6,497	5,081	178	400	11,310
			High-cost estimate		
1967	$2,943	$2,683	$94	$45	$1,332
1968	4,051	3,208	112	66	2,129
1969	4,396	3,815	134	192	2,768
1970	4,604	4,525	158	104	2,793
1971	4,790	5,320	186	85	2,162
1972	5,263	5,992	210	47	1,270
1973	5,993	6,397	224	13	655
1974	6,245	6,799	238	(1)	(1)
1975	6,497	7,200	252	(1)	(1)

[1] Fund exhausted in 1974.

Note: The transactions relating to the noninsured persons, the cost for whom is borne out of the general funds of the Treasury, are not included in the above figures.

(e) *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 for almost all other persons aged 65 and over in 1966 (and for many of those attaining this age in the next few years) who are not insured under either of these two social insurance systems. Such benefit protection is provided to any person aged 65 before 1967 who is not eligible as an old-age, survivors, and disability insurance or railroad retirement beneficiary, except for certain 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 and except for certain short-residence aliens.

Under present law, persons meeting such conditions who attain age 65 before 1968 also qualify for the hospital benefits, while those attaining age 65 after 1967 must have some old-age, survivors, and disability insurance or railroad retirement coverage to qualify—namely, 3 quarters of coverage (which can be acquired at any time after 1936) for each year elapsing after 1965 and before the year of attainment of age 65 (e.g., 6 quarters of coverage for attainment of age 65 in 1968, 9 quarters for 1969, etc.) This transitional provision "washes out" under present law for men attaining age 65 in 1974 and for women attaining age 65 in 1972, since the fully insured status requirement for monthly benefits for such categories is then no greater than the special-insured status requirement.

Under the committee-approved bill, these requirements for noninsured persons would be liberalized. Such persons attaining age 65 in 1968 would need only 3 quarters of coverage, 1969 attainments would need only 6 quarters of coverage, etc. The "wash out" points would be for men attaining age 65 in 1975 and women attaining age 65 in 1974. This change would make an additional 5,000 persons who attain age 65 in 1968 eligible for hospital benefits.

The benefits for the noninsured group would be paid from the hospital insurance trust fund, but with simultaneous reimbursement therefor from the general fund of the Treasury on a current basis, or if not simultaneous, with appropriate interest adjustment.

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

	Present law	Committee bill
Calendar year:		
1966 (last 6 months, estimate based on actual experience)	$174	$174
1967	439	439
1968	468	468
1969	474	474
1970	462	462
1971	434	434
1972	405	405

The estimated cost to the general fund of the Treasury decreases slowly after 1969 for the closed group involved. Offsetting, in large part, the decline in the number of eligibles blanketed-in are the increasing hospital utilization per capita as the average age of the group rises and the increasing hospital costs in future years. It may be noted that the cost is estimated to be the same under the committee bill as under present law, because the cost effect of the changes made by the committee bill is relatively negligible (see the previous discussion of table C).

11. Actuarial Cost Estimates for the Voluntary Supplementary Medical Insurance System

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

The committee-approved bill has expanded somewhat the protection provided by the supplementary medical insurance program. The only changes that are significant from a cost standpoint are (1) the transfer of the outpatient diagnostic benefits from the hospital insurance program to this program (except for the professional component thereof, which has always been included in the supplementary medical insurance program), (2) making the deductible and coinsurance provisions inapplicable to the professional component of pathology and radiology services furnished to inpatients in hospitals, (3) covering the services of chiropractors, and (4) extending the coverage of physical therapy benefits outside of hospitals.

The increase in cost for these changes, which would be effective after March 1968, will be recognized by the Secretary of Health, Education, and Welfare in his determination of the standard premium rate for April 1968 through June 1969, which in accordance with the provisions of present law, as modified by the committee-approved bill, will be promulgated before January 1, 1968, along with a statement of the actuarial assumptions and bases underlying the determined premium rate.

(*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 March 1968, the premium rate is established at $3 per month, so that the total income of the system per participant per month is $6. Persons who do not elect to come into the system at as early a time as possible will generally have to pay an additional charge on enrollment, under the provisions of the committee-approved bill. The standard monthly premium rate can be adjusted for periods after March 1968 so as to reflect the expected experience, 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.

Under present law, the standard premium rate (for persons enrolling in the earliest possible enrollment period) is generally to be established for 2-year periods in the future—namely, for April 1968 through December 1969 and then for each following 2-calendar-year period. Under the committee bill, this basis would be changed to an annual one on a permanent basis—namely, for April 1968 through June 1969 and then for 12-month periods beginning with July 1969 and each July thereafter. Thus, the premium periods will not correspond with the benefit periods, which are on a calendar-year basis. This will make the actuarial analysis underlying the promulgation of the premium rates more difficult. It will probably be necessary first to compute the estimated premium rates on calendar-year bases and

then to prorate them for the applicable premium period. For example, under this procedure, the premium rate to be determined for the period July 1969 through June 1970 would be the average of the premium rates estimated to be suitable for calendar years 1969 and 1970 (if the premium period had been on that calendar-year basis).

The present law provides for the establishment of an advance appropriation from the general fund of the Treasury that will serve as an initial contingency reserve in an amount equal to $18 (or 6 months' per capita contributions from the general fund of the Treasury) times the number of individuals who were estimated to be eligible for participation in July 1966. This amount, which is approximately $345 million (of which $100 million has actually been appropriated), has not actually been transferred to the trust fund and will not be transferred unless, and until, some of it would be needed. This contingency amount is available only during the first 18 months of operations (July 1966 through December 1967), and any amounts actually transferred to the trust fund would be subject to repayment to the general fund of the Treasury (without interest).

Under the committee-approved bill, the availability of the contingency reserve would be extended for 2 years, through December 1969. It is anticipated that none of the authorized and appropriated funds will be needed, but the committee believes that it is desirable to take this action so that the premium rate to be established for periods after March 1968 can be set at an intermediate level, rather than at a level that is certain to be adequate even if experience follows the high estimates. It may be noted that it has not yet been possible to make a full analysis, on an accrual basis, of the actual experience for the first year of operation (July 1966 through June 1967), so as to determine whether and to what extent a contingency reserve has been built up. In the event that the operations in the 21-month period when the initial $3 premium rate is effective show a deficit on an accrual basis, this should be made up from the inclusion of a small amount in the premium rates in the next few years. It should be observed that the system may well have a considerable trust-fund balance on a cash basis—due to the lag in presenting and adjudicating claims—even though it may have a deficit on an accrual basis.

In any event, the committee believes that there should be no need for any further extension of this contingency-reserve provision after 1969. By then, either sufficient contingency funds should be built up by the existing financing provisions, or else this will be able to be accomplished from the future premium rates being set at a proper level, based on adequate experience which will be available by that time.

(2) ACTUARIAL SOUNDNESS OF SYSTEM

The concept of actuarial soundness for the supplementary medical insurance system is somewhat different than that for the old-age, survivors, and disability insurance system and for the hospital insurance system. In essence, the first-mentioned 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

The committee-approved bill makes a number of changes in the benefit provisions of the supplementary medical insurance program, of which some expand the scope of the program, whereas several limit it slightly. The only changes which have a significant cost effect are as follows, along with the cost per participant per month relative to the current $6 monthly premium rate (for the participant and the Government combined):

Item	*Cost*
Nonprofessional component of outpatient diagnostic services	$0.12
Elimination of cost-sharing for inpatient pathology and radiology services	.20
Covering chiropractor services	.20
Extending coverage of physical-therapy services benefits	.05
Total	.57

The total cost of $0.57 per month per capita is equivalent to an annual cost of $123 million with respect to 18 million participants.

12. Actuarial cost estimates for the old-age, survivors, and disability insurance system

(a) Summary of actuarial cost estimates

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

The old-age and survivors insurance system as modified by the committee-approved bill shows an actual balance of −0.05 percent of taxable payroll under the intermediate-cost estimate. Accordingly, the old-age and survivors insurance program, as it would be changed by the committee-approved bill, is in close actuarial balance, and thus remains actuarially sound.

The separate disability insurance trust fund, established under the 1956 act, shows an actuarial balance of −0.05 percent of taxable payroll under the provisions that would be in effect after enactment of the committee-approved bill, according to the intermediate-cost estimate. Accordingly, the disability insurance program, as it would be modified by the committee bill, is in close actuarial balance.

(b) Financing policy

(1) CONTRIBUTION RATE SCHEDULE FOR OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE IN COMMITTEE-APPROVED BILL

The contribution schedule for old-age, survivors, and disability insurance contained in the committee-approved bill, as to the combined

employer-employee rate, is lower than under present law by 0.2 percent in 1968, and 0.4 percent in 1969–70, and higher by 0.4 percent in 1971–72, 0.3 percent in 1973–75, and 0.4 percent in 1976 and after. The maximum earnings base to which these tax rates are applied is $8,000 in 1968, $8,800 per year for 1969 through 1971, and $10,800 for 1972 and after under the committee-approved bill as compared with $6,600 under present law and $7,600 in 1968 and after under the House-approved bill. These tax schedules are as follows:

[In percent]

Calendar year	Combined employer-employee rate			Self-employed rate		
	Present law	House-approved bill	Committee-approved bill	Present law	House-approved bill	Committee-approved bill
1967	7.8	7.8	7.8	5.9	5.9	5.9
1968	7.8	7.8	7.6	5.9	5.9	5.8
1969–70	8.8	8.4	8.4	6.6	6.3	6.3
1971–72	8.8	9.2	9.2	6.6	6.9	6.9
1973–75	9.7	10.0	10.0	7.0	7.0	7.0
1976 and after	9.7	10.0	10.1	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-approved 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-approved bill	Present law	House-approved bill	Committee-approved bill
1967	7.10	7.10	7.10	0.70	0.70	0.70
1968	7.10	6.85	6.65	.70	.95	.95
1969–70	8.10	7.45	7.45	.70	.95	.95
1971–72	8.10	8.25	8.25	.70	.95	.95
1973–75	9.00	9.05	9.05	.70	.95	.95
1976 and after	9.00	9.05	9.15	.70	.95	.95

(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 soundly-financed 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. These additional assets and liabilities must be considered in order to determine whether the system is in actuarial balance.

Accordingly, it may be said that the old-age, survivors, and disability insurance program is actuarially sound if it is in actuarial balance. This will be the case if the estimated future income from contributions and from interest earnings on the accumulated trust fund investments will, over the long-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. Traditionally, the view has been held that for the old-age and survivors insurance portion of the program, if such actuarial insufficiency has been no greater than 0.25 percent of payroll, when measured over perpetuity, it is at the point where it is within the limits of permissible variation. The corresponding point for the disability insurance portion of the system is about 0.05 percent of payroll (lower because of the relatively smaller financial magnitude of this program). Based on the recommendation of the 1963–64 Advisory Council on Social Security Financing (see app. V of the 25th Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, H. Doc. No. 100, 89th Cong.), the cost estimates are now being made on a 75-year basis, rather than on a perpetuity basis. On this approach, the margin of variation from exact balance should be

smaller—no more than 0.10 percent of taxable payroll for the combined old-age, survivors, and disability insurance program.

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

The changes provided in the committee-approved bill are in conformity with these financing principles.

(c) *Basic assumptions for cost estimates*

(1) GENERAL BASIS FOR LONG-RANGE COST ESTIMATES

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

The long-range cost estimates (shown for 1975 and thereafter) are presented on a range basis so as to indicate the plausible variation in future costs depending upon the actual trends developing for the various cost factors. Both the low- and high-cost estimates are based on assumptions that are intended to represent close to full employment, with average annual earnings at about the level prevailing in 1966. The use of 1966 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 1966 the aggregate amount of earnings taxable under the program was $314 billion. Of course, for future years the total taxable earnings are estimated to increase, because there will be larger numbers of covered workers. In addition to the presentation of the cost estimates on a range basis, intermediate estimates developed directly from the low- and high-cost estimates (by averaging their components) are shown so as to indicate the basis for the financing provisions.

The cost estimates are extended beyond the year 2000, since the aged population itself cannot mature by then. The reason for this is that the number of births in the 1930's was very low as compared with 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 $300 per month. Under the committee-approved bill such an individual would have a primary insurance amount of $129.30. If his earnings rate should be 50 percent higher (i.e., $450), his primary insurance amount would be $167.90. Under these conditions, the contributions payable with respect to his earnings would increase by 50 percent, but his benefit rate would increase by only 30 percent. Or, to put it another way, when his earnings rate was $300 per month, his primary insurance amount represented 43.1 percent of his earnings, whereas, when his earnings increased to $450 per month, his primary insurance amount relative to his earnings decreased to 37.3 percent.

(3) GENERAL BASIS FOR SHORT-RANGE COST ESTIMATES

The short-range cost estimates (shown for the individual years 1967–72) are not presented on a range basis since—assuming a continuation of present economic conditions—it is believed that the demographic factors involved (such as mortality, fertility, retirement rates, and so forth.) can be reasonably closely forecast, so that only a single estimate is necessary. A gradual rise in the earnings level in the future (about 3 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 been prepared on the basis of the same assumptions and methodology as those contained in the 1967 Annual Report of the Board of Trustees (H. Doc. No. 65, 90th Cong.).

(4) LEVEL-COST CONCEPT

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

(5) FUTURE EARNINGS ASSUMPTIONS

The long-range estimates for the old-age, survivors, and disability insurance program are based on level-earnings assumptions, under which earnings levels of covered workers by age and sex will continue over the next 75 years at the levels experienced in 1966. This, however,

does not mean that 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.

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

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

(8) REIMBURSEMENT FOR COSTS OF ADDITIONAL POST-1967 MILITARY SERVICE WAGE CREDITS

Under the committee-approved bill, individuals in active military service after 1967 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. 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 a few million dollars a year) since there will be relatively few cases arising, almost all due to death and disability. After several decades, this cost might rise to as much as $100 million per year if the size of the uniformed services remains as large as at present—and, of course, a lower figure if such size is lower.

(*d*) *Actuarial balance of program in past years*

(1) STATUS AFTER ENACTMENT OF 1952 ACT

The actuarial balance under the 1952 act [1] was estimated, at the time of enactment, to be virtually the same as in the estimates made at the time the 1950 act was enacted, as shown in table I. This was the case, because the estimates for the 1952 act took into consideration the rise in earnings levels in the 3 years preceding the enactment of that act. This factor virtually offset the increased cost due to the benefit liberalizations made. New cost estimates made 2 years after the enactment of the 1952 act indicated that the level-cost (i.e., the average long-range cost, based on discounting at interest, relative to taxable payroll) of the benefit disbursements and administrative expenses was somewhat more than 0.5 percent of payroll higher than the level equivalent of the scheduled taxes (including allowance for interest on the existing trust fund).

[1] The term "1952 act" (and similar terms) is used to designate the system as it existed after the enactment of the amendments of that year.

TABLE I.—ACTUARIAL BALANCE OF OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM UNDER VARIOUS ACTS FOR VARIOUS ESTIMATES, INTERMEDIATE-COST BASIS

[Percent]

Legislation	Date of estimate	Level-equivalent [1]		
		Benefit costs [2]	Contributions	Actuarial balance [3]
Old-age, survivors, and disability insurance [4]				
1935 act	1935	5.36	5.36	0.00
1939 act	1939	5.22	5.30	+.08
1939 act (as amended in the 1940's) [5]	1950	4.45	3.98	−.47
1950 act	1950	6.20	6.10	−.10
1950 act	1952	5.49	5.90	+.41
1952 act	1952	6.00	5.90	−.10
1952 act	1954	6.62	6.05	−.57
1954 act	1954	7.50	7.12	−.38
1954 act	1956	7.45	7.29	−.16
1956 act	1956	7.85	7.72	−.13
1956 act	1958	8.25	7.83	−.42
1958 act	1958	8.76	8.52	−.24
1958 act	1960	8.73	8.68	−.05
1960 act	1960	8.98	8.68	−.30
1961 act	1961	9.35	9.05	−.30
1961 act	1963	9.33	9.02	−.31
1961 act (perpetuity basis)	1964	9.36	9.12	−.24
1961 act (75-year basis)	1964	9.09	9.10	+.01
1965 act	1965	9.49	9.42	−.07
1965 act	1966	8.76	9.50	+.74
1967 bill (House-approved)	1967	9.70	9.74	+.04
1967 bill (committee-approved)	1967	9.95	9.85	−.10
Old-age and survivors insurance [4]				
1956 act	1956	7.43	7.23	−0.20
1956 act	1958	7.90	7.33	−.57
1958 act	1958	8.27	8.02	−.25
1958 act	1960	8.38	8.18	−.20
1960 act	1960	8.42	8.18	−.24
1961 act	1961	8.79	8.55	−.24
1961 act	1963	8.69	8.52	−.17
1961 act (perpetuity basis)	1964	8.72	8.62	−.10
1961 act (75-year basis)	1964	8.46	8.60	+.14
1965 act	1965	8.82	8.72	−.10
1965 act	1966	7.91	8.80	+.89
1967 bill (House-approved)	1967	8.75	8.79	+.04
1967 bill (committee-approved)	1967	8.95	8.90	−.05
Disability insurance [4]				
1956 act	1956	0.42	0.49	+0.07
1956 act	1958	.35	.50	+.15
1958 act	1958	.49	.50	+.01
1958 act	1960	.35	.50	+.15
1960 act	1960	.56	.50	−.06
1961 act	1961	.56	.50	−.06
1961 act	1963	.64	.50	−.14
1961 act (perpetuity basis)	1964	.64	.50	−.14
1961 act (75-year basis)	1964	.63	.50	−.13
1965 act	1965	.67	.70	+.03
1965 act	1966	.85	.70	−.15
1967 bill (House-approved)	1967	.95	.95	.00
1967 bill (committee-approved)	1967	1.00	.95	−.05

[1] Expressed as a percentage of effective taxable payroll, including adjustment to reflect the lower contribution rate on self-employment income and on tips, as compared with the combined employer-employee rate. Estimates prepared before 1964 are on a perpetuity basis, while those prepared after 1964 are on a 75-year basis. The estimates prepared in 1964 are on both bases.

[2] Including adjustments (a) to reflect the lower contribution rate on self-employment income and on tips, as compared with the combined employer-employee rate, (b) for the interest earnings on the existing trust fund, (c) for administrative expense costs, and (d) for the net cost of the financial interchange with the railroad retirement system.

[3] A negative figure indicates the extent of lack of actuarial balance. A positive figure indicates more than sufficient financing, according to the particular estimate.

[4] The disability insurance program was inaugurated in the 1956 act so that all figures for previous legislation are for the old-age and survivors insurance program only.

[5] The major changes being in the revision of the contribution schedule; as of the beginning of 1950, the ultimate combined employer-employee rate scheduled was only 4 percent.

Note: The figures for the 1950 act and for the 1952 act according to the 1952 estimates have been revised as compared with those presented previously, so as to place them on a comparable basis with the later figures.

(2) STATUS AFTER ENACTMENT OF 1954 ACT

Under the 1954 act, the increase in the contribution schedule met all the additional cost of the benefit changes and at the same time reduced substantially the actuarial insufficiency that the then current estimates had indicated in regard to the financing of the 1952 act.

(3) STATUS AFTER ENACTMENT OF 1956 ACT

The estimates for the 1954 act were revised in 1956 to take into account the rise in the earnings level that had occurred since 1951–52, the period that had been used for the earnings assumptions for the estimates made in 1954. Taking this factor into account reduced the lack of actuarial balance under the 1954 act to the point where, for all practical purposes, it was nonexistent. The benefit changes made by the 1956 amendments were fully financed by the increased contribution income provided. Accordingly, the actuarial balance of the system was unaffected.

Following the enactment of the 1956 legislation, new cost estimates were made to take into account the developing experience; also, certain modified assumptions were made as to anticipated future trends. In 1956–57, there were very considerable numbers of retirements from among the groups newly covered by the 1954 and 1956 amendments, so that benefit expenditures ran considerably higher than had previously been estimated. Moreover, the analyzed experience for the recent years of operation indicated that retirement rates had risen or, in other words, that the average retirement age had dropped significantly. The cost estimates made in early 1958 indicated that the program was out of actuarial balance by somewhat more than 0.4 percent of payroll.

(4) STATUS AFTER ENACTMENT OF 1958 ACT

The 1958 amendments recognized this situation and provided additional financing for the program—both to reduce the lack of actuarial balance and also to finance certain benefit liberalizations made. In fact, one of the stated purposes of the legislation was "to improve the actuarial status of the trust funds." This was accomplished by introducing an immediate increase (in 1959) in the combined employer-employee contribution rate, amounting to 0.5 percent, and by advancing the subsequently scheduled increases so that they would occur at 3-year intervals (beginning in 1960) instead of at 5-year intervals.

The revised cost estimates made in 1958 for the disability insurance program contained certain modified assumptions that recognized the emerging experience under the new program. As a result, the moderate actuarial surplus originally estimated was increased somewhat, and most of this was used in the 1958 amendments to finance certain benefit liberalizations, such as inclusion of supplemental benefits for certain dependents and modification of the insured status requirements.

(5) STATUS AFTER ENACTMENT OF 1960 ACT

At the beginning of 1960, the cost estimates for the old-age, survivors, and disability insurance system were reexamined and were modified in certain respects. The earnings assumption had previously

been based on the 1956 level, and this was changed to reflect the 1959 level. Also, data first became available on the detailed operations of the disability provisions for 1956, which was the first full year of operation that did not involve picking up "backlog" cases. It was found that the number of persons who meet the insured status conditions to be eligible for these benefits had been significantly overestimated. It was also found that the disability incidence experience for eligible women was considerably lower than had been originally estimated, although the experience for men was very close to the intermediate estimate. Accordingly, revised assumptions were made in regard to the disability insurance portion of the program. As a result, the changes made by the 1960 amendments could, according to the revised estimates, be made without modifying the financing provisions.

(6) STATUS AFTER ENACTMENT OF 1961 ACT

The changes made by the 1961 amendments involved an increased cost that was fully met by the changes in the financing provisions (namely, an increase in the combined employer-employee contribution rate of 0.25 percent, a corresponding change in the rate for the self-employed, and an advance in the year when the ultimate rates would be effective—from 1969 to 1968). As a result, the actuarial balance of the program remained unchanged.

Subsequent to 1961, the cost estimates were further reexamined in the light of developing experience. The earnings assumption was changed to reflect the 1963 level, and the interest-rate assumption used was modified upward to reflect recent experience. At the same time, the retirement-rate assumptions were increased somewhat to reflect the experience in respect to this factor. The further developing disability experience indicated that costs for this portion of the program were significantly higher than previously estimated (because benefits were not being terminated by death or recovery as rapidly as had been originally assumed). Accordingly, the actuarial balance of the disability insurance program was shown to be in an unsatisfactory position, and this had been recognized by the Board of Trustees, who recommended that the allocation to this trust fund should be increased (while, at the same time, correspondingly decreasing the allocation to the old-age and survivors insurance trust fund, which under the law in effect at that time was estimated to be in satisfactory actuarial balance even after such a reallocation).

(7) STATUS AFTER ENACTMENT OF 1965 ACT

The changes made by the 1965 amendments involved an increased cost that was closely met by the changes in their financing provisions (namely, an increase in the contribution schedule, particularly in the later years, and an increase in the earnings base). The actuarial balance of the program remained virtually unchanged.

In 1966, the cost estimates for the old-age, survivors, and disability insurance system were completely revised, based on the availability of new data since the last complete revision was made in 1963. The new estimates showed significantly lower costs for the old-age and survivors insurance portion of the system, but higher costs for the dis-

ability insurance portion. The factors leading to lower costs were as follows: (1) 1966 earnings levels, instead of 1963 ones; (2) an interest rate of 3¾ percent for the intermediate-cost estimate, instead of 3½ percent; (3) an assumption of greater future participation of women in the labor force (resulting in reduction in cost of the program because of the "antiduplication of benefits" provision as between women's primary benefits and wife's or widow's benefits); (4) an assumption of less improvement in future mortality than had previously been assumed; and (5) an assumption that, despite a significant decline in future fertility rates, such decline would not occur as rapidly as had been assumed previously.

The cost of the disability insurance system was estimated to be significantly higher, as a result of increasing disability prevalence rates. This change was necessary to reflect the substantially larger number of disability beneficiaries coming on the roll with respect to disabilities occurring in 1964 and after, which experience had not been available in 1965 when the cost estimates for the legislation of that year were considered.

For more details on these revised cost estimates for the old-age, survivors, and disability insurance system, see *Actuarial Study No. 63* of the Social Security Administration, Department of Health, Education, and Welfare, January 1967.

(e) *Intermediate-cost estimates*

(1) PURPOSES OF INTERMEDIATE-COST ESTIMATES

The long-range intermediate-cost estimates are developed from the low- and high-cost estimates by averaging them (using the dollar estimates and developing therefrom the corresponding estimates relative to payroll). The intermediate-cost estimate does not represent the most probable estimate since it is impossible to develop any such figures. Rather, it has been set down as a convenient and readily available single set of figures to use for comparative purposes.

The Congress, in enacting the 1950 act and subsequent legislation, was of the belief that the old-age, survivors, and disability insurance program should be on a completely self-supporting basis and actuarially sound. Therefore, a single estimate is necessary in the development of a tax schedule intended to make the system self-supporting. Any specific schedule will necessarily be somewhat different from what will actually be required to obtain exact balance between contributions and benefits. This procedure, however, does make the intention specific, even though in actual practice future changes in the tax schedule might be necessary. Likewise, exact balance cannot be obtained from a specific set of integral or rounded tax rates increasing in orderly intervals, but rather this principle of self-support should be aimed at as closely as possible.

(2) INTEREST RATE USED IN COST ESTIMATES

The interest rate used for computing the level-costs for the committee-approved bill is 3¾ percent for the intermediate-cost estimate. This is slightly below the average yield of the investments of the trust funds at the end of June 1967 (about 3.79 percent), and is considerably

below the rate currently being obtained for new investments (5¼ percent for October 1967).

(3) ACTUARIAL BALANCE OF OASDI SYSTEM

Table I has shown that, according to the latest cost estimates made for the 1965 act, there is a very favorable actuarial balance for the combined old-age, survivors, and disability insurance system, but that there is a deficit of 0.15 percent of taxable payroll for the disability insurance portion, and a favorable balance of 0.89 percent of taxable payroll for the old-age and survivors insurance portion.

Under the committee-approved bill, the benefit changes proposed would be financed by utilizing the existing favorable actuarial balance and by the increases in the contribution rates and the earnings base.

Table II 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 committee-approved bill, by type of major changes involved.

TABLE II.—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-APPROVED BILL, BASED ON 3.75 PERCENT INTEREST

[Percent]

Item	Old-age and survivors insurance	Disability insurance	Total system
Actuarial balance of present system	+0.89	−0.15	+0.74
Increase in earnings base	+.48	+.04	+.52
Earnings test liberalization	−.17	(1)	−.17
Disabled widow's benefits	−.06	(2)	−.06
Special disability insured status under age 31	(2)	−.02	−.02
Liberalized benefits with respect to women workers	−.06	(1)	−.06
Special benefits for blind persons	(2)	−.05	−.05
Childhood disability benefits for those disabled at ages 18–21	(1)	(1)	(1)
Reduction of minimum eligibility age from 62 to 60	(1)	(1)	(1)
Benefit formula change	−1.23	−.12	−1.35
Revised contribution schedule	+.10	+.25	+.35
Total effect of changes in bill	−.94	+.10	−.84
Actuarial balance under bill	−.05	−.05	−.10

[1] Less than 0.005 percent.
[2] Not applicable to this program.

Several benefit-provision changes made by the committee-approved bill would have cost effects which are of a magnitude of less than 0.005 percent of taxable payroll when measured in terms of long-range level costs. Such changes involving small increases in cost are the liberalization of eligibility conditions for certain adopted children, the elimination of marriage as a cause of termination for child's benefits payable to children attending school, the simplification of benefit computations based on 1937–50 wages, the reduction of the length-of-marriage requirement for survivor benefits, the liberalization of the offset provision for disability benefits when workmen's compensation benefits are also payable, the reduction in the penalties for failure to file timely reports of earnings and other events and the payment of childhood disability benefits to persons becoming disabled at ages 18–21. The reduction in the minimum eligibility age from 62 to 60 for primary, wife's, husband's, widower's, and parent's benefits

has no significant cost effect, because the reduced benefits available are, for all practical purposes, on an actuarial-reduction basis (so that the increased outgo in the early years will be counterbalanced by reduced outgo later). Such changes involving small decreases in cost are the additional limitations on payment of benefits to certain aliens outside the United States.

The changes made by the committee-approved bill would maintain the sound actuarial position of the old-age, survivors, and disability insurance system. The estimated actuarial balance is just at the established limit within which the system is considered substantially in actuarial balance.

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

The level contribution rate equivalent to the graded schedules in the law may be computed in the same manner as level costs of benefits. These are shown in table I, as are also figures for the net actuarial balances.

(4) 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 1965 act, according to the latest intermediate-cost estimate, is 7.91 percent of taxable payroll, and the corresponding figure for the program as it would be modified by the committee-approved bill is 8.95 percent. The corresponding figures for the disability benefits are 0.83 percent for the 1965 act and 0.98 percent for the committee-approved bill.

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

TABLE III.—ESTIMATED LEVEL-COST OF BENEFIT PAYMENTS, ADMINISTRATIVE EXPENSES, AND INTEREST EARNINGS ON EXISTING TRUST FUND UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, AFTER ENACTMENT OF COMMITTEE-APPROVED BILL, AS PERCENTAGE OF TAXABLE PAYROLL,[1] BY TYPE OF BENEFIT, INTERMEDIATE-COST ESTIMATE AT 3.75 PERCENT INTEREST

[In percent]

Item	Old-age and survivors insurance	Disability insurance
Primary benefits	6.10	0.79
Wife's and husband's benefits	.52	.05
Widow's and widower's benefits	1.30	[2]
Parent's benefits	.01	[2]
Child's benefits	.79	.14
Mother's benefits	.14	[2]
Lump-sum death payments	.09	[2]
Total benefits	8.95	.98
Administrative expenses	.12	.03
Railroad retirement financial interchange	.03	.00
Interest on existing trust fund[3]	—.15	—.01
Net total level-cost	8.95	1.00

[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.

(5) INCOME AND OUTGO OF OASI TRUST FUNDS IN NEAR FUTURE

Under the committee-approved bill, old-age and survivors insurance benefit disbursements for the calendar year 1968 will be increased by about $3.2 billion. The corresponding increase for calendar year 1969 (the first full year of operation of all the new benefit provisions) is $5.3 billion.

In calendar year 1968, benefit disbursements under the old-age and survivors insurance system as modified by the committee-approved bill will total about $23.5 billion. At the same time, contribution income for old-age and survivors insurance in 1968 will amount to about $23.9 billion under the committee-approved bill, or $165 million less than under present law. Thus, benefit outgo under the committee-approved bill will be less than contribution income by about $0.4 billion whereas under present law, the corresponding figure is about $3.8 billion. The size of the old-age and survivors insurance trust fund under the committee-approved bill will, on the basis of this estimate, increase by about $400 million in 1968 (interest receipts are about the same as the outgo for administrative expenses and for transfers to the railroad retirement account); under present law, it is estimated that this trust fund would increase by about $3.9 billion as between the beginning and the end of 1968.

For the old-age, survivors, and disability insurance system as a whole, contribution income in 1968 is $0.7 billion more under the committee-approved bill than it would be under present law, a relative increase of 3 percent.

Under the program as modified by the committee-approved bill, according to this estimate, the old-age and survivors insurance trust fund will increase by about $0.4 billion in 1968 and $1.9 billion in 1969, reaching $26.3 billion at the end of 1969. In 1970, the estimated increase in the size of this trust fund is about $2.3 billion, while in 1971

and 1972, the corresponding figures are $5.3 billion and $7.4 billion, respectively. Table IV presents these short-range estimates, as well as the corresponding ones for the present law.

TABLE IV.—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 [1]	Interest on fund [2]	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	[4] 162	−2	556	22,393
1958	7,566	8,327	[4] 194	124	552	21,864
1959	8,052	9,842	184	282	532	20,141
1960	10,866	10,677	203	318	516	20,324
1961	11,285	11,862	239	332	548	19,725
1962	12,059	13,356	256	361	526	18,337
1963	14,541	14,217	281	423	521	18,480
1964	15,689	14,914	296	403	569	19,125
1965	16,017	16,737	328	436	593	18,235
1966	20,658	18,267	256	444	644	20,570
	Estimated data (short-range estimate), committee-approved bill					
1968	$23,920	$23,496	$438	$477	$882	$24,425
1969	28,250	26,321	412	545	918	26,315
1970	29,955	27,498	419	697	1,005	28,661
1971	33,787	28,539	431	665	1,195	34,008
1972	36,540	29,608	444	646	1,515	41,365
	Estimated data (short-range estimate), present law					
1967	$23,210	$19,635	$393	$508	$794	$24,038
1968	24,085	20,247	378	477	960	27,981
1969	28,004	21,053	393	492	1,192	35,239
1970	29,270	21,901	404	483	1,522	43,243
1971	30,070	22,778	416	460	1,902	51,561
1972	30,884	23,676	429	459	2,315	60,196

[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 3.75 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] 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] These figures are artificially high because of the method of reimbursements between this trust fund and the disability insurance trust fund (and, likewise, the figure for 1959 is too low).

Note: Contributions include reimbursement for additional cost of noncontributory credit for military service and for the special benefits payable to certain noninsured persons aged 72 or over. For the purposes of this table, it is assumed that the enactment date is in November 1967.

(6) INCOME AND OUTGO OF DI TRUST FUND IN NEAR FUTURE

Under the disability insurance system, as it would be affected by the committee-approved bill in calendar year 1968, benefit disbursements will total about $2.3 billion, and there will be an excess of contribution income over benefit disbursements of about $0.9 billion. In 1968 and the years immediately following, contribution income will be well in excess of benefit outgo (as a result of the increased allocation to this trust fund, and the increased taxable earnings base, as provided by the commitee-approved bill). As contrasted with present law, benefit outgo would be increased by about $300 million in 1968 under the committee-approved bill, while contribution income would be increased by about $900 million.

The disability insurance trust fund is estimated to increase by about $840 million in 1968 under the committee-approved bill, as compared with a corresponding increase of about $270 million under present law (and an increase of about $330 million in 1967 under present law). The trust fund at the end of 1968 will be about $2.9 billion under the committee-approved bill, and thereafter it will increase in every year. Table V presents these short-range estimates, as well as the corresponding ones for present law.

TABLE V.—PROGRESS OF DISABILITY INSURANCE TRUST FUND, SHORT-RANGE COST 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 date			
1957	$702	$57	[3] $3	.....	$7	$649
1958	966	249	[3] 12	.....	25	1,379
1959	891	457	50	—$22	40	1,825
1960	1,010	568	36	—5	53	2,289
1961	1,038	887	64	5	66	2,437
1962	1,046	1,105	66	11	68	2,368
1963	1,099	1,210	68	20	66	2,235
1964	1,154	1,309	79	19	64	2,047
1965	1,188	1,573	90	24	59	1,606
1966	2,022	1,784	137	25	58	1,739
			Estimated data (short-range estimate), committee-approved bill			
1968	$3,254	$2,334	$157	$21	$99	$2,905
1969	3,619	2,747	128	22	135	3,762
1970	3,777	2,888	126	26	174	4,673
1971	3,918	3,012	129	31	215	5,634
1972	4,191	3,133	135	36	260	6,781
			Estimated data (short-range estimate), present law			
1967	$2,313	$1,920	$107	$31	$73	$2,067
1968	2,359	2,039	114	21	86	2,338
1969	2,436	2,155	116	24	96	2,575
1970	2,512	2,260	119	26	106	2,788
1971	2,591	2,357	123	29	115	2,985
1972	2,665	2,449	129	32	122	3,162

[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 3.75 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] These figures are artificially low because of the method of reimbursements between the trust fund and the old-age and survivors insurance trust fund (and, likewise, the figure for 1959 is too high).

Note: Contributions include reimbursement for additional cost of noncontributory credit for military service. For the purposes of this table, it is assumed that the enactment date is in November 1967.

(7) INCREASES IN BENEFIT DISBURSEMENTS IN 1968, BY CAUSE

The total benefit disbursements of the old-age, survivors, and disability insurance system would be increased by about $3.5 billion in 1968 and by $5.9 billion in 1969 as a result of the changes that the committee-approved bill would make. Table VI presents the distribution of these figures according to the more important changes and also corresponding ones for 1972.

TABLE VI.—ESTIMATED ADDITIONAL OASDI BENEFIT PAYMENTS IN CALENDAR YEARS 1968, 1969, AND 1972 UNDER COMMITTEE-APPROVED BILL

[In millions]

Item	1968	1969	1972
General benefit increase	$3,066	$4,259	$4,806
Benefit increase for transitional insured	16	20	15
Benefit increase for transitional noninsured	140	156	89
Liberalized benefits with respect to women workers	67	92	103
Special disability insured status under age 31	55	74	79
Disabled widow's benefits	53	76	86
Earnings test liberalizations	140	450	691
Reduction of minimum eligibility age from 62 to 60	.....	555	522
Special benefits for blind persons	.....	165	210
Childhood disability benefits for those disabled at ages 18-21	6	8	10
Total	3,543	5,855	6,611

(8) LONG-RANGE OPERATIONS OF OASI TRUST FUND

Table VII gives the estimated operation of the old-age and survivors insurance trust fund under the program as it would be changed by the committee-approved bill for the long-range future, based on the intermediate-cost estimate. It will, of course, be recognized that the figures for the next two or three decades are the most reliable (under the assumption of level-earnings trends in the future) since the populations concerned—both covered workers and beneficiaries—are already born. As the estimates proceed further into the future, there is, of course, much more uncertainty—if for no reason other than the relative difficulty in predicting future birth trends—but it is desirable and necessary nonetheless to consider these long-range possibilities under a social insurance program that is intended to operate in perpetuity.

In every year after 1967 for the next 20 years, contribution income under the system as it would be modified by the committee-approved bill is estimated to exceed old-age and survivors insurance benefit disbursements. Even after the benefit-outgo curve rises ahead of the contribution-income curve, the trust fund will nonetheless continue to increase because of the effect of interest earnings (which more than meet the administrative expense disbursements and any financial interchanges with the railroad retirement program). As a result, this trust fund is estimated to grow steadily under the intermediate long-range cost estimate (with a level-earnings assumption), reaching $39 billion in 1975, $67 billion in 1980, and about $150 billion at the end of this century. In the very far distant future; namely, in about the year 2020, the trust fund is estimated to reach a maximum of about $280 billion.

(9) LONG-RANGE OPERATIONS OF DI TRUST FUND

The disability insurance trust fund, under the program as it would be changed by the committee-approved bill, grows slowly but steadily after 1967, according to the intermediate long-range cost estimate, as shown by table VIII. In 1975, it is shown as being $5 billion, while in 1990, the corresponding figure is $7 billion. In the following years, the trust fund decreases slowly and is exhausted about 20 years later. There is a small excess of contribution income over benefit disbursements for every year after 1967 until about 1980.

(f) *Cost estimates on range basis*

(1) LONG-RANGE OPERATIONS OF TRUST FUNDS

Table VII shows the estimated operation of the old-age and survivors insurance trust fund under the program as it would be changed by the committee-approved bill for not only the intermediate-cost estimates but also for the low- and high-cost estimates, while table VIII gives corresponding figures for the disability insurance trust fund.

Under the low-cost estimate, the old-age and survivors insurance trust fund builds up quite rapidly and in the year 2000 is shown as being about $267 billion and is then growing at a rate of about $15 billion a year. Likewise, the disability insurance trust fund grows steadily under the low-cost estimate, reaching about $10 billion in 1980 and $30 billion in the year 2000, at which time its annual rate of growth is about $1 billion. For both trust funds, under these estimates, benefit disbursements do not exceed contribution income in any year after 1967 for the next 35 years.

TABLE VII.—ESTIMATED PROGRESS OF OLD-AGE AND SURVIVORS INSURANCE TRUST FUND UNDER SYSTEM AS MODIFIED BY COMMITTEE-APPROVED BILL, LONG-RANGE COST ESTIMATES

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange [1]	Interest on fund [2]	Balance in fund at end of year
			Low-cost estimate			
1975	$36,349	$30,403	$421	$400	$1,606	$45,528
1980	40,007	34,643	462	240	3,154	83,187
1990	45,653	43,775	537	40	6,293	159 411
2000	53,906	49,286	593	−70	10,589	266,779
			High-cost estimate			
1975	$35,788	$31,585	$483	$470	$905	$32,428
1980	39,202	36,292	531	320	1,503	52,287
1990	44,088	46,119	629	140	1,940	64,876
2000	50,768	52,647	684	30	1,484	51,142
			Intermediate-cost estimate			
1975	$36,068	$30,994	$452	$435	$1,224	$38,880
1980	39,605	35,467	496	260	2,246	67,333
1990	44,871	44,947	583	90	3,825	109,957
2000	52,337	50,967	638	−20	5,279	151,557
2025	67,893	84,874	941	−120	9,292	256,778

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

[2] At interest rates of 3.75 percent for the intermediate-cost estimate, 4.25 percent for the low-cost estimate, and 3.25 percent for the high-cost estimate.

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 1967—or of the corresponding reimbursement therefor, which is exactly counterbalancing from a long-range cost standpoint. For the purposes of this table, it is assumed that the enactment date is in November 1967.

TABLE VIII.—ESTIMATED PROGRESS OF DISABILITY INSURANCE TRUST FUND UNDER SYSTEM AS MODIFIED BY COMMITTEE-APPROVED BILL, LONG-RANGE COST ESTIMATES

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange [1]	Interest on fund [2]	Balance in fund at end of year
			Low-cost estimate			
1975	$3,827	$3,375	$144	−$9	$252	$6,767
1980	4,165	3,801	124	−14	379	9,801
1990	4,751	4,360	121	−20	696	17,645
2000	5,608	5,312	135	−20	1,200	30,066
			High-cost estimate			
1975	$3,768	$3,738	$143	−$3	$114	$3,800
1980	4,081	4,325	154	−6	85	2,909
1990	4,589	5,056	169	−10	[3]	[3]
2000	5,282	6,262	205	−10	[3]	[3]
			Intermediate-cost estimate			
1975	$3,797	$3,557	$144	−$6	$175	$5,251
1980	4,123	4,063	139	−10	213	6,250
1990	4,670	4,708	145	−15	239	6,994
2000	5,445	5,787	170	−15	225	6,555
2025	7,049	8,338	245	−15	[4]	[4]

[1] A negative figure indicates payment to the trust fund from the railroad retirement account, and a positive figure indicates the reverse.
[2] At interest rates of 3.75 percent for the intermediate-cost estimate, 4.25 percent for the low-cost estimate, and 3.25 percent for the high-cost estimate.
[3] Fund exhausted in 1986.
[4] Fund exhausted in 2008.

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 1967—or of the corresponding reimbursement therefor, which is exactly counterbalancing from a long-range cost standpoint. For the purposes of this table, it is assumed that the enactment date is in November 1967.

On the other hand, under the high-cost estimate, the old-age and survivors insurance trust fund builds up to a maximum of about $65 billion in about 25 years, but decreases slowly thereafter until it is exhausted in the year 2016. Under this estimate, benefit disbursements from the old-age and survivors insurance trust fund are lower than contribution income during all years after 1967 and before 1986.

As to the disability insurance trust fund, under the high-cost estimate, in the early years of operation the contribution income slightly exceeds the benefit outgo. Accordingly, the disability insurance trust fund, as shown by this estimate, will increase to a maximum of $3.8 billion in 1975 and will then slowly decrease until it is exhausted in 1986.

The foregoing results are consistent and reasonable, since the system on an intermediate-cost-estimate basis is intended to be approximately self-supporting, as indicated previously. Accordingly, a low-cost estimate should show that the system is more than self-supporting, whereas a high-cost estimate should show that a deficiency would arise later on. In actual practice, under the philosophy in the 1950 and subsequent acts, as set forth in the committee reports therefor, the tax schedule would be adjusted in future years so that none of the developments of the trust funds under the low-cost and high-cost estimates shown in tables VII and VIII would ever eventuate. Thus, if experience followed the low-cost estimate, and if the benefit provisions

were not changed, the contribution rates would probably be adjusted downward—or perhaps would not be increased in future years according to schedule. On the other hand, if the experience followed the high-cost estimate, the contribution rates would have to be raised above those scheduled. In any event, the high-cost estimate does indicate that, under the tax schedule adopted, there will be ample funds to meet benefit disbursements for several decades, even under relatively high-cost experience.

(2) BENEFIT COSTS IN FUTURE YEARS RELATIVE TO TAXABLE PAYROLL

Table IX shows the estimated costs of the old-age and survivors insurance benefits and of the disability insurance benefits under the program as it would be changed by the committee-approved bill as a percentage of taxable payroll for various future years, through the year 2040, and also the level-costs of the two programs for the low-, high-, and intermediate-cost estimates (as was previously shown in tables I and III for the intermediate-cost estimate).

TABLE IX.—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-APPROVED BILL

[In percent]

Calendar year	Low-cost estimate	High-cost estimate	Intermediate-cost estimate [2]
	Old-age and survivors insurance benefits		
1975	7.59	8.01	7.80
1980	7.94	8.49	8.21
1990	8.79	9.59	9.18
2000	8.38	9.51	8.93
2025	9.99	12.92	11.44
2040	9.82	13.62	11.48
Level-cost [3]	8.37	9.65	8.95
	Disability insurance benefits		
1975	0.84	0.95	0.90
1980	.87	1.01	.94
1990	.88	1.05	.96
2000	.90	1.13	1.01
2025	.96	1.31	1.12
2040	1.00	1.35	1.15
Level-cost [3]	.89	1.12	1.00

[1] Taking into account the lower contribution rate for self-employment income and tips, as compared with the combined employer-employee rate.
[2] Based on the averages of the dollar payrolls and dollar costs under the low-cost and high-cost estimates.
[3] Level contribution rate, at an interest rate of 3.25 percent for high-cost, 3.75 percent for intermediate-cost, and 4.25 percent for low-cost, for benefits after 1966, taking into account interest on the trust fund on December 31, 1966, future administrative expenses, the railroad retirement financial interchange provisions, and the reimbursement of military-wage-credits cost.

13. Actuarial Cost Estimates for Combined Old-Age, Survivors, Disability, and Hospital Insurance System for 1968 and 1969

This section compares the benefit outgo and the contribution income in 1968 and 1969, under the committee-approved bill, the House-approved bill, and present law for the old-age, survivors, and disability insurance system and the hospital insurance system combined. Such a combination is meaningful since each of these two systems is financed by payroll taxes (unlike the supplementary medical insurance system). The hospital insurance benefit outgo for noninsured persons is not included, because it is reimbursed on a current basis by the general fund of the Treasury.

The pertinent data are as follows:

[In billions]

Basis	Contribution income	Benefit outgo	Excess of contributions over benefits
CALENDAR YEAR 1968			
Present law	$29.6	$25.5	$4.1
Committee-approved bill	31.2	29.0	2.2
House-approved bill [1]	30.8	28.7	2.1
CALENDAR YEAR 1969			
Present law	33.7	26.9	6.8
Committee-approved bill	36.3	32.7	3.6
House-approved bill	34.9	30.3	4.6

[1] Assumes that increased benefits would be payable for all 12 months of the year.

B. Public Welfare

1. Aid to Families With Dependent Children

Like the Committee on Ways and Means of the House, this committee has become concerned about the continued growth in the number of families receiving aid to families with dependent children (AFDC). In the last 10 years, the program has grown from 646,000 families that included 2.4 million recipients to 1.2 million families and nearly 5 million recipients. Moreover, according to estimates of the Department of Health, Education, and Welfare, the annual amount of Federal funds allocated to this program will increase greatly (from $1.46 billion to $1.84 billion) over the next 5 years unless constructive and concerted action is taken now to deal with the basic causes of the anticipated growth. Although the growth which has occurred can be accounted for, in part, by the inclusion in the program of assistance to the children of the unemployed (added in 1961 on an optional basis to the States) and to increases in the child population, a very large share of the program growth is due to family breakup and births out of wedlock.

We are very deeply concerned that such a large number of families have not achieved and maintained independence and self-support, and are very greatly concerned over the rapidly increasing costs to the taxpayers. Moreover, we are aware that the growth in this program has received increasingly critical public attention.

It is now 5 years since the enactment of the 1962 legislation, which allowed Federal financial participation in a wide range of services to AFDC families—services which the Congress was informed and believed would help reverse these trends. The provisions for services in the 1962 amendments have been implemented by all the States, with varying emphasis from State to State on which aspects receive the major attention. There have been some important and worthwhile developments stemming from this legislation. The number of staff working in the program has increased so that the caseworkers have smaller, more manageable caseloads. The volume of social services has increased and some constructive results have been reported. It is also obvious, however, that further and more definitive action is needed if the growth of the AFDC program is to be kept under control.

The plan which the committee has developed, with the advice and help of the Department of Health, Education, and Welfare and the

Department of Labor, amounts to a new direction for AFDC legislation. It follows the basic outline of the bill passed by the House but incorporates certain desirable changes in the method of administration and program emphasis. The committee is recommending the enactment of a series of amendments to carry out its intent of reducing the AFDC rolls by restoring more families to employment and self-reliance.

The first series of amendments is designed to encourage and make possible the employment of adults in AFDC families. Three provisions are aimed at this purpose:

(1) The establishment of a work incentive program under the Department of Labor for the purpose of restoring members of AFDC families (including those with little or no work experience) to regular employment through counseling, placement services and training, and arranging for all others to get paid employment in special work projects to improve the communities in which they live;

(2) A requirement that all States furnish day-care services and other social services to make it possible for adult members of the family to take advantage of the work and training opportunities under the work incentive program; and

(3) A requirement that all States exempt part of the AFDC recipient's earnings to provide incentives for work in regular employment.

The second series of amendments would set up new protections for the children in AFDC families and would make more certain the fulfillment of parental responsibilities:

(1) A requirement that the States establish a comprehensive plan of social services for each AFDC child to assure the child the maximum opportunity to become a productive and useful citizen;

(2) A requirement that State welfare agencies refer cases of child abuse or neglect to appropriate law-enforcement agencies and courts;

(3) A requirement that protective payments and vendor payments be made where appropriate to protect the welfare of the children;

(4) Federal payments for additional foster care situations under the AFDC program;

(5) A requirement to assure that fathers who desert or abandon their families will contribute to the support of their families by using available tax records and the enforcement power of the Internal Revenue Service. In addition, there would be a requirement that the States establish separate units to enforce the child-support laws, including financial help to the courts and prosecuting agencies to enforce court orders for support; and

(6) A program of emergency assistance to families with minor children for a temporary period.

(7) A more definitive and uniform program for the children of unemployed fathers.

The third series of amendments would make other changes in the program designed to deal with the expanding AFDC rolls.

(1) A requirement that all States establish programs to reduce the number of children born out of wedlock; and

(2) A requirement that all the States offer family planning services to appropriate AFDC recipients.

(a) *Work incentive program*

The committee received testimony from many witnesses on the work and training provisions of the House bill. The committee gave a great deal of attention both to the testimony and to the rationale underlying the House provisions. This committee is in complete agreement with the purpose of the House bill that as many AFDC recipients as possible become employed and independent. We believe, however, that the program which we have developed will better serve that purpose.

The committee believes that the most effective program can be mounted, in the most rapid fashion, by placing the work incentive program under the Secretary of Labor. As stated in the bill, the purpose of this part is:

> The establishment of a program utilizing all available manpower services, including those authorized under other provisions of law, under which individuals receiving aid to families with dependent children will be furnished incentives, opportunities, and necessary services in order for (1) the employment of such individuals in the regular economy, (2) the training of such individuals for work in the regular economy, and (3) the participation of such individuals in special work projects, thus restoring the families of such individuals to independence and useful roles in their communities. It is expected that the individuals participating in the program established under this part will acquire a sense of dignity, self-worth, and confidence which will flow from being recognized as a wage-earning member of society and that the example of a working adult in these families will have beneficial effects on the children in such families.

By utilizing the full range of manpower services provided under legislative authorities available through the Department of Labor, it will be possible to put the program into effect a year earlier than the House bill contemplated. The Department of Labor informs the committee that this action should result in the training and employment of several hundred thousand more persons during the first 5 years. Moreover, the Department of Labor states that it can perform the required functions at a lower net cost, even though many more persons will be trained and employed.

As in the House bill, welfare agencies under the Department of Health, Education, and Welfare would be responsible for providing the maintenance payments and health care, making the child care arrangements, and providing supportive social services to families involved. (The social services program described below will support and make possible the referral of additional people to this program.)

To provide guidelines and to clarify the manner in which the program will operate, the committee bill sets forth a number of categories of individuals who would not be considered as "appropriate" for referral to the Secretary of Labor for the work incentive program. Persons described in those categories would not be placed in any work situation unless they chose to request employment or training. Each

member of the family who has attained 16 years of age (and is not in school full-time) would be considered appropriate for referral except—

(1) A person with illness, incapacity, or advanced age;

(2) A person whose remoteness from a project precludes effective participation in work or training;

(3) A person whose substantially continuous presence in the home is required because of the illness or incapacity of another member of the household;

(4) A mother (or person acting as a mother) who is in fact caring for one or more children of preschool age, if such mother's presence in the home is necessary and in the best interest of the children; or

(5) A person whose participation the State welfare agency finds would not be in his best interest and would be inconsistent with the objectives of the program.

All recipients of assistance under this title who are not referred to the Secretary of Labor, including individuals within the above categories, who want to take advantage of these new opportunities to become self-supporting may request referral. Each person making such a request must be referred to the Secretary of Labor unless the State welfare agency determines that such participation is not in the best interest of such person or the family. If they do not make such a finding the individual would be referred and the necessary child care and other arrangements would have to be made by the welfare agency.

A refusal to accept work or undertake training without good cause by a person who has been referred would be reported to the State agency by the Labor Department. The Department of Labor would use its regular hearing procedures to consider appeals from its decisions on questions of what constitutes good cause.

The State welfare agency must offer counseling and advice aimed at persuading return to or participation in the work incentive program for any person who makes such a refusal. For a period of up to 60 days the total family assistance will continue to be paid, but in the form of protective or vendor payments. If the individual refuses the counseling or continues to refuse the work or training after 60 days, his needs will no longer be taken into account in determining the family grant. Under the House-passed bill, protective or vendor payments for the children would be optional with the State in these cases, but under the committee's proposal the children must be given this protection.

As in the House bill, work and training programs under the bill must be established in each political subdivision of a State in which the Secretary of Labor determines that there is a significant number of AFDC recipients who have attained age 16 years. In addition, however, the Secretary of Labor must use his best efforts to establish programs in all other political subdivisions or provide transportation to a neighboring area where there is a program. Consequently, it is anticipated that virtually all individuals who are referred to the Secretary of Labor by the welfare agencies will participate in the program.

People referred to the Secretary of Labor by the welfare agencies would be handled in the following priorities, always pointing an individual toward regular employment but providing him a work or training experience regardless of his present level of skill.

The Secretary of Labor would use a number of procedures to assist persons referred to him by the welfare agencies to become self-sufficient through employment. Although the ultimate goal will be to move as

many persons as possible into regular employment, the Secretary would have to establish alternative programs to meet the needs of recipients for whom this approach is not immediately feasible.

Priority I.—Regular Employment and On-the-Job Training

Under the first priority the Department of Labor would inventory the work history of each person, using aptitude and skill testing where indicated, in order to get a good picture of the employment potential of each person. Those who have work skills needed in the locality would be referred to potential employers. As many of such individuals as possible would be moved immediately into regular employment. Others might be moved into on-the-job training slots under existing Federal training programs (where the employer could be reimbursed for extra costs for training these people). The earnings exemption would apply to their earnings; if earnings are high enough, the family would leave the AFDC rolls.

Priority II.—Institutional and Work Experience Training

Under the second priority those individuals for whom some form of training, classroom or work experience, is needed would be assigned to the training suitable for them and for which jobs were available in the area. During the training period these individuals would receive their public assistance grant plus up to $20 a week as a training incentive. No payments would be made to these individuals by the organization furnishing the training. The type of training available would include basic education, teaching of skills in a classroom setting, employment skills, work experience, and any other training found useful. Only public employers and private nonprofit employers organized for a public purpose (including councils of Indian tribes living on a reservation) could be used in work experience projects in order to avoid any possible abuse.

Priority III.—Special Work Projects

Under the third priority, the Department of Labor would enter into agreements with public agencies and private nonprofit agencies organized for a public purpose (including councils of Indian tribes living on a reservation) for special work projects to employ those for whom jobs in the regular economy cannot be found at the time and for whom training may not be appropriate.

Participants in these projects will receive a wage from their employer for time worked instead of their regular assistance grant. The assistance grant for each participant (or 80 percent of the wages, whichever is less) will be paid by the State welfare agency to the Secretary of Labor. The Secretary will place the money received into special accounts which would be used to reimburse employers of participants in special work projects for a portion of the wages paid to participants.

The Secretary of Labor would contract for work for the participants in the project on the best terms he could negotiate and the amount of the funds paid by him to an employer would depend on those negotiations. The amount of funds sent to employers could not be larger than the funds sent to the Secretary of Labor by the State welfare agency.

The Secretary of Labor would negotiate each special work project in order to obtain a contribution to the wage payment from each employer which fairly represents the net value of the services which the employer will receive from participants. It is expected that in many

cases the Secretary will be able to arrange for a high enough contribution from employers so that he will not need all of the money paid into the accounts by the welfare agency. Any moneys returned to the welfare agency will be regarded as overpayments of assistance which is subject to recovery by the States and the Federal Government.

During fiscal year 1969, the first full fiscal year of operations, and for public agencies and councils of Indian tribes only, the Secretary of Labor would be authorized to pay into such accounts the difference between the amount paid in by the welfare agency and the wages each participant would get—in effect the Government could pay the public agencies' share for that year. (The cost of this provision would be about $8 million.)

Employees who work under these agreements would have their situations reevaluated by the local Department of Labor agency at regular intervals (at least every 6 months) for the purpose of moving as many such employees as possible into training or regular employment under priority I or II.

An important facet of this suggested work program is that in most instances the recipient would no longer receive a welfare check. The wage paid by employers to each participant will be a "true" wage in the sense that it will be subject to all of the income, social security, and other taxes just as if it were a wage in regular private employment. The bill guarantees each participant that he will receive the minimum wage required by law if such law is applicable to the work he performs.

Participants are guaranteed that their total income while engaged in the project will equal at least the amount of the assistance grant to which they are entitled plus 20 percent of the wages paid to them by their employer under the project. If the wages alone do not equal that amount, the bill provides for a supplemental assistance grant to be paid to such participants by the State welfare agency. In no case does the State welfare agency pay to the program a total which is more than the maintenance grant otherwise would have been.

The agreements between the Secretary of Labor and public or private nonprofit employers, including Indian tribes, for operation of these projects will provide for—

1. The portion of the wage to be paid by the employer and the portion to be paid by the Secretary;
2. The wage rate to be paid to each participant and the number of scheduled hours of work per week;
3. Access by the Secretary to the premises where the work will be conducted;
4. Termination of any agreement by the Secretary at any time.

The Secretary of Health, Education, and Welfare will take appropriate steps, under the provisions of the bill, to assure that the payments from State welfare agencies to the Secretary of Labor are made in a timely manner so as to insure that the Secretary of Labor will be able to make the regular payments to special work project employers in accordance with the agreements for the operation of the projects.

Each State is authorized to establish one or more review panels which will have authority to approve finally the establishment of all special work projects in which participants are to be employed. These panels may be composed of not more than five members—one

representing industry, one representing labor, and the remainder representing the general public.

The bill would require the Secretary of Labor to limit institutional and work experience training (priority II) so that the average training period does not exceed 1 year in each area in which a program is established. The committee expects the Secretary will be able to operate programs with an even shorter average duration, but does want to have an outside limit.

The committee believes that attention must be given to job development, and job placement, if the goals of the committee are to be realized. It seems obvious that the regular labor market channels are insufficient, and sometimes discriminate against those on welfare. The utilization of the Department of Labor enhances the possibility of reaching employers and unions for purposes of developing permanent, meaningful jobs. Special placement efforts are also required. Both of these efforts must begin early in the training of the individual, and any job placement should be followed up to insure that initial employment difficulties are overcome. The purpose of the program is employment, not simply training, and the Labor Department is encouraged to put emphasis on these aspects to assure the highest possible degree of success.

The bill would provide that "followup" services related to the work incentive program and provided by the Secretary of Labor may continue for such period as the Secretary determines is necessary in order to qualify an individual for full employment even though he may no longer be eligible for an assistance grant. Consultation with the Secretary of Health, Education, and Welfare is required prior to issuance of regulations on continuation of services in order to assure proper coordination with the continuation of necessary welfare services such as day care. The Department of Labor believes that followup services provided in this manner will indirectly reduce AFDC rolls by substantially cutting the number of families returning to welfare from unsatisfactory working experiences.

The Secretary of Labor may assist participants to relocate their residence when necessary in order to enable them to become permanently employable and self-supporting. Such assistance may not exceed the reasonable cost of transportation for the family and its household goods and a reasonable relocation allowance. Relocation assistance may only be given to persons who will be employed at their place of relocation at wage rates which will meet at least their full need as determined by the State to which they will be relocated. No participant may be forced to relocate. The committee envisions only rare and limited use of this provision. The average cost of relocating each family is estimated by the Department of Labor at only $360, substantially less than what it expects, on the average, to save in public assistance funds per family.

Under the bill the Secretary of Labor is to conduct evaluations of the program. Despite the full responsibility in the Labor Department for the operation of the work incentive program, the Secretary of Health, Education, and Welfare must also play a role in evaluation since his agencies will have the responsibility for referral and the provision of social and welfare services.

Under the bill, the Secretary of Labor has been given full authority over the work incentive program. Full responsibility and accounta-

bility accompany this authority. Thus it is particularly essential that the Congress be kept fully informed on the progress achieved and the problems developing under the program. Accordingly, the Secretary of Labor is required to submit an annual report to the Congress, the first one due on or before July 1, 1970. The committee, on the experience with the work incentive program, urges that the Secretary report, if possible, by July 1, 1969.

Financing

Federal contributions to the cost of work incentive programs under the new part C of title IV may not exceed 90 percent of the total cost. The required 10 percent non-Federal contribution may be in cash or in kind. In computing the cost of a program, the amount of employers' contributions to wages under the special work projects and the cost of evaluation and research are not included.

In the event the 10 percent non-Federal contribution is not made in any State, the Secretary of Health, Education, and Welfare may withhold amounts due to the State under other specified public assistance titles of the Social Security Act until the amount so withheld together with the amount of any non-Federal contribution made within the State equals 10 percent of the cost of the work incentive program. Any amounts so withheld will be transferred to the Secretary of Labor for use in paying the cost of work experience programs within the State and shall be considered as if they were a non-Federal contribution. This provision is an expression of the committee's determination that this program shall be fully and expeditiously implemented.

Costs

The tables below (supplied by the Department of Labor and the Department of Health, Education, and Welfare) indicate the estimated relative costs and savings and the numbers of people involved under the House bill and the proposed program. The net costs to the program over a 5-year period are somewhat less under the proposal—$1.18 billion as compared to $1.25 billion under the House bill—even though during the period, the Labor Department estimates that 310,000 more persons are trained under the proposal than would have trained under the House version. Moreover, it is estimated that 230,000 more persons will be placed in full-time employment (not including employment in the special projects under priority 3) under the proposal than under the House bill. Also, it should be noted that by the end of fiscal year 1972, savings through welfare roll reductions are expected to total $710 million in Federal funds as opposed to only $195 million under the House-passed bill. (See also State and local savings in footnote 1 of table I.) The increased first-year costs under the program are due largely to the Labor Department's ability to get the program operational in a very short period of time and serve a larger number of persons.

The estimates of greater full-time job placements and AFDC savings result from the increased utilization of the manpower training expertise and resources of the Department of Labor.

Increased taxes employed recipients would pay are not reflected in the table. Neither, of course, are the intangible benefits to society, such as the fact that the children in these homes will have the example of a

working parent to emulate, and the fact that the working parent may have a more positive attitude toward society in general.

TABLE I.—WORK-TRAINING IMPACT UNDER HOUSE BILL AND PROPOSAL

Fiscal year	Work-training expenses (millions)		Federal AFDC reduction due to training (millions)		Trainees (thousands) [2]		Full-time job placements	
	House bill	Proposal	House bill	Proposal [1]	House	Proposal	House	Proposal
1968	.....	$130	.....	.....	.....	100	.....	.....
1969	$45	[3] 190	.....	−$41	50	140	.....	50
1970	90	195	−$10	−115	100	150	[4] 10	70
1971	135	247	−55	−214	150	190	20	75
1972	225	364	−130	−340	250	280	30	95
Total	495	1,126	−195	−710	550	860	60	290

[1] State-local costs will also be reduced as follows: Fiscal year 1969, $31,900,000; fiscal year 1970, $90,200,000; fiscal year 1971, $168,300,000; fiscal year 1972, $267,300,000.
[2] Does not include recipients on phase III work projects.
[3] Includes $8,000,000 1-year cost for phase III work projects (for public agencies).
[4] Based on 20-percent placement assumption used by HEW in preparing figures.

TABLE II.—NUMBER OF CHILDREN RECEIVING FEDERALLY SUPPORTED DAY CARE AND FEDERAL SHARE OF THE COST

[Dollar amounts in millions]

	Children of mothers in training		Children of employed mothers		Total Federal cost	
	Children	Cost	Children	Cost	House	Proposal
1968	.....	.....	.....	.....	.....	.....
1969	50,000	$55	.....	.....	$75	$55
1970	100,000	100	25,000	$15	155	115
1971	160,000	160	70,000	30	250	190
1972	340,000	340	120,000	60	470	400
Total	.....	655	.....	105	950	760

RELATION TO TITLE V OF THE POVERTY PROGRAM

Finally, it is the understanding of the committee that the administration is going to phase out the work experience and training program under title V of the Economic Opportunity Act. Such action appears highly desirable inasmuch as there is much duplication between that temporary program and the permanent work training programs provided by this committee, and the Committee on Ways and Means, under the Social Security Act.

ILLUSTRATIONS OF HOW WORK INCENTIVE PROGRAM MIGHT OPERATE

Priority I.—Regular Employment and On-the-Job Training

A local public welfare agency screens all of its AFDC cases and finds after furnishing various social and medical services that 45 women and six men are appropriate for referral to the Secretary of Labor for participation in the work incentive program. The welfare agency works out child-care arrangements for the mothers where necessary.

The Secretary of Labor provides employment testing, interviewing, and counseling and determines that seven of the women have skills that are wanted in the locality and places them in jobs. (In several cases it was the lack of day care services which previously had kept the women from taking regular work.) The earnings of some of these women are high enough that they need no more assistance and go

off the welfare rolls. In other cases they earn enough to reduce their assistance payments, in varying amounts.

The Secretary of Labor arranges for one of the men to go into an on-the-job training project where an employer pays him regular wages. Such on-the-job training programs exist now under the Department of Labor and the proposed program would follow the same pattern.

All AFDC recipients who go into employment would qualify for the earnings exemption provided under the bill.

Priority II.—Institutional and Work Experience Training

The Secretary of Labor finds that 20 of the women referred to him show manual dexterity skills which offer good promise that they can be trained for jobs in the area. Those women are referred to a training course established under the Manpower Development and Training Act. They are paid $20 a week as a training incentive in addition to their assistance payment. The women actually are enrolled in a classroom type course learning how to be nurses' aides.

Eight of the women are referred to a work-training project with a department of the city government because it was determined that they needed several weeks of actual work experience to get accustomed to a pattern of employment and to gain self-confidence in a work situation. These women also were given $20 a week as a training incentive. Several of these were later trained in a specific skill and placed in regular employment. Four of the five remaining men were placed in an electronics course to learn how to be TV repairmen. Their families continued to receive the AFDC assistance grant (increased to take into account any increased needs arising from the training) while they were in training plus the $20 a week incentive payment. When the training is over the men would be placed in regular jobs and would go off the AFDC rolls.

Priority III.—Special Work Projects

The labor agency finds that 10 of the women and one man have no skills which are in demand in the area and have very low aptitude for learning skills which are likely to be in demand. The labor agency enters into an agreement with a local school board under which the 10 women act as playground assistants in various schools and the man acts as hall guard in a school with severe discipline problems. The agreement further specifies that these people will work for 35 hours a week at $1 an hour and that the $1 will be evenly divided between the school board and the labor agency. (The agreement would be subject to approval by the State work incentive review board if the State established one.)

Thus, each person—working 35 hours a week at $1 an hour—will receive about $150 a month in wages. In this case the welfare office would pay the following amounts of public assistance to these workers if they were not in the program:

4 women, grant of $80	$320
4 women, grant of $100	400
2 women, grant of $110	220
1 man, grant of $200	200
Total	1,140

The welfare office sends $1,080 to the labor agency—retaining $80 it would otherwise have paid to the recipient receiving a grant of $200.

The four women whose grant would have been $80 are $70 better off; the women getting $100 are $50 better off, the women receiving $110 are $40 better off, and the man whose grant would have been $200 would get his wages of $150 plus $80 in payment from the welfare agency. (This latter computation is made under the provision which would guarantee that a worker will receive at least 20 percent of his wages plus the family grant for his work.)

Since the labor agency has negotiated an agreement which provides for a substantial employer contribution to the wages, it is able to return $235 to the welfare agency. This saving is shared by the States and Federal Government.

The labor office keeps in close touch with the school board about the performance and work habits of the people and furnishes counseling where needed. In one case, the labor office arranges for the welfare agency to furnish social services to help with a family problem which is influencing behavior at work. After several weeks the labor office receives a request from a private day care center for a classroom aide and one of the women, who has learned good work habits, is referred to and gets the job. There she becomes self-supporting and leaves the welfare rolls.

(b) Employment and comprehensive service program for each family

Under the Social Security Act Amendments of 1962, an amendment was added to title IV requiring the State welfare agency to make a program for each child, identifying the services needed, and then to provide the necessary services. This has proven a useful amendment, for it has required the States to give attention to the children and to provide services necessary to carry out the plans for the individual child. For instance, it has made social workers see that children are in school. With the emphasis in the bill on plans for employment of all adults, the prevention of births out of wedlock and otherwise strengthening family life, the committee believes that it is essential to broaden the requirement for the program of services for each child to include the entire family. The committee bill would require, therefore, that the States establish a social services program for each AFDC family. Thus there will be a broadened emphasis to include a recognition of the needs of all members of the family, including "essential persons."

State welfare agencies would be required to provide the social services determined to be needed for an effective work incentive program. Family planning services are also to be offered to the recipient and, in accordance with provisions in the bill, can be accepted or rejected in accordance with the dictates of the individual's religion or conscience. The term "family services," under the committee bill, is defined to include services to preserve, rehabilitate, reunite, or strengthen the family. The term includes services which are specifically designed to assist the family members to attain or retain capability for maximum self-support and personal independence.

The committee believes that many mothers of children on AFDC would like to work and improve the economic situation of their families if they could be assured of good facilities in which to leave their children during working hours. In addition to other provisions which

will provide incentives to work and training, the bill would require that the State welfare agencies make arrangements for adequate day care facilities for the children of working mothers. In addition, the committee believes that it may be worthwhile for the States to work out arrangements under which some mothers on AFDC can care for the children (and get paid for it) of other AFDC mothers who take jobs. (The committee is aware that this is an idea dating back to the 1930's, but urges the States to experiment with this and other methods to bring these families into the mainstream of American economic life.) The House bill contains no provision defining the day care arrangements which would be satisfactory. Under the committee bill the day care standards applicable to child welfare plans (as modified by another provision in the committee bill) would also apply to the day care arrangements for AFDC children.

The committee is aware that in a few States child welfare services are in separate organizational units from services offered through the unit providing services to AFDC recipients. This separation, whether it occurs on the State level or in the local unit of the welfare department, diminishes the prospect of the State being able to concentrate the available help for the families that need this help. For this reason, the House bill provided that the services for each family must be provided by a single State and local agency by July 1, 1969. The committee is aware that there are separate State agencies in two States, Kentucky and Illinois, which for some years have been functioning successfully. The services of one agency includes child welfare services and another administers the AFDC program. The committee is recommending a modification of the bill to permit separate State agencies to exist under this provision, if they were in existence prior to July 1, 1967. The bill would not require the merger of separate local agencies responsible for these programs. It expects, however, that within the State agencies not covered by this exemption, the Department of Health, Education, and Welfare will bring about the closest integration of all services for children by eliminating separate units for the different services thus focusing the total resources of the agency on the children most in need of such services. This can most effectively be done by a single organizational unit in the State agency dealing in an overall fashion with the provision of services for all children.

Under the bill, the States would submit reports to the Secretary of Health, Education, and Welfare showing the results of their experience with the social services program for each family for encouraging and making possible the employment of adults and for strengthening family life. The Secretary, in turn, would publish his findings of the programs developed by the States and would be required to submit an annual report to the Congress (beginning not later than July 1, 1970) on the programs developed and administered by the States to carry out these provisions. The report would include such factors as the numbers of AFDC recipients referred to the work incentive program; the frequency with which the programs were reviewed and revised; the extent to which, in the opinion of the States and the Secretary, the programs contributed to making families economically independent; the extent to which family planning services have been offered and accepted; the extent to which people asked to be referred to the work incentive program and the disposition of such cases; and other

pertinent factors, information, and recommendations which the Congress could use in assessing the effectiveness of these provisions.

The committee is well aware that the services which the States will be required to furnish AFDC families will impose an additional financial burden on the States. Therefore, the provisions of law relating to Federal financial participation would be amended by the committee bill to provide 75 percent Federal financial participation in the cost of all the services provided under these new requirements upon the States. In addition, as is provided under present law, 75 percent Federal sharing would be available for services for applicants and families that are near dependency. Provision of such services can help families to remain self-supporting. As appropriate for this purpose, services may be made available to those who need them in low-income neighborhoods and among other groups that might otherwise include more AFDC cases. Seventy-five percent Federal matching would also continue to be available to help meet the cost of training staff who are employed by the State or local agency or who are preparing for such employment.

Until July 1, 1969, however, the matching ratio for these various services would be 85 percent for State plans complying with the new requirements before that date, in order to encourage earlier implementation of these provisions in those States where it is feasible.

The 1962 amendments relating to social services provide that, with certain exceptions, the basic services must be provided by the staff of the State or local welfare agency. The committee bill proposes some changes in this provision to take into account the need for a variety of services in State implementation of the plan for each family. Thus, an exception is permitted, to the extent specified by the Secretary, to permit child welfare, family planning, and other family services to be provided from sources other than the staff of the State and local agency. This will permit the purchase of day-care services, which, as indicated above, the committee anticipates will be needed in great volume under the bill, and other specialized services not now available or feasible to be provided by the staff of the public welfare agency and which are available elsewhere in the community. Services may be provided by the staff of the State or local agency in some part of the State and may be provided in other parts of the State by purchase. The Secretary, in his standards governing this aspect of the program, may permit purchase from other agencies and institutions. The basic reason for the exception is the variety of existing arrangements around the country in which some kinds of services are now provided, usually institutional services, by other than the State or local public welfare agency.

The committee bill also authorizes similar flexibility in the purchase of services in the OAA, AB, and APTD programs. Provision of services with 75 percent Federal matching should be effectively available, as in the AFDC program, for recipients and those near dependency in these categories.

(c) *Incentives for employment*

Disregarding some earned income.—A key element in any program for work and training for assistance recipients is an incentive for people to take employment. If all the earnings of a needy person are deducted from his assistance payment, he has no gain for his effort.

Currently, there is no provision in the Social Security Act under which States may permit an employed parent or other relative under the AFDC program to retain some of his earnings. There is no doubt, in the opinion of the committee, that the number of recipients who seek and obtain employment will be greatly increased if, in conjunction with the work incentive program, there may be added to title IV some specific earnings incentives for adults to work. The Department of Health, Education, and Welfare has informed the committee that research and demonstration projects have illustrated that more recipients will go to work when an incentive exists.

Currently, the law provides that States may disregard the earnings of children under the AFDC program up to $50 a month per child with a family maximum of $150 a month, and up to $5 a month per recipient of any income. In addition, the earnings or any other income of a family under the AFDC program may be set aside for the future identifiable needs of children in the family.

In the past few years, there has been a proliferation of provisions enacted by the Congress, in legislation other than the Social Security Act, disregarding the income of certain public assistance recipients if the income comes from certain programs. For instance title VII of the Economic Opportunity Act provides for the disregarding of payments, for purposes of public assistance, under titles I, II, and III of that act. The first $85 a month of such income and one-half of the remainder is specified to be disregarded. Section 109 of the Elementary and Secondary School Act of 1965 provides that, for a period of 1 year, the first $85 a month earned in any month for services under that act shall be disregarded for purposes of determining need under the AFDC program. The enactment of the committee's recommendations, will supersede provisions in other legislation, as they would apply to public assistance.

These provisions for the disregarding of earnings for public assistance recipients illustrate that the principle has been well recognized that an economic incentive for employment is essential in work programs. Yet, all these provisions, taken together, are piecemeal in approach, have gaps in their coverage, are confusing to public welfare personnel administering assistance programs and are discriminatory in that earnings from regular employment are treated differently than earnings under specified programs.

Under the House-approved bill, the total earnings of children under the age of 16 are to be disregarded. Under the committee bill this provision would apply to children under 16 only if they are in school full time. Without this provision, such children might be tempted to truancy or to leave school in order to increase their earnings.

Similar provisions will apply with respect to any other individuals whose needs are taken into account in determining the need of the child and its family. The committee believes that this provision will furnish incentives for members of public assistance families to take employment and, in many cases increase their earnings to the point where they become self-supporting.

The exemption provided by the Committee on Ways and Means would require that the States disregard the first $30 a month and one-third of all additional earnings made by adults in the family. The committee bill increases the exemption to $50 a month and one-half of the additional earnings. The committee also proposes that the

same earnings exemption apply to the old-age assistance program and the permanently and totally disabled program. Under present law, the States may disregard the first $20 of monthly earnings and one-half of the next $60 a month. Thus, under the committee bill the same mandatory earnings exemption which would apply to the AFDC program will apply to the assistance programs for the aged and disabled.

The earnings exemption provisions will apply to the AFDC program only if for any one of the past 4 months the family was eligible for a payment. This provision gives people an opportunity to try employment without worrying about forfeiting their eligibility to receive assistance if their employment terminates quickly.

The bill contains provisions which will prevent increasing the number of persons receiving AFDC as a result of the earnings exemptions. The provisions discussed above are to become available for AFDC only with respect to persons whose income was not in excess of their needs as determined by the State agency without the application of this provision itself. That is, only if a family's total income falls below the standard of need will the earnings exemption be available. One possible result of this provision is that one family, who started out below assistance levels, will have some grant payable at certain earnings levels because of the exemption of earnings received after going on the rolls while another family which already had the same earnings will not be eligible for an assistance grant. The committee appreciates the objections to this type of situation which can be made; but the alternative would have increased the costs of the proposal by about $160 million a year by placing people on the AFDC rolls who now have earnings in excess of their need for public assistance as determined under their State plan. In short, the various provisions included in the committee's bill are designed to get people off AFDC rolls, not put them on. The provisions would apply only to payments with Federal participation and would in no way limit the authority of a State to include other persons at State expense. (For the aged and disabled the earnings exemption would be available without the restrictions applicable to the AFDC program.)

As an example of how these provisions would work, consider a family consisting of a mother and three children who have a grant of $200 a month. If the mother goes to work and earns $120 in a month, her family will get the $120 of earnings plus $165 of grant (one-half of the earnings above $50 would have been deducted) for a total of $285.

In order to avoid situations where people under the AFDC program would deliberately bring their earnings down in order to qualify for the earnings exemptions, the committee bill provides that individuals who deliberately reduce their earned income or terminate their employment within a period of not less than 30 days specified by the Secretary before applying for aid will not qualify for the earnings exemption.

These provisions would become mandatory on the States on July 1, 1969. States could include such provisions earlier.

(*d*) *Assistance to families with unemployed fathers*

The program of benefits for the dependent children of unemployed parents was established on a 1-year basis in 1961, extended for 5 years by the 1962 amendments to the Social Security Act and extended to

June 30, 1968, by Public Law 90-36. The program is optional with the States and currently 22 States, including nearly 60 percent of the population of the United States, have programs under the Federal legislation. Moreover, substantial numbers of similar families not living in those 22 States are receiving assistance under title V of the Economic Opportunity Act.

The committee is concerned about the effect that the absence of a State program for unemployed fathers has on family stability. Where there is no such program there is an incentive for an unemployed father to desert his family in order to make them eligible for assistance. This will be a matter of continuing study by the committee.

A major characteristic of the existing law is the authority left to the States to define "unemployment." The committee believes that this has worked to the detriment of the program because of the wide variation in the definitions used by the States. In some instances, the definitions have been very narrow so that only a few people have been helped. In other States, the definitions have been relatively broad. The committee bill is designed to correct this situation and to make other improvements in the program.

The amendments proposed by the committee would authorize a Federal definition of unemployment by the Secretary and would tie the program to the work incentive program established by the bill.

This program was originally conceived by Congress as one to provide aid for the children of unemployed fathers. However, some States make families in which the father is working but the mother is unemployed eligible for assistance. The bill would not allow such situations. Under the bill, the program could apply only to the children of unemployed fathers.

The committee bill in most respects follows the House bill, including the requirement that when a family is provided cash assistance because of the unemployment of the father, such father shall be assigned to a work or training project within 30 days.

The committee bill differs from the House bill in two significant respects. The House bill requires that in order to qualify for assistance on the basis of unemployment, a father must meet certain tests of prior attachment to the labor force. While the committee does not wish to encourage irresponsible marriages, it believes that no one needs the advantages of the work and training programs more than the man who has a wife and children but has no significant history of employment. The committee bill accordingly does not include work attachment requirements.

The House bill prohibits the payment of assistance (with Federal participation) to a family that receives any amount of unemployment compensation during the same month. Since the unemployment compensation may be for only a small part of the month, a family's income could be far below the State's standard of need and still the family would be ineligible for assistance. The committee bill returns to existing law under which the choice as to whether unemployment compensation payments can be supplemented is left to the States.

With these changes the committee bill would make the present program permanent but still at the option of the States.

(e) *Parental desertion and enforcement of support orders*

A substantial proportion of the persons receiving aid under the AFDC program are eligible because of the desertion by a parent of

the child. Several provisions are already in the law and more are proposed under the bill to provide additional ools to States and to impose further obligations on them to assure the determination of legal responsibility for support and to make efforts to make these collections. The committee believes it is essential to make certain that all legally responsible parents of sufficient means make their appropriate contribution to the support of their children.

One of the major factors which has prevented the full utilization of the resources of the law enforcement agencies is the lack of authority for the welfare agencies to reimburse the law enforcement agencies, with Federal sharing, for their expenses. The committee is proposing that this weakness be corrected by allowing Federal sharing in the reasonable expenses of the law enforcement agencies with respect to welfare recipients as a usual administrative expense of the welfare program. The committee expects that this expenditure of Federal funds will result in increased effort to enforce the laws against desertion and nonsupport. The committee also expects of the Department of Health, Education, and Welfare extreme diligence in working out the implementation of this provision to protect the Federal funds and to assure maximum benefit from the money expended. Reimbursement should be limited to the basic expenses for the personnel directly involved in the establishment of paternity, location of deserting parents, and for obtaining support from such individuals. Inasmuch as this is a normal function of Government and, thus, should be available to welfare recipients as well as all others in the community, the committee believes that a relatively small Federal contribution toward the cost of this operation should be sufficient. The committee urges, also, that local legal agencies funded through the Economic Opporнity Act give attention to helping deserted families secure support from the father.

The above requirements on the States having to do with establishment of paternity, location, and obtaining support from absent parents will absorb the attention of some full-time staff members of the State and local agencies in many areas. In order to make certain that these functions are executed with diligence and are fully coordinated, the committee bill provides that there shall be a unit established in the State agency and in each political subdivision responsible for these functions. Although in some instances these functions can be carried out by persons also carrying other responsibilities, this requirement will, normally, require staff working in this area full time.

Under previously enacted provisions of law, it is possible for State public welfare agencies to have the help of the Social Security Administration to locate the names of employers of parents who have deserted and against whom a support order is pending. From this information, it is possible for many addresses to be identified and collection procedures to be initiated. Another resource which should prove useful in the location process of locating parents who have deserted is the master file of income tax payers maintained by the Internal Revenue Service. The committee bill, therefore, sets forth a procedure by which this file is to be used in those instances in which the social security file has not provided the needed information about the parents' whereabouts.

Under this procedure the appropriate State welfare agency is to submit to the Secretary of HEW a list of fathers who cannot be

located and against whom an order for support has been issued or a petition for support has been filed. HEW then is to furnish the names to the Internal Revenue Service, together with other available information, such as social security account numbers, etc. The Service in turn is to attempt to ascertain the current address of the fathers from its master file of taxpayers and furnish them to the State agency. It is thought that by this procedure many of the fathers who have not been located under the existing procedures will be found.

Information regarding the location of the deserting parent is to be released to courts in interstate proceedings under the Uniform Reciprocal Enforcement of Support Act. State welfare agencies would also be required to provide each other full assistance in locating absent parents or in collecting from them when their location is known.

In addition to the procedure for locating deserting parents by use of the Internal Revenue Service's master file, the bill provides for the establishment of a Federal liability of the parent who is not in compliance with a court support order for the portion of the AFDC payments being made with respect to his child that is attributable to the Federal contribution, and for the collection of this liability by the Internal Revenue Service through its tax collection procedures.

These provisions apply where a court support order has been issued and the parent resides in a different State than the one in which the child resides.

If such an order has been issued, and the father is not in compliance, or in good faith partial compliance, the State agency is to attempt to obtain compliance with the order to the extent of the father's ability. In attempting to obtain compliance, the State agency is expected to inform the father that in the event he does not comply, his liability to the United States under the new procedure will be established and collected by the Internal Revenue Service.

If the State agency is unable to secure compliance, it will report the name of the father to the Department of Health, Education, and Welfare, along with information bearing upon the ability of the parent to furnish support. The State will make an assessment of the ability of the parent to make support payments, using criteria developed by the Secretary. The criteria will take into account the income of the parent and his current obligations.

If the Department of Health, Education, and Welfare determines that the State's judgment that a parent is capable of making payments is correct, it will certify to the Internal Revenue Service the amount which the parent is able to pay, and the amount so certified will become a liability of the parent to the United States. (Neither the establishment nor the payment of such liability will affect the obligation of the parent under the court's support order.) The amount certified may not exceed the Federal contributiou (determined on a general percentage basis for the State) of the aid payments being made because of the dependent child, or the amount the father would be required to pay under the court order, whichever is less. Upon receipt of a certification from the Department of Health, Education, and Welfare, the Internal Revenue Service is to assess and collect the amount certified in the same manner as it does income taxes withheld and employment taxes (except that the interest and penalties do not apply); that is, by the issuance of a notice and demand for payment and the use of the

regular tax collection procedures, including levy and distraints if payment is not received within 10 days.

The amendment authorizes the payment of the costs involved to the Internal Revenue Service in aiding in the location of the fathers and for the Service's cost in the collection of the Federal liability. The expense to the Internal Revenue Service of these procedures is to be reimbursed by the Department of Health, Education, and Welfare.

This amendment is to be effective as of January 1, 1969, with respect to amounts expended as aid to families with dependent children during periods beginning on or after April 1, 1968.

(f) Referral to courts

The committee bill would, as would the House bill, add a plan requirement on the relationship of the public welfare agency to the courts and law enforcement officials. Under present law, the States are required to report to the appropriate law enforcement officials the granting of assistance to any child who is made eligible by the desertion or abandonment by his parents (see also section (d)). This provision has not been broad enough to accomplish objectives which the committee believes are essential. There needs to be a cooperative arrangement between the courts and law enforcement officials and the welfare agencies in several program areas. The arrangement should cover the manner in which referrals are made to the court when the welfare agency believes the child's home is unsuitable because of neglect, abuse, or exploitation of a child. The agreement should also provide for calling the attention of the law enforcement agencies to such instances and giving all necessary information to the appropriate law enforcement officials. Thus, for example, if an AFDC mother is not caring properly for her children, the matter would quickly come to the attention of the courts and appropriate action taken, including the possibility of placing the children in foster care.

The arrangement might appropriately cover other areas of joint interest between the welfare agencies and the courts and the law enforcement agencies including the manner of referral to the welfare agency of instances of dependency and the need for public social services coming to the attention of the courts and law enforcement officials.

(g) Foster care in AFDC

The committee believes that some children now receiving AFDC would be better off in foster homes or institutions than they are in their own homes. This situation arises because of the poor home environment for child upbringing in homes with low standards, including multiple instances of births out of wedlock. Foster care for children is relatively costly, and States have reported that they cannot finance it without some additional Federal help. This item of care for children is frequently the responsibility of local government rather than State government. There are two limited sources for Federal funds for this program. Under the AFDC program, as amended in 1961, Federal funds are available for the care of children in foster family care or in voluntary institutions if they were recipients of AFDC when they were removed from their home by a court. This

part of the program is a small one with approximately 9,000 children currently aided under these provisions. In addition, the States may use part of their Federal child welfare grants under part 3 of title V of the Social Security Act for foster care costs. Only small sums of Federal funds are actually available from these grant funds for this purpose because of the great demands for other services.

The committee is aware of the limitations on the provision described above for foster care through the AFDC program when children are removed from their home by court order. For the State to receive any Federal sharing, the children must be recipients of AFDC when the court issues its order. The committee believes that this is an unduly limiting restriction and is proposing that this limitation be changed. There is some evidence that courts may be reluctant to place a child in foster care because Federal funds are not available (and the cost of the care must come out of local funds in many areas) unless the child is in the home of a specified relative. The proposed change would make the cost of caring for children in foster care subject to Federal sharing if the child has been placed in foster care by a court order (if the child is removed from the home of a relative as a result of a judicial determination that continuation in such home would be contrary to his welfare) and if the child would have been eligible for aid under the AFDC program if an application had been made on his behalf. Also included are children placed under court order who had been living with one of the specified relatives enumerated in the law within 6 months and would have been eligible upon application for AFDC if he were living with such relative and were removed from the home of such relative by order of the court. This latter group would include some children already in foster care at the time of this legislation and who, except for this provision, would not be eligible because they had already been removed from their homes. Temporary plans may be needed, for example, for children both of whose parents are killed in an accident and for whom the court does not take immediate jurisdiction. The child need not live with a relative and may be in a foster family home or in a voluntary institution at the time the court makes its decision.

The committee believes that the AFDC program already offers an opportunity for States to receive Federal financial assistance in the cost of care for many children who have no parents or who are not able to live with their parents. Under AFDC, children are eligible for assistance only if they are living with one or more specified relatives. Thus, if children are deprived of parental support or care for the reasons now available to States under title IV, Federal sharing is available to meet the cost. It is not necessary for the relatives who, under State law, are not legally responsible for support, to meet the test of need applicable under the State AFDC plan, if they are caring for children who are eligible under the plan. Federal sharing is available to reimburse the relative for the cost of providing a home for the child. The committee believes that greater use could be made of these present provisions of the AFDC program in this respect in order to obtain the best possible environment for the child.

Under the committee bill, Federal funds will be available on a more liberal basis than for the basic program out of a recognition that foster family care is more costly than care in the child's home. Effective July 1, 1969, State plans would have to provide for foster care

under these terms. Federal sharing will be possible in payments up to $100 a month (on an average basis) for children in foster care. The committee believes that these liberalizations will be of material assistance to States and localities and will facilitate plans being developed for children based on the need of the child rather than the fiscal condition of the local government.

(h) Protective payments in AFDC

One of the measures included in the 1962 amendments provided the State and local agencies with an additional tool to deal with an infrequent but persistent problem of misuse of assistance money. This provision for a protective payment made to a third party in behalf of the recipient has been used very little. Only seven States have approved plans for protective payments and the beneficiaries of this aspect of the program number less than 50 families in the Nation. The committee believes this is potentially a valuable provision and is including in the bill some changes to make it more usable by the States. First, each State would have to have a program available for this type of payment. Moreover, as noted previously, States would have to make these types of payments (including vendor payments) on behalf of children where the adult caretaker has refused to accept employment or participate in a work incentive program. Second, the House bill would eliminate the requirement that the States meet need in full for the particular child in order to qualify for plan approval for protective payments. The committee concurs. The House bill also would remove the limitation in the law setting 5 percent of the recipients as the maximum number of persons to whom protective payments may be made with Federal sharing. The committee bill would impose a 10-percent limitation (not including those cases where such payments were made because an adult in the family refused work or training without good cause). The bill would also require the States to have machinery to make a vendor payment with Federal sharing when the need for this kind of payment is clearly indicated. The requirements which apply to protective payments would also apply to vendor payments.

(i) Temporary emergency assistance

The committee's bill is concerned with several major objectives—to assure needed care for children, to focus maximum effort on self-support by families, and to provide more flexible and appropriate tools to accomplish these objectives. The bill broadens the provisions of protective payments, authorizes vendor payments, provides a work-incentive program, expands foster care for children, and makes day care available where needed to children of working parents. Thus, it materially improves the program in relation to the care and protection of children.

The committee understands that the process of determining AFDC eligibility and authorizing payments frequently precludes the meeting of emergency needs when a crisis occurs. In the event of eviction, or when utilities are turned off, or when an alcoholic parent leaves children without food, immediate action is necessary. It frequently is unavailable under State programs today. When a child is suddenly deprived of his parents by their accidental death or when the agency

finds that conditions in home are contrary to the child's welfare, new arrangements and court referrals may have to be made.

To encourage public welfare agencies to move promptly and with maximum effectiveness in such situations, the bill contains an offer to the States of 50-percent participation in emergency assistance payments and the usual 75-percent participation in social services that may be provided. Under the House bill, the time period in which such assistance might be provided is limited to one period of 30 days or less in any 12-month period. Under the committee bill the period would be 60 days rather than 30. The eligible families involved are those with children under 21 who either are, or have recently been, living with close relatives. The families do not have to be receiving, or eligible upon application to receive, AFDC (although they are generally of the same type), but they must be without a available resources and the payment or service must be necessary in order to meet an immediate need that would not otherwise be met.

Assistance might be in any form—money, medical aid, payment of rent or utilities, orders from food or clothing stores, etc. The provision is broad enough that emergencies can be met in migrant families as well as those meeting residence requirements of the State's AFDC program. Its utilization would be optional with the States.

The committee bill would also authorize emergency assistance for migratory labor families. The latter provision is in addition to those contained in the House bill.

(j) Limitation on aid to families with dependent children eligibles

One of the provisions in the House-approved bill would impose a limitation, for Federal financial participation purposes, on the number of children whose eligibility is based upon the absence from the home of a parent. Under the House provisions, the number of AFDC children for which Federal sharing would be available could not exceed the proportion of the AFDC children eligible because of the father's absence from the home to the total child population as of January 1, 1967.

The committee has stricken this provision from the bill. The additional changes made in the bill by the committee, especially those relating to the work-incentive program and the parental support provisions, should accomplish what the House had in mind without running the risk of depriving needy children of the assistance they require.

(k) Summary

The committee recognizes that the bill would require the States to take on new and expensive tasks. Yet, if the job is to be done—if the number of families on AFDC is to be kept to the minimum—these new activities must begin in earnest. The Federal Government, which is the main financial support for the program, must be assured that the States carry out the intent of the Congress when taking on the new and expanded functions which will be required of them.

The bill provides adequate Federal financial support for these expanded functions. It is estimated that by July 1, 1972, a cumulative 5-year total of $2,735 million will have been spent by the Federal Government on these functions. At the same time it is estimated

that the new provisions will mean that fewer children will be receiving aid in that year than if the law were continued in its present form.

Moreover, the committee intends that the Department of Health, Education, and Welfare make changes in its administrative directives under existing provisions of law which will be appropriate under the new provisions added by the bill. Specifically, the committee intends that the Department interpret its authority under present law to prescribe methods of administration which "are found by the Secretary to be necessary for the proper and efficient operation of the plan" in a manner which will support the intent of the committee.

2. Public Assistance and Child Welfare

(a) Social work manpower

The successful operation of public welfare as well as many other programs is dependent upon sufficient numbers of trained social work personnel. The effective operation of all such programs is endangered by the serious shortage of such people. At the present time, the graduate schools of social work are operating at capacity, yet the number of graduate social workers is totally inadequate to meet the growing need for persons with such skills. Undergraduate preparation for social work is almost totally lacking, yet persons with such preparation have an important part to play in many of the social welfare programs, especially the administration of vitally important public welfare services. It is well to remember that the solutions to the vexing social problems of our times may well come from those social workers who combine a sound educational background with face-to-face contact with the recipients of public welfare. The committee is concerned about the growing gap between the numbers of social workers needed and the numbers being prepared to work in this field. For many years, States have been able to receive Federal sharing in the cost of training employees or those preparing to become employees. Under the 1962 legislation, the rate of Federal sharing in this cost was raised from 50 to 75 percent. This has been a useful provision and a significant number of persons have received some training. The number, however, is totally inadequate for the needs of the public welfare program. Only about 4 percent of the workers in public welfare have a graduate degree in social work. The bottleneck right now is the capacity of the schools and colleges to prepare people for social work careers.

The committee believes that it would be a wise investment for some Federal funds to be made available to public or nonprofit private colleges and universities and to accredited graduate schools of social work (or an association of such schools or a regional education association) to help meet the cost of expanding their capacity to train social workers. The committee bill, therefore, authorizes an appropriation of $5 million for the fiscal year 1969 and each of the three succeeding fiscal years to meet part of the cost of development, expansion, or improvement of undergraduate programs in social welfare or social work and graduate training of professional social work personnel, including the cost of additional faculty, administrative personnel and minor improvements to existing facilities. Under the committee bill, no less than one-half the amount appropriated is to be devoted to the undergraduate program.

The distribution of social workers around the country is uneven and although all parts of the Nation have a shortage, in some parts the shortage is critical. It is the expectation of the committee that the Department will administer this provision in such a manner as to take into account relative need among the States for social work personnel.

(b) Homeownership and home repairs for assistance recipient

In its review of State practices in the determination of need, the committee gave some attention to the extent to which State policies make it possible for people applying for public assistance who are homeowners to retain ownership of their homes. The committee believes there are many advantages in homeownership and does not want the assistance programs to diminish homeownership. To accomplish the committee's goal, the cost of taxes, home repair and maintenance must be recognized as an item in the State standards of assistance. There is authority under present law for States to give consideration to these costs and it is indeed essential for States to do so if the housing standards of assistance recipients are to be maintained and improved.

Obviously, States have no difficulty in including in the assistance standards amounts for taxes and other regular charges in lieu of rent. Problems do arise, however, when it becomes necessary for repairs to be made in order to achieve or maintain decent housing for recipients who own their homes. It is usually not feasible to give recipients even relatively small sums for repair. The House bill provides that States may under title I, X, XIV, or XVI make payments, under certain specified conditions, for home repairs or capital improvements, with Federal sharing at the dollar-for-dollar rate. The committee bill would also apply this provision to the AFDC program under title IV. This kind of expenditure is limited to a total of $500 and would be made only when such expenditures will assure the recipient of continued use of his home and when the expenditure will provide housing at less cost than rent for suitable accommodations.

The committee concurs with the Committee on Ways and Means in asking the Secretary of HEW to make a study of State policies with respect to homeownership and to report his findings to the committees together with recommendations on ways the housing standards of assistance recipients may be improved. The committee expects to have the report by January 1, 1969.

(c) Demonstration projects

One of the most potentially useful provisions included in the 1962 amendments provided the Secretary with authority to waive requirements in the law in the interest of encouraging demonstration projects in States and to provide some additional financing. The statute authorized $2 million a year to be available to help finance demonstration projects by State public welfare agencies. A program that expends in excess of $5 billion annually in Federal funds needs the advantage of experimentation in order to discover ways of improving the quality of administration and to further assist the needy to become self-supporting or better able to care for themselves. States have reported limitations on their ability to initiate demonstration projects because the

$2 million does not permit all worthy proposals to be approved. The House bill proposes that this amount be raised to $4 million. The committee bill would raise this amount to $10 million.

While the committee realizes that not all demonstrations will be successful, and is aware of criticism which has been made about the present program, it has urged the Department of HEW to use these funds in an intelligent, imaginative fashion. To assure that these projects and other experimental, pilot, or demonstration projects which are funded in total through the Social Security Act achieve these goals, the Secretary or Under Secretary of Health, Education, and Welfare must personally approve each such project and promptly notify the Congress with respect to its purpose, cost, and expected duration. It is also expected that reasonable efforts will be made to avoid duplication with respect to such projects.

(*d*) *Partial payments to States*

Under current provisions of law, when a State fails to comply with its State plan or otherwise does not comply with any of the provisions for State plans contained in titles I, IV, X, or XIV of the Social Security Act, the penalty, after proper notice to the State and an opportunity for a fair hearing, is the suspension of Federal funds for the entire categorical program under question. This is such a severe penalty that it is virtually impossible to invoke. To remedy this situation, the committee bill includes a provision giving the Secretary the authority to withhold payments to a State with respect to that part of the State plan which is not being complied with.

(*e*) *Repatriation program*

For some years, a small program has been in existence to provide temporary assistance to Americans in this country who have been repatriated from abroad because of personal difficulties or because of international incidents. This is a program which has helped only a relatively few people, but for the individual involved, the help has been important. The Department of State has responsibility to bring the individual to the shores of the United States, but it has no authority to provide help in the United States. The provision is scheduled to expire June 30, 1968. The committee bill would extend this date one year to June 30, 1969.

(*f*) *Increasing the benefits for the aged*

Social security benefits have been increased 15 percent across the board by the committee with a minimum of $70, for an average increase of 20 percent. However, there is no similar across-the-board increase in the amount of benefits payable to aged welfare recipients. To the contrary, for those social security beneficiaries who are also receiving public assistance the increase in social security would usually result in a reduction of their old-age assistance payment, unless the increase should be sufficient to make the receipt of assistance unnecessary and they lose their eligibility for welfare altogether. In view of this situation and the need to recognize that the increase in the cost of living since the last change made in the Federal matching formula in 1965 also is detrimental to the well-being of these recipients, the

committee is recommending a further change in the law. It is proposed that the law be amended to provide that recipients of old-age assistance, aid to the blind, and aid to the permanently and totally disabled shall receive an average increase in assistance plus social security or assistance alone (for the recipients who do not receive social security benefits) of $7.50 a month. This would be financed in large part by the savings the States would otherwise make from the social security benefit increase. The increase described above would be about three-fourths of the savings that would otherwise be realized from the benefit increase. The other one-fourth represents a savings to the States and the Federal Government.

Inasmuch as the impact of this change does not fall evenly on all States because of the differences in the proportion of recipients who are receiving social security benefits, a further provision is included under which the Federal Government may pay the additional amount, approximately $25 million a year, to some States which would otherwise not be able to meet these costs from savings during the 2-year period ending June 30, 1970.

To accomplish these changes, the States would have to adjust their standards and any maximums imposed on payments by July 1, 1968, so as to produce an average increase of $7.50 from assistance alone or assistance and social security benefits (or other income). Any State which wishes to do so can claim credit for any increase it may have made since December 31, 1966. Thus, no State needs to make an increase to the extent that it has recently done so.

States would be required to price their standards used for determining the amount of assistance under the AFDC program by July 1, 1969 and to reprice them at least annually thereafter, adjusting the standards and any maximums imposed on payments to reflect changes in living costs.

(g) *Use of subprofessional and volunteer staff*

The committee is aware that a variety of jobs must be done in the administration of the public assistance programs and that not all of them require the services of professional staff. Some tasks can be done by persons with less than college education—high school graduates or even by persons with less than high school education. The use of subprofessional staff has not been sufficiently developed by public welfare agencies nor has the use of community service aides reached its potential. For this reason, the bill would require the States to amend their plans by July 1, 1969, to provide for the training and effective use of paid subprofessional staff emphasizing the full-time or part-time employment of recipients and other persons of low income as community aides.

Volunteers have a place in the administration of the public welfare in providing services to recipients and by their serving on advisory committees of the State and local agencies. Volunteer services have a mittees of the State and local agencies. Volunteer services have a distinguished history in social welfare agencies of this country and a greater use of this source of help is needed in public welfare. For this reason, the bill also provides that States must, effective July 1, 1969, use the services of volunteers. These amendments would apply to all the public assistance programs including medical assistance.

Although the provisions would become mandatory on the States on July 1, 1969, they would be optional with the States immediately upon enactment of the bill.

(h) Study of services given to recipients

The committee is aware of the lack of authoritative information on the extent to which the staff of public welfare and medical assistance agencies or staff of related programs are serving the needs of public welfare recipients in securing the full protection of local, State, and Federal health, housing, and related laws and in making the full use of public assistance and related programs in the community. Public assistance recipients come to public welfare and medical assistance agencies with a variety of problems of which the need for financial or medical assistance is only one. Although the Federal law has been amended several times to make clear the obligation of the staff of such agencies to provide constructive, helpful services, this is not always done and to some degree, therefore, the needs of needy people for services are not met.

The committee is directing, therefore, that the Secretary make a study of this situation and report back to the Congress by July 1, 1969, the results and recommendations of his study. It may be that additional changes to the law are needed and if so, it is expected that the Secretary will make the necessary recommendations. It is expected that the study will also include information on the extent to which the public assistance program should be used as a means of enforcing local, State and, where applicable, Federal health, housing, and related laws. The committee is concerned over the persistent reports that assistance recipients live in housing which does not meet the standards of local housing codes, that assistance recipients often pay more for goods and services than do self-supporting persons, and that the education laws are not fully enforced with respect to the school attendance of children in recipient families. This entire situation needs exploration and some proposals made, where indicated, to improve the protection afforded by the community to the most needy people living therein.

(i) Simplifying administrative procedures

The committee has been concerned over the reports it has received of the excessive paperwork and unduly burdensome procedures which hamper the administration of the public assistance programs. The point in the process in which these seem to concentrate is in the determination of eligibility for assistance and medical care. Complicated budgeting procedures delay the receipt of assistance by eligible persons and take unwarranted time of the administering staff. The Department of Health, Education, and Welfare has recognized this problem and has by administrative action moved to require the States to simplify their procedures. The committee believes the Department is correct in this action and that a provision in law will further support the Department in its efforts. For this reason, your committee is recommending an amendment to the public assistance titles of the act—I, IV, X, XIV, and XVI—to require the States, effective July 1, 1969, to simplify administration consistent with the best interests of the recipients.

(j) Child welfare services

In addition to providing substantially greater Federal participation in the cost of foster home care under the aid to families with dependent children program, the House bill would consolidate grants for child welfare services under the same title of the Social Security Act as AFDC and would strengthen the program by—

(1) Increasing the authorizations for appropriation from $55 million for the fiscal year ending June 30, 1969, and $60 million for the fiscal year ending June 30, 1970, and each fiscal year thereafter to $100 million for the fiscal year 1969 and $110 million for each fiscal year thereafter with a large part of the increase intended to meet the costs of foster care; and

(2) Amending the child welfare research and demonstration authority now contained in section 526 of the Social Security Act to make possible dissemination of research and demonstration findings into program activity through multiple demonstrations on a regional basis and to encourage State and local agencies administering public child welfare services programs to develop and staff new and innovative services; and to provide contract authority to make it possible to direct research into neglected and vital areas.

The committee agrees with the changes made in child welfare in the House bill, but would place greater emphasis on day care. The committee bill would increase the child welfare services authorization by $25 million for 1969 and by $50 million for 1970 and succeeding years, thus providing child welfare services authorizations of $125 million for 1969 and $160 million annually thereafter.

The committee bill also would add language to the statute assuring the involvement of parents as well as of the child in day care programs established under the bill. Opportunities would be provided for parents to participate in decisionmaking, in program activities and in parent education activities such as classes in child nutrition and child rearing.

States use Federal funds together with State and local funds to provide child welfare services through State and local departments of public welfare. States are required to match Federal funds appropriated under the authorization on a variable basis ranging from 33⅓ to 66⅔ percent, but actually the Federal share amounts to only about 10 percent of total expenditures.

Foster children are not the orphans that agencies frequently served in the past. Less than 2 percent of the children in public child welfare agency caseloads have lost both parents by death. Today, the majority are the children of immature and inadequate parents who themselves usually show the scars of harmful family conditions. It is estimated that at least 10,000 child abuse cases annually result from injury inflicted on children by their own parents. However, this figure represents only about 10 percent of the larger problem of child neglect cases.

In March 1966 nearly 574,000 children received services from public child welfare agencies, a 9-percent increase over March 1965. Just under half of these children lived with parents or relatives, about a third were in foster family homes, 10 percent were in institutions, and

7 percent in adoptive homes. Total expenditures for public child welfare services in 1966 were over $397 million.

In March 1966, the number of children receiving foster care through public child welfare agencies increased to about 245,600 or a 6-percent increase over March 1965. Expenditures for foster care payments in 1965 were about $229 million, with State and local governments meeting 98 percent of the costs. They accounted for 65 percent of the total expenditures of State and local public welfare agencies for child welfare services in that year. In 1966 expenditures for foster care were over $258 million.

The committee believes that the increase in the authorization for appropriations for child welfare services included in the House bill will be of substantial help to States in meeting the costs of foster care of children in need of such care, and will expect States to use most of their increased allotments of Federal funds which result from the House increase for foster care of children. The change in the foster care provisions of the AFDC program described previously will increase Federal participation in foster care by $20 million in the fiscal year 1970. The committee further expects States to use most of their increased allotments as the result of this committee's action for day care.

(k) Cooperative research and demonstration projects

In 1956, Congress enacted section 1110 of the Social Security Act which authorizes grants, contracts, and other cooperative arrangements for projects related to the reduction of dependency and similar purposes. The authority is limited to such arrangements with public and nonprofit private agencies. The Department of Health, Education, and Welfare has advised the committee that in the field of social research some of the best work is being done by profitmaking establishments and that the number of nonprofit organizations engaging in such research is extremely limited. While the committee does not believe it would be appropriate to make grants to profitmaking agencies, it does believe that the Department should be able to contract with whatever organization or agency can best do research jobs that are desired to be undertaken by the Department. The bill accordingly deletes the requirement that contracts be limited to nonprofit agencies.

(l) Puerto Rico, Virgin Islands, and Guam

The committee has been advised by representatives of the Government of Puerto Rico that the dollar limitation of $9.8 million on assistance payments and certain other expenses which is included in section 1108 of the Social Security Act unduly limits the expansion and improvement of public assistance programs and that certain other provisions of the committee's bill cannot be promptly implemented. The bill accordingly provides for five annual increases in the limitations and makes a number of other adjustments. Proportionate in-

creases have been made in the dollar ceilings and similar delays in effective dates have been authorized for the Virgin Islands and Guam. The dollar ceilings would be:

Fiscal year	Puerto Rico	Virgin Islands	Guam
1968	$12,500,000	$425,000	$575,000
1969	15,000,000	500,000	690,000
1970	18,000,000	600,000	825,000
1971	21,000,000	700,000	960,000
1972 and thereafter	24,000,000	800,000	1,100,000

In addition to these amounts, the Secretary is authorized to certify additional payments to be used in relation to work incentive programs and for family planning services in the following amounts:

Puerto Rico	$2,000,000
Virgin Islands	65,000
Guam	90,000

The provisions of the bill which impose limitations on Federal sharing with respect to medical assistance relate income eligibility for such assistance to the amount of cash assistance paid. In Puerto Rico, these amounts are about $8 for an adult recipient and $13 for a family. These provisions would impose a cutback in these programs greatly exceeding that of any State. The bill would accordingly exempt the three jurisdictions from the relationship applicable to the States. In lieu thereof, it would place the following limitation on the amount of Federal contribution to title XIX programs.

Puerto Rico	$20,000,000
Virgin Islands	650,000
Guam	900,000

The rate of Federal participation in medical assistance for the three jurisdictions is reduced from 55 to 50 percent (the same percentage that is applicable to other assistance).

The requirement for freedom of choice in medical assistance programs (i.e., of hospital, doctor, etc.) is deferred to July 1, 1972; as is the requirement for partial exemptions of earnings. With regard to the latter, the committee expects the Secretary and the Commonwealth, or the appropriate agencies of the other jurisdictions to work out a somewhat lower figure that is appropriate in view of the differences in income.

The rate of Federal participation in social services would be 60 percent in these jurisdictions.

(m) *Detail of public welfare costs in committee bill*

PUBLIC WELFARE COSTS IN H.R. 12080 AND COMMITTEE BILL

[In millions of dollars]

	Fiscal year 1968		Fiscal year 1972	
	Committee bill	House bill	Committee bill	House bill
Public assistance:				
AFDC costs if there is no change in present law [1]	$1,462	$1,462	$1,837.0	$1,837.0
Title XIX costs if there is no change in present law [2]	1,391	1,391	3,118.0	3,118.0
All other public assistance costs if there is no change in present law [3]	1,647	1,647	1,776.0	1,776.0
Subtotal, present law	4,500	4,500	6,731.0	6,731.0
ncrease in the bill:				
Day care	(4)	(5)	400.0	470.0
Other social services	(4)	(5)	125.0	125.0
Earnings exemption	(4)	(5)	55.0	35.0
Work-training	130	(5)	364.0	225.0
Foster care under AFDC	(4)	(5)	40.0	40.0
Emergency assistance	(4)	(5)	70.0	35.0
Puerto Rico, et al	(4)	(5)	17.5	17.5
Demonstration projects	(4)	(5)	8.0	2.0
Additional child health requirements in title XIX	.....	.....	50.0	50.0
OAA, AB, APTD spouses under medicaid	(4)	.....	17.0	.....
Medical review program for nursing homes, and mental hospitals	.....	.....	10.0	.....
Unemployed parent amendments	(4)	.....	4.0	.....
Subtotal, increases	[4] 150	[5] 25	1,160.5	999.5
Decreases in the bill:				
AFDC reductions for persons trained	.....	.....	−340.0	−130.0
Restrictions on title XIX	.....	.....	−1,294.0	−1,434.0
Decrease in public assistance due to social security benefit increase	−50	−85	−75.0	−210.0
Federal participation in cost of care in "physical care facilities"	.....	.....	−29.0	.....
Collections from runaway parents	.....	.....	−3.0	.....
AFDC limitation	.....	−18	.....	.....
Subtotal, decreases	−50	−103	−1,741.0	−1,774.0
Net cost or savings due to public assistance amendments	100	−78	−580.5	−774.5
Total, public assistance as amended by bill	4,600	4,422	6,150.5	5,956.5
hild welfare:				
Present law	55	55	60.0	60.0
Increase for child welfare services	.....	.....	100.0	50.0
Increases for child welfare research	.....	.....	15.0	15.0
Subtotal, increases	.....	.....	115.0	65.0
ocial work manpower	.....	.....	5.0	5.0
Net public welfare cost or savings in bill	100	−78	−460.5	−704.5

[1] Assumes annual increase in the rolls of about 200,000 based on the experience of the past several years; allows increase of $1 each year in the average monthly payment per recipient, in line with recent experience.
[2] Includes all medical vendor payments; assumes 5 percent annual increase in unit costs after 1968, assumes implementation in all jurisdictions by fiscal 1969.
[3] Assumes continued decline in number of OAA and AB recipients, and continued increase in APTD, based on experience; allows increases for average payments.
[4] 1968 cost of $20,000,000 related to these items is undistributed.
[5] 1968 cost undistributed.

3. Medical Assistance Provisions

(a) *Background of provisions*

The Congress included in the Social Security Amendments of 1965 provision for grants to the States for a medical assistance program—title XIX of the Social Security Act. This Federal-State program, designed to assist low-income persons who were unable to meet the costs of necessary medical care, was built upon the principles of the 1960 medical assistance for the aged program by extending it to in-

clude needy children and other persons encompassed within the public assistance categories for the blind and disabled. States availing themselves of the new program were provided a more systematic basis for medical payments on behalf of recipients of public assistance and other medically needy persons.

States have taken advantage of the new title rapidly. Thirty-six States, Guam, Puerto Rico, and the Virgin Islands already have programs in operation. While most of the State plans raise no question at this time, a few go well beyond the committee's intent and what the committee believes to have been the intent of the Congress.

(b) Limitation on Federal financial participation under title XIX

The committee has followed the developments in the medical assistance program with deep concern over its rapidly rising costs. The tendency of some States to identify as eligible for medical assistance under title XIX large numbers of persons who could reasonably be expected to pay some, or all, of their medical expenses has not only significantly increased the amount of Federal funds flowing into this program currently but has developed future cost projections of a level totally inconsistent with the expectations of the Congress when it enacted title XIX in 1965.

This problem was considered in the House, and the bill which that body passed contained provisions which would limit the persons classifiable as "medically indigent." While agreeing with the objective of the House bill, the Committee bill contains substitute provisions for those approved by the House. These changes are designed to reach the same, perhaps even a greater, magnitude of reduction in Federal obligation as does the House-approved bill, but does so in a more equitable, simple, and direct manner.

Under the House-approved bill, Federal sharing would not be available toward the medical costs for a family whose income exceeds 133⅓ percent of the highest amount paid to a family of the same size, without any income or resources, in the form of a money payment under the aid to families with dependent children (AFDC) program, or, if lower, 133⅓ percent of the average per capita income of a State applied to a family of four. If the average per capita income provision applies, it would be proportionately reduced or increased to reflect the level for smaller or larger groups.

The committee is proposing an alternative way of accomplishing the basic purpose of the House bill—substantially limiting Federal financial participation in the medicaid program. Under the committee bill, the full Federal medical assistance percentage would continue to be available for medical assistance granted to those persons most in need, specifically those who are—

1. Cash assistance recipients;
2. Persons eligible for cash except that they do not meet durational residence requirements;
3. Children under 21 eligible for AFDC except for age or school attendance requirements; and
4. Individuals in medical institutions who would qualify for cash assistance if they lived outside of the institutions.

With respect to the above groups there would be no cutback of Federal matching funds. However, with respect to the medically indigent—those whose income is too high for them to be characterized

by a State as in need of welfare—there would be substantial cutbacks in Federal matching funds.

Under the committee bill two restrictions would apply to the medically needy. First, effective July 1, 1968, Federal funds would not be provided to the States with respect to persons who have incomes greater than 150 percent of the old-age assistance standard used in the State. Second, the Federal share of medical assistance granted to the medically needy would be significantly reduced. Beginning July 1, 1969, Federal participation in the cost of medical services for the medically needy would be determined by squaring a State's Federal medical assistance percentage. Thus, States whose Federal medical assistance percentage is 50 percent under present law would, under the committee bill, receive only 25 percent Federal matching toward the costs of the medically needy. For a State whose medical assistance percentage is 83 percent, the Federal share in medical assistance granted to the medically needy would be 69 percent ($0.83 \times 0.83 = .6889$).

This proposal has the advantage over the House approach, of treating the States more equitably—resulting in a proportionately greater reduction in the wealthier States—and simplifying the process for determining the amount of Federal funds which can be expended. The Department of Health, Education, and Welfare estimates that the long-term savings, including the years beyond 1972, to the Federal Government under the committee bill would be comparable with those under the House bill.

The figures given to the committee by the Department are tentative and predicated upon a number of variables relative to an evaluation of the intentions of 50 State governments in years to come—obviously an almost impossible task. The committee, however, is certain that its amendment will result in a reduction of hundreds of millions of dollars annually in the Federal expenditures which would occur if present law were not changed. There can be no question about the effects of the committee amendment. Under the House provision, it is possible for the States to develop the broadest and most expensive of programs for those whose incomes fall between 100 percent and 133 percent of the AFDC payments (the estimates of the savings under the House bill are based on such assumptions). In future years, AFDC payment levels will undoubtedly be increased by virtually every State, automatically increasing the potential Federal commitment for medical assistance. However, under the committee bill, for every one of those dollars expended by a State there would be a clear and identifiable reduction in the Federal portion of that dollar. This results from the absolute reduction in the Federal matching formula for the medically indigent.

TABLE A.—SHORT TERM ESTIMATED REDUCTIONS IN TITLE 19 COSTS

[In millions]

Fiscal year	House bill	Committee bill
1969	$336	$45
1970	692	702
1971	1,058	998
1972	1,434	1,294

TABLE B.—MEDICAL ASSISTANCE—FEDERAL PERCENTAGE OF PAYMENTS UNDER COMMITTEE BILL

State	Payments on behalf of—		State	Payments on behalf of—	
	Persons with income at or below the assistance level	Persons who are medically needy only		Persons with income at or below the assistance level	Persons who are medically needy only
Alabama	78.60	61.78	Montana	64.01	40.97
Alaska	50.00	25.00	Nebraska	60.48	36.58
Arizona	64.99	42.24	Nevada	50.00	25.00
Arkansas	79.81	63.70	New Hampshire	60.12	36.14
California	50.00	25.00	New Jersey	50.00	25.00
Colorado	55.31	30.59	New Mexico	70.15	49.21
Connecticut	50.00	25.00	New York	50.00	25.00
Delaware	50.00	25.00	North Carolina	75.30	56.70
District of Columbia	50.00	25.00	North Dakota	70.74	50.04
Florida	65.09	42.37	Ohio	52.64	27.71
Georgia	72.85	53.07	Oklahoma	69.61	48.46
Guam	[1] 50.00	[1] 50.00	Oregon	54.37	29.56
Hawaii	50.00	25.00	Pennsylvania	55.03	30.28
Idaho	67.87	46.06	Puerto Rico	[1] 50.00	[1] 50.00
Illinois	50.00	25.00	Rhode Island	52.61	27.68
Indiana	53.39	28.50	South Carolina	80.50	64.80
Iowa	59.60	35.52	South Dakota	73.26	43.67
Kansas	57.90	33.52	Tennessee	76.14	57.97
Kentucky	75.25	56.63	Texas	67.10	45.02
Louisiana	74.58	55.62	Utah	65.24	42.56
Maine	69.92	48.89	Vermont	69.00	47.61
Maryland	50.00	25.00	Virgin Islands	[1] 50.00	[1] 50.00
Massachusetts	50.00	25.00	Virginia	65.85	43.36
Michigan	50.00	25.00	Washington	50.00	25.00
Minnesota	58.40	34.11	West Virginia	75.84	57.52
Mississippi	83.00	68.89	Wisconsin	56.68	32.13
Missouri	58.40	34.11	Wyoming	59.20	35.05

[1] Statutory dollar ceiling applies in this jurisdiction.

TABLE C.—COMPARISON OF AMOUNT OF ANNUAL INCOME LEVEL, TITLE XIX, WITH LEVELS BASED ON HOUSE BILL (133.3 PERCENT OF AFDC STANDARDS) [5] AND COMMITTEE BILL (150 PERCENT OF OAA STANDARDS)

1. STATES CURRENTLY OPERATING MEDICAL ASSISTANCE PROGRAMS UNDER TITLE XIX THAT INCLUDE THE "MEDICALLY NEEDY"

State	Current income level (title XIX)		1 person [1]		4 persons [2]	
	1 person	4 persons	House bill [5] (133.3 percent of AFDC standard)	Committee bill (150 percent of OAA standard)	House bill [5] (133.3 percent of AFDC standard)	Committee bill (150 percent of OAA standard)
California	$2,028	$3,900	$1,600	$2,800	$3,100	$5,900
Connecticut	2,100	4,400	1,900	2,200	3,800	4,800
Delaware	1,500	3,300	1,500	2,000	3,000	4,200
Hawaii	1,440	3,000	1,800	2,000	3,600	4,200
Illinois	1,800	3,600	1,400	1,700	2,800	3,600
Iowa	1,600	3,600	1,200	1,800	2,400	3,800
Kansas [3]	1,600	3,000	1,900	1,900	3,800	4,300
Kentucky	1,620	3,420	1,400	1,600	2,700	3,300
Maryland [3]	1,800	3,120	1,400	1,600	2,700	3,100
Massachusetts	2,160	4,176	2,200	2,500	4,300	5,300
Michigan	1,900	3,540	1,500	2,000	3,000	4,200
Minnesota [3]	1,620	3,036	1,800	1,800	3,500	3,900
Nebraska [3]	1,600	3,000	1,000	2,100	1,900	5,000
New Hampshire	2,088	4,056	1,700	1,900	3,300	4,100
New York [4]	2,900	6,000	2,000	2,400	3,900	5,100
North Dakota [3]	1,600	3,000	1,600	2,200	3,200	4,600
Oklahoma	1,728	2,448	1,400	2,100	2,700	4,500
Pennsylvania	2,000	4,000	1,600	1,800	3,200	3,800
Rhode Island	2,500	4,300	1,500	2,300	2,900	4,800
Utah [3]	1,200	2,640	1,500	1,600	3,000	3,400
Washington	2,040	3,480	1,700	2,400	3,400	5,200
Wisconsin	1,800	3,700	1,800	1,800	3,600	3,900

2. STATES CURRENTLY OPERATING MEDICAL ASSISTANCE PROGRAMS UNDER TITLE XIX THAT DO NOT INCLUDE THE "MEDICALLY NEEDY"

[Income levels not applicable]

State	1 person [1]		4 persons [2]	
	House bill [5] (133.3 percent of AFDC standard)	Committee bill (150 percent of OAA standard)	House bill [5] (133.3 percent of AFDC standard)	Committee bill (150 percent of OAA standard)
Georgia [3]	$1,000	$1,500	$1,900	$3,400
Idaho	1,700	2,000	3,300	4,200
Louisiana	1,000	2,300	1,900	4,800
Maine	1,100	2,100	2,200	4,400
Missouri [3]	800	2,400	1,500	4,100
Montana	1,800	2,000	3,500	4,300
Nevada	1,100	2,500	2,100	5,400
New Mexico	1,500	2,000	2,900	4,300
Ohio	1,500	2,100	2,900	4,500
Oregon	1,600	1,800	3,200	3,800
South Dakota [3]	1,600	2,200	3,200	4,500
Texas	800	1,500	1,500	3,200
Vermont	1,200	2,200	2,300	4,800
West Virginia [3]	1,400	2,000	2,700	4,100
Wyoming	1,600	2,400	3,200	5,200

3. STATES NOT CURRENTLY OPERATING MEDICAL ASSISTANCE PROGRAMS UNDER TITLE XIX

Alabama	$500	$2,300	$1,000	$4,900
Alaska	900	4,000	1,800	8,600
Arizona [3]	900	2,000	1,800	4,200
Arkansas	700	2,000	1,300	4,300
Colorado	1,100	2,200	2,100	4,700
District of Columbia	1,300	1,800	2,600	3,800
Florida	500	2,000	900	4,300
Indiana	900	2,300	1,700	4,900
Mississippi [3]	400	1,800	700	3,500
New Jersey [3]	2,000	2,500	4,000	5,100
North Carolina	1,200	1,700	2,400	3,700
South Carolina	500	1,400	900	3,100
Tennessee [3]	900	1,700	1,700	3,600
Virginia	1,300	2,100	2,500	4,500

[1] Based on standards in effect Jan. 1, 1967; rounded to nearest $100.
[2] Ratio of 4 persons to 1 OAA for States not having common standard for all programs.
[3] States having common standards for all programs.
[4] Figures apply in family with 1 wage earner. For families with no wage earner, 1 person, $2,300; 4 persons, $5,150.
[5] Actual amounts may be lower than those shown because House bill applies 133.3 percent limitation to actual payments under AFDC in a given State which may, in fact, be less than the standard of need determined by that State.

(c) *Maintenance of State effort*

As a part of the Social Security Amendments of 1965, a provision was included to assure that States did not replace existing State expenditures with Federal dollars made available under that legislation. The provision is in effect from January 1, 1966 to July 1, 1969. This provision applied to the combined expenditures for money payments and for medical care. Some States have stated that in order to comply with this requirement, it was necessary for them to expand their medical assistance programs more rapidly than they otherwise might have. In order to avoid this situation, the committee bill gives the States an alternative of meeting the maintenance of State effort provision on the basis of their expenditures for money payments alone. An additional option is provided to permit expenditure for child welfare services to be taken into account. Thus, no State is penalized for limiting its medical assistance program to what it conceives to be sound and proper levels. Under the committee bill the House provisions are retained, but the expiration date is advanced to June 30, 1968, and, effective date changed from January 1, 1966, to July 1, 1966.

(d) Coordination of title XIX and the supplementary medical insurance program

Under existing law, States may "buy-in" for their cash public assistance recipients aged 65 and over, to the supplementary medical insurance program (SMI), authorized under title XVIII of the Social Security Act. Twenty-eight States and Guam have chosen to "buy-in," and others have been interested but have felt unable to do so because of certain other provisions of title XIX, which are being modified in the committee bill.

Because of the desirability of attaining the highest possible participation of the aged in the SMI program and because of the advantages to States of "buying in" not only for the cash-assistance recipients, but also for other medically needy aged persons, a number of changes to achieve such results are incorporated in the committee bill.

The States would be given the option to "buy in" for all of their aged who are eligible for medical assistance, not just for those receiving cash assistance. In order to protect the SMI program from immediate claims from people already ill when the revised agreements are made, SMI protection would not be effective until the third month after the agreement was made. Individuals included later would also have a "waiting period" after they were included. These provisions should encourage States to secure and maintain SMI coverage for all medically needy aged persons.

Because the committee believes that both recipients and the States should have a maximum incentive to maintain SMI coverage, the bill provides that there will be no Federal participation in medical expenses which would have been covered by the SMI program had the individual for whom the expenditure was made been enrolled in that program.

Under existing law, States may not include in an agreement for SMI coverage individuals who become eligible after December 31, 1967. The bill would require that States desiring to enter into an agreement with the Secretary must request the agreement before January 1, 1970, but it would amend present law to permit individuals who become eligible after that time to be covered under the agreement.

The committee believes that it is very much to the advantage of States to cover their medically needy aged under the SMI program, under which one-half of the cost is met from general revenues of the Federal Government. It accordingly does not believe that it is appropriate for States to also receive Federal financial participation in the $3 monthly premium they pay on behalf of medically needy persons, and the bill so provides.

Medically needy persons included in the State "buy in" plan whose eligibility for medical assistance terminated would have the opportunity to continue their SMI coverage on an individual basis, just as cash assistance recipients may under existing law if they become ineligible for assistance. Most of the persons who have been cash assistance recipients, however, would probably continue to be covered as medically needy under the expanded "buy in" provision of the bill.

(e) Comparability provision modification

Under existing law, a State plan for medical assistance must provide that benefits of the same amount, scope, and duration be provided to

all individuals eligible for cash assistance under titles I, IV, X, XIV, and XVI; and that benefits of the same amount, scope, and duration must be made available to all medically needy persons included under the plan. It further provides that eligibility shall be determined under comparable standards.

Some of the implications of these so-called comparability provisions in title XIX could not be fully determined when they were placed in juxtaposition with the health insurance for the aged provisions of title XVIII hospital insurance under part A and supplementary medical insurance under part B. It was not fully realized that comparability would be a deterrent to States "buying in" for services under the supplementary medical insurance program (part B) inasmuch as the comparability provisions require that, if the States "bought in" for the aged, they have to provide the services (such as physicians' services) covered under part B of title XVIII for their title XIX eligibles of all ages.

The committee bill would correct this situation by providing an exception to present law to the effect that the arrangement made by a State to "buy in" to part B of title XVIII or provision for meeting part or all of the deductibles, cost sharing, or similar charges under part B, does not impose an obligation on the State to make comparable services available to other recipients. This provision will free the States to enter into agreements to pay the premium charges under part B or to pay the deductibles and other charges under that program without obligating States to provide the range of part B benefits to others under the program.

(*f*) *Required services in title XIX*

Present law provides that a State medicaid plan must provide for the inclusion of five basic services: Inpatient hospital services, outpatient hospital services, other laboratory and X-ray services, skilled nursing home services, and physicians' services. States may also select from among nine other services once their plan includes provision for the basic five. Under the House bill, the States would be able to choose either the five basic services as enumerated above or to select a total of seven of the first 14 services identified as services possible for inclusion in the program.

The committee is recommending a further change in the existing law and a slight modification of the provisions as approved by the House. Under the committee bill, the States would be required to provide at least the five basic health services (plus home health services after July 1, 1970) to those recipients who are receiving a cash assistance payment. For the medically needy, the States could provide either the five basic health services as enumerated above or could provide any seven of the 14 services listed in the present law. In any event, however, the States providing nursing home or hospital services would also need to provide physicians' services in the institutions. This will give the States, as an option to including the five services mentioned above, seven services for the medically needy from a list which includes (in addition to the five): medical care, or any other type of remedial care recognized under State law furnished by a licensed practitioner within the scope of his practice as defined by State law; home health care services; private duty nursing services; clinic

services; dental services; physical therapy and related services; prescribed drugs, dentures and prosthetic devices and eyeglasses; other diagnostic, screening, preventive, and rehabilitative services; and inpatient hospital services and skilled nursing home services for individuals over age 65 in an institution for mental diseases.

The change in the bill made by the committee would make certain that the five basic medical services are provided for the most needy recipients; that is, those who are already receiving a money payment, and would give the States the flexibility contained in the House bill with reference to the medically needy. The committee also believes that services provided in a nursing home or a hospital, to be truly effective, require that the patient must have the services of a physician. For this reason, the committee has amended the bill so as to require the provision of physicians' services whenever hospital or nursing home care is provided. The committee also believes that home health services need to be added to the five basic services under present law in order to assure that such services are available as a more economic alternative to skilled nursing home and hospital care.

(g) Extent of Federal participation in certain administrative expenses

The Social Security Amendments of 1965 provided that there should be 75 percent Federal participation in sums attributable to the compensation and training of skilled professional medical personnel and staff directly supporting such personnel of the State or local agency administering title XIX. In a number of States, where the welfare agency has been designated as the State agency, administrative responsibility for the medical phases of the program has been contracted out to the State health department. In this situation, however, the health department is not the single State agency, and the special 75 percent Federal matching is not available to meet the costs of its skilled medical personnel and supportive staff who are directly involved in administering the title XIX program. The committee bill would remedy this situation by allowing 75 percent matching not only for the skilled professional medical personnel of the State agency, but also for any other public agency involved in administration of the program. The requirement in existing law that such matching shall be extended only to such expenditures as the Secretary of Health, Education, and Welfare finds necessary for the proper and efficient administration of the State plan would be retained.

(h) Advisory Council on Medical Assistance

The Health Insurance Benefits Advisory Council, established under title XVIII of the Social Security Act has provided the Department of Health, Education, and Welfare with an opportunity to obtain advice and learn of the views of a variety of individuals interested and knowledgeable about medical administration. Although the Department has made use of advisory groups in the administration of title XIX, the law does not provide the machinery for the orderly use of a permanent advisory group. To correct this weakness in title XIX, the committee bill would provide for an Advisory Council on Medical Assistance comparable to that authorized under title XVIII. The Council would consist of 21 members with one of the members acting, upon appointment by the Secretary, as chairman. The members

are to include representatives of State and local agencies and nongovernmental groups concerned with health, and consumers of health services, with a majority to consist of representatives of consumers of health services. Members are to hold office for a term of 4 years, with the initial membership appointed for terms of varying length to permit the subsequent staggering of membership appointments. Members would not be permitted to serve for more than two consecutive terms. Members would be reimbursed for their travel expenses and would receive compensation at a rate not to exceed $100 a day. In view of the common interests of this Council and the Health Insurance Benefits Advisory Council, the committee expects the Secretary to assure full coordination of effort of the two bodies through various means such as having some members serving on both bodies.

(i) Free choice of medical services

Under the current provisions of law, there is no requirement on the State that recipients of medical assistance under a State title XIX program shall have freedom in their choice of medical institution or medical practitioner. In order to provide this freedom, a new provision is included in the law to require States to offer this choice. Effective July 1, 1969, States are required to permit the individual to obtain his medical care from any institution, agency, or person, qualified to perform the service or services, including an organization which provides such services or arranges for their availability on a prepayment plan. Under this provision, an individual is to have a choice from among qualified providers of service. Inasmuch as States may, under title XIX, set certain standards for the provision of care, and may establish rates for payment, it is possible that some providers of service may still not be willing or considered qualified to provide the services included in the State plan. This provision does not obligate the State to pay the charges of the provider without reference to its schedule of charges, or its standards of care. The provisions would apply to Puerto Rico, Guam, and the Virgin Islands on July 1, 1972.

(j) Consultation to institutions providing medical care

One of the problems which has been recognized in the administration of titles XVIII and XIX is the difficulty in certifying the eligibility of certain suppliers of medical service. For this reason, the committee has included in the bill a provision requiring the States to offer special consultation, effective July 1, 1969, to various medical agencies to enable them to qualify for payment under the law, to establish and maintain fiscal records necessary for the proper and efficient administration of the law, and to provide information needed to determine payments due under the titles XVIII (medicare), title V (child health) and title XIX (medicaid). The medical suppliers included are hospitals, nursing homes, home health agencies, laboratories and other institutions as the Secretary shall specify. Provisions now in title XVIII which apply to certain providers of medical care would be repealed effective also July 1, 1969.

(k) Payment for services by a third party

It is obvious that many people need medical care because of an accident or illness for which someone else has fiscal liability; for example, a health insurer or a party who is determined by a court to have legal liability. In order to make certain that the State and the Federal Governments will receive proper reimbursement for medical assistance paid to an eligible person when such third-party liability exists, a new requirement would be included in title XIX. Under this provision, the State or local agency would have to take all reasonable measures to ascertain the legal liabilities of third parties to pay for covered services. Where the legal liability is known it would be treated as a resource of the recipient. In addition, if medical assistance is granted and legal liability of a third party is established later, the State or local agency must seek reimbursement from such party. The Federal Government would, of course, recover its share of any reimbursement received.

The committee has not included a similar provision in title XVIII of the Social Security Act, although it recognizes the possibility that duplicate payments can in some instances be made for services covered under both the health insurance program and a private health, disability or personal injury insurance policy. Such situations will, however, become increasingly infrequent. Most private insurance companies have modified their health insurance policies for the aged to make them supplementary to the benefits that are payable under the title XVIII health insurance program, and in other instances the private policies bar payment of benefits for services covered by a government program. The committee expects that the private insurance companies, including those which are intermediaries or carriers under medicare and medicaid which have not yet taken steps to avoid duplication of their benefits with those of the Federal health insurance program will take such steps. It is to be expected also that the Department of Health, Education, and Welfare will give continuing attention to the developments that take place in private insurance practices with respect to persons having insurance protection against the same risk under multiple health insurance policies and programs. If provisions for sharing the risk among health insurance policies covering the same risk are developed, and these provisions are equitable to the insurers and the insured, consideration should be given to the possible application of such provisions to health insurance under social security.

(l) Direct payment to recipient of physicians and dentists bills

Under the present provisions of title XIX, Federal sharing is available only toward the cost of medical assistance paid to a third party in behalf of eligible persons—a vendor payment. States cannot receive Federal sharing toward the costs of medical care if they give the individual the money to pay a physician. The rigidity of the law in this respect was recognized by the House in a provision which would authorize States, at their option to claim Federal sharing toward the cost of medical payments which a State made directly to a medically needy person for physician's services, whether the doctor's bill was paid or not paid. The committee concurs in this action by the House and

has further broadened it to also include persons who are recipients of money payments and to cover services of dentists as well as physicians. States may pay the individual directly or the State may reimburse the individual for money he has spent for physician's services. The Secretary is authorized to establish appropriate safeguards to assure against overutilization and that the physician's charges are reasonable.

(m) Date on which States must meet certain requirements on sources of State funds

Under the bill, States would have until July 1, 1969, rather than July 1, 1970, either to finance the State share under title XIX wholly from the State funds or to establish a tax equalization plan which would, in effect, serve the same purpose. The committee believes that the localities in many States should not be subjected to disproportionate burdens any longer than necessary. The States would have adequate time during which to modify their plans to meet this requirement by July 1, 1969.

(n) Licensing administrators of nursing homes

Nursing home care is growing in volume and complexity in this country as a result of the accumulating need for facilities offering skilled medical services for the aged. This trend has been accelerated by titles XVIII and XIX. At present, Federal expenditures for services in extended care facilities and nursing homes is estimated at about three-fourths of a billion dollars annually. This heavy involvement and expansion increases the importance of having a formal measure of the skill and experience of those charged with operating responsibility in this important field. State licensing of the administrators of such institutions is virtually nonexistent at present. For this reason, the committee has included in the bill provisions affecting States with title XIX plans. Under the committee bill, each State would be required to have a program for licensing administrators of nursing homes. Licensure of administrators should result in increased professionalization and enhanced status for those charged with the important responsibility of caring for hundreds of thousands of older Americans. A licensed nursing home administrator will become clearly identified as a health professional. Until July 1, 1972, States may grant a provisional license to anyone who has actually been administering a home. The latter provision is essential so that existing services supervised by those who cannot qualify initially will not be disrupted. States are required to offer a program of training to help those licensed on a provisional basis to become fully qualified.

Federal matching funds will be available to assist the States in instituting and operating programs of training and licensing. Such programs are expected to be established and operated after consultation with and with the cooperation of private and public organizations and agencies concerned. The committee expects that these provisions will be coordinated by the Secretary with other provisions of law under which the Department is responsible for improving the quality of care in nursing homes.

An advisory group will be appointed by the Secretary prior to July 1, 1968, 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.

(o) *Private health insurance provisions*

The committee had called to its attention the fact that some State agencies administering medical assistance programs have been unable to recover the cost of some care provided, even though the beneficiaries have private insurance policies which would ordinarily cover such cost. The reason for this is that some private health insurance policies contain a clause which excludes payment when the policyholder is receiving institutional care for which he has no legal obligation to pay. States or localities which operate their own medical facilities, the committee believes, are justified in assuming that they should collect for the cost of the care provided from the insurance resources of the individual. The solution of this problem, the committee has concluded, lies not so much in changes in the Federal law, but, rather, in increased effort by States to modify the policies of such insurance companies which are subject to State authority. Therefore, the committee urges States to review this situation with their insurance regulatory authorities so that effort may be made to eliminate such restrictive clauses from insurance contracts—particularly with respect to services provided in an accredited public medical facility. This should result in a saving of State and Federal funds.

(p) *Deductibles and coinsurance for hospital services*

At present, States are not allowed to impose any deductibles or cost sharing devices with respect to inpatient hospital services provided to the categorically needy and the medically needy and are required to meet any deductibles under the hospital insurance program under title XVIII. The States now have authority, however, to impose deductible and coinsurance payment requirements with respect to all other items of medical service provided to the medically needy. The committee's amendment gives the States further latitude by also authorizing them to impose deductible and coinsurance payment requirements with respect to inpatient hospital services furnished to medically needy individuals. It would not be appropriate to impose such charges upon cash assistance recipients because such persons have been determined to have no income or resources available to meet such charges. In addition, the bill would remove the requirement that the plan meet the deductibles under the hospital insurance program.

(q) *Eligibility of essential spouses under title XIX*

Under the old-age assistance program and other cash assistance programs for adults, it has been possible for States, in determining the amount of assistance to be paid the eligible individual, to take into account the needs of any person who is related to the eligible person and who is essential to his well-being. Thus, States are able to include the needs of a spouse of an old-age assistance recipient who is not yet 65 and eligible for aid on her own account. Under title XIX, however, this has not been possible, Federal sharing is available only for the eligible person himself and no other member of his family.

The committee agrees with the contention of a number of States that this is an unnecessarily limiting provision since it denies medical assistance to persons for whom the State-Federal program has already recognized some measure of responsibility for maintenance. There is often little, if any, difference between the circumstances of a 65-year-old man who is in need and his 63-year-old wife.

For this reason, the committee's bill includes provisions permitting the States, at their option, to make medical assistance available to the spouse of an aged, blind, or disabled person who is receiving a money payment and who is in need of medical assistance. The spouse must be living with the recipient, must be determined to be essential to his well-being, and must have her needs and income taken into account in determining the cash needs of the recipient.

(r) Review of records and premises of medicaid suppliers

Although the Federal Government pays well over $1 billion annually toward the cost of State medical assistance programs, it has only limited authority to review certain essential aspects of the program's operations. The Department of Health, Education, and Welfare and the General Accounting Office have been handicapped by an apparent lack of authority to review the records of the suppliers of medical services and to examine their premises, even when strong indications of fraud are present. For this reason the committee bill includes a provision authorizing the General Accounting Office and the Department of Health, Education, and Welfare to perform audits of the records and to inspect the premises of the providers of services (including providers of services who are not agencies or institutions to the extent determined reasonable by the Secretary) under title XIX on a spot check basis or when there are indications of possible fraud.

(s) Medical services for persons with certain religious views

It has been pointed out to the committee that under present law a Christian Scientist might be required to accept some medical service, contrary to his convictions. In order to make sure that such a situation does not arise by virtue of any provision in the Federal law, the committee is proposing an amendment to title XIX and title V that no individual will be compelled by reason of the Federal law to undergo medical screening or other diagnosis which is contrary to his religious beliefs. In cases involving infectious or contagious diseases or environmental health the States could, as under present law, provide for detection of such diseases, and isolation of persons found to be infected, in order to prevent the further spread of such diseases. However, nothing in this act is to be interpreted to require the States to provide for treatment of any disease if the person involved has religious convictions against such treatment.

(t) Supplementation of nursing home rates

There are wide variations among the States in the manner of financing the cost of nursing home care provided to the needy. In some States, the full cost of care is paid. In others, a negotiated rate is developed which may or may not approximate the reasonable cost or

reasonable charges for the services provided. Some States, however, depend upon the supplementation of the State agency's below-cost allowances for care with contributions from relatives or the needy individual himself. As a matter of public policy, it would be best for all concerned: the needy individual, his relatives, the State agency, and the nursing home if the reimbursement made by the State represented the reasonable cost or reasonable charges for comparable services. Until such time as proper and adequate payments are made, a problem exists for those States which have been using the supplementation system as a means of providing the additional funds necessary as a result of the State's payment of less than the full costs of nursing home care. The committee has considered this matter carefully and has determined not to include any legislation dealing with this situation upon the assurance of the Department of Health, Education, and Welfare that existing supplementation programs will be permitted to continue until January 1, 1971, where a State determines and advises the Secretary that its payments for nursing home care are less than the reasonable cost of the care and services provided. Such States are expected to provide the Secretary, prior to 1971, with a plan for phasing out such supplementation during a reasonable period of time subsequent to January 1, 1971.

Any limitations in supplementation are not intended to preclude additional payments for the reasonable costs or charges for nonstandard nursing home services such as private room, telephone, television, et cetera, nor would they in any way affect the payment toward the reasonable costs of care by a patient who has income in excess of the amount the State determines is needed for his personal expenses other than nursing home care.

(u) Intermediate care homes

Good skilled nursing home care is expensive. At the present time, under the medical assistance program, skilled nursing home services are offered with Federal sharing in the cost. These homes have relatively high standards for approval. Serious questions have been raised with the committee concerning the limitation, under the Federal law, on the kinds of facilities for which Federal sharing is available. The committee believes that a strong case exists for introducing another level of care for which vendor payments would be available.

At the present time old-age assistance recipients whose primary need is for care in an institution other than a skilled nursing home are frequently classified as in need of "skilled nursing home" care and placed in such institutions because of a decided financial advantage to a State under present matching formulas.

Title XIX does not provide Federal matching funds for institutional care which provides more than room and board but less than skilled nursing home care—only for "skilled nursing home care." But, if a State classifies a needy individual as in need of "skilled nursing home care" it can receive unlimited Federal matching funds. If it classifies him as in need of other institutional care, the State receives the standard old-age assistance cash matching, which is available only up to $75 a month on the average.

Thus, the Federal and State governments often may pay upwards of $300 a month for skilled nursing home care for a patient who

could be adequately taken care of in another type of institution for $150 or $200 a month. The American Nursing Home Association and the Department of Health, Education, and Welfare both advised the committee that as many as 50 percent of the assistance recipients in skilled nursing homes are not, in fact, in need of skilled nursing home care. Thus, the committee has adopted an amendment to provide for vendor payments in behalf of needy people qualifying for OAA, AB, or APTD who are or who should be in intermediate care homes, and that the rate of Federal sharing be the same as the formula in title XIX if the State elects to be paid under that formula. Intermediate care homes would be defined and licensed by the States and would be those institutions which provide services beyond ordinary board and room but below the level of skilled nursing homes.

This amendment could result in a reduction in the costs of title XIX, by enabling States to use lower cost facilities more appropriate to the needs of thousands of persons, thus avoiding the higher charges for skilled nursing homes when care of that kind is not needed. This provision would remove the incentive to classify such people as "skilled nursing home" patients.

The amendment would also solve many of the problems encountered by small institutions which are now technically classified as nursing homes but which basically provide lesser care. They cannot possibly meet title XIX standards for skilled nursing homes and while often appropriate to provide the types of care envisaged by this amendment they might very well be forced out of business when required to meet title XIX standards. Such facilities are frequently the only nonhospital institutions available in rural areas and do meet a legitimate need for care less than that found in skilled nursing homes.

The committee expects that the institutions covered by this provision will be subject to periodic professional review and audit as to the care provided and its appropriateness for individuals in such institutions. The Secretary of Health, Education, and Welfare is expected to assist States in developing suitable review procedures to meet these objectives.

(v) *Standards for nursing homes*

As has been noted previously, the extent of the Federal dollar commitment in the nursing home field is enormous. The Federal responsibility extends, however, beyond dollars to the safety and standards of care in those institutions in which hundreds of thousands of public assistance recipients are housed along with many thousands of other patients.

In large part, that responsibility will be more fully met by the Federal Government under the committee's amendment, which would require that certain basic conditions and standards exist in skilled nursing homes which provide care to recipients under title XIX.

The amendment would provide a State plan requirement that the States shall place welfare recipients only in those skilled nursing homes which are licensed as meeting proper standards of safety and care.

Skilled nursing homes are to meet the environmental, sanitation, and housekeeping requirements at least equal to those applied to extended care facilities under title XVIII. States which do not now have fire protection codes applicable to skilled nursing homes which

are found to be adequate by the Secretary would require their skilled nursing homes, subsequent to December 31, 1969, to meet the Life Safety Code of the National Fire Protection Association. The committee expects that such codes will be enforced in a manner designed to properly protect the health and safety of patients. At the same time, however, it is expected that due recognition will be given to waivers of specific conditions where rigid interpretations would result in undue hardship and heavy and avoidable expense, and where such temporary or permanent waiver of requirements will not jeopardize the health or safety of patients in such institutions. States would also be required to establish systems of periodic review of their nursing home codes and licensure.

The committee amendment also specifies that proper conditions relating to meal planning, nursing staff, medical recordkeeping, and, to the extent feasible, appropriate arrangements with hospitals for transfer of patients be met. It is understood that, in general, the type of care rendered by skilled nursing homes under title XIX is not identical to the extended care provided under title XVIII. Title XIX care tends to be long-term care, while title XVIII is designed for care of a more intensive and relatively short-term nature. In this context, therefore, the committee expects that the Secretary and the States will not seek to impose unrealistic requirements upon title XIX skilled nursing homes.

In particular, requirements relating to nursing personnel (other than the requirement of a full-time registered nurse on the staff of the institution) should give due recognition to shortages of such personnel, where such shortages exist, and determine needs for other nursing and auxiliary personnel on a realistic basis consistent with the actual needs of the types of patients in particular institutions. Such an approach is not intended, however, to excuse or permit continued understaffing.

The amendment provides, furthermore, for the States to have in operation a professional medical review program under which periodic evaluations of the care provided title XIX patients in nursing homes and mental hospitals are made. Such regular independent review made by or on behalf of the State agency will provide a mechanism for assuring that patients are receiving appropriate care in an appropriate setting. To the extent possible, it is intended to develop active care designed to enhance the capacity of patients to care for themselves—frequently in a lower cost facility or setting. To the extent this is achieved, Federal, State, and local costs will be reduced. So as to provide a lower cost alternative to institutional care, States will also be expected to have home health care services available, effective July 1, 1970, for those persons eligible for skilled nursing home care.

(w) Study of financing care of patients in mental institutions

The Social Security Amendments of 1965 provide medicare benefits to patients with mental diseases under limitations different from those applicable to other illnesses. The amendments also provide for Federal participation in public assistance payments to or on behalf of aged persons in mental institutions, but those payments are not available for individuals who are under age 65.

The committee has received numerous comments and suggestions regarding these limitations and it is concerned about inequities which

may result from the special limitations that are involved. It accordingly requests the Secretary to study the experience under the 1965 provisions as well as to evaluate the problems involved in expanding or extending those provisions and to submit a report, including his recommendations for changes in the various provisions of law that are involved, to the committee by January 1, 1969.

C. Improvement of Child Health

Title V of the original Social Security Act provided formula grants to States for two separate health programs: maternal and child health and crippled children's services. Authorizations for these programs have been increased by the Congress from time to time, most recently in 1965.

Beginning in 1963, new earmarked authorizations were enacted for separate additional programs. Amendments in 1963 established new programs of project grants for maternity and infant care in low-income areas and grants for research relating to health services for mothers and children. Additional amendments in 1965 set up a project grant program of comprehensive health services to children and youth in low-income areas and another program to train professional personnel for the care of crippled children. A proposal in the committee bill would initiate yet another project grant program, this one for the dental health of children.

In view of these developments as well as the initiation of other health programs for the children of low-income families, both within and beyond the jurisdiction of the committee, it was believed that the time had come to consolidate and more rationally arrange the various title V programs. (The child welfare services program, as indicated earlier, is moved to title IV.) The committee believes that these changes will facilitate the review of these programs by Congress and other interested organizations and individuals. Representatives of the Department of Health, Education, and Welfare assured the committee that there is a high degree of coordination between the various executive agencies providing health services to low-income children. It is hoped that this legislation will further this coordination as well as lead to more orderly program development.

The bill consolidates the existing authorities into a single authorization with broad flexible categories. The House bill accordingly eliminates all present earmarked programs beginning July 1, 1968, and replaces them with one total dollar authorization. Under the House bill for the 4 fiscal years 1969 to 1972, 50 percent of the authorization will be for formula grants to States; 40 percent will be for project grants; and 10 percent will be for research and training. The Secretary would have limited authority to adjust these percentages. The Secretary would also determine the allocations within these percentages for different types of formula grants, projects, etc.

Under existing law, project grant authority rests with the Secretary of Health, Education, and Welfare. The committee is concerned with the tendency of such authorization to be continued, through legislative extensions, indefinitely into the future and believes that the basic responsibility for health services for mothers and children rests with the States. The bill, therefore, requires the States to assume responsibility for the project grants beginning July 1972; as of that date, the Secre-

tary's project grant authority will lapse and the funds will be given directly to the States.

The authorizations in the House bill are shown in the following table:

[In millions of dollars]

	Fiscal year				
	1969	1970	1971	1972	1973
Total authorization	250	275.0	300	325.0	350
Grants to States (50 percent of total until July 1972; 75 percent thereafter)	125	137.5	150	162.5	315
Project grants (40 percent of total until July 1972 when authority expires)	100	110.0	120	130.0	.....
Research and training (10 percent of total)	25	27.5	30	32.5	35

The authorizations in the committee bill are shown in the following table:

	Fiscal year				
	1969	1970	1971	1972	1973
Total authorization	$250	$305	$360	$385	$410
Grants to States (50 percent of total until July 1972; 90 percent thereafter)	125	152.5	180	192.5	369
Project grants (40 percent of total until July 1972 when authority expires)	100	123	144	154	.....
Research and Training (10 percent of total)	25	30.5	36	38.5	41

1. Formula Grants to States

Present law provides separate State grant programs for maternal and child health and crippled children's services.

(a) Maternal and child health services

Federal funds expended by States in fiscal year 1966 for maternal child health services amounted to approximately $42.9 million; expenditures from State and local funds were approximately $87.3 million—more than twice as much. States use Federal funds, together with State and local funds, to pay the costs of conducting prenatal and postpartum clinics where mothers may receive family planning services if they wish them; for visits by public health nurses to homes before and after babies are born to help mothers care for their babies; for well-child clinics where mothers can bring their babies and young children for examination and immunizations, where they can get competent advice on how to prevent illnesses and where their many questions about the care of babies can be answered. Such measures have been instrumental in the reduction of maternal and infant mortality, especially in rural areas. Funds are used to make doctors, dentists, and nurses available to schools for health examinations, and they are also used for immunizations. These funds support 134 mental retardation clinics in 50 States where over 30,000 children received diagnostic treatment and counseling services last year.

During fiscal year 1966 State maternal and child health programs provided the following clinic, hospital, and public health nursing services:

Prenatal and postpartum care in medical clinics for 282,000 maternity cases.

Hospital inpatient care (prenatal or delivery) for 61,000 maternity cases.

Public health nursing visits for 521,000 maternity cases.

Child health supervision (through well-child conferences) of 1,722,000 children, including 680,000 infants.

These programs also provided examinations, tests, and immunizations during that year as follows:

1,926,000 school health medical examinations.
8,847,000 school health vision screening tests.
5,425,000 school health hearing screening tests.
2,386,000 school health dental screening tests.
2,840,389 smallpox immunizations.
4,074,868 diphtheria immunizations.
2,430,417 pertussis immunizations.
4,425,412 tetanus immunizations.

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

About $116 million, of which about $44 million or 38 percent was from Federal funds, was expended by States for crippled children's services during fiscal year 1966. State crippled children's agencies use their funds to locate children, to provide diagnostic services, and then to see that each child gets the medical care, hospitalization, and continuing care by a variety of professional people that he needs. Less than half of the children served have orthopedic handicaps; the rest include epilepsy, hearing impairment, cerebral palsy, cystic fibrosis, heart disease, and many congenital defects. A State crippled children's agency holds clinics periodically, some traveling from place to place; others are held in permanent locations. Any parent may take his child to a crippled children's clinic for diagnosis.

The number of children served under the crippled children's program has more than doubled since 1950. In fiscal year 1966, about 438,000 children received care under this program. About 325,000 children attended diagnostic clinics and nearly 80,000 children received hospitalization.

(*c*) *Consolidated programs*

The committee bill combines the maternal and child health program and crippled children's services into one program with the same State plan requirements of existing law except for the new requirements noted under the next three headings and for the State assumption of responsibility for project grants in 1972. Existing requirements on States such as extending the provision of maternal and child health and crippled children's services to make them available by 1975 to children in all parts of the State and requiring the States to pay the reasonable cost of inpatient hospital care are continued. The bill also defines a crippled child in order to assure that there will be no duplication of services provided under this program with those provided through community mental health programs.

(d) Early identification of health defects of children

States will be required to make more vigorous efforts to screen and treat children with disabling conditions. Though all States have crippled children's services programs, there are substantial differences in the rate of children served among the States, the highest being 17.7 per 1,000 population under 21 years of age and the lowest being 1.6 per 1,000. Many handicapped children or children with potentially crippling conditions fail to receive needed care because their conditions may not be included under the State's program. Other States have not carried on aggressive programs of early identification of children in need of treatment because of lack of funds to provide the necessary care and treatment.

The committee believes that the new plan requirement coupled with increases in funds authorized will help States with early identification of children in need of correction of defects. Organized and intensified casefinding procedures will be carried out in well-baby clinics, day care centers, nursery schools, Headstart centers in cooperation with the Office of Economic Opportunity, by periodic screening of children in schools, through followup visits by nurses to the homes of newborn infants, by checking birth certificates for the reporting of congenital malformation and by related activities. Title XIX (medical assistance) would be modified to conform to this requirement under the formula grant program.

(e) Dental care and other demonstration services in needy areas

The committee believes that the States should put more emphasis on their demonstration services in needy areas and among groups in special need. Special attention is to be given to dental care for children.

(f) Family planning services

The House bill would require States to offer family planning services to all appropriate recipients of AFDC and would provide matching at the 75-percent rate. The report of the Committee on Ways and Means on the bill states that family planning services can be accepted or rejected in accordance with the dictates of the individual's religion or conscience. The committee has amended the bill to make the safeguard against coercion a statutory one and to prevent making the acceptance of family planning services a prerequisite to eligibility for financial or medical assistance or social services.

The committee has also included language to insure that funds for family planning services will be available through the maternal and child health authorizations of title V of the Social Security Act.

The authorizations for title V have been increased over the House bill and earmarked as follows for family planning purposes:

[In millions of dollars]

	H.R. 12080	Increased authorization	New total	Percentage earmarking	Amount
1969	$250	----------	$250	6	$15.0
1970	275	$30	305	15	46.5
1971	300	60	360	20	72.0
1972	325	60	385	20	77.0
1973	350	60	410	20	82.0

This will assure that some funds appropriated under the increased authorizations in the maternal and child health provisions of the bill will be used for family planning services even if the full authorizations should not be appropriated.

The committee believes that these amendments will safeguard the provision of family planning services and provide families increased access to services that will permit them to choose the number and spacing of their children within the dictates of individual conscience.

2. Project Grants

There is authority in present law for two kinds of special project grants, for maternity and infant care and for comprehensive health care for school-age and preschool children. The committee bill adds a program of pilot projects of dental services for children. All of these projects are in areas with concentrations of low-income families.

(a) Special projects for maternity and infant care

Legislation enacted in 1963 set up a 5-year program of project grants to pay up to 75 percent of the cost of comprehensive health care to mothers and infants in low-income areas where health hazards are higher.

The maternity and infant care projects promote public understanding of the importance of prenatal care in low-income neighborhoods, employ casefinding methods (through local churches, high schools, stores, laundromats, publicity, etc.) to find patients early in pregnancy, establish neighborhood clinics affiliated with hospitals, provide prenatal care, nutritional advice, homemaker services, public health nursing, and social services; and pay for hospital care for mothers and infants in hospitals staffed to give the quality of services high risk patients need. It is these programs that have opened the door to family planning services for thousands of low-income families for the first time. Because the brief period of pregnancy is too short a time in which to detect and correct all the factors adversely affecting the outcome of pregnancy, continuing health supervision for mothers who had complications of pregnancy is essential. This makes it possible to improve the health of mothers for a subsequent pregnancy and to begin prenatal care early. It is also essential to provide periodic medical examinations for women who are receiving family planning services.

Programs are in operation in rural counties as well as in the largest cities. In the 12-month period from July 1966 to June 1967, more than 86,000 women were delivered under the program. In this same period, over 58,000 women requested and received family planning services. Patients are currently being admitted to the program at the rate of over 9,000 per month.

In 1966, the infant mortality rate was reduced by 5 percent as compared with 1965, reaching a new low of 23.4 per 1,000 live births. This was the largest reduction in any year since 1950. Significant reductions are taking place particularly in the Nation's large cities which were experiencing some of the highest rates in the country prior to the development of their maternity and infant care projects.

(b) Project grants for health of school and preschool children

The 1965 amendments to the Social Security Act established a 5-year program of project grants for comprehensive health services for children and youth.

In the geographic area served by a project, all the health problems of the children are to be taken care of by the program, either through direct services or by an appropriate referral to other sources which are prepared to provide at least equivalent services. Both medical and dental care must be included for children of school age; children with emotional as well as physical health problems are accepted. The projects attempt to meet the medical needs of a given child population in a specified area. The emphasis is on reaching out into the community for early casefinding and preventive health services among a population most acquainted only with care in emergencies.

These projects together with the projects for maternity and infant care are bringing organized community health services to the people in low-income areas where there are few physicians in private practice and are creating new patterns of delivering comprehensive care.

(c) Project grants for the dental health of children

By the time children enter school, 90 to 95 percent are in need of dental attention. The average child on entering school has three decayed teeth. According to the American Dental Association, obtaining dental care for children is related to family income, the educational level of the parents, the effectiveness of dental health education and the extent to which a community has organized a dental care program for its children.

Comprehensive services may include casefinding, screening, and referral, preventive services and procedures, diagnosis, health education, remedial care and continuity of service through recall and followup. Projects would have to include preventive services, treatment, and aftercare to the extent required in regulations of the Secretary.

Any meaningful effort to solve the dental health problem must concentrate a major share of attention, and of resources, on the dental health of children. For these diseases, which begin in childhood, can also be most successfully and economically treated and prevented in these formative years. It is obvious, also, that the child who receives adequate dental health protection will have a better chance of maintaining high standards of dental health throughout his adult years.

(d) Project grants in the committee bill

The committee believes that ultimately the basic responsibility for providing health services to mothers and children must rest with the States. The committee also recognizes, however, the important purposes served by project grants in providing services in low-income areas with special needs. The bill therefore continues to authorize the project grant approach until July 1972; after that date, the funds will be granted to the States, who will be required to assume this responsibility.

The bill increases the authorization for maternity and infant care projects from $30 to $35 million in fiscal year 1968; that is the only change made for this fiscal year.

Beginning with fiscal year 1969, however, and continuing for the following 3 years, all project grant authority will be consolidated into one authorization. The new authorization will include projects for comprehensive maternity and infant care, comprehensive health care for school-age and preschool children, and dental care for children.

Maternity and infant care: Progress in reducing infant mortality depends on our ability to provide services where the risks to mothers and infants are greatest. Maternity and infant care projects are now in operation in 27 of the 56 counties whose high infant mortality rates have contributed most heavily to keeping the national rate from decreasing. This past year saw a significant reduction in the national infant mortality rate. Programs of maternity and infant care and family planning (entirely voluntary with the patient) must be developed, continued, and expanded especially in these counties if the reduction in infant mortality is to be accelerated. The committee's bill expands the present authority (1) by explicitly stating that one purpose of the projects is to reduce infant and maternal mortality and thus making clear that the full range of care may be made available to mothers and children from groups where such mortality is highest; (2) by making possible grants for the support of hospital intensive care units for high risk newborn infants as well as other projects for infants; and (3) by authorizing grants to local voluntary and public agencies for family planning clinics.

Health care for school-age and preschool children: The committee's bill provides for the continuation of these kinds of project grants until July 1972, when the States will be required to make provision for them.

Dental health of children: Within the overall project grant authorization, the committee has included an additional authority for supporting up to 75 percent of the cost of projects to provide comprehensive dental health services for children. Payments for treatment would be limited to children from low-income families.

Because of the magnitude of the problem of providing dental care to children of low-income families, the committee will expect that the projects will not only provide dental care, but will also study various methods of organizing community dental health programs, including ways of increasing the efficiency of dentists through the use of assistants and auxiliary personnel.

3. Research and Training

Present law authorizes (1) research grants to support studies which show promise of improving health services for mothers and children, and (2) grants for the training of professional personnel for health and related care of crippled children, particularly mentally retarded children and those with multiple handicaps.

The expansion of health services to mothers and children provided for in this bill will require a continuing supply of trained personnel and further research in the delivery of health services.

The committee's bill will permit a modest expansion of the appropriation authorization as the total child health authorization rises.

At the same time, the committee has broadened the scope of both the research and training authorities.

Research

Research projects support up to now has concentrated on such problems as mental retardation, development of prosthetics for children infant mortality studies, utilization of pediatric outpatient departments, and prenatal care.

The committee has modified the authority in present law to accord special emphasis in the future on projects to study new and more efficient ways of delivering health services. Present and anticipated manpower requirements in obstetrics and pediatrics are so great that we will soon face a crisis in maternal and child health care unless we can find ways of increasing the supply and expanding the efficiency of professional personnel. The committee has directed that research projects supported will test the feasibility, cost, and effectiveness of the use of personnel with varying levels of training, of the use of medical assistants and health aides, and will experiment with methods of training such personnel.

Training

In line with the personnel needs of the programs expanded in other sections of the bill, the committee has broadened the training authority to include all personnel involved in providing health care and related services to mothers and children. This expanded authority will, of course, include the new types of personnel developed under the research program. The House bill directed that priority shall be given to training at the undergraduate level. The committee bill modifies the House language to direct the Secretary of Health, Education, and Welfare "to give special attention to" rather than "priority to" programs providing training at the undergraduate level in making grants for training of such personnel.

Personnel for such programs must come from a wide variety of disciplines such as medicine, nursing, social work, nutrition, physical and occupational therapy, et cetera, and training programs must be established at a number of different levels—undergraduate, graduate, and postgraduate.

The committee wishes to assure adequate attention to undergraduate training but believes that the Secretary should have sufficient flexibility in administration of this training program to adjust the program to changing needs.

4. Administration of the crippled children's program

The committee bill combines the maternal and child health program and crippled children's services into one program with the same State plan requirements of existing law except for two new requirements and for the State assumption of responsibility for project grants in 1972. The combination of these two programs into one program together with the consolidation of the existing authorities under title V into a single authorization is a major step in advancing the coordination of the child health programs.

Both the Children's Bureau and the Rehabilitation Services Administration are units of the new Social and Rehabilitation Serv-

ice. The committee believes that the close and desirable coordination of the crippled children's program with that of the Rehabilitation Services Administration can be assured in this way. The committee is impressed by the strong support coming from medical and related groups for the continued administration of the crippled children's program by the Children's Bureau. The committee therefore has amended the House bill to assure the administration of the crippled children's program by the Children's Bureau.

The amendment in the committee bill requiring early casefinding of children with handicapping conditions in the crippled children's program will necessitate the closest coordination of the crippled children's and maternal and child health programs. Organized and intensified case-finding procedures will be carried out in well-baby clinics, day care centers, nursery schools, Headstart centers in cooperation with the Office of Economic Opportunity, by periodic screening of children in schools, through followup visits by nurses to the homes of newborn infants, by checking birth certificates for the reporting of congenital malformations, and by related activities.

D. Employment and Income Tax

1. Deduction of medical expenses for taxpayers and their dependent parents who have attained the age of 65 (amends sec. 213 of the Internal Revenue Code)

(*a*) *Present law*

The Social Security Amendments of 1965 amended the medical expense deduction provision of the Internal Revenue Code to delete several special rules applicable with respect to persons age 65 or over. In general, medical expenses are deductible only to the extent they exceed 3 percent of the taxpayer's adjusted gross income. Similarly, the cost of medicines and drugs are treated as medical expenses only to the extent they exceed 1 percent of the taxpayer's adjusted gross income. Prior to the 1965 amendments, these 3- and 1-percent floors did not apply with respect to the medical expenses of dependent parents of a taxpayer or his spouse if the parents were age 65 or over. In addition, these floors did not apply to the medical expenses of the taxpayer himself or of his spouse if either of them was age 65 or older. The 1965 amendments made the floors applicable to the medical expenses of these older persons for 1967 and later years.

(*b*) *Problem presented*

In 1965 Congress removed the 3-percent and 1-percent floors (effective for 1967). This was an action originated by the House with which the Senate was not initially in accord but which it finally agreed to in conference. The House report indicated that the waiving of the 3-percent and 1-percent floors would not be justified after passage of the 1965 act because the broad health insurance coverage provided by that act met the medical care needs of the elderly, making the concession to them with respect to the floors no longer desirable. It also pointed out that the restoration of a uniform floor would provide additional revenue which would help defray the cost to the general fund of the voluntary health provisions of the 1965 act at those income levels where the individuals involved were financially capable

of providing for this cost themselves. On the other hand, the Finance Committee and the Senate had initially opposed the application of the 3-percent and 1-percent floors in the case of the elderly because they were unwilling "to increase the income taxes of aged, ill, and infirm taxpayers who provide for their own medical protection."

The committee is still concerned. For those taxpayers age 65 and over who either do not make use of the medicare program, or prefer not to do so, the application of the 3-percent and 1-percent floors constitutes the withdrawal of a benefit under the 1965 act without any commensurate benefit under the medicare programs.

(c) *Changes made by amendment*

For the reasons given above, the committee has restored the law applicable prior to 1967 with respect to the deduction of medical expenses for persons age 65 and over but only where they have waived any rights they might have to payments under the medicare programs—both the hospitalization insurance program and the voluntary supplemental medical care program.

More specifically, the amendment adds to present law a new category of persons eligible for a medical expense deduction to which the 3- and 1-percent floors are not applicable. The new category consists of a taxpayer or his spouse where either has reached age 65 and the mother or father of the taxpayer or his spouse who has attained the age of 65 (in this latter case whether or not the taxpayer or his spouse has reached age 65). However, this new category, where the 3- and 1-percent floors do not apply, is limited to those who irrevocably waive all of their rights to medicare payments.

As a general rule the amendment provides that a waiver may not be filed if the individual has received any benefits under the health insurance program. This rule does not apply, however, with respect to benefits paid before June 30, 1968, on behalf of an individual who attained age 65 before that date.

In the case of an individual who is 65 by June 30, 1968, a waiver filed by that date (or if later, by the due date for the income tax return for 1967) is to be effective for 1967 (and later years); that is, for such an individual the 3-percent and 1-percent floors are not to apply in 1967. All other waivers are effective for a year if filed within the time for filing an income tax return for the year (and for later years). The due date for filing an income tax return for purposes of this provision includes extensions of time for filing a return.

2. Tax-exempt status for entities organized to perform services for tax-exempt hospitals (amends sec. 501(c) of the Internal Revenue Code)

(a) *Present law*

If two or more tax-exempt hospitals join together in creating an entity to perform services for the hospitals, the Internal Revenue Service takes the position that the entity constitutes a "feeder organization" and is not entitled to income tax exemption because of a special provision of the code applicable to such organizations. This is true

even though the service performed, if performed by each of the hospitals individually, would be considered an integral part of their exempt activities. In spite of this position of the Service, the leading case in point held such an entity furnishing services to hospitals to be exempt from tax.[1]

(*b*) *Problem presented*

A number of hospitals have formed organizations to perform various services such as data processing, diagnostic laboratory services, laundering, purchasing, and recordkeeping, etc., for the hospitals as a group. In addition, others desire to form such organizations. The committee wishes to encourage the formation of such joint service organizations because the performance of services in a joint operation can be expected to keep down the cost of hospital care, a matter of great concern to your committee at the present time.

The hospitals, although desiring to carry on the joint operations, nevertheless, are hesitant to form these organizations because of the view of the Internal Revenue Service that they are taxable. In addition, in some instances, tax-exempt charitable foundations have expressed a desire to make grants to finance the creation of the service entity. These charitable foundations, however, are reluctant to make the grants to the service entity unless it, itself, is exempt from tax under section 501(c)(3), because they fear so doing would jeopardize their own exempt status. In addition, others making gifts to enable the building of these joint facilities would not, under existing law, be eligible to claim a charitable contribution deduction for these amounts. Even if the contributions were made directly to the hospitals with the understanding that the funds would be used for these joint facilities it might be that a charitable contribution deduction would be denied.

Tax-exempt status for the service organization is desired for an additional reason. In determining exemptions from State and local taxes, many State and local governments rely upon the existence of an exemption from Federal income tax. Consequently, if tax-exempt status under the Federal income tax laws is granted to these organizations, it will in many instances make it possible for the organization to obtain exemption from State and local taxes.

(*c*) *Changes made by amendment*

For the reasons given above, the committee has added an amendment to the bill permitting organizations providing joint services for hospitals, where certain conditions are met, to be exempt from income tax (under sec. 501(c)(3)) contributions to them are to be deductible (under sec. 170) as charitable contributions. To qualify for this treatment the following conditions must be met:

(1) the joint entity must be organized and operated on a cooperative basis and allocate, or pay out, currently all of its net earnings to the hospital patrons on the basis of the services performed for them;

[1] *Hospital Bureau of Standards and Supplies, Inc.* v. *United States*, 1 AFTR 2d 633 (1958), 158 F. Supp. 560, U.S. Court of Claims.

(2) the joint entity must be organized and operated exclusively to provide services;

(3) the services the joint entity provides must be of a type which, if performed by the hospitals on their own behalf, would constitute an integral part of their exempt activities;

(4) the services must be performed solely for tax-exempt hospitals described in section 501(c)(3), or hospitals that are part of a tax-exempt organization described in section 501(c)(3) (such as an educational institution which operates a hospital), or a Federal, State, or local governmental hospital; and

(5) If the organization has capital stock outstanding, all of it must be owned by the hospitals.

Joint service organizations, where the above conditions are met, are to be classified as organizations which are exempt under section 501(c)(3) of the code, and charitable contribution deductions for income tax purposes are to be available with respect to gifts or bequests made to these organizations. In addition, they are to be treated as the type of organization where the limitation for charitable contributions is 30 percent (instead of 20 percent), when the contribution is made by an individual. This treatment of contributions to these joint entities as deductible charitable contributions, will also be available for estate and gift tax purposes.

This amendment applies to taxable years ending after the date of enactment of this bill.

3. Time for filing applications for exemption from self-employment tax by the Amish (amends sec. 102(h)(2) of the Internal Revenue Code)

(a) Present law

The Social Security Amendments of 1965 provided that members of religious sects who conscientiously oppose certain types of insurance in accordance with an established tenet of the sect may elect exemption from the self-employment tax. The provision was adopted on behalf of the Amish who oppose the acceptance of benefits of any private or public insurance which makes payments in the event of death or disability, old-age, or retirement, or makes payments toward the cost of medical care.

Generally, applications for exemption were required to be filed on or before April 15, 1966, in the case of those taxpayers with self-employment income for 1964 or any prior year. Taxpayers first deriving self-employment income in 1965 or any subsequent year are required to file applications on or before the due date (including any extension) of the income tax return for such first year.

(b) Problem presented

The committee has been advised that at least 164 taxpayers have filed applications for exemption from the self-employment tax which cannot be approved because they were filed after the date required by present law. In addition, it is believed a number of other qualified persons, who desire to file applications, failed to do so within the prescribed period. The Internal Revenue Service will be required to proceed to collect self-employment taxes from these taxpayers by levy

on their bank accounts or seizure of their other property unless the law is amended to allow more time for filing the applications. The committee believes that some extension of time for applying for the exemption is warranted, both for persons already engaged in self-employment, and for persons who first have self-employment income in the future.

(c) Changes made by amendment

The committee has added an amendment to the bill that would extend the period of time for filing these exemption applications. The amendment would permit the filing of an application for exemption by December 31, 1968, if the person has self-employment income for years ending before December 31, 1967. If a person first receives self-employment income in a later year, as under present law, the application would be timely if filed by the due date for the income tax return for the year. However, in these latter cases, the amendment also provides that the application is timely if filed within the 3 months following the month in which the person is first notified in writing by the Internal Revenue Service that a timely application has not been filed.

The exemption can be effective as early as January 1, 1951. For this reason the 1965 act provided as an exception to the general statute of limitations on tax refunds that full refunds of taxes paid (without interest) could be made for the past periods for which the exemption applies. The committee's amendment provides this same treatment with respect to applications for exemption by persons who had self-employment income for years ending before December 31, 1967, if they apply for the refund by December 31, 1968.

4. Employee status of fishermen and truck loaders and unloaders (amends section 210 of the Social Security Act and sections 3121 and 3401 of the Internal Revenue Code)

(a) Present law

The liability for employment or social security taxes on wages (FICA) is imposed with respect to each "employee" and that term is defined to mean "* * * any individual who, under the usual common law rules applicable in determining the employer-employee relationship, has the status of an employee. * * *" These same rules are generally applicable for income tax withholding purposes. The FICA taxes are not imposed with respect to a worker who is regarded under the common law as an independent contractor. However, an independent contractor would be subject to the tax on self-employment income.

(b) Problem presented

A problem has arisen with respect to two categories of workers. The first of these categories includes fishermen employed on or in connection with fishing vessels, and the second includes truck loaders and unloaders. For many years both the Internal Revenue Service and the Social Security Administration have held that these fishermen and truck loaders and unloaders are common law employees and, as such, subject to the FICA taxes. However, the classification of these workers as employees, rather than as independent contractors, involves what is

essentially a factual question, and, as a result, has produced widespread litigation and considerable confusion. The court decisions dealing with this problem have been inconsistent; some holding that these fishermen or truck loaders and unloaders are independent contractors not subject to the FICA taxes, while others performing essentially the same functions under very similar circumstances have been held to be employees subject to these taxes. Generally, if a worker is held not to be an employee for FICA tax purposes, the employer also fails to withhold the income tax on the compensation he pays to him. The Treasury Department has indicated that there are over 150 cases pending that involve the question of the employment status of fishermen and that several cases involving the employment status of truck loaders or unloaders are also pending.

The amendment is designed to obtain uniformity in the treatment of these workers and to relieve the courts and the Government of the caseload the present confusion has produced. Furthermore, the amendment avoids the existing situation in which competing firms employing individuals under essentially similar circumstances bear unequal social security tax burdens. In addition, the amendment would result in the collection of income taxes through withholding which are unlikely to be collected in any other way.

(c) Changes made by amendment

For the reasons given above the amendment classifies fishermen and truckloaders or unloaders as "employees" for social security and income tax withholding purposes. This will make it clear that they have "employers" who are liable for the FICA social security taxes and for income tax withholding on the compensation that they pay.

In the case of fishermen the amendment classifies the owner of a fishing boat as the "employer" of the boat's crewmembers unless the owner has leased the boat to another under a charter under which the owner has no interest in the catch and the lessee does. Where these conditions are both present, the lessee is classified as the "employer." Where, however, both conditions are not present, the owner of the fishing boat is considered the employer of the boat's crewmembers.

In the case of truckloaders and unloaders the amendment provides that the driver in charge of a truck that is loaded or unloaded is to be considered the employer of the person who loads or unloads it unless the truckdriver is himself an employee of another person. In that case, the truckdriver's employer is to be considered the employer of the loader or unloader. However, where a third person acknowledges that he is the employer of the loader or unloader, the third person will be so considered for FICA tax and income tax withholding purposes. Thus, for example, where loaders and unloaders are furnished by a warehouse and the warehouseman acknowledges that he is the employer of these workers, the warehouseman, and not the truckdriver or his employer, is to be considered the employer of the loaders and unloaders.

The amendments to the Social Security Act made by this provision are retroactive and are designed to make it clear that these fishermen and truckloaders and unloaders were covered as employees for social security benefit purposes as if the amendments had been part of the

Social Security Act from 1951 on. For purposes of the tax liability, in instances where this liability does not presently exist, the amendment applies with respect to remuneration paid after December 31, 1967, for services performed after that date.

5. Refund of certain overpayments by employees of hospital insurance tax (amends secs. 6413(c) and 6051 (a) and (c) of the Internal Revenue Code)

(a) Present law

If more than the maximum amount of employment or social security tax (FICA) is withheld from an employee's wages, usually because he worked for two or more employers during the year, the excess may be claimed by the employee as a credit against his Federal income tax.

The maximum FICA tax under present law is the tax on $6,600 of wages. Under the committee's amendments, the maximum taxable wage base is $8,000 effective for 1968, $8,800 for 1969–71 and $10,800 for 1972 and later years. However, if an employee had wages withheld by one employer under FICA and by another employer under the Railroad Retirement Tax Act, he is not entitled to a credit against his income tax liability because, apart from hospital insurance, the two acts provide for separate and distinct taxes and separate and distinct benefits.

(b) Problem presented

As part of the Social Security Amendments of 1965, the hospital insurance benefits program was enacted and applies to all employees insured under either the social security or railroad retirement programs. The hospital insurance tax is paid as a part of the tax imposed under FICA and the Railroad Retirement Tax Act. Thus, although the employee taxes imposed by the two acts are separate and distinct, the hospital insurance tax paid as a part of these taxes is the same as it goes into the same trust fund to provide the same benefits. Therefore, when an employee has wages withheld by one employer under FICA and another under the Railroad Retirement Tax Act, he may pay the hospital insurance portion of the tax on wages in excess of the $6,600 wage base (or higher base under the committee's amendments) and is not allowed a credit for the excess hospital insurance tax paid.

(c) Change made by amendment

In order to prevent an employee (or self-employed person) from paying both the FICA and railroad retirement tax with respect to hospital insurance where the individual works for two employers, one covered by one act and one by the other, or where he is self-employed and also works for an employer covered by the Railroad Retirement Act, the committee has amended present law to prevent the imposition of a double tax burden on the employee or self-employed person. This result is accomplished by treating the tax payable under the Railroad Retirement Tax Act by the employee, to the extent it represents hospital insurance, as if it were a FICA tax paid with respect to such insurance. The effect of this is to make the credit and refund provisions of present law available with respect to this hospital insurance tax to the extent it is paid on more than the maximum wage base.

In addition, present law has been amended (sec. 6051(a) and (c)) to provide that the provision of the tax laws dealing with employment tax withholding forms (Form W–2) is to require that the wages paid subject to the Railroad Retirement Tax Act, the tax imposed by that act, and the portion of the tax which is attributable to the hospital insurance tax, are to be specified on this form. This is necessary to inform the employee of the amount of any overpayment and consequently the credit that he may claim against this income tax or amount with respect to which he may claim a refund.

This amendment is to be effective with respect to earnings in calendar year 1968 and subsequent years.

6. Joint Employees of Certain Tax-Exempt Organizations

(*a*) *Present law*

Employment taxes for social security tax purposes are imposed on wages of an employee up to a stated dollar maximum. Under present law this wage base is $6,600. Under the amendments made by the committee, the wage base is increased to $8,000 for 1968, to $8,800 for 1969 and to $10,800 for 1972 and later years. If an employee receives wages from more than one employer during a year, each employer is subject to the employer tax to the extent of the wages he pays the employee within the wage base limitation.

(*b*) *Problem presented*

The attention of the committee has been called to cases where certain related tax-exempt organizations providing hospital and medical insurance make use of the same employees in order to provide the services for which they are exempt on a more economical basis. The payments to the employees in these cases have generally been made by only one of the exempt organizations. Nevertheless, the Internal Revenue Service in some instances has taken the position that the employees who furnish the services are joint employees of both tax-exempt organizations. This results in additional employer taxes on up to $6,600 of wages under present law, where the employee has wages over this amount, and could result in additional employer taxes on wages of up to $8,000 in 1968 under the committee's amendments (or up to $8,800 of wages in 1969 and $10,800 of wages for 1972 and subsequent years). This position of the Internal Revenue Service could also result in serious effects on the pension plan of the organization which had thought itself to be the sole employer of these employees.

The cases called to the committee's attention involved Blue Cross and Blue Shield State organizations. Blue Cross and Blue Shield are organized on a local basis throughout the country and are usually separate legal entities in each locality. Generally Blue Cross was organized first and Blue Shield, when later organized, contracted with Blue Cross to provide the services involved in the performance of its functions. While in many States the Internal Revenue Service has generally held the employees involved to be employees of Blue Cross, which in turn is held to be providing services for Blue Shield on a contract basis, it has not so held in the case of all State organizations.

The committee believes that in the case of these tax-exempt organizations it is unfortunate that the Internal Revenue Service holds that the double employer tax applies in some cases merely because of technicalities in its interpretation of the manner in which the service contracts read—particularly since it is clear that the double employer tax is not imposed in all States in similar instances.

(*c*) *Change made by amendment*

For the reasons given above, the committee's amendment specifies that in these situations where one of these tax-exempt organizations makes all of the wage or salary payments to the individual for his employment by the tax-exempt organizations, the organization making the payments is to be treated as the employer for tax purposes. For this treatment to apply, however, the organization paying the wages must have the consent of the other tax-exempt organizations to this treatment.

IV. SECTION-BY-SECTION ANALYSIS OF THE BILL

TITLE I—OLD-AGE, SURVIVORS, DISABILITY, AND HEALTH INSURANCE

PART 1—BENEFITS UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM

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

The bill provides a benefit increase of 15 percent with new minimum and maximum benefit amounts.

Primary insurance amount; column IV of the revised benefit table

Subsection 101(a) 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 March 1968 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 at least 15 percent over the primary insurance amounts provided in present law for average monthly earnings up to $550—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 72.42 percent of the first $110 of average monthly earnings, plus 26.34 percent of the next $290, plus 24.61 percent of the next $150, plus 28.06 percent of the next $150, plus 26.34 percent of the remaining $200. Benefits in the table in present law approximate 62.97 percent of the first $110 of average monthly earnings, plus 22.9 percent of the next $290, plus 21.4 percent of the next $150.

The primary insurance amounts provided by the new table range from a minimum of $70 for people whose average monthly earnings are $96 or less to a maximum of $288 for people who have average monthly earnings of $900. Average monthly earnings as high as $900 will become possible in the future under the $10,800 contribution and benefit base which the bill (in sec. 109) provides. The primary insurance amounts of workers getting benefits under present law (i.e., workers who will not have the advantage of the increased contribution and benefit base) are raised from $44 to $70 at the minimum and from $168 to $193.20 at the maximum.

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 $183) 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 $450 (one-half of the maximum possible average monthly earnings—$900—under a $10,800 contribution and benefit base) plus 40 percent of the worker's average monthly earnings above $450. This formula produces, at the maximum possible average monthly earnings of $900, a maximum family benefit of three-fifths of the average monthly earnings. Under the bill, the maximum amount of monthly benefits payable to a family will range from $105 to $540.

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 March 1968 as a result of applications filed in or before that month. 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 family members' benefits computed under present law, increased by 15 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 benefit 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 the effective month of the benefit increase on the basis of two or more earnings records. Under present law, where 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 where 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) as amended by the bill, which guarantees every beneficiary a 15 percent increase—that is, the provisions of the bill which guarantee a 15 percent increase to each member of the family (described above) are to be applied last. Where 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 the effective month of the benefit increase.

Average monthly earnings; column III of the revised benefit table

Section 101(c)(1) 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 March 1968; or (2) who dies in or after that month without having been entitled to old-age or disability insurance benefits; or (3) whose benefit is recomputed for months beginning with or after that month.

Section 101(c)(2) of the bill repeals section 215(b)(5) of the act (which preserves the method in effect before enactment of the 1965 amendments of computing average monthly earnings for people who became entitled to benefits or a recomputation of benefits before 1966) since it is now obsolete.

Primary insurance amount under 1965 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 March 1968 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 1965 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 the bill will be effective for monthly benefits for and after March 1968 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 February 1968 and who becomes entitled to old-age insurance benefits (for example, by reason of attainment of age 65) or dies in March 1968, to make certain that his primary insurance amount is increased. The general rule, provided in section 215(a)(4) of present law, 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, this section 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. (This primary insurance amount in column II is equal to the primary insurance amount on which 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.

Increase in special payments to transitionally insured people

Section 102(a) of the bill amends section 227 of the Social Security Act to increase from $35 to $50 the monthly amount payable to 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 $17.50 to $25 the amount payable to the wives of men who qualify for benefits under that section.

Increase in special payments to certain uninsured people

Section 102(b) of the bill amends section 228 of the act to increase from $35 to $50 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 $17.50 to $25 the monthly amount payable to a wife when both husband and wife are entitled to benefits under that section.

Effective date

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 March 1968.

SECTION 103. MAXIMUM AMOUNT OF A WIFE'S OR HUSBAND'S INSURANCE BENEFIT

Section 103(a) of the bill amends section 202(b)(2) of the Social Security Act to provide that a wife's insurance benefit (payable to a wife or an aged divorced wife), which is otherwise 50 percent of the worker's primary insurance amount, may not exceed $105.

Section 103(b) of the bill amends section 202(c)(3) of the act to provide that a husband's insurance benefit, which is otherwise 50 percent of the wife's primary insurance amount, may not exceed $105.

Section 103(c) of the bill amends section 202(e)(4) of the act to provide that a remarried widow's benefit (payable to a widow who marries an individual other than another beneficiary after she attains age 60), which is otherwise 50 percent of the deceased worker's primary insurance amount, may not exceed $105.

Section 103(d) of the bill amends section 202(f)(5) of the act to provide that a remarried widower's benefit (payable to a widower who

marries an individual other than another beneficiary after he attains age 62), which is otherwise 50 percent of the deceased wife's primary insurance amount, may not exceed $105.

Section 103(e) of the bill makes these amendments effective for monthly benefits beginning with March 1968 (although, of course, wife's or husband's benefits as high as $105 will not be possible immediately.)

SECTION 104. BENEFITS TO DISABLED WIDOWS AND WIDOWERS

Section 104 of the bill provides that a disabled widow or widower may become entitled to full-rate widow's or widower's benefits. Present law does not provide social security benefits for widows and widowers on the basis of disability; they can receive benefits beginning at age 62 (or at age 60 in the case of a widow who chooses to receive a reduced benefit).

Widow's insurance benefits

Section 104(a)(1) of the bill amends section 202(e)(1)(B) of the Social Security Act (relating to payment of widow's insurance benefits) to provide that a widow or surviving divorced wife may become entitled to widow's insurance benefits if she is disabled as defined in section 223(d) of the act (as amended by the sections of this bill relating to the definition of disability and to disability benefits for the blind) and her disability began within the period specified in the new section 202(e)(5) (discussed below) even though such individual has not attained age 60.

Section 104(a)(2) of the bill amends section 202(e)(1) of the act to permit entitlement to widow's benefits on account of disability to begin with the month following the waiting period prescribed by the new section 202(e)(6) (discussed below), or with the first month of disability if the widow becomes reentitled on account of subsequent disability within a specified period after termination of a previous entitlement to disabled widow's benefits. The amendment also provides that widow's benefits based on disability will end with the third month following the month in which the disability ceases (unless the widow attains age 62 before such third month, in which case benefits can continue on the basis of age).

Section 104(a)(3) of the bill further amends section 202(e)(1) of the act by adding a new sentence at the end which provides that widow's insurance benefits will not be payable in any month in which the individual engages in substantial gainful activity if entitlement to such benefits is solely by reason of disability as defined in section 223(d)(1)(B) of the act (as amended by the sections of this bill relating to the definition of disability and to disability benefits for the blind).

Section 104(a)(4) of the bill amends section 202(e) of the act by adding new paragraphs (5), (6), and (7). The new paragraph (5) provides that for purposes of widow's benefits based on disability a widow must have become disabled before age 62 and before her husband's death, before the end of her entitlement to mother's benefits or within 7 years after either event, or within 7 years after a previous entitlement to disabled widow's benefits has terminated because her disability ceased. The new paragraph (6) provides that the waiting

period before disabled widow's benefits can begin is a period of 6 consecutive calendar months throughout which the widow is under a disability; months of disability before the husband's death or before termination of entitlement to mother's benefits can be counted in this waiting period. The new paragraph (7) provides that entitlement to widow's insurance benefits will be deemed to be based on disability for months after the waiting period and prior to the month of attainment of age 62 if the individual is under a disability, as defined. (In effect, such benefits are subject to the requirements relating to benefits based on disability rather than to the requirements—retirement test, for example—relating to benefits based on age.)

Section 104(a)(5) of the bill amends section 202(q)(5) of the act by adding a new subparagraph (E) which provides that widow's insurance benefits based on disability are not reduced because the individual has not attained age 62, unless such individual previously received actuarially reduced benefits, in which case the benefit amount is determined as though such individual attained age 62 in the first month for which widow's benefits are payable on the basis of disability.

Widower's insurance benefits

Section 104(b)(1) of the bill amends section 202(f)(1)(B) of the act (relating to payment of widower's insurance benefits) to provide that a dependent widower may become entitled to widower's insurance benefits if he is disabled as defined in section 223(d) of the act (as amended by the sections of this bill relating to the definition of disability and to disability benefits for the blind) and his disability began within the specified period even though such individual has not attained age 62.

Section 104(b)(2) of the bill amends section 202(f)(1) of the act to permit entitlement to widower's benefits on account of disability to begin with the month following the prescribed waiting period, or with the first month of disability if the widower becomes reentitled on account of subsequent disability within a specified period after termination of a previous entitlement to disabled widower's benefits. The amendment also provides that widower's benefits based on disability will end with the third month following the month in which the disability ceases (unless the widower attains age 62 before such third month, in which case the benefits can continue on the basis of age).

Section 104(b)(3) of the bill further amends section 202(f)(1) of the act by adding a new sentence at the end which provides that widower's insurance benefits will not be payable in any month in which the individual engages in substantial gainful activity if entitlement to such benefits is solely by reason of disability as defined in section 223(d)(1)(B) of the act as amended by the sections of this bill relating to the definition of disability and to disability benefits for the blind.

Section 104(b)(4) of the bill amends section 202(f) of the act by adding new paragraphs (6), (7), and (8). The new paragraph (6) provides that for purposes of widower's benefits based on disability a widower must have become disabled before age 62 and before, or within 7 years after, his wife's death, or within 7 years after a previous entitlement to disabled widower's benefits has terminated because his

disability ceased. The new paragraph (7) provides that the waiting period before disabled widower's benefits can begin is a period of 6 consecutive months throughout which the widower is under a disability; months of disability before the wife's death can be counted in this waiting period. The new paragraph (8) provides that entitlement to widower's insurance benefits will be deemed to be based on disability for months after the waiting period and prior to the month of attainment of age 62 if the individual is under a disability, as defined. (In effect, such benefits are subject to the requirements relating to benefits based on disability rather than to the requirements—retirement test, for example—relating to benefits based on age.)

Related amendments

Section 104 (c) (1) (A) of the bill amends section 203(c) of the act to provide that no deduction on account of noncovered work outside the United States will be made in the case of a widow's or widower's insurance benefits, for any month for which a widow or widower is entitled to such benefits on the basis of disability. (Entitlement on the basis of disability ends no later than the month prior to the month of attainment of age 62.)

Section 104(c) (1) (B), (C), and (D) of the bill amend section 203 (f) of the act to provide that the retirement test will not apply in the case of a widow or widower entitled to widow's insurance benefits on the basis of disability.

Section 104(c) (2) of the bill amends section 216(i) (1) of the act to exclude disabled widow and widower beneficiaries from the definition provided for a period of disability for disabled worker beneficiaries (the "disability freeze").

Section 104(c) (3) of the bill amends subsections (a) and (b) of section 222 of the act to extend to disabled widows and widowers the policy that disability claimants be referred for vocational rehabilitation services and the requirement that benefits based on disability be withhold for months in which the disabled beneficiary refuses without good cause to accept rehabilitation services.

Section 104(c) (4) of the bill amends section 222(c) of the act to extend to disabled widows and widowers the provisions for a period of trial work. A period of trial work for such individual will begin with the month for which she or he becomes entitled to widow's or widower's insurance benefits on the basis of disability.

Section 104(c) (5) of the bill amends section 222(d) (1) of the act to extend to disabled widows and widowers the provisions now applicable for other disability beneficiaries authorizing payment from the Trust Funds for the cost of vocational rehabilitation services.

Section 104(c) (6) of the bill amends section 225 of the act to extend to disabled widows and widowers the provision for suspension of benefits during investigation of eligibility

Effective date

Section 104(d) of the bill provides that these amendments relating to benefits for disabled widows and widowers will be effective with respect to monthly benefits for and after March 1968 on the basis of applications filed in or after the month of enactment.

SECTION 105. REDUCED BENEFITS AT AGE 60

Section 105 provides for paying reduced benefits to workers, wives, husbands, widowers and parents beginning at age 60.

Age of eligibility

Paragraphs (1), (2), and (3) of section 105(a) amend section 202(a), (b), and (c) of the Social Security Act to lower the age of eligibility to 60 for old-age, wife's, and husband's insurance benefits, respectively.

Paragraph (4) of section 105(a) amends section 202(f) of the act. Subparagraphs (A) and (C) of paragraph (4) lower the age of eligibility to 60 for widower's benefits and provide that widower's benefits would be subject to actuarial reduction; the benefits payable to widowers before age 62 would be reduced to take account of the longer period over which they would be paid. (Under present law, unreduced benefits equal to 82½ percent of the deceased wife's primary insurance amount are payable to a widower at or after age 62.)

Subparagraph (B) of paragraph (4) amends section 202(f)(1)(C) to provide that no application for widower's benefits would be required from a man who had attained age 62 and was getting husband's benefits in the month before the month his wife died. Under this change an automatic conversion from husband's to widower's benefits would not be made if the husband is age 62 or older at the time of his wife's death, and, consequently, the conversion would not force him to take a reduced benefit.

Subparagraph (D) of paragraph (4) provides that if a widower remarries after age 60 (rather than after age 62 as in present law) someone other than a person getting wife's, widow's, or mother's, or parent's benefits his benefit would be reduced to 50 percent of the primary insurance amount on which it was based.

Paragraph (5) of section 105(a) amends section 202(h) to lower the age of eligibility to 60 for parent's insurance benefits and to provide that section 202(q) of the act would be applicable to parent's benefits. Section 202(q) provides that benefits taken before retirement age will be reduced to take account of the longer period over which they would be paid.

Reduction factors

Paragraph (1) of section 105(b) amends the heading of subsection (q) of section 202 of the act to take account of the fact that 2 more categories of beneficiaries could get reduced benefits under the provisions of the subsection.

Paragraph (2) of section 105(b) amends section 202(q)(1) of the act, which governs the reduction of benefits payable to people who claim them prior to retirement age, to provide (1) that widower's and parent's insurance benefits to which an individual is entitled for a month before he is 62 would be reduced by five-ninths of 1 percent for each month in the reduction period (the months prior to the attainment of age 62 for which the individual is entitled to a widower's or parent's benefit) and (2) that the benefits to which a widower or parent is entitled for the months in and after the month in which he attains age 62 would be reduced by the same percentage (five-ninths of 1 percent) for each month in the adjusted reduction period (the months

prior to attainment of age 62 for which the individual was actually paid a benefit). This is the same factor that applies in present law to old-age or widow's benefits payable prior to retirement age. Under the bill, the benefits provided for an old-age insurance beneficiary and for a wife or husband may be reduced for as many as 60 months; the benefits for a widower and a parent may be reduced for as many as 24 months, the same number of months as a widow's benefit may be reduced under present law. A person who takes an old-age insurance benefit at age 60 would get a benefit equal to 66⅔ percent of the amount he would have gotten if he had stopped working at age 60 and waited until he reached age 65 to claim his benefits; a wife's benefit would be 58⅓ percent of the benefit she would have gotten at age 65; a widower's or parent's benefit would be 86⅔ percent of the benefit payable at age 62, as is now the case for a widow's benefit.

Entitlement to benefits on own earnings

Subparagraphs (A), (B), (C) of paragraph (3) of section 105(b) amend subparagraphs (A), (B), and (C) of section 202(q)(3) of the act to provide that where a person is entitled to a disability benefit or a reduced old-age benefit based on his own earnings, and, at age 60 or later, becomes entitled to a reduced wife's, husband's, widow's, widower's, or parent's benefit, the reduction in the wife's, husband's, widower's, or parent's benefit would apply only to the excess of such unreduced benefit over the unreduced benefit on the individual's own earnings record. For example, where a widower is entitled to an old-age insurance benefit for the month for which he first becomes entitled to a widower's benefit, the reduction factor for the widower's benefit would apply only to the amount by which the widower's benefit exceeds his unreduced old-age insurance benefit. A similar reduction is applied in present law where a person is entitled to a reduced old-age benefit and becomes entitled to a reduced wife's or husband's benefit.

Entitlement to a dependent or survivors benefit

Subparagraph (D) of paragraph (3) of section 105(b) amends section 202(q)(3)(C) of the act to provide that where an individual is entitled before age 62 to a widower's or parent's benefit, and is not entitled to an old-age or disability insurance benefit the reduction factor set out in paragraph (2) of subsection (b) (five-ninths of 1 percent) would apply.

Reduction in subsequent old-age insurance benefits

Subparagraph (E) of paragraph (3) of section 105(b) amends section 202(q)(3)(E) to provide for reducing the old-age insurance benefit of a person who is entitled to a reduced widower's or parent's benefit. The old-age insurance benefit (whether the widower or parent begins to get it before or after he reaches age 65) would be reduced by whichever of the following would be larger: (1) the reduction which would have been made in the old-age benefit if no widower's or parent's benefit had been payable or (2) the dollar amount of the reduction in the widower's or parent's benefit for the month in which the person attained age 62 plus the amount resulting from (a) subtracting the unreduced widower's or parent's benefit from the unreduced old-age benefit and (b) applying the reduction factor for the old-age benefit to the excess. A similar provision applies in present law where

a woman getting reduced widow's benefits becomes entitled to an old-age benefit based on her own earnings record.

Reduction in subsequent disability benefit

Subparagraphs (F) and (G) of paragraph (3) of section 105(b) amend section 202(q)(3)(F) and (G) of the act to provide that where a person getting a reduced widower's or parent's benefit becomes entitled to a disability benefit based on his own earnings record, the disability benefit would be reduced to take account of the widower's or parent's benefits paid to him prior to age 62. If the person becomes entitled to the disability benefit in or after the month in which he attains age 62, the reduction in the disability benefit would be the dollar amount of the reduction in the widower's or parent's benefit for the month in which the person attained age 62. If the person had been entitled to an intervening reduced old-age benefit, the disability benefit would be reduced by whichever of the following would be larger: (1) the amount by which the disability benefit had been reduced because of prior entitlement to a reduced old-age benefit, or (2) the sum equal to the amount by which the widower's or parent's benefit was reduced at age 62 plus the amount by which the disability benefit would be reduced (because of prior entitlement to a reduced old-age benefit) if the disability benefit were equal to the difference between the unreduced disability benefit and the unreduced widower's or parent's benefit. If the person becomes entitled to the disability benefit before age 62, the disability benefit would be reduced by the dollar amount that the widower's or parent's benefit would have been reduced if the person had attained age 62 in the first month for which he was entitled to the disability benefit.

A similar provision applies in present law where a woman getting a reduced widow's benefit subsequently becomes entitled to a disability benefit based on her own earnings record.

Certificate of election

Paragraph (4) of section 105(b) amends section 202(q)(5)(B) of the act to provide that when a woman files a certificate electing to get reduced wife's benefits, the certificate could be effective as early as age 60, rather than as early as age 62 as under present law.

Reduction period

Paragraph (5) of section 105(b) amends section 202(q)(6) of the act to provide that, in the case of widower's or parent's benefits, the "reduction period" would begin with the first month for which the person is entitled to a reduced widower's or parent's benefit and would end with the month before the month in which the person attains age 62. The number of months in the "reduction period" is the number that is multiplied by five-ninths of 1 percent to determine the reduction in the benefits.

Adjusted reduction period

Paragraph (6) of section 105(b) amends section 202(q)(7) of the act, which describes the months which are eliminated from the "reduction period" in determining the "adjusted reduction period" for purposes of establishing the benefit amount payable for months beginning with the month the person attains retirement age, to provide that, in determining the widower's or parent's adjusted reduction period at

age 62, months in which his benefit was withheld because he had earnings from work and months beginning with the month in which the widower's or parent's benefit was terminated through the month prior to the month of attainment of age 62, would not be counted. For example, if a parent elects to start getting benefits at age 60 his benefit amount would be reduced by five-ninths of 1 percent for each of the 24 months in the reduction period; if he has 6 months' benefits withheld because of his earnings before he reaches age 62, his benefit amount would be adjusted at age 62; for future months, it would be reduced by five-ninths of 1 percent for each of the 18 months he had actually been paid a benefit.

Definitions

Paragraph (7) of section 105(b) amends section 202(q)(9) of the act to provide that for the purposes of the actuarial reduction provisions "retirement age" for widowers or parents would be 62.

Subsection (c) of section 105 of the bill amends section 202(r)(1) of the act to provide that if a person under age 65 files an application for old-age benefits and is also eligible for a wife's, husband's, widow's, widower's, or parent's insurance benefit, he would be deemed to have filed an application for such dependents or survivors benefits.

Subsection (d) of section 105 amends section 214 of the act to clarify the definition of the period to be used in determining a fully-insured status for a woman, since, under the bill, she would be eligible for benefits at age 60, even though her insured status would continue to be figured up to the year she reaches age 62.

Paragraph (1) of section 105(e) amends section 215(b)(3) of the act to clarify the definition of the period to be used in determining the number of elapsed years for benefit computation purposes for a woman, since, under the bill, a woman would be eligible for benefits at age 60 but the number of years to be used in figuring average monthly earnings for computation purposes would continue to be figured up to the year she reaches age 62.

Paragraph (2) of section 105(e) amends section 215(f)(5) of the act (as added by sec. 155(a)(6) of the bill) to provide that the primary insurance amount of a woman who was entitled to an actuarially reduced old-age benefit and who died before age 62 would be recomputed using the period up to the year of death instead of the period up to the year of attaining age 62, regardless of whether she had earnings after 1965. (Sec. 155(a)(4) of the bill provides that benefits for people on the benefit rolls would be recomputed for years after 1965 only where a person had creditable earnings after 1965.) The recomputed primary insurance would be effective for and after the month of the worker's death; i.e., would be the amount from which the survivor's benefits and lump-sum death payment would be determined.

Subsection (f) of section 105 of the bill amends subsections (b), (c), (f), and (g) of section 216 of the act to change the definition of wife, widow, husband, and widower relating to age, so that a person can meet such definitions at age 60, rather than at age 62 as under present law.

Change to bar the payment of a full benefit to a divorced wife entitled to wife's insurance benefits before age 65

Paragraphs (1) and (2) of section 105(g) amend subparagraphs (A) and (C) of section 202(q)(5) of the act, which set out the con-

ditions under which wife's insurance benefits will not be reduced, to restrict the application of these paragraphs to a woman who is legally married to the insured worker.

Paragraphs (3) and (4) of section 105(g) amend paragraphs (6) and (7) of section 202(q), which define the reduction period and adjusted reduction period, to make conforming changes to take account of the fact that a divorced wife's benefit will be reduced if she claims such benefits before age 65, even for months in which she has a child in her care.

Workmen's compensation

Subsection (h) of section 105 amends section 224(a) of the act to provide that social security disability benefits may be reduced because of concurrent entitlement to workmen's compensation payments only prior to the month in which the beneficiary attains age 60 instead of age 62 as under present law. This change would maintain the effect of present law.

Disabled widowers

Subsection (i) of section 105 amends section 202(q)(5)(E) of the act by adding conforming language to provide that a disabled widower's benefit is not reduced because he is under age 62 unless he previously received actuarially reduced benefits, in which case his benefit is recalculated as if he had reached age 62 when his disabled widower's benefits began.

Effective dates

Subsection (j) of section 105 provides that reduced old-age, wife's, husband's widower's, and parent's insurance benefits would be payable for months after November 1968 based on applications filed after the month of August 1968.

SECTION 106. INSURED STATUS FOR YOUNGER DISABLED WORKERS

Section 106 of the bill provides an alternative disability insured-status requirement for workers who become disabled from causes other than blindness before age 31. Present law provides such an alternative requirement for those who are blind, but others must satisfy the basic requirement of at least 20 quarters of coverage in the 40 calendar quarters ending with the quarter of disablement. This section provides that any worker disabled before age 31, regardless of the cause of his disability, will be insured for social security disability protection if he meets the alternative insured-status requirement provided in present law for workers disabled by blindness before age 31—i.e., at least half (and not less than six) of the quarters elapsing after attainment of age 21 and up to and including the quarter of disablement are quarters of coverage, or if disability occurs before attainment of age 24, at least six of the twelve quarters ending with the quarter of disablement are quarters of coverage.

Section 106(a) of the bill amends subparagraph (B)(ii) of section 216(i)(3) of the act to remove for purposes of a period of disability (the "disability freeze") the limitation which restricts the alternative insured-status requirement to those whose disability is based on blindness.

Section 106(b) of the bill amends subparagraph (B)(ii) of section 223(c)(1) of the act to remove for purposes of disability insurance benefits the limitation which restricts the alternative insured-status requirement to those whose disability is based on blindness.

Section 106(c) provides that the amendments made by section 106 (a) will apply with respect to applications for a period of disability that are filed in or after the month of enactment, and that the amendments made by section 106(b) will apply with respect to monthly benefits for and after March 1968 on the basis of applications filed in or after the month of enactment.

SECTION 107. BENEFITS IN CASE OF MEMBERS OF THE UNIFORMED SERVICES

Section 107 of the bill adds at the end of title II of the Social Security Act a new section 229 to provide noncontributory wage credits for service in the uniformed services of the United States after 1967, in addition to social security credits earned through coverage, under present law, of basic service pay.

The new section 229(a) provides that a serviceman will receive noncontributory wage credits, for purposes of determining entitlement to and the amount of social security benefits payable on the basis of his wages and self-employment income, for every calendar quarter occurring after 1967 in which he is paid wages for service in the uniformed services which is covered under social security on a contributory basis—i.e., for service in the uniformed services within the meaning of section 210(l). The credits will ordinarily be $300 for each calendar quarter in which the serviceman receives such covered wages, but (to take account of calendar quarters in which the serviceman receives pay for only a short period of service) will be $100 for any calendar quarter in which his service pay is $100 or less, and $200 for any calendar quarter in which his service pay is more than $100 but not more than $200.

The new section 229(b) provides an authorization for an annual appropriation to reimburse the social security trust funds from the general funds of the Treasury for the additional costs that would result from the new section 229(a). In addition to the cost of additional benefits, there is to be reimbursement for the additional administrative expenses and the loss of interest to the trust funds resulting from the noncontributory wage credits. Additional benefit costs resulting from the new section 229(a) are defined as the cost of the additional benefits which result from the noncontributory wage credits over and above the benefits that would have been payable based on all other credits, including noncontributory military service credits provided for in section 217 of the act.

SECTION 108. LIBERALIZATION OF EARNINGS TEST

Annual and monthly measures of retirement

Section 108(a)(1) 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 and still get benefits.

Paragraph (1) of section 203(f) as amended provides that, for purposes of the earnings test (the provision in the law under which

some or all benefits are withheld when a beneficiary under age 72 has specified amounts of earnings), any earnings of a beneficiary in excess of the amount he may have 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 or render services for wages of more than $140 for taxable years ending after December 1967 and before January 1969, and $166⅔ for taxable years ending after December 1968, instead of $125 as in present law. The effect of this change is that benefits may not be withheld for any month in which the beneficiary (or the person on whose wage record his benefits are payable) did not have wages of more than $140 for taxable years ending in 1968 and $166⅔ for taxable years ending in 1969 and thereafter (or engage in self-employment).

Paragraph (3) of section 203(f) as amended provides that a person's "excess earnings" for any taxable year will be his earnings in excess of $140 for taxable years ending in 1968 and $166⅔ for taxable years ending in 1969 and thereafter (rather than $125) times the number of months in the taxable year. The effect of this provision is that if a beneficiary's earnings (or the earnings of the person on whose wage record his benefits are payable) amount to no more than $140 for taxable years ending in 1968 and $166⅔ for taxable years ending in 1969 and thereafter times the number of months in the taxable year, he will get all monthly benefits for that year. Since in the great majority of cases a taxable year consists of the 12 calendar months, the new annual exempt amount will be $1,680 for taxable years ending in 1968, and $2,000 for taxable years ending in 1969 and thereafter, rather than $1,500 as in present law.

Paragraph (4)(B) of section 203(f) as amended provides that in determining whether a beneficiary earned more than $140 for taxable years ending in 1968 and $166⅔ for taxable years ending in 1969 and thereafter (rather than $125 as in present law) in a month for purposes of applying the monthly exemption under section 203(f)(1) of the act, he will be presumed to have earned more than that amount until it is shown to the satisfaction of the Secretary of Health, Education, and Welfare that he did not do so.

Requirement for reporting annual earnings

Section 108(a)(2) amends paragraph (1)(A) of section 203(h) of the act to require a beneficiary to report his earnings to the Secretary whenever his annual earnings exceed $140 for taxable years ending in 1968 and $166⅔ for taxable years ending in 1969 and thereafter (rather than $125 as in present law) times the number of months in his taxable year.

Effective date

Section 108(b) of the bill provides that these amendments will be effective for taxable years ending after December 1967.

SECTION 109. INCREASE OF EARNINGS COUNTED FOR BENEFIT AND TAX PURPOSES

Section 109 of the bill provides a 3-step schedule of increases in the amount of annual earnings that is subject to social security contributions and counted toward social security benefits (the contribution

and benefit base) from $6,600 to $8,000 for the year 1968, from $8,000 to $8,800 for the years 1969 through 1971, and from $8,800 to $10,800 for years beginning with 1972.

Amendments of Title II of the Social Security Act

Definition of wages

Section 109(a)(1) of the bill amends section 209(a) of the Social Security Act (defining "wages" for benefit purposes) to make the $8,000 contribution and benefit base applicable to wages paid after 1967 and before 1969, the $8,800 base applicable to wages paid after 1968 and before 1972, and the $10,800 base applicable to wages paid after 1971.

Definition of self-employment income

Section 109(a)(2) amends section 211(b)(1) of the act (defining "self-employment income" for benefit purposes) to make the $8,000 contribution and benefit base applicable for taxable years ending after 1967 and before 1969, the $8,800 base applicable for taxable years ending after 1968 and before 1972, and the $10,800 base applicable for taxable years ending after 1971.

Quarter of coverage

Section 109(a)(3) amends clauses (ii) and (iii) of section 213(a)(2) of the act (defining "quarter of coverage") to provide that an individual will be credited with a quarter of coverage for each quarter of a calendar year in which his wages for such year equal the amount of the contribution and benefit base in effect after 1967: $8,000 in 1968, $8,800 in 1969 through 1971, and $10,800 beginning in 1972. An individual will also be credited with a quarter of coverage for each quarter any part of which falls within a taxable year in which the sum of his wages and self-employment income equals the amount of the contribution and benefit base in effect after 1967: $8,000 for taxable years ending after 1967 and before 1969, $8,800 for taxable years ending after 1968 and before 1972, and $10,800 for taxable years ending after 1971.

Average monthly wage

Section 109(a)(4) 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 the maximum amount of annual earnings that may be counted in the computation of an individual's average monthly wage for purposes of determining benefit amounts from the present $6,600 to $8,000, effective for calendar years after 1967 and before 1969, from $8,000 to $8,800, effective for calendar years after 1968 and before 1972, and from $8,800 to $10,800, effective for calendar years after 1971.

Amendments to the Internal Revenue Code of 1954

Definition of self-employment income

Section 109(b)(1) of the bill amends section 1402(b)(1) of the Internal Revenue Code of 1954 (defining "self-employment income" for social security tax purposes) by increasing the upper limit on annual self-employment income subject to social security contribu-

tions from $6,600 to $8,000 for taxable years ending after 1967 and before 1969, to $8,800 for taxable years ending after 1968 and before 1972, and to $10,800 for taxable years ending after 1971.

Definition of wages

Section 109(b)(2) amends section 3121(a)(1) of the code (defining "wages" for social security tax purposes) by increasing the upper limit on annual wages subject to social security contributions from $6,600 to $8,000 effective for calendar years after 1967 and before 1969, from $8,000 to $8,800 effective for calendar years after 1968 and before 1972, and from $8,800 to $10,800 effective for calendar years after 1971.

Federal service

Section 109(b)(3) amends section 3122 of the code (relating to Federal service) to conform its provisions to the increases in the contribution and benefit base from $6,600 to $8,000 for calendar year 1968, from $8,000 to $8,800 for calendar years after 1968 and before 1972, and from $8,800 to $10,800 for calendar years after 1971.

Returns in the case of certain governmental employees

Section 109(b)(4) 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 increases in the contribution and benefit base from $6,600 to $8,000 for calendar year 1968, from $8,000 to $8,800 for calendar years after 1968 and before 1972, and from $8,800 to $10,800 for calendar years after 1971.

Special refunds of employee contributions

Sections 109(b)(5) and 109(b)(6) of the bill amends section 6413(c) of the code (relating to special refunds of social security contributions paid by an employee who had more than one employer and who had total wages in excess of $6,600) to conform the special refund provisions to the increases in the contribution and benefit base: from $6,600 to $8,000 for calendar year 1968, from $8,000 to $8,800 for calendar years after 1968 and before 1972, and from $8,800 to $10,800 for calendar years after 1971.

Effective Date

Section 109(c) provides effective dates for the changes made by the section. The amendments made by sections 109(a)(1), 109(a)(3)(A), and section 109(b) (except paragraph (1) thereof), all of which relate to wages, are applicable with respect to remuneration paid after December 1967; the amendments made by sections 109(a)(2), 109(a)(3)(B), and section 109(b)(1), all of which relate to self-employment income, are applicable with respect to taxable years ending after 1967; and the amendment made by section 109(a)(4) (relating to the computation of a person's average monthly wage) is applicable with respect to calendar years after 1967.

SECTION 110. CHANGES IN TAX SCHEDULES

Section 110 of the bill provides new schedules of social security tax rates, both for old-age, survivors, and disability insurance and for hospital insurance.

Old-age, survivors, and disability insurance rates

Section 110(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, 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—	*Tax rate (percent)*
1966 (and before 1969)	5.9
1968 (and before 1973)	6.6
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—	*Tax rate (percent)*
1966 (and before 1968)	5.9
1968 (and before 1969)	5.8
1969 (and before 1971)	6.3
1971 (and before 1973)	6.9
1972	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:	*Tax rate, employer and employee, each (percent)*
1967 to 1968, inclusive	3.90
1969 to 1972, inclusive	4.40
1973 and after	4.85

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:	*Tax rate, employer and employee, each (percent)*
1967	3.9
1968	3.8
1969–70, inclusive	4.2
1971–72, inclusive	4.6
1973–75, inclusive	5.0
1976 and after	5.05

Hospital insurance rates

Section 110(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, employees, and employers.

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

Taxable years beginning after—	*Tax rate (percent)*
1966 (and before 1973)	0.50
1972 (and before 1976)	.55
1975 (and before 1980)	.60
1979 (and before 1987)	.70
1986	.80

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

Taxable years beginning after—	*Tax rate (percent)*
1966 (and before 1968)	0.50
1968 (and before 1973)	.60
1973 (and before 1980)	.65
1980	.75

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:	*Tax rate employer and employee, each (percent)*
1967 to 1972, inclusive	0.50
1973 to 1975, inclusive	.55
1976 to 1979, inclusive	.60
1980 to 1986, inclusive	.70
1987 and after	.80

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

Calendar years:	*Tax rate employer and employee, each (percent)*
1967	0.50
1968–1972, inclusive	.60
1973–1979, inclusive	.65
1980 and after	.75

Effective dates

Section 110(c) of the bill provides that the amendments made by subsections 109 (a)(1) and (b)(1) of this section are to apply with respect to taxable years which begin after December 31, 1967, and that the remaining amendments made by this section are to apply with respect to remuneration paid after December 31, 1967.

SECTION 111. ALLOCATION TO DISABILITY INSURANCE TRUST FUND

Section 111(a) of the bill amends section 201(b)(1) of the Social Security Act to increase the percentage of taxable wages allocated to the Disability Insurance Trust Fund (now 0.70 of 1 percent) to 0.95 of 1 percent, effective with respect to wages paid after 1967.

Section 111(b) of the bill amends section 201(b)(2) of the act to increase the percentage of taxable self-employment income allocated to the Disability Insurance Trust Fund (now 0.525 of 1 percent) to 0.7125 of 1 percent, effective with respect to taxable years beginning after 1967.

SECTION 112. EXTENSION OF TIME FOR FILING APPLICATIONS FOR DISABILITY FREEZE

Section 112 of the bill provides that an individual who meets the requirements of the provisions may become entitled to a disability freeze if he files an effective application to establish a closed period of disability within certain time limitations; under present law, a closed period of disability cannot be established unless an individual files

an application before or within 12 months after the end of the period of disability.

Section 112 of the bill adds a new subparagraph (F) to section 216(i)(2) of the Social Security Act to provide that (1) in the case of a period of disability which ends after the month of enactment of this provision, where an individual failed—because of a physical or mental condition which rendered him incapable of executing an application—to file an application within 12 months after the end of his period of disability, the time provided for filing an effective application to establish such period of disability would be extended to 36 months after the month in which the disability ended; (2) in the case of a closed period of disability that ended in or before the month of enactment of this provision where an application had been filed within 36 months after the disability ended, a new valid application could be filed within a 12-month period after the month of enactment if failure to file the prior application timely was due to a physical or mental condition which rendered the individual incapable of executing such an application; and (3) for purposes of arriving at a determination with respect to the disability or period of disability of an individual who files a valid application within the extended period provided by this amendment, provisions in effect at the time such determination is made shall apply. Monthly insurance benefits for months prior to the month of enactment would not be payable (or increased) by reason of the provisions of this section of the bill.

SECTION 113. MARRIAGE NOT TO TERMINATE CHILD'S BENEFITS OF CERTAIN CHILDREN WHO ARE FULL-TIME STUDENTS

Section 113 adds a new paragraph (11) to section 202(d) of the Social Security Act to provide that the entitlement of a child to benefits would not be terminated because of marriage if the child is a full-time student, and, in the case of a girl, if her husband was also a full-time student. The new paragraph (11) would also provide that a child whose benefits have been terminated because of marriage may again become entitled to child's benefits upon filing an application for such benefits if the child is a full-time student (and, in the case of a girl, if her husband is also a full-time student). The provision would apply with respect to monthly benefits for months after February 1968 and, in the case of an individual who was not entitled in the month of enactment, on the basis of an application filed in or after the month of enactment.

PART 2—COVERAGE UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM

SECTION 115. COVERAGE OF MINISTERS

Section 115 of the bill provides social security coverage for the services performed by ministers, members of religious orders, and Christian Science practitioners in the exercise of their professions unless they elect, as provided in the bill, to have their services exempt from the social security self-employment tax. (Under present law the reverse is true; such services are exempt from the tax unless coverage is elected.)

Amendments to title II of the Social Security Act

Under existing law, services performed by a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry, or by a member of a religious order in the exercise of duties required by such order, are excepted from the term "employment" under section 210(a)(8)(A) of the Social Security Act, and from the term "trade or business" under section 211(c)(4) of the act, and thus from social security coverage. The services performed by a Christian Science practitioner in the exercise of his profession are also excepted from the term "trade or business" under section 211(c)(5) of the act and thus excluded from coverage. However, such a clergyman, member (other than a member who has taken a vow of poverty as a member of his order), or practitioner may file a certificate electing to be covered with respect to his services in such professions under the provisions applicable to the self-employed, in the manner prescribed in section 1402(a) of the Internal Revenue Code of 1954.

Section 115(a) of the bill amends the last sentence of section 211(c) of the act to provide that the coverage exceptions in section 211(c)(4) and (5) will not apply to the services (other than service performed by a member of a religious order who has taken a vow of poverty of such order) performed in such professions by a minister, member, or practitioner unless an exemption from the social security self-employment tax is effective with respect to him as provided for under section 1402(e) of the code, as amended by section 115(b)(2) of the bill.

Amendments to the Internal Revenue Code of 1954

Under existing law, services performed by a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry, or by a member of a religious order in the exercise of duties required by such order, are excepted from the term "employment" under section 3121(b)(8)(A) of the Internal Revenue Code of 1954, and from the term "trade or business" under section 1402(c)(4) of the code, and thus from social security taxes. The services performed by a Christian Science practitioner in the exercise of his profession are also excepted from the term "trade or business" under section 1402(c)(5) of the code and thus excluded from the social security self-employment tax. However, such a clergyman, member (other than a member who has taken a vow of poverty as a member of his order), or practitioner may file a certificate electing to be covered with respect to his services in such professions under the provisions applicable to the self-employed, in the manner prescribed in section 1402(e) of the code.

Section 115(b)(1) of the bill amends the last sentence of section 1402(c) of the code to provide that the exceptions from the term "trade or business", and thus from the social security self-employment tax, in section 1402(c)(4) and (5) of the code, will not apply to the services (other than service performed by a member of a religious order who has taken a vow of poverty of such order) performed in such professions by a minister, member, or practitioner unless an exemption from the social security self-employment tax is effective with respect to him as provided for under section 1402(e) of the code, as amended by section 115(b)(2) of the bill.

Section 115(b) (2) of the bill substitutes for the present section 1402 (e) of the code (permitting clergymen, members of religious orders who have not taken a vow of poverty, and Christian Science practitioners to secure social security coverage by filing a waiver certificate with the Internal Revenue Service) a new section 1402(e) which permits clergymen, members of religious orders who have not taken a vow of poverty, and Christian Science practitioners to secure an exemption from the social security self-employment tax upon meeting the requirements of the new section 1402(e).

The new section 1402(e) (1) provides that a clergyman, member, or practitioner, to secure the exemption, must file an application with the Internal Revenue Service, together with a statement that he is conscientiously opposed or opposed on religious principle to the acceptance (based on his services as a minister, member, or practitioner) of public insurance which makes payments in the event of death, disability, old age, or retirement or makes payments toward the cost of, or provides services for, medical care. An exemption under the new section 1402(e) will apply only to services performed as a minister, member, or practitioner. An exemption may not be granted to an individual who had elected social security coverage by filing an effective waiver certificate under section 1402(e) of present law.

The new section 1402(e) (2) provides that an individual's application for exemption must be filed on or before the due date of the individual's income tax return for the second taxable year for which he has net earnings from self-employment of $400 or more, any part of which was derived from his services as a clergyman, member, or practitioner, or the due date of his tax return for his second taxable year ending after 1967, whichever date is later. The effect of this provision (with respect to persons who are on a calendar year basis) is that an individual performing services as a clergyman, member, or practitioner in 1968 or before (and who has not elected coverage under present law) will have until April 15, 1970, to obtain an exclusion from coverage under the new section 1402(e); those individuals first performing such services in 1969 or later will have until the due date of the tax return for the second year in which they performed such services to obtain the exclusion.

The new section 1402(e) (3) provides that an exemption from taxes under the new section 1402(e) will be effective for the first taxable year in which such clergyman, member, or practitioner has net earnings of $400 or more, any part of which was derived from performing services as a clergyman, member, or practitioner, and for all succeeding taxable years. Section 1402(e) (3) also provides that an exemption under the new section 1402(e) is irrevocable.

Section 115(c) of the bill provides that the amendments made by sections 115 (a) and (b) of the bill are to apply only with respect to taxable years ending after 1967. The effect of section 115(c) of the bill, with respect to existing law, is to provide that an individual who performed services as a clergyman, member, or practitioner in 1966 or 1967 and whose time for electing coverage under present law, by filing an effective waiver certificate under present section 1402(e) of the code, had not expired before the enactment date will retain his rights under present law to elect coverage for those 2 years. Thus, an individual who

first had such services in 1966 will have until April 15, 1968, to choose to cover his services performed in 1966 and 1967; an individual who first had such services in 1967 will have until April 15, 1969, to choose to cover his services performed in 1967.

An individual not electing coverage under present law will be covered under social security for taxable years ending after December 31, 1967, unless he is granted an exemption under the new section 1402(e) of the code.

SECTION 116. COVERAGE OF STATE AND LOCAL EMPLOYEES

Coverage for certain persons who are in positions under a State or local retirement system but are ineligible to join such system

Section 218(d)(6)(D) of the Social Security Act provides that when social security coverage is extended to persons under a retirement system under the divided retirement system procedure provided for under section 218(d)(6)(C), the coverage does not apply to persons who are in positions under the retirement system but are ineligible to join the system. Section 116(a) of the bill amends section 218(d)(6)(D) of the act to permit the coverage of all such "ineligibles" other than those to whose services the agreement already applies.

Under present law, when persons in positions covered under a retirement system who are personally ineligible to join the system are brought under social security with a nonretirement system group, the State is required to specify whether their social security coverage is to continue or to be terminated in the event they later become eligible to join the retirement system. This same requirement will apply in the case of persons brought under coverage under the amendment made by section 116(a).

Mandatory exclusion of emergency services

Sections 116(b)(1) and (2) of the bill remove the present provision (sec. 218(c)(3)(A) of the act) that "emergency services" may be excluded from coverage under a State coverage agreement at the option of the State, and substitute a new provision (sec. 218(c)(6)(E)) for the mandatory exclusion from such coverage of service performed by an individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency.

Section 116(b)(3) of the bill provides that these changes will be effective with respect to services performed on or after January 1, 1968.

Optional exclusion of certain services performed by election workers

Section 116(c) of the bill amends section 218(c) of the act by adding a new paragraph (8) to give the States the option under a State coverage agreement of excluding from coverage service preformed by election officials and election workers if the remuneration paid in a calendar quarter for such service is less than $50. A State will be permitted to modify its agreement on or after January 1, 1968, to exclude such services. The exclusion will become effective with a date specified by the State, but not before the first day of the calendar quarter after the quarter in which the modification is mailed, or delivered by other means, to the Secretary.

Additional period for electing coverage under the divided retirement system

Section 116(d) of the bill amends section 218(d)(6)(F) of the Social Security Act to grant an additional opportunity to obtain coverage to State and local government employees (in a State permitted to use the divided retirement system procedure) who had not previously chosen coverage under the divided retirement system provisions. The present law allows such employees a further opportunity to elect coverage only if a modification providing for such election is mailed or otherwise delivered to the Secretary before 1967, or, if later, 2 years after the date on which coverage was approved for the group that originally elected coverage; any coverage elected after the original division must begin on the same date as was provided when the group was originally covered. Under the amendment the time in which such persons could elect to be covered will be extended until the end of 1969 (or, if later, the expiration of 2 years after the date on which coverage was approved for the group that originally elected coverage).

SECTION 117. INCLUSION OF ILLINOIS AMONG STATES PERMITTED TO DIVIDE THEIR RETIREMENT SYSTEMS

Section 117 of the bill amends section 218(d)(6)(C) of the Social Security Act by adding Illinois to the list of States which are permitted to divide their retirement systems into two divisions or parts for social security coverage purposes, one division or part consisting of those members desiring coverage under the act and the other consisting of those who do not, with all new members being covered on a compulsory basis.

SECTION 118. TAXATION OF CERTAIN EARNINGS OF RETIRED PARTNER

Amendments to the Internal Revenue Code of 1954

Under existing law, retirement payments received by a retired partner from a partnership (of which he is a member or a former member) are, in general, counted as net earnings from self-employment under section 1402(a) of the Internal Revenue Code of 1954 and, subject to the provisions of section 1402(b) of the code (defining self-employment income), are subject to the social security self-employment tax. Section 118(a) of the bill amends section 1402(a) of the code by adding a new paragraph (10), which provides that under specified conditions there shall be excluded from the term "net earnings from self-employment", and thus excluded from the social security self-employment tax, certain periodic payments made by a partnership to a retired partner which are made on account of retirement pursuant to a written plan of the partnership. The new section 1402(a)(10) specifies that the plan (if the exclusion is to be effective) must meet such requirements as are prescribed by the Secretary of the Treasury or his delegate, apply to partners generally or to a class or classes of partners, and provide such payments at least until the retired partner's death. The new section 1402(a)(10) further provides that the exclusion will be effective with respect to retirement payments received by the retired partner in a year only if he renders no services in any trade or business conducted by the partnership or its successors during the

taxable year of such partnership, or its successors, which ends within or with the taxable year of the retired partner, and at the end of such partnership's taxable year (1) there is no obligation from the other partners in the partnership to the retired partner other than to make retirement payments under the partnership plan, and (2) the retired partner's share in the capital of the partnership has been paid to him in full.

Amendments to title II of the Social Security Act

Under existing law, retirement payments received by a retired partner from a partnership (of which he is a member or a former member) are, in general, counted as net earnings from self-employment under section 211(a) of the Social Security Act and, subject to the provisions of section 211(b) of the act (defining self-employment income), are covered under social security. Section 118(b) of the bill amends section 211(a) of the act by adding a new paragraph (9), which provides that under specified conditions there shall be excluded from the term "net earnings from self-employment", and thus excluded from social security coverage for benefit computation and retirement test purposes, certain periodic payments made by a partnership to a retired partner which are made on account of retirement pursuant to a written plan of the partnership. The new section 211(a)(9) specifies that the plan (if the exclusion is to be effective) must meet such requirements as are prescribed by the Secretary of the Treasury or his delegate, apply to partners generally or to a class or classes of partners, and provide such payments at least until the retired partner's death. The new section 211(a)(9) further provides that the exclusion will be effective with respect to retirement payments received by the retired partner in a year only if he renders no services in any trade or business conducted by the partnership or its successors during the taxable years of such partnership, or its successors, which ends within or with the taxable year of the retired partner, and at the end of such partnership's taxable year (1) there is no obligation from the other partners in the partnership to the retired partner other than to make retirement payments under the partnership plan, and (2) the retired partner's share in the capital of the partnership has been paid to him in full.

Effective date

Section 118(c) of the bill provides that the amendments made by section 118 (a) and (b) will apply with respect to net earnings from self-employment in taxable years which end on or after December 31, 1967.

SECTION 119. COVERAGE OF POLICEMEN AND FIREMEN IN NEBRASKA AND PUERTO RICO

Section 119(a) of the bill amends section 218(p) of the Social Security Act by adding Nebraska and Puerto Rico to the list of States permitted to modify their agreements to cover the services performed by employees of the State or any of its political subdivisions in a policeman's or fireman's position covered by a retirement system.

Section 119(b) of the bill permits the State of Nebraska to modify its agreement, at any time before 1970, to validate the earnings erroneously reported by the State for services performed by persons in firemen's positions for a political subdivision before enactment date and with respect to which the State has, before enactment date, paid the required social security contributions; such a modification could be made only if the State agreement has been modified to cover the future services of firemen for such political subdivision.

SECTION 120. COVERAGE OF FIREMEN'S POSITIONS PURSUANT TO A STATE AGREEMENT

Section 120(a) of the bill adds a new paragraph (2) to section 218(p) of the Social Security Act providing that a State not listed in section 218(p)(1) of the Social Security Act, as redesignated by section 120(a)(1) of the bill, as one of the States permitted to extend social security coverage to persons in policemen's and firemen's positions covered by a retirement system, shall be deemed to be a State listed in such redesignated section 120(a)(1) for the purpose of extending social security coverage to service in firemen's positions covered by a retirement system under the special conditions specified in the new section 120(p)(2). Coverage could be extended under the authorization in the new subsection (p)(2) only if the Governor of the State certifies that the overall benefit protection of the group of firemen which would be brought under social security coverage would be improved by reason of the extension of social security coverage to the group.

Section 120(b) of the bill provides that nothing in the new section 218(p)(2) of the Social Security Act shall authorize the extension of social security coverage under the provisions of section 218(d)(6)(C) of the Social Security Act (the section listing those States which may provide social security coverage under the divided retirement system procedure) to service in any fireman's position.

Section 120(c) of the bill provides that the amendments made by sections 120 (a) and (b) of the bill shall be effective with respect to modifications entered into after the date of enactment.

SECTION 121. COVERAGE FOR CERTAIN ERRONEOUSLY REPORTED STATE AND LOCAL EMPLOYEES

Section 121 of the bill amends section 218(f) of the Social Security Act by adding a new paragraph (3), which will permit a State, when it modifies its social security coverage agreement to apply to an additional coverage group, to specify that whatever retroactive coverage is provided for the current employees, under the present generally applicable provisions of law, would also be provided for all former employees in the group with respect to whose services social security contributions had been timely paid, in good faith, to the Secretary of the Treasury. The retroactive coverage would not apply to any former employees for whom a refund of taxes had been made.

SECTION 122. COVERAGE OF FEES OF STATE AND LOCAL GOVERNMENT EMPLOYEES AS SELF-EMPLOYMENT INCOME

Amendments to title II of the Social Security Act

Definition of trade or business

Under existing law the performance of the functions of a public office are excepted from the term "trade or business" under section 211(c)(1) of the Social Security Act and the performance of services as an employee are generally excepted from the term "trade or business" under section 211(c)(2) of the Social Security Act and thus from social security coverage under the self-employment provisions of the law.

Section 122(a)(1) of the bill amends section 211(c)(1) of the Act to provide that the exception of the performance of the functions of a public office from the term "trade or business", and thus from social security coverage under the self-employment provisions of the law, will not apply to functions of public office of a State or a political subdivision thereof with respect to fees received in positions which are compensated solely on a fee basis if the fees are received in a period in which the position is not covered under a State social security coverage agreement.

Section 122(a)(2) of the bill amends section 211(c)(2) of the Social Security Act by adding a new subparagraph (E) to provide that the exception of the performance of service by an individual as an employee from the term "trade or business", and thus from social security coverage under the self-employment provisions of the law, will not apply to services performed by employees of State or local governments in positions compensated solely on a fee basis with respect to fees received in a period in which the position is not covered under a State social security coverage agreement.

The coverage under the self-employment provisions of law of services performed in positions compensated solely on a fee basis will not affect in any way the social security coverage, or the status under State or local law, of other persons who may be working in the same office with or who may be under the supervision of the fee-basis employees.

Amendments to the Internal Revenue Code of 1954

Definition of trade or business

Under existing law the performance of the functions of a public office are excepted from the term "trade or business" under section 1402(c)(1) of the Internal Revenue Code of 1954, and the performance of services by an individual as an employee are generally excepted from the term "trade or business" under section 1402(c)(2) of the code and thus excluded from the social security self-employment tax.

Section 122(b)(1) of the bill amends section 1402(c)(1) of the code to provide that the exception of the performance of the functions of a public office from the term "trade or business", and thus from the social security self-employment tax in section 1401 of the code, will not apply to functions of public offices of a State or a political subdivision thereof with respect to fees received in positions which are

compensated solely on a fee basis if the fees are received in a period in which the position is not covered under a State social security agreement under section 218 of the Social Security Act.

Section 122(b)(2) of the bill amends section 1402(c)(2) of the code by adding a new subparagraph (E) to provide that the exception of the performance of service by an individual as an employee from the term "trade or business", and thus from the social security self-employment tax in section 1401 of the code, will not apply to services performed by employees of State or local governments in positions compensated solely on a fee basis with respect to fees received in a period in which the position is not covered under a State social security coverage agreement under section 218 of the Social Security Act.

Effective date

Section 122(c)(1) of the bill provides that coverage under the self-employment provision of services performed in positions compensated solely on a fee basis will be effective with respect to fees received after 1967.

Individual election of exemption from coverage

Section 122(c)(2) of the bill provides that any individual who in 1968 is in a position which is compensated solely on a fee basis may elect not to have his fees covered under the self-employment provisions for 1968 and all subsequent years if he files with the Secretary of the Treasury by the due date of his tax return for 1968 an irrevocable certificate electing such exemption.

Amendments to title II of the Social Security Act

Positions compensated solely on a fee basis

Section 122(d) of the bill amends section 218 of the Social Security Act by adding a new subsection (u), which establishes special conditions for the extension of coverage, and the removal from coverage, of services in positions compensated solely on a fee basis.

Paragraph (1) of the new subsection (u) provides that services in positions compensated solely on a fee basis which were not covered under a State agreement before 1968 can be covered under a State's coverage agreement by any modification agreed to by the State and the Secretary of Health, Education, and Welfare after 1967 only if the State specifically requests such coverage.

Paragraph (2) of the new subsection (u) provides that, unlike present law, a State may at any time in the future modify its agreement to remove from coverage services performed in any class or classes of positions compensated solely on a fee basis.

Paragraph (3) of the new subsection (u) provides that if the State modifies its agreement to terminate or extend social security coverage under the authorizations provided under subsection (u), the coverage must begin or end, with no choice on the part of the State, at the end of the calendar year in which the modification is agreed to.

Paragraph (4) of the new subsection (u) provides that any class or classes of positions compensated solely on a fee basis that have been removed from coverage cannot thereafter again be covered under the agreement.

SECTION 123. FAMILY EMPLOYMENT IN A PRIVATE HOME

Amendments to title II of the Social Security Act

Under existing law, domestic service in a private home of the employer, performed by an individual in the employ of his son or daughter, is excluded from "employment" under section 210(a)(3)(B) of the Social Security Act. Section 123(a) of the bill amends section 210(a)(3)(B) of the Social Security Act to provide that the existing exclusion will not apply if certain conditions are met. The conditions are that, during the calendar quarter in which the individual performs the domestic service, the employer have living in his home at least one son or daughter (including an adopted son or daughter or a stepson or stepdaughter) who is under age 18 or who has a mental or physical condition which requires the personal care and supervision of an adult for at least four continuous weeks in the calendar quarter in which the service is rendered, and that the employer is a surviving spouse or a divorced individual, and has not remarried, or that he has a spouse living in the home who has a mental or physical condition which results in the spouse being incapable of caring for the child for at least four continuous weeks in the calendar quarter in which the service is rendered.

Amendments to the Internal Revenue Code of 1954

Under existing law, domestic service in a private home of the employer, performed by an individual in the employ of his son or daughter, is excluded from "employment" under section 3121(b)(3)(B) of the Internal Revenue Code of 1954. Section 123(b) of the bill amends section 3121(b)(3)(B) of the Code to provide that the existing exclusion will not apply if certain conditions are met. The conditions are that, during the calendar quarter in which the individual performs the domestic service, the employer have living in his home at least one son or daughter (including an adopted son or daughter or a stepson or stepdaughter) who is under age 18 or who has a mental or physical condition which requires the personal care and supervision of an adult for at least four continuous weeks in the calendar quarter in which the service is rendered, and that the employer is a surviving spouse or a divorced individual, and has not remarried, or that he has a spouse who has a mental or physical condition which results in the spouse being incapable of caring for the child for at least four continuous weeks in the calendar quarter in which the service is rendered.

Effective date

Section 123(c) of the bill provides that the amendments made by section 123 (a) and (b) will apply with respect to services rendered after December 31, 1967.

SECTION 124. EXCLUSION OF PRISONERS FROM COVERAGE UNDER CERTAIN PROGRAMS

Amendments to title II of the Social Security Act

Exclusion of Federal employment of prisoners from social security coverage

Section 124(a)(1) of the bill amends subparagraph (C) of section 210(a)(6) of the Social Security Act, which defines those services per-

formed in the employ of the United States or any of its instrumentalities which are excluded from social security coverage, by adding a new clause (vii). The new clause (vii) provides that service performed in the employ of the United States or any of its instrumentalities will be excluded from covered employment for social security benefit purposes if such service is performed by any individual who has been convicted of any offense under Federal or State law and sentenced for a term of imprisonment for such offense in any penal or correctional institution, if such service is performed while he is an inmate of such institution or during any period for which he has been temporarily released or paroled therefrom on condition that he engage in any particular training or employment.

Amendments to the Internal Revenue Code of 1954

Exclusion of Federal employment of prisoners from social security coverage

Section 124(a)(2) of the bill amends subparagraph (C) of section 3121(b)(6) of the Internal Revenue Code of 1954, which defines those services performed in the employ of the United States or any of its instrumentalities which are not employment for the purposes of the Federal Insurance Contributions Act, by adding a new clause (vii). The new clause (vii) provides that service in the employ of the United States or any of its instrumentalities will not be employment for the purposes of the Federal Insurance Contributions Act, if such service is performed by an individual who has been convicted of any offense under Federal or State law and sentenced for a term of imprisonment for such offense in any penal or correctional institution, and if such service is performed while he is an inmate of such institution or during any period for which he has been temporarily released or paroled therefrom on condition that he engage in any particular training or employment.

Amendment to title 5 of the United States Code

Exclusion of Federal employment of prisoners from unemployment compensation

Section 124(b) of the bill amends section 8501(1) of title 5 of the United States Code, which defines, for purposes of Federal employees' unemployment compensation, the term "Federal service" by adding a new clause (M). New clause (M) provides that, for the purposes of Federal employees' unemployment compensation, there will be excluded from the term "Federal service," service in the employ of the United States or any of its instrumentalities performed by an individual who has been convicted under any Federal or State law and sentenced for a term of imprisonment for such offense in any penal or correctional institution, if such service is performed while he is an inmate of such institution or during any period for which he has been temporarily released or paroled therefrom on conditions that he engage in any particular training or employment.

Other amendments to title 5 of United States Code

Exclusion of Federal employment of prisoners from Federal civil service retirement system and certain other Federal employee programs

Section 124(c) of the bill provides that no service performed by any individual convicted of any offense under Federal or State law and sentenced to a term of imprisonment for such offense in any penal or correctional institution will be considered to be performed as a Federal employee for purposes of (1) subchapter III (relating to civil service retirement) of chapter 83 of title 5, United States Code, (2) chapter 87 (relating to Federal employees' group life insurance) of title 5, United States Code, (3) chapter 89 (relating to Federal employees health benefits) of title 5, United States Code, or (4) subchapter I (relating to Federal employees' compensation for work injuries) of chapter 81 of title 5, United States Code, if such service is performed while such individual is an inmate of such institution or during any period for which he has been temporarily released or paroled therefrom on condition that he engage in any particular training or employment.

Amendments to the Internal Revenue Code of 1954

Exclusion of non-Federal employment of prisoners from unemployment insurance

Section 124(d)(1) of the bill amends section 3304(a) of the Internal Revenue Code of 1954, relating to requirements for approval of State laws for the purposes of the Federal Unemployment Tax Act, by redesignating paragraph (6) as paragraph (7) and adding a new paragraph (6). New paragraph (6) provides that, as a requirement for Federal approval of a State unemployment compensation law, no compensation will be paid to any individual on account of service performed by him if he has been convicted of and sentenced to a penal or correctional institution for any offense under Federal or State law, and if such service is performed while he is an inmate of such institution or during any period for which he has been temporarily released or paroled therefrom on condition that he engage in any particular training or employment.

Section 124(d)(2) of the bill amends section 3306(c) of the Internal Revenue Code of 1954, which defines the term employment for the purposes of the Federal Unemployment Tax Act, by adding a new paragraph (19). New paragraph (19) provides that there will be excluded from the term employment, for the purposes of the Federal Unemployment Tax Act, services performed by any individual who has been convicted of and sentenced to a term of imprisonment for an offense under Federal or State law, if such service is performed while such individual is an inmate of such institution or during any period for which he has been temporarily released or paroled therefrom on condition that he engage in any particular training or employment.

Effective dates

Section 124(e) of the bill provides that the amendments made by subsections (a), (b), and (c) of this section will be applicable to

service performed after the month following the month of enactment, that the amendment made by subsection (d)(1) will take effect January 1, 1969, and that the amendment made by subsection (d)(2) will be applicable to service performed after December 31, 1968.

SECTION 124A. STATE AND LOCAL GOVERNMENT EMPLOYEES IN MASSACHUSETTS

Section 124a(a) of the bill provides that the State of Massachusetts, notwithstanding the provisions of section 218(g)(1) of the Social Security Act (which sets forth the conditions under which a State may terminate coverage), would be permitted, under such conditions as the Secretary deems appropriate, to terminate the coverage of the employees of the Massachusetts Turnpike Authority before the expiration of two years after giving advance notice.

Section 124a(b) of the bill provides that if the employees of the Massachusetts Turnpike Authority are removed from coverage under this section, coverage cannot later be extended to the employees of the Massachusetts Turnpike Authority.

PART 3—HEALTH INSURANCE BENEFITS

SECTION 125. METHOD OF PAYMENT TO PHYSICIANS UNDER SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

Section 125(a) of the bill amends section 1842(b)(3)(B) of the Social Security Act by providing, in lieu of the receipted bill method of payment provided under present law, that medical insurance benefits for services reimbursable on the basis of reasonable charges may be paid to the beneficiary on the basis of an itemized bill. The assignment method provided under present law for payment of such benefits to the physician (or other individual providing covered services) would be retained.

Section 125(a) of the bill further amends section 1842(b)(3)(B) of the act to establish, in the case of bills submitted, or requests for payment made, after March 1968, a time limit on the period of time within which payment may be requested under the supplementary medical insurance program with respect to physicians' services and other services reimbursable on a reasonable charge basis. Claims for the services in question must be filed no later than the end of the calendar year following the year in which the services were furnished; for purposes of applying this limitation, services furnished in the last 3 months of a calendar year will be deemed to have been furnished in the subsequent year.

Section 125(b) of the bill provides that the amendments made by subsection (a) shall be effective with respect to claims on which a final determination has not been made on or before the date of enactment of the bill.

SECTION 126. ELIMINATION OF REQUIREMENT OF PHYSICIAN CERTIFICATION IN CASE OF CERTAIN HOSPITAL SERVICES

Section 126 of the bill amends section 1814(a) of the Social Security Act (as amended by sec. 129(c)(5) of the bill) and section 1835

(a) of the act with respect to the requirements for physicians' certifications. The effect of section 126(a) is to eliminate the requirement for hospital insurance payments that there be a physician's certification of medical necessity with respect to admissions to hospitals which are neither psychiatric nor tuberculosis institutions; the effect of section 126(b), in combination with the amendment made by section 129 (c)(5) of the bill, is to eliminate all requirements for physicians' certifications with respect to outpatient hospital services.

Section 126(a) of the bill amends section 1814(a) of the act so as to eliminate the hospital insurance program requirement that there be a physician's certification of medical necessity with respect to each admission to a general hospital, and to require such a certification only in cases of hospital stays of extended duration (and in cases of admissions to and stays in tuberculosis and psychiatric hospitals).

Section 126(b) of the bill amends section 1835(a)(2)(B) of the act by eliminating the supplementary medical insurance program requirement that there be a physician's certification with respect to services furnished by providers of services which are incident to a physician's service to outpatients (or to hospital outpatient diagnostic services).

Section 126(c) of the bill provides that these amendments will apply to services furnished after the date of the bill's enactment.

SECTION 127. INCLUSION OF PODIATRISTS' SERVICES UNDER SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

Section 127(a) of the bill amends section 1861(r) of the Social Security Act to include within the definition of the term "physician" a doctor of podiatry or surgical chiropody, but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them. A doctor of podiatry or surgical chiropody will not, however, be considered a "physician" for purposes of section 1814(a) of the act (relating to certification and recertification of medical necessity under pt. A of title XVIII), section 1835 of the act (relating to certification and recertification of medical necessity under pt. B), or section 1861(k) of the act (relating to utilization review).

Section 127(b) of the bill amends section 1862(a) of the act, which provides that no payment may be made under part A or part B (regardless of any other provision of title XVIII) for any expenses incurred for certain specified health items and services, by adding a new paragraph (13). The new paragraph (13) provides that no payment may be made for any expenses incurred for the treatment of flat foot conditions and the prescription of supportive devices therefor, the treatment of subluxations of the foot, or routine foot care (including the cutting or removal of corns, warts, or calluses, the trimming of nails, and other routine hygienic care).

Section 127(c) of the bill provides that these amendments will apply with respect to services furnished after December 31, 1967.

SECTION 128. EXCLUSION OF CERTAIN SERVICES

Section 128 of the bill amends section 1862(a)(7) of the Social Security Act, which provides that no payment may be made under part A or part B (regardless of any other provision of title XVIII) for ex-

penses incurred for routine physical checkups, eyeglasses, eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, or hearing aids or examinations therefor, by adding a provision that no payment may be made for expenses incurred for procedures performed (during the course of any eye examination) to determine the refractive state of the eyes (other than procedures performed in connection with furnishing prosthetic lenses).

SECTION 129. TRANSFER OF ALL OUTPATIENT HOSPITAL SERVICES TO SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

Section 129(a) of the bill amends section 1861(s)(2) of the Social Security Act to include in the definition of medical and other health services for which payment may be made under the supplementary medical insurance program diagnostic services which are (1) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and (2) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study.

Section 129(b) of the bill further amends section 1861(s) of the act to exclude from the diagnostic services referred to in paragraph (2) thereof for which medical insurance payments may be made (other than the services of "physicians") any item or service which (1) would not be covered under the hospital insurance program if it were furnished to an inpatient of a hospital, or (2) is furnished by others under arrangements with them made by the hospital unless furnished in the hospital or in other facilities operated by or under the supervision of the hospital or its organized medical staff.

Section 129(c) of the bill, in order to reflect the transfer of all outpatient hospital diagnostic services from part A (the hospital insurance program) to part B (the supplementary medical insurance program), makes various conforming amendments in both part A and part B of title XVIII of the act. Paragraphs (1) and (2) of section 129(c) of the bill eliminate outpatient hospital diagnostic services from the list of services covered under part A. Paragraphs (3) and (4) eliminate the special $20 deductible and 20 percent coinsurance provisions of part A relating to these services (which will become subject to the regular deductible and coinsurance provisions of pt. B), and paragraphs (7) and (8) eliminate provisions of part B relating to the treatment of the present outpatient hospital diagnostic services deductible under part A for purposes of part B. Paragraph (6) eliminates the present part A authorization of payment for emergency outpatient hospital diagnostic services and provides that payment may be made directly to the patient if the hospital does not claim payment, and paragraph (9) provides (in a new sec. 1835(b) of the act) that payment may be made under part B to any hospital for outpatient hospital diagnostic services furnished to an individual entitled to benefits under the supplementary medical insurance program even though such hospital does not have an agreement under title XVIII in effect if (A) such services were emergency services and (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment but only if the hospital elects to be paid for such services. Such

payments will be made only on the basis of 80 percent of costs, as provided under section 1833(a)(2), and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of the agreement under part A of title XVIII under which participating hospitals are not permitted to charge the patient for covered services. Paragraphs (5), (10), (11), (12), and (13) make conforming changes. If, however, the hospital does not so elect the individual may be paid for such services on the basis of an itemized bill.

Section 129(d) of the bill provides that the amendments made by section 129 (a), (b), and (c) will apply with respect to services furnished after March 31, 1968, except that the change made by subsection (c)(5) which eliminates the physician certification requirement with respect to outpatient hospital diagnostic services, will be effective with respect to services furnished after the date of enactment of the bill.

SECTION 130. BILLING BY HOSPITAL FOR SERVICES FURNISHED TO OUTPATIENTS

Section 130(a) of the bill amends section 1835(a) of the Social Security Act (as amended by sec. 129(c)(9)(A) of the bill) to take account of the exception to the payment procedures for providers of services that is added to the act by section 130(b) of the bill.

Sction 130(b) of the bill further amends section 1835 of the act (as amended by section 129(c)(9)(B) of the bill) to provide in a new subsection (c) that, notwithstanding section 1832 (which provides, in part, that medical insurance payments for hospital services may be made only to the hospital), section 1833 (which provides, in part, for reimbursement for hospital services to be made only on a reasonable-cost basis), and section 1866(a)(1)(A) (which bars a hospital from collecting charges beyond the deductible and coinsurance amounts for covered hospital services), hospitals may elect, subject to such limitations as the Secretary may prescribe, to collect from an individual covered by the supplementary medical insurance program the customary charges for covered outpatient hospital services, but only if such charges do not exceed $50. Such charges will be considered to be expenses incurred by the beneficiary for purposes of applying the medical insurance deductible and making payments under the supplementary medical insurance program. Payments under the supplementary medical insurance program to hospitals which have elected to make collections from individuals pursuant to this provision are to be adjusted periodically to place the hospital in the same position as it would have been in had it not elected to make such collections.

Section 130(c) of the bill provides that these amendments will apply with respect to services furnished after March 31, 1968.

SECTION 131. PAYMENT OF REASONABLE CHARGES FOR RADIOLOGICAL OR PATHOLOGICAL SERVICES FURNISHED BY CERTAIN PHYSICIANS TO HOSPITAL INPATIENTS

Section 131(a) of the bill amends section 1833(a)(1) of the Social Security Act by increasing from 80 to 100 percent of reasonable charges the amount payable under the supplementary medical insurance program with respect to expenses incurred for radiological or

pathological services which are covered under the program if such services are furnished to a hospital inpatient by a physician who is a specialist in the field of radiology or pathology, as the case may be.

Section 131(b) of the bill amends section 1833(b) of the act (as amended by section 129(c)(7) of the bill) to provide that payments under the supplementary medical insurance program with respect to expenses for the radiological and pathological services referred to in the amendment made by section 131(a) will not be subject to the $50 medical insurance deductible.

Section 131(c) of the bill provides that these amendments will apply with respect to services furnished after March 31, 1968.

SECTION 132. PAYMENT FOR PURCHASE OF DURABLE MEDICAL EQUIPMENT

Section 132(a) of the bill amends section 1861(s)(6) of the Social Security Act, which presently provides for payment to be made under the supplementary medical insurance program with respect to expenses incurred in the rental of durable medical equipment, to provide that payments may also be made with respect to expenses incurred in the purchase of durable medical equipment.

Section 132(b) of the bill amends section 1833 of the act to provide, in a new subsection (f), that when payments under the supplementary medical insurance program are made with respect to the purchase of durable medical equipment, the payments will be made in amounts which the Secretary determines to be equivalent to the payments that would have been made over the period involved had the equipment been rented. Such payments are to be made over the period of time for which the Secretary finds that the new equipment will be used for the patient's medical treatment (but in no case may payments exceed the purchase price, less applicable deductible and coinsurance amounts, for the equipment). However, payment in the case of purchase of inexpensive equipment may be made in a lump sum if the Secretary finds that such method of payment is less costly or more practical than periodic payments.

Section 132(c) of the bill provides that these amendments will apply with respect to items purchased after December 31, 1967.

SECTION 133. PAYMENT FOR PHYSICAL THERAPY SERVICES FURNISHED TO OUTPATIENTS

Section 133(a) of the bill amends section 1861(s)(2) of the Social Security Act (as amended by the sec. 129(a)(2) of the bill) to include outpatient physical therapy services as a "medical and other health service" for which payment may be made under the supplementary medical insurance program.

Section 133(b) of the bill amends section 1861 of the act to define in a new subsection (p) (in lieu of subsection (p) repealed by sec. 129(c)(10) of the bill) the term "outpatient physical therapy services" to mean physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, or agency to an individual (1) who is under the care of a doctor of medicine or osteopathy, (2) with respect to whom a plan describing the type, amount, and duration of physical therapy

services that are to be furnished to such individual has been established and is periodically reviewed by a doctor of medicine or osteopathy, but excluding, however, (3) any item or service if it would not be included under section 1861(b) of the act (which defines the term "inpatient hospital services") if furnished to an inpatient of a hospital, and (4) any such service furnished by a clinic, rehabilitation agency, or by others under arrangements with such clinic or agency, unless such clinic or agency meets certain standards and requirements. A clinic or rehabilitation agency must (i) provide an adequate program of physical therapy services for outpatients and have the facilities and personnel required for the supervision of such a program, in accordance with requirements the Secretary of Health, Education, and Welfare may specify, (ii) have policies established by a group of professional personnel, including one or more physicians (associated with the clinic or rehabilitation agency) and one or more qualified physical therapists, to govern the physical therapy services, (iii) maintain clinical records on all patients, (iv) if such clinic or agency is situated in a State in which State or applicable local law provides for the licensing of institutions of this nature, be licensed pursuant to such law, or be approved, by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing, and (v) meet such other conditions relating to the health and safety of individuals who are furnished services by such clinics or agency as the Secretary may find necessary. A public health agency would have to meet only the requirements of (v) above (conditions established by the Secretary) relating to health and safety in order to qualify for outpatient physical therapy payments.

Section 133(c) of the bill amends section 1866 of the act to provide that the term "provider of services" for purposes of that section shall include a clinic, rehabilitation agency, or public health agency if such clinic or agency meets the requirements of section 1861(p) of such act (as amended by subsection (b) of this section) but only with respect to the furnishing of outpatient physical therapy services.

Section 133(d) of the bill amends section 1832(a) of the act to include outpatient physical therapy services as a benefit for which an individual enrolled in the supplementary medical insurance program is entitled to have payment made on his behalf on the basis of the reasonable cost of such services.

Section 133(e) of the bill amends section 1835(a)(2) of the act (as amended by sec. 126(b) of the bill) to provide that payment for outpatient physical therapy services may be made only to a provider of services which is eligible therefor and to a clinic, rehabilitation agency, or public health agency which meets the requirements of section 1861(p) of the act (as amended by subsection (b) of this section), but only with respect to the furnishing of outpatient physical therapy services, and only if a physician certifies (and recertifies, where appropriate) that (1) such services were required because the individual needed physical therapy services on an outpatient basis, (2) a plan for furnishing such services has been established and periodically reviewed by a physician, and (3) such services are or were furnished while the individual is or was under the care of a physician.

Section 133(e) of the bill further provides that for purposes of section 1835(a) of the act, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if such clinic or agency meets the requirements of section 1861(p) of the act (as amended by sec. 133(b) of the bill), but only with respect to the furnishing of outpatient physical therapy services.

Section 133(f) of the bill amends the first sentence of section 1864 (a) of the act to provide that the Secretary shall make an agreement with any State which is able and willing to do so to utilize the services of the State health agency or other appropriate agency (or the appropriate local agencies) for the purpose of determining whether a clinic, rehabilitation agency, or public health agency, meets the requirements of section 1861(p) of the act (as amended by sec. 133(b) of the bill) for an approved clinic, rehabilitation agency, or public health agency.

Section 133(g) of the bill provides that these amendments will apply with respect to services furnished after June 30, 1968.

SECTION 134. PAYMENT FOR CERTAIN PORTABLE X-RAY SERVICES

Section 134(a) of the bill amends section 1861(s)(3) of the Social Security Act to provide that the diagnostic X-ray tests for which payments may be made under the supplementary medical insurance program will include tests conducted by a nonphysician in a place of residence used as the patient's home if they are performed under the supervision of a physician (which need not be direct supervision) and if the tests meet such conditions relating to health and safety as the Secretary may find necessary.

Section 134(b) of the bill provides that this amendment will apply with respect to services furnished after December 31, 1967.

SECTION 135. BLOOD DEDUCTIBLES

Section 135(a) of the bill amends section 1813(a)(2) of the Social Security Act as redesignated by section 129(c)(3) of the bill (sec. 1813(a)(3) under present law), which provides that payment cannot be made to any provider of services under the hospital insurance program for the cost of the first 3 pints of whole blood furnished to an individual during a spell of illness. The amendment makes the 3-pint deductible also applicable to equivalent quantities of packed red blood cells, as defined by the Secretary under regulations.

Section 135(b) of the bill amends section 1866(a)(2)(C) of the act (as amended by section 129(c)(12)(B) of the bill) to provide that to the extent that a provider of services may charge for blood under section 1866(a)(2)(C) of the act, it may do so in accordance with its customary practices; (2) to include, in addition to whole blood for which a provider of services may charge under present law, equivalent quantities of packed red blood cells; and (3) to provide that blood furnished an individual under part A will be considered to be replaced when the provider is given 1 pint of blood for each pint of blood (or equivalent quantities of packed red blood cells) furnished the individual to which the 3-pint deductible applies.

Section 135(c) of the bill amends section 1833(b) of the act (as amended by sections 129(c)(7) and 131(b) of the bill) to provide that there shall be a deductible under the supplementary medical

insurance program equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells as defined under regulations) furnished to an individual during a calendar year. This deductible is to be appropriately reduced in accordance with regulations to the extent that such blood has been replaced, and such blood will be considered to have been replaced when the institution or other person furnishing such blood is given 1 pint of blood for each pint of blood (or equivalent quantities of packed red blood cells) furnished the individual to which the 3-pint deductible applies.

Section 135(d) provides that these amendments will apply with respect to payments for blood furnished an individual after December 31, 1967.

SECTION 136. ENROLLMENT UNDER SUPPLEMENTARY MEDICAL INSURANCE PROGRAM BASED ON ALLEGED DATE OF ATTAINING AGE 65

Section 136(a) of the bill amends section 1837(d) of the Social Security Act to provide that where the Secretary finds that an individual who has attained age 65 failed to enroll in the supplementary medical insurance program because the individual, relying on erroneous documentary evidence, was mistaken about his age, the individual may enroll in such program, using the date of attainment of age 65 that he alleges and for which he presented documentary evidence. In such a case, the provisions in the law relating to enrollment, reenrollment, and coverage periods will be applied as if the individual's alleged date of attainment of age 65 were his actual date of attainment.

Section 136(b) of the bill provides that this amendment will apply to persons enrolling in the supplementary medical insurance program in months beginning after the date of enactment of the bill.

SECTION 137. EXTENSION BY 60 DAYS DURING INDIVIDUAL'S LIFETIME ON MAXIMUM DURATION OF BENEFITS FOR INPATIENT HOSPITAL SERVICES

Section 137(a) of the bill amends section 1812(a)(1) and section 1812(b)(1) of the Social Security Act (relating to the number of days of inpatient hospital services for which payment may be made) to provide additional days of inpatient hospital services, not to exceed 60 such days during an individual's lifetime, for which such individual is entitled to have payment made whenever he has exhausted the 90 days of inpatient hospital services for which he is entitled to have payment made during any spell of illness. Payment will be made for such additional days of inpatient hospital services unless the individual specifies in accordance with regulations of the Secretary that he does not desire to have such payment made.

Section 137(b) of the bill amends section 1831(a)(1) of the act to provide that the amount payable for inpatient hospital services will be reduced by a coinsurance amount equal to one-fourth of the inpatient hospital deductible (the amount of which is determined under sec. 1813(b)) for each day following the 60th day of inpatient hospital services furnished during any spell of illness.

Section 137(c) of the bill provides that amendments made by sections 137 (a) and (b) will apply with respect to services furnished after December 31, 1967.

SECTION 138. LIMITATION ON SPECIAL REDUCTION IN ALLOWABLE DAYS OF INPATIENT HOSPITAL SERVICES

Section 138(a) of the bill makes two changes in section 1812(c) of the Social Security Act, which presently provides that if an individual is an inpatient of a psychiatric or tuberculosis hospital on the first day of the first month for which he is entitled to benefits under the hospital insurance program, the days on which he was an inpatient of such a hospital in the 90-day period immediately before such first day will reduce the number of days of inpatient hospital benefits for which payment could otherwise be made during his first spell of illness. First, section 1812(c) (as further amended by sec. 149 of the bill, relating to elimination of the special reduction of days of inpatient hospital services for patients in tuberculosis hospitals) is amended so that the limitation will not reduce an individual's eligibility to have payment made for inpatient hospital services furnished by a hospital which is not a psychiatric institution if the services are not primarily for the diagnosis or treatment of mental illness. Second, conforming changes in section 1812(c) are made to take account of the 60 additional days of inpatient hospital benefits (provided for under sec. 137 of the bill) for which payment can be made and to increase from 90 days to 150 days the period prior to the institutionalized psychiatric patient's entitlement under the hospital insurance program during which days of care in a psychiatric institution count against his inpatient hospital benefits eligibility.

Section 138(b) of the bill provides that these amendments will apply with respect to payments for services furnished after December 31, 1967.

SECTION 139. TRANSITIONAL PROVISION ON ELIGIBILITY OF PRESENTLY UNINSURED INDIVIDUALS FOR HOSPITAL INSURANCE BENEFITS

Section 139 of the bill amends section 103(a)(2) 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. The amendment reduces from six quarters of coverage to three quarters of coverage the minimum quarters of coverage required for persons attaining age 65 in 1968 for entitlement under this provision. A person attaining age 65 after 1968 will need three additional quarters of coverage for each year that elapsed between 1965 and the year he attains age 65.

SECTION 140. ADVISORY COUNCIL TO STUDY COVERAGE OF THE DISABLED UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT

Section 140(a) of the bill requires the Secretary of Health, Eeducation, and Welfare to appoint an Advisory Council to study the need of the disabled for coverage under the health insurance program.

Section 140(b) of the bill provides that the Council shall consist of 12 members representing organizations of employers and employees (in equal numbers), self-employed persons, and the public.

Section 140(c) of the bill provides that the Council may engage such technical assistance as it needs, and that the Secretary shall make available to it such secretarial, clerical, and other assistance, and such

actuarial and other pertinent data prepared by the Department of Health, Education, and Welfare, as it requires.

Section 140(d) provides that the members of the Council are to be compensated at rates fixed by the Secretary, not exceeding $100 a day, and may be allowed travel expenses.

Section 140(e) of the bill requires the Council to make findings with respect to the unmet need of the disabled for health insurance protection, the cost of providing the disabled with insurance protection against the costs of hospital and medical services, and the ways of financing this protection. The Council is also required to make recommendations on the financing of such protection and on the extent to which the cost of such protection could appropriately be borne by the Hospital Insurance and Supplementary Medical Insurance Trust Funds. The Council is required to submit a report on these questions to the Secretary of Health, Education, and Welfare no later than January 1, 1969, and to transmit the report to the Congress and the boards of trustees of the trust funds. After such report is transmitted to the Congress, the Council will cease to exist.

SECTION 141. STUDY TO DETERMINE FEASIBILITY OF INCLUSION OF CERTAIN ADDITIONAL SERVICES UNDER PART B OF TITLE XVIII OF THE SOCIAL SECURITY ACT

Section 141 of the bill requires the Secretary of Health, Education, and Welfare to study the question of adding to the services now covered under the supplementary medical insurance program the services of additional types of licensed practitioners performing health services in independent practice. The Secretary is required to report to the Congress, prior to January 1, 1969, his finding with respect to the need for covering under the supplementary medical insurance program any or all of the various types of services performed by such practitioners and the costs of such coverage. The Secretary is also required to make recommendations as to the priority of covering these services, the methods of coverage, and the safeguards that should be included in the law if any such coverage is provided.

SECTION 142. ALLOWANCE FOR DEPRECIATION AND INTEREST IN DETERMINING REASONABLE COST UNDER TITLES V, XVIII, AND XIX

Section 142(a) of the bill amends section 1861(v) of the Social Security Act by adding a new paragraph providing that the term "reasonable cost" shall include amounts attributable to depreciation and to interest on funds borrowed for plant and equipment except where a provider of services makes a capital expenditure determined by a State agency (established or designated pursuant to section 314(a)(2) of the Public Health Service Act) as not conforming to the overall plan developed by the agency for adequate health-care facilities. In such case, the Secretary shall deduct as necessary from future payments to such provider the amounts attributable to depreciation of the plant or equipment item acquired by, and interest on funds borrowed for, such capital expenditure (if the provider of services had notice that such capital expenditure did not conform to such plan at the time of such expenditure). The term "capital expenditure" is

defined as an expenditure not properly chargeable as an operating or maintenance expense and which either exceeds $50,000, or changes borrowed for, such capital expenditure (if the provider of services of the facility. The provision is effective with respect to capital expenditures made after June 30, 1970, or, if earlier, the last day of the calendar quarter in which a request is made by such State.

Section 142(b)(1)(A), (B), (C), and (D) of the bill amends section 1902(a)(13) of the Social Security Act (as amended by sec. 224 of the bill) by redesignating the provisions thereof. Section 142(b)(1)(E) of the bill further amends such section 1902(a)(13) of the act by adding thereto a new requirement that a State plan for medical assistance must provide that the reasonable cost of inpatient hospital services provided under the plan will be determined by including an amount attributable to the depreciation of, and interest on funds borrowed for, plant and equipment, but not with respect to a capital expenditure in the case of any institution furnishing such services, for such periods specified by the Secretary, after a State agency (established pursuant to sec. 314(a)(2) of the Public Health Service Act) determines (and the institution has been so notified) that such a capital expenditure (as defined in sec. 1861(v)(5)(C) of the Social Security Act added by sec. 142(a)(1) of the bill) for plant and equipment of such institution does not conform to such State agency's overall plan for adequate health-care facilities and the institution had notice of such nonconformity when such capital expenditure was made.

Section 142(b)(2) of the bill amends section 1903(b) of the act (as amended by sec. 222(c) of the bill) by adding thereto a new paragraph (3). Such paragraph (3) provides that, notwithstanding the previous provisions of section 1903 of the act, where an institution furnishing care and services under the plan made a capital expenditure which, as provided in the amendment made by section 142(b)(1)(E) of the bill, must be excluded in determining the reasonable cost of inpatient hospital services, the Federal matching payment determined under section 1903(a)(1) of the act for care and services furnished by such institution shall not take into account, for periods specified by the Secretary, the amounts attributable to depreciation of, and interest on, funds borrowed for such capital expenditure.

Section 142(c) of the bill amends sections 505(a)(6), 506(a), and 509(a) of title V of the act (added by section 301 of the bill) by further amending and adding thereto various provisions relating to the determination of the reasonable cost of inpatient hospital services comparable to those added to title XIX of the act by section 142(b)(1)(E) and (2) of the bill.

Subsection (d) of section 142 of the bill provides that the amendments made by subsections (b) and (c) of such section 142 shall apply, in the case of any State, with respect to care, services, or treatment provided after June 30, 1970, or, if earlier, the last day of the calendar quarter in which the State requested that the amendment made by subsection (a) of such section 142 be made applicable in such State or any part thereof.

SECTION 143. STATE AGREEMENTS FOR COVERAGE UNDER THE HOSPITAL INSURANCE PROGRAM FOR THE AGED

Section 143 of the bill adds a new section 1818 at the end of part A of title XVIII of the Social Security Act. Subsection (a) of the new section 1818 provides that the Secretary shall, at the request of a State, enter into an agreement with such State under which all individuals in one or more coverage groups described in subsection (b) will be entitled to hospital insurance benefits.

Section 1818(f)(2) provides that entitlement to benefits of an individual who is in a coverage group covered under such an agreement will end with the earliest of: (1) the last day of the month in which he dies; (2) the last day of the month preceding the month in which he either becomes entitled to monthly cash benefits under the Social Security or Railroad Retirement Acts or becomes entitled to hospital insurance benefits under the special transitional provision in the Social Security Amendments of 1965; (3) the first day of the month following the month in which he ceases to be in the coverage group covered under the agreement; (4) the day on which the agreement terminates; (5) the day on which the agreement terminates with respect to his coverage group.

Section 1818(g) provides that each agreement must provide that the State will: (1) reimburse the Federal Hospital Insurance Trust Fund for payments made from the Fund to pay for the services furnished to those individuals covered under the State's agreement and the administrative expenses that the Department of Health, Education, and Welfare and such public or private agencies it may employ incur in carrying out the agreements; (2) comply with such rules and regulations as the Secretary may issue in carrying out the agreement; (3) furnish the Secretary timely information and reports and maintain and provide the access to the records which the Secretary finds necessary to assure both the correctness of these reports and information and to perform his functions with respect to the agreement. The agreement will also contain any other terms and conditions not inconsistent with section 1818 which the Secretary may find necessary and appropriate.

Section 1818(h) provides that the State may, upon giving the Secretary 6 months notice in writing, terminate its agreement, either in its entirety or with respect to a coverage group. Termination will be effective at the end of the calendar quarter the State specifies in the notice.

Section 1818(i) provides that if the Secretary, after giving reasonable notice and opportunity for a hearing, finds the State has failed or is no longer legally able to substantially comply with any provision of its agreement, he will notify the 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 that time he finds that the State no longer fails to comply with its agreement or that the legal inability to comply with the agreement has been removed.

Section 1818(j) provides that the determination by the State as to whether an individual is an annuitant or member of a retirement system or the wife, husband, widow, or widower of an annuitant or member will be final and conclusive upon the Secretary.

Section 1818(k)(1) provides that if more or less than the correct amount due under an agreement is paid, proper adjustments will be made, without interest, in such manner and at such time as prescribed by the regulations of the Secretary.

Section 1818(k)(2) provides that if the State does not make timely payments due under its agreement, interest at the rate of 6 percent per annum from the date due until the payment is made will be added as part of the amounts due.

SECTION 144. PROVISIONS FOR BENEFITS UNDER PART A OF TITLE XVIII OF THE SOCIAL SECURITY ACT FOR SERVICES TO PATIENTS ADMITTED PRIOR TO 1968 TO CERTAIN HOSPITALS

Section 144(a) of the bill provides that payment may be made to an individual on the basis of an itemized bill for charges relating to inpatient hospital services provided to him by certain nonparticipating hospitals. Such hospitals will be required to have full-time nursing services, be licensed as a hospital, and be primarily engaged in providing medical care under the supervision of a doctor of medicine or osteopathy. The individual will be required to file application for such payment before January 1, 1969.

Section 144(b) of the bill provides that payment may be made for charges relating to inpatient hospital services deriving from admissions occurring prior to 1968, excluding charges for such services provided prior to July 1, 1966. Services with respect to admissions occurring after 1967 will not be affected by this provision. In cases where the hospital providing the services does not participate in the program before January 1, 1969, payment may be made for a maximum of 20 days of services in a spell of illness; such maximum will be reduced by the number of days of inpatient hospital services in excess of 70 furnished during the spell of illness and with respect to which the beneficiary was entitled to have payment made under present law. In cases where the hospital providing services participates in the program before January 1, 1969, payment may be made for a maximum of 90 days of services in a spell of illness if the hospital applies its utilization review plan to such services; such maximum will be reduced by the number of days of inpatient hospital services furnished during the spell of illness and with respect to which the beneficiary was entitled to have payment made under present law.

Section 144(c) of the bill provides that payment to individuals will be subject to the deductible and coinsurance provisions of present law and will be limited to 60 percent of the room and board charges plus 80 percent of charges for ancillary services. If separate charges are not made for ancillary services, payment will be limited to two-thirds of the total reasonable charges based on semiprivate accommodations.

SECTION 145. PAYMENTS FOR EMERGENCY HOSPITAL SERVICES

Section 145(a) amends section 1861(e) of the Social Security Act by providing a new definition of hospital for purposes of making payment for emergency hospital services. Under the new definition such hospitals will be required to have full-time nursing services, to be licensed as a hospital, and to be primarily engaged in providing medical or rehabilitative care by or under the supervision of a doctor

of medicine or osteopathy. Such hospitals will not, as formerly, have to meet requirements related to clinical records, medical staff bylaws, patient being under care of physician, and utilization review.

Section 145(b) of the bill amends section 1812(a) of the Social Security Act by providing that payment for emergency hospital services may be made to the individual as well as on his behalf.

Section 145(c) of the bill amends section 1814(d) of the Social Security Act by providing that payment to hospitals for emergency inpatient services will, in addition to the contingencies for payment specified in present law, be contingent upon election by the hospital to claim payment for such services. The election will apply to all emergency inpatient services provided in a calendar year.

Section 145(c) of the bill further amends section 1814(d) to provide that payment for emergency hospital services may be made to an individual if the hospital does not elect to claim payment for all such services provided in a calendar year. Payment to the individual will be subject to the deductible and coinsurance provisions of present law and will be limited to 60 percent of the room and board charges plus 80 percent of charges for ancillary services. If separate charges are not made for ancillary services, payment will be limited to two-thirds of the total reasonable charges based on semiprivate accommodations.

Section 145(d) of the bill provides that the amendment made by subsection (a) will become effective as of July 1, 1966. These amendments made by subsections (d) and (c) will apply to services furnished with respect to admissions occurring after December 31, 1967, and to outpatient hospital diagnostic services furnished after December 31, 1967, and before April 1, 1968.

SECTION 146. PAYMENT FOR CERTAIN SERVICES FURNISHED OUTSIDE THE UNITED STATES

Section 146(a) of the bill amends section 1814 of the Social Security Act to substitute a new subsection (f), entitled "Payment for Certain Services Furnished Outside the United States," for the present subsection (f) which provides hospital insurance benefits for emergency inpatient hospital services furnished outside the United States if the beneficiary is physically present within the United States when the emergency arises and the foreign hospital is more accessible than the nearest hospital within the United States which is adequately equipped to deal with, and available for the treatment of, the beneficiary's illness or injury.

Paragraph (1) of the new subsection (f) provides that payment may be made for inpatient hospital services (as defined in sec. 1861 of the act, but without regard to subsec. (e) of such section) furnished to an individual entitled to hospital insurance benefits under section 226 of the act by a hospital (or under arrangements (as defined in sec. 1861(w) of the act) with it) which is situated within 50 miles of the United States in a country contiguous thereto if such individual is a resident of the United States.

The new subsection (f)(1) further provides, in subparagraph (A), that benefits may be paid for hospital services furnished outside the United States only if (i) such hospital is closer to, or substantially

more accessible from, the residence of such individual that the nearest hospital within the United States which is adequately equipped to deal with, and is available for the treatment of, such individual's illness or injury, or, where such services are emergency services, (ii) the emergency occurs in a place within (I) the United States or (II) 50 miles outside the United States in a country contiguous thereto and such hospital is closer to or substantially more accessible from such place than the nearest hospital within the United States which is adequately equipped to deal with, and is avaliable for the treatement of, such individual's illness or injury.

Subparagraph (B) of the new subsection (f)(1) provides that payment shall be made for inpatient hospital services furnished outside the United States only if (i) the hospital is accredited by the Joint Commission on Accreditation of Hospitals or (ii) the Secretary finds that the accreditation standards of a program of the country in which the hospital is located are equivalent to those of the Joint Commission on Accreditation of Hospitals and the hospital is accredited by such program.

Paragraph (2) of the new subsection (f) provides that payment for the services defined in paragraph (1) of such subsection may not be made for more than 20 days in a spell of illness (as defined in sec. 1861(a) of the Social Security Act) and, further, that any days in excess of 20 in which such inpatient hospital services are furnished during such spell of illness for which payment, but for this paragraph, would be made under the new section 1814(f) shall not be taken into account for purposes of the maximum number of days of inpatient hospital services (as specified in sec. 1812(b)(1) of the act, as amended by this bill) for which payment under the hospital insurance program may be made.

Paragraph (3) of the new subsection (f) provides that payments for the inpatient hospital services covered under such subsection shall be made to the individual on the basis of an itemized bill, if such individual files application for such payment within such time and in such form and manner, and containing and supported by such information as the Secretary shall by regulations prescribe.

Paragraph (4) of the new subsection (f) provides that the amounts payable for the inpatient hospital services defined in paragraph (1) of such subsection shall, subject to the hospital insurance deductible and coinsurance provisions specified in section 1813 of the act, be equal to 60 precent of the hospital's reasonable charges for routine services furnished in the accommodations occupied by the individual or in semiprivate accommodations defined as two-bed, three-bed, or four-bed accommodations in section 1861(v)(4) of the act, whichever is less, plus 80 percent of the hospital's reasonable charges for ancillary services. The paragraph further provides that, if separate charges for routine and ancillary services are not made by the hospital, reimbursement may be based on two-thirds of the hospital's reasonable charges for the services received but not to exceed the charges which would have been made if the patient had occupied semiprivate accommodations. In addition, the paragraph defines the term "routine services" as the regular room, dietary, and nursing services, minor medical and surgical supplies and the use of equipment and facilities for which a separate charge is not customarily made, and the term "ancillary serv-

ices" as those special services for which charges are customarily made in addition to routine services.

Section 146(b) of the bill provides that the amendments made by subsection (a) would apply to services furnished with respect to admissions occurring after March 31, 1968.

SECTION 147. PAYMENT UNDER SUPPLEMENTARY MEDICAL INSURANCE PROGRAM FOR CERTAIN INPATIENT ANCILLARY SERVICE

Section 147(a) of the bill amends section 1861(s) of the Social Security Act, to permit patients of participating facilities who, for example, have exhausted their benefits under the hospital insurance plan, or who have not met the 3-day hospitalization requirement for extended care benefits, or who are not otherwise entitled to benefits under the hospital insurance program to receive protection under the medical insurance program for certain ancillary services described in such section 1861(s)(3), by eliminating the restriction therein that medical and other health services (ancillary services) cannot be paid for under the medical insurance program when such services would otherwise constitute inpatient hospital services, extended care services, or home health services.

Section 147(b) of the bill amends section 1861(s) of the Social Security Act to provide that diagnostic tests performed in a laboratory can be covered under the medical insurance program if the facility in which such diagnostic tests are performed meets the definition of a hospital for emergency purposes.

Section 147(c) of the bill further amends section 1861(s) of the Social Security Act to provide that medical and other health services (other than physicians' services and services incident to physicians' services) furnished a patient of a facility which meets the definition of a hospital for emergency services will be covered under the medical insurance program only if such facility satisfies such health and safety requirements as are appropriate for the item or service furnished as the Secretary may determine are necessary.

Section 147(d) of the bill amends section 1861(s)(6) of the Social Security Act to prevent payment under the medical insurance program for the rental of durable medical equipment to inpatients of institutions which are primarily engaged in providing diagnostic and therapeutic or rehabilitative services or to inpatients of institutions primarily engaged in providing skilled nursing care.

Section 147(e) of the bill provides that the amendments made by this section will apply with respect to services furnished after March 31, 1968.

SECTION 148. GENERAL ENROLLMENT PERIOD UNDER TITLE XVIII

Section 148(a) of the bill amends section 1837(b)(1) of the Social Security Act to permit an individual enrolling in the supplementary medical insurance program for the first time to enroll at any time in a general enrollment period which begins within 3 years of the close of his initial enrollment period.

Section 148(b) of the bill amends section 1837(e) of the act to provide for an annual general enrollment period for the supplementary

medicial insurance program. This period would begin January 1 and end March 31 of each year, beginning in 1969.

Section 148(c) of the bill amends section 1838(b) of the act to provide that an individual may file a notice that he wishes to terminate his coverage under the supplementary medical insurance program at any time. His termination would take effect with the close of the calendar quarter following the quarter in which such notice was filed.

Section 148(d) of the bill amends section 1839(b)(2) of the act to provide that the Secretary shall, during December of each year, beginning in 1968, determine and announce the amount (whether or not such amount was applicable for premiums for any prior month) of the supplementary medical insurance premium for the 12-month period beginning on July 1 of each following year. The premium shall be such that the aggregate premiums will equal one-half the estimated benefit and administrative expenses of the supplementary medical insurance program for such 12-month period. At the time of announcement of the premium amount the Secretary shall make public the actuarial assumptions and bases employed in deciding the amount of the premium.

Section 148(e) of the bill amends section 1839(c) of the act to provide that where an individual has a period of delayed enrollment he shall be assessed a late enrollment charge if such period is 12 full months or more. This charge will be the sum of 2 monthly premiums if such period was 12 to 23 months, and the sum of 3 monthly premiums if such period is 24 or more months. A period of delayed enrollment is defined as the number of months between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus, if he enrolls for a second time, the number of months between the date of termination of his first coverage period and the close of the enrollment period in which he enrolled for the second time.

Section 148(f) of the bill provides that the amendments made by subsections (a), (b), and (c) shall become effective April 1, 1968, and that the amendments made by subsection (d) shall become effective December 1, 1968, notwithstanding section 2 of Public Law 90-97.

Section 148(f) of the bill further provides that the amendments made by subsection (e) shall apply to individuals who enroll in a general enrollment period which begins after September 30, 1967, except that in the case of an individual who enrolled in the general enrollment period beginning October 1, 1967, and ending March 31, 1968 (as provided for in Public Law 90-97) his period of delayed enrollment, for purposes of section 1839(c) of the act, as amended by this section, shall not include January through March 1968.

SECTION 149. ELIMINATION OF SPECIAL REDUCTION IN ALLOWABLE DAYS OF INPATIENT HOSPITAL SERVICES FOR PATIENTS IN TUBERCULOSIS HOSPITALS

Section 149(a) of the bill amends section 1812(c) of the Social Security Act (as amended by sec. 138 of the bill) so that the limitation of allowable days of inpatient hospital services will not apply to services provided to an inpatient of a tuberculosis hospital.

Section 149(b) of the bill provides that this amendment will apply with respect to services furnished after December 31, 1967.

SECTION 149a. INCLUSION OF OPTOMETRISTS' SERVICES UNDER SUPPLEMENTARY MEDICAL INSURANCE

Section 149a(a) of the bill amends section 1861(r) of the Social Security Act (as amended by sec. 127(a) of the bill), which defines the term "physician," to include within the definition a doctor of optometry, but only for purposes of section 1861(s)(1) of the act (relating to physicians' services for which payment may be made under pt. B of title XVIII) and section 1861(s)(2)(A) of the act (relating to services and supplies furnished as an incident to a physician's professional services for which payment may be made under pt. B) and only with respect to functions which he is legally authorized to perform as such by the State in which he performs them, and not with respect to procedures in connection with the diagnosis or detection of eye diseases unless he is legally authorized to treat such diseases by such State.

Section 149a(b) of the bill amends section 1862(a) of the act (as amended by sec. 127 of the bill), which provides that no payment may be made under part A or part B (regardless of any other provision of title XVIII) for any expenses incurred for certain specified health items or services, by adding a new paragraph (14). The new paragraph (14) provides that no payment may be made for expenses which constitute charges with respect to the referral of an individual to a doctor of medicine or osteopathy by a doctor of optometry arising out of a procedure in connection with the diagnosis or detection of eye diseases.

Section 149a(c) of the bill provides that these amendments will apply with respect to services furnished after March 31, 1968.

SECTION 149b. INCLUSION OF CHIROPRACTORS' SERVICES UNDER SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

Section 149b(a) of the bill amends section 1861(r) of the Social Security Act (as amended by sec. 127(a) and sec. 149a(a) of the bill) which defines the term "physician," to include within the definition a chiropractor who is licensed as such by a State, but only for purposes of section 1861(s)(1) of the act (relating to physicians' services for which payment may be made under pt. B of title XVIII) and section 1861(s)(2)(A) of the act (relating to services and supplies furnished as an incident to a physician's professional services for which payment may be made under pt. B) and only with respect to functions which he is legally authorized to perform as such by the State in which he performs them.

Section 149b(b) of the bill provides that these amendments will take effect with respect to services furnished after March 31, 1968.

PART 4—MISCELLANEOUS AND TECHNICAL AMENDMENTS

SECTION 150. ELIGIBILITY OF ADOPTED CHILD FOR MONTHLY BENEFITS

Payment of benefits to certain adopted children

Section 150(a) of the bill amends section 216(e) of the Social Security Act to provide an alternative to the present provision under which a child may be considered the adopted child of a deceased worker if the child is adopted by the worker's widow within 2 years of the worker's death. Under the alternative a child adopted by the

worker's widow will also qualify as the worker's child if he was living in the worker's household when the worker died and if proceedings for the adoption had been instituted by the worker before he died, regardless of whether the adoption was completed within 2 years.

Effective date

Section 150(b) of the bill provides that this amendment will be effective for months after February 1968 on the basis of applications filed in or after the month of enactment.

SECTION 151. CRITERIA FOR DETERMINING CHILD'S DEPENDENCY ON MOTHER

Section 151 of the bill provides that a child will be deemed dependent upon his mother or adopting mother according to the same criteria that are used to determine whether a child is dependent on his father or adopting father under existing law.

Dependency on mother

Section 151(a) of the bill amends section 202(d)(3) of the Social Security Act to provide that a child will be deemed dependent on his mother or adopting mother (as well as on his father or adopting father) if the child has not been legally adopted by another person and if the child is the parent's legitimate or legally adopted child (or the parent was either living with or contributing to the support of the child). Section 151(a) also amends section 202(d)(3) to provide that the child of any individual who meets the definition of relationship described in section 216(h)(2)(B) (regarding children of certain invalid marriages) or in 216(h)(3) (regarding certain illegitimate children) will be deemed to be the legitimate child of that individual, whether the individual is the child's father or mother; present law restricts the application of this provision to fathers.

Dependency on stepmother

Section 151(b) of the bill amends section 202(d)(4) of the act to provide that a child will be deemed dependent on his stepmother (as well as on his stepfather if the child is living with the stepparent or if the stepparent is contributing at least one-half of the child's support.

Elimination of special requirements for dependency on mother

Sectioon 151(c) of the bill eliminates section 202(d)(5) of the act, thus striking out the provisions that (1) a child will be deemed dependent on his mother or adopting mother if she is currently insured, and (2) a child can be deemed dependent on a mother who is not currently insured only if she is contributing one-half of the child's support or, if the child is not living with his father nor being supported by him, only if she is then living with or supporting the child.

Conforming changes

Section 151(d) of the bill makes conforming changes (including changes in the Railroad Retirement Act of 1937) required by the renumbering of the paragraphs in section 202(d) of the act.

Effective date

Section 151(e) of the bill makes these amendments effective for monthly benefits for months after February 1968 on the basis of applications filed in or after the month of enactment.

SECTION 152. RECOVERY OF OVERPAYMENTS

Section 152 of the bill substitutes a new subsection (a) for the present subsection (a) of section 204 of the act (relating to the adjustment of overpayments and underpayments), and a new subsection (b) for the present subsection (b) of section 204 (relating to waiver of adjustment or recovery of overpayments).

The new subsection (a) of section 204 of the act broadens the Secretary's authority to adjust overpayments and clarifies and broadens the Secretary's authority to adjust underpayments. Paragraph (1) of the new subsection (a) provides that where a person is paid more than the correct amount, the overpayment shall be adjusted, or recovered under regulations prescribed by the Secretary, by requiring the overpaid person or his estate to make a refund, or by decreasing any social security benefits payable to the overpaid person or to any other person on the earnings record that served as the basis of the benefit payments to the overpaid person. (Under present law, recovery from persons other than the overpaid person can be made only in cases where the overpaid person has died.)

Paragraph (2) of the new subsection (a) provides that where a person is paid less than the correct amount, the Secretary shall pay the balance due to the underpaid person. If the underpaid person dies before receiving the full amount due him, or after receiving but before negotiating checks representing the correct payments, the balance of the amount due, or the amount for which checks were properly issued but not negotiated, shall be paid under section 204(d) of the act as amended by section 154(a) of the bill.

The new subsection (b) of section 204 of the act broadens the Secretary's authority to waive adjustment or recovery of overpayments. Under present law, a condition for waiving adjustment or recovery of an overpayment is that the overpaid person be without fault; waiver is not authorized if the overpaid person is at fault even though the person from whom adjustment or recovery is sought is without fault. The new subsection (b) authorizes the Secretary to waive adjustment or recovery of an overpayment from any person who is without fault, even where he is not the overpaid person and the latter is at fault.

SECTION 153. PAYMENTS BASED ON ERRONEOUS REPORT OF DEATH

Section 153(a) of the bill amends section 204(a) of the Social Security Act as amended by section 152 of the bill to provide that where payment has been made on the basis of an erroneous report by the Department of Defense of the death of an individual in the line of duty while he is a member of the uniformed services on active duty, such payment shall be considered a correct payment.

Section 153(b) of the bill provides that the amendment made by subsection (a) shall apply with respect to people entitled to monthly benefits in or after the month of enactment.

SECTION 154. UNDERPAYMENTS

Section 154(a) of the bill amends section 204(d) of the Social Security Act to provide that when less than the correct amount is paid to a person and he dies before any payment due him is completed,

the amount due will be paid the following order of priority: (1) to the surviving spouse who was either living with the deceased beneficiary at the time of his death or entitled to benefits on the same earnings record; (2) to the child or children entitled to benefits on the same earnings record as the deceased beneficiary; (3) to the parent or parents entitled to benefits on the same earnings record as the deceased beneficiary; (4) to the surviving spouse who was neither living with the deceased beneficiary nor entitled to benefits on the same earnings record; (5) to the child or children not entitled to benefits on the same earnings record as the deceased beneficiary; (6) to the parent or parents not entitled to benefits on the same earnings record as the deceased beneficiary; (7) to the legal representative of the deceased beneficiary's estate, if any; (8) to the relative, related to the deceased beneficiary by blood, marriage, or adoption, who is determined by the Secretary to be the proper person to receive benefits on behalf of the estate.

Sections 154 (b) and (c) of the bill amend section 1870 of the act to provide that where a person dies after receiving covered services for which reimbursement is due him under the health insurance program but before reimbursement has been made, and the bill for such covered services has been paid, the health insurance benefits will be paid to the person who paid the bill. If there is no such person, the benefit will be paid to the legal representative of the deceased beneficiary's estate, if any. If there is no legal representative, the medical insurance benefits will be paid according to the following order of priority:

> (1) to the surviving spouse who was either living with or entitled to benefits on the same earnings record as the deceased beneficiary; (2) to his child or children if they were entitled to benefits on the same earnings record as the deceased beneficiary; (3) to his parent or parents if they were entitled to benefits on the same earnings record as the deceased beneficiary; (4) to the surviving spouse who was neither living with nor entitled to benefits on the same earnings record as the deceased beneficiary; (5) to his child or children not entitled to benefits on the same earnings record as the deceased beneficiary; (6) to his parent or parents not entitled to benefits on the earnings record of the deceased beneficiary; (7) to a relative of the deceased beneficiary who is determined by the Secretary to be the proper person to receive payments on behalf of the estate. If none of the persons mentioned in the bill exist, no payment would be made.

Section 154(c) further amends section 1870 of the act to provide that where a person enrolled in the supplementary medical insurance program who received covered services under the plan dies, and no assignment of benefits for such services was made and these services have not been paid for, reimbursement under the medical insurance program can be made to the physician or other person who provided such services, but only if the physician (or other person) agrees to accept the "reasonable charge" for such services as his full charge.

Section 154(d) amends section 1842(b)(3)(B) of the act (as amended by sec. 125(a) of the bill) to provide an exception to the usual method of reimbursement on the basis of charges in cases where the beneficiary dies.

SECTION 155. SIMPLIFICATION OF COMPUTATION OF PRIMARY INSURANCE AMOUNT AND QUARTERS OF COVERAGE IN CASE OF 1937–1950 WAGES

Section 155 of the bill provides a simplified method of computing benefits when earnings before 1951 are included in the computation, and of determining quarters of coverage for the period before 1951 when quarters of coverage in this period are needed to establish a fully insured status, so that machine, rather than manual, procedures can be used in making such computations and determinations.

Primary insurance benefit; column I of the revised benefit table

Section 155(a) of the bill amends section 215(d) of the Social Security Act to provide a simplified method of computing benefits where earnings before 1951 are included in the computation.

Section 155(a)(1) amends section 215(d)(1) of the act to provide a revised method for computing the "primary insurance benefit," from which the worker's primary insurance amount (the amount on which the worker's benefit and the benefits of his dependents and survivors are based) is ultimately derived, when pre-1951 wages are used in the computation. The revised method for computing the primary insurance benefit is as follows: As under present law, the worker's average monthly wage will be determined over a number of years equal to 5 less than the number of years elapsing after 1936 (or after the year in which he attains 21) and up to the year in which he attains age 65 (62 for women), becomes disabled, or dies. Where the worker's total wages in that period do not exceed $27,000, he will be deemed, for benefit computation purposes, to have been paid those wages in 9 years prior to 1951; where the total wages are more than $27,000 but less than $42,000, he will be deemed to have been paid the wages at the rate of $3,000 a year (the maximum annual amount creditable before 1951) with any amount over a multiple of $3,000 being assigned to 1 additional year; and where the total wages credited before 1951 are at least $42,000, he will be deemed to have been paid $3,000 in each of the 14 calendar years prior to 1951. (Under present law, the worker's actual wages as paid to him in each year for the period 1937–50 must be used, and annual breakdowns of wages earned during that period 1937–50 are not available for machine use.) Total wages before 1951, for purposes of determining the primary insurance benefit, are defined as the sum of the remuneration credited to the workers' earnings record for 1937–50 plus any military wage credits and compensation under the Railroad Retirement Act of 1937 creditable for that period. The formula for determining the primary insurance benefit is to be 45.6 percent of the first $50 of average monthly earnings, plus 11.4 percent of the next $200 of average monthly earnings. This formula gives the same effect as the present-law formula for computing benefits where the period used is the one beginning with 1937 and where 14 "increments" are given. (Under present law, an "increment" is the term used to describe the 1-percent increase in the primary insurance benefit that is given for each year before 1951 in which the worker was paid wages of $200 or more; the maximum possible is 14—the number of years in the period 1937–50.)

Section 155(a)(2) of the bill amends section 215(d)(2) of the act to specify that the revised computation method is to be available only for a person who (A) as under present law, has at least one quarter of

coverage before 1951; (B) as under present law, reaches age 22 after 1950 (but, unlike the requirement in present law, not if he reached age 21 before 1951), provided that he has less than six quarters of coverage after 1950; and (C) either (i) becomes entitled to old-age or disability insurance benefits after the date of enactment of the bill, (ii) dies after the date of enactment without having been entitled to old-age or disability insurance benefits, or (iii) has his primary insurance amount recomputed.

Section 155(a)(3) of the bill amends section 215(d)(3) of the act to provide that the computation provisions in effect before the enactment of the bill are to apply (A) to a person who attained age 21 after 1936 and before 1951, and (B) to a disabled person when his period of disability began before 1951 and the years in his period of disability are excluded in computing his benefit. These provisions are necessary in order to assure that these people do not get smaller benefit amounts than they would get under present law. The new computation method was designed for use only in those cases where at least 9 years before 1951 would have to be used in the computation, and 9 years before 1951 would not have to be used in computing a benefit where the person reached age 21 after 1936 and before 1951 or where years of disability before 1951 are excluded in the computation.

Section 155(a)(4) of the bill amends section 215(f)(2) of the act to provide that benefits for people on the benefit rolls will be recomputed for years after 1965 only in the case of a person who has creditable earnings after 1965. Under present law, a recomputation is made regardless of earnings, but if there are no earnings since the last previous computation the benefit is not increased by the recomputation. The change provided by the bill is made to avoid increases in benefits that would be possible solely as a result of recomputing the benefits for everyone on the benefit rolls under the revised computation method provided under this amendment.

Section 155(a)(5) of the bill amends section 215(f)(2) of the act to change the designation of two paragraphs therein to conform with changes made by section 155(a)(4).

Section 155(a)(6) of the bill adds to section 215(f) of the Act a new paragraph (5) to provide that the primary insurance amount of a man who was entitled to an actuarially reduced old-age benefit and who died before age 65 will be recomputed using the period up to the year of death instead of the period up to the year of attaining age 65, regardless of whether he had earnings after 1965. (Sec. 155(a)(4) of the bill provides that benefits for people on the benefit rolls are to be recomputed for years after 1965 only where a person had creditable earnings after 1965.) The recomputed primary insurance amount will be effective for and after the month of the worker's death; i.e., will be the amount from which the survivor's benefits and lump-sum death payment are determined.

Section 155(a)(7) of the bill provides that (A) the changes made by section 155(a)(4) (which specify that recomputation for years after 1965 will be made only if a person has creditable earnings after 1965), and the conforming change in section 155(a)(5) will apply to recomputations made after the date of enactment of the bill, and (B) the changes made by section 155(a)(6) (which provide for recomputing

the primary insurance amount of a man who was entitled to an actuarially reduced old-age benefit and who died before age 65) will apply in the case of men who die after the date of enactment.

Section 155(a)(8) of the bill assures that a person who is getting a benefit based on a primary insurance amount determined under the revised computation method between the date of enactment and the effective month of the general benefit increase under section 101 of the bill will get the benefit increase. Where a person becomes entitled to a social security benefit after the date of enactment and before the second month after the month of enactment, and the benefit is based on a primary insurance amount that was determined under the revised computation method, the primary insurance amount will be deemed (for purposes of col. II in the revised benefit table, which shows the primary insurance amounts in effect before the enactment of the bill) to have been computed under the law in effect before the enactment of the bill.

Section 155(a)(9) of the bill provides that the changes made by section 155(a) for computing benefits where pre-1951 wages are used will not apply for monthly benefits before January 1967; that is, where, under the provisions regarding retroactivity of benefits in present law, benefits are payable for some months of 1966, the benefit amounts will be figured under the computation provisions in effect before the enactment of the bill; where benefits are payable for months in 1967, the benefits will be figured under the revised computation method provided in section 153(a) of the bill.

Alternative method for determining quarters of coverage

Section 155(b) of the bill amends section 213 of the act to provide an alternative method for determining quarters of coverage for the period 1937–50, based on total wages in that period.

Section 155(b)(1) provides that a person will be deemed to have one quarter of coverage for each $400 of total wages prior to 1951. This alternative method is to be used only to determine fully insured status, and is limited to those people who need seven or more quarters of coverage for a fully insured status. If the person is not fully insured based on the quarters of coverage determined for the period 1937–50 under the alternative method, plus the quarters of coverage determined under the provisions of present law for the period after 1950, his quarters of coverage will be determined under the provisions of present law.

Section 155(b)(2) of the bill provides that the alternative method for determining quarters of coverage is to apply for a worker who files an application for old-age insurance benefits in or after the month of enactment and for a worker whose death occurs in or after that month if the worker was not previously entitled to an old-age or disability insurance benefit.

Section 155(c) of the bill amends section 303(g)(1) of the Social Security Amendments of 1960 to preserve for people who were eligible for benefits before 1961 the benefit computation provisions that were in effect before the 1960 amendments (and are retained in present law). Under these provisions, the worker's benefit amount can be based on his average monthly wage over a period as short as 16 years where earnings before 1951 are used (rather than a minimum of 19

years, as would be needed under the computation provisions enacted in 1960), but the worker cannot substitute, for earnings in a year prior to eligibility, earnings in a year after he became eligible (as is possible under the computation provisions enacted in 1960): The revised computation method would, however, be available for people who were eligible for benefits before 1961 when their benefits are computed under the provisions in effect after the 1960 amendments (which require that at least 19 years after 1936 be used in figuring their average monthly earnings).

SECTION 156. DEFINITIONS OF WIDOW, WIDOWER, AND STEPCHILD

Section 156(a) of the bill amends section 216(c) of the Social Security Act, relating to the definition of widow, to reduce the duration-of-relationship requirement—the length of time a widow not otherwise qualifying must have been married to her deceased husband in order to get benefits on his earnings record—from 1 year to 9 months.

Section 156(b) of the bill amends section 216(e) of the act, relating to the definition of stepchild, to reduce the duration-of-relationship requirement for stepchildren of deceased workers from 1 year to 9 months.

Section 156(c) of the bill amends section 216(g) of the act, relating to the definition of widower, to reduce the duration-of-relationship requirement from 1 year to 9 months.

Section 156(d) of the bill amends section 216 of the act by adding a new subsection (k) to provide that where a member of a uniformed service dies in line of duty while serving on active duty, or where a deceased individual's death was accidental, the 9-month duration-of-relationship requirement applicable to the surviving spouse and stepchild of the deceased individual shall be deemed to be satisfied if the marriage lasted 3 months unless the Secretary determines that at the time of the marriage the individual could not reasonably have been expected to live for 9 months. For this purpose an individual's death is "accidental" if he receives bodily injuries solely through violent, external, and accidental means and, as a direct result of these injuries and independently of all other causes, dies within 3 months.

Section 156(e) of the bill provides that these amendments will be effective for months after February 1968 on the basis of applications filed in or after the month of enactment.

SECTION 157. HUSBAND'S AND WIDOWER'S INSURANCE BENEFITS WITHOUT REQUIREMENT OF WIFE'S CURRENTLY INSURED STATUS

Section 157 provides for the payment of benefits to the dependent husband or widower of a retired, disabled, or deceased woman worker regardless of whether the woman was currently insured.

Husband's benefits

Section 157(a) of the bill amends section 202(c)(1) of the Social Security Act to eliminate the provision that in order for a man to become entitled to a husband's benefit based on his wife's earnings the woman must have been currently insured. The requirement that a husband must have been receiving one half of his support from his wife is not changed by the amendment. The section also makes a conforming change in section 202(c)(2).

Widower's benefits

Section 157(b) of the bill amends section 202(f)(1) of the act to eliminate the provision that in order for a man to get widower's benefits based on his wife's earnings the wife must have died currently insured. The requirement that a widower must have been receiving one-half of his support from his wife is not changed by the amendment. The section also makes a conforming change in section 202(f)(2).

Filing of proof of support

Section 157(c) of the bill provides that any husband or widower who was not previously eligible for the husband's or widower's benefits solely because his spouse did not meet the currently-insured requirement may file proof of support within 2 years after the enactment of the bill and thus establish his entitlement to benefits on her account. In the absence of this provision a husband or widower whose wife was not currently insured and came on the rolls or died more than 2 years before enactment would be unable to get benefits, since under present law a husband or widower must file proof of his dependency on his wife within the 2-year period immediately after the month of her entitlement to benefits or her death. Evidence of support must be filed within the appropriate period even though the husband may not have been eligible for benefits at that time.

Effective date

Section 157(d) of the bill makes these amendments effective for monthly benefits for months after February 1968 on the basis of applications filed in or after the month of enactment.

SECTION 158. DEFINITION OF DISABILITY

Section 158 of the bill amends section 223 of the Social Security Act to clarify and amplify the definition of "disability" for purposes of the social security program (and to provide a special definition for purposes of widow's and widower's insurance benefits which are based on disability). Under the amendments made by sections 158 (a) and (b), the definition is contained in a new section 223(d) of the act, with the existing definition in section 223(c)(2) being eliminated.

Paragraph (1) of the new section 223(d) states the basic definition of the term "disability" exactly as it is stated in existing law; i.e. (A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, or (B) in the case of an individual aged 55 or over who is blind as defined in section 216(i)(1), inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time.

Paragraph (2)(A) of the new section 223(d) provides that in applying the basic definition (except the special definition for the blind, and except for purposes of widow's or widower's insurance benefits on the basis of disability), an individual shall be determined to be under a disability only if his impairment or impairments are so severe that he is not only unable to do his previous work but cannot, considering his

age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the general area in which he lives, or whether a specific job vacancy exists, or whether he would be hired if he applied for work.

Paragraph (2)(B) of the new section 223(d) provides that (in applying the basic definition) a widow, surviving divorced wife, or widower shall not be determined to be under a disability for purposes of widow's or widower's insurance benefits unless his or her impairment or impairments are of a level of severity which under regulations prescribed by the Secretary is deemed sufficient to preclude an individual from engaging in any substantial gainful activity.

Paragraph (3) of the new section 223(d) defines a physical or mental impairment as one that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

Paragraph (4) of the new section 223(d) directs the Secretary by regulations to prescribe the criteria for determining when services or earnings demonstrate ability to engage in substantial gainful activity, and provides that an individual whose work or earnings meet these criteria will be found not to be disabled (except in the case of work performed during a "period of trial work").

Paragraph (5) of the new section 223(d) provides that an individual will not be considered to be under a disability unless he furnishes such medical and other evidence of the existence of disability as the Secretary may require.

Section 158(c) of the bill makes necessary conforming changes in various provisions of the act to reflect the elimination of the existing definition of disability and the substitution of the new definition.

Section 158(d) of the bill amends section 216(i) of the act to provide that paragraphs (2)(A), (3), (4), and (5) of the new section 223(d)—relating to the requirements that must be met for an individual to be determined to be under a disability, the meaning of "impairment," the demonstration of ability to engage in substantial gainful activity, and the furnishing of evidence—are to apply also in determining whether an individual is under a disability for purposes of establishing a period of disability (the "disability freeze").

Section 158(e) of the bill provides that the amendments made by section 158 are to 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 so given before such month but a civil action thereon is commenced (whether before, in, or after such month) under section 205(g) of the Social Security Act and the decision in such civil action has not become final before such month.

SECTION 159. DISABILITY BENEFITS AFFECTED BY RECEIPT OF WORKMEN'S COMPENSATION

Section 159 of the bill amends section 224 of the Social Security Act—the provision of present law under which social security disability benefits are reduced in certain cases where a disabled worker under age 62 qualifies for both workmen's compensation periodic payments and social security disability benefits. Under present law, the social security benefits payable to him and his family are reduced by the amount, if any, by which 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 considered to be equal to the larger of (a) the average monthly wage used for computing his social security benefits, or (b) his average monthly earnings in covered employment and self-employment during his 5 consecutive years of highest covered earnings after 1950 (not counting that part of the earnings in excess of the maximum annual amount that is taxable and creditable for social security purposes). Under the bill, covered earnings in employment and self-employment in excess of the maximum annual amount that is taxable and creditable for social security purposes are to be included in computing the disabled worker's average monthly earnings during his 5 consecutive years of highest covered earnings after 1950, thus permitting payment of a larger social security benefit than under present law in some cases.

Paragraph (1) of section 159(a) of the bill amends clause (B) of the last sentence of section 224(a) of the act to provide that the computation of 1/60th of the total of the individual's wages and self-employment income for the high 5 consecutive calendar years after 1950 (to determine average current earnings) will be made without regard to the limitations in sections 209(a) and 211(b)(1) of the act (relating to the maximum amounts of wages and self-employment income that are creditable for social security purposes).

Paragraph (2) of section 159(a) of the bill further amends section 224(a) of the act to authorize the Secretary, under regulations, to estimate on the basis of such information as is available to him the total of an individual's annual earnings from wages and self-employment (for purposes of clause (B) of the last sentence of sec. 224(a)) for years in which the individual's earnings as reported reach the maximum creditable amount.

Paragraph (1) of section 159(b) of the bill provides that the amendment made by section 159(a) will apply only with respect to monthly benefits for and after March 1968.

Paragraph (2) of section 159(b) of the bill provides that, where a redetermination is made under section 224(f) of the act of the amount of social security disability benefits which are still subject to reduction, and the reduction was first applied to benefits payable for the month of enactment or a prior month, the amendments made by section 159(a) will be deemed to have applied in the initial determination of average current earnings.

SECTION 160. EXTENSION OF TIME FOR FILING REPORTS OF EARNINGS

Section 160(a) of the bill amends section 203(h)(1)(A) of the Social Security Act to permit the Secretary of Health, Education, and Welfare to grant to a beneficiary, or to an individual receiving benefits on behalf of a beneficiary, a reasonable extension—not to exceed 3 months—of the time in which the beneficiary or other individual is required to file with the Secretary a report of his annual earnings, if a valid reason for the delay exists. Under present law, the time for filing reports of earnings cannot be extended; the Secretary may, however, waive the penalties imposed for late filing of such a report if the beneficiary shows that he had good cause for failing to make the report in time.

Section 160(b) of the bill amends section 203(h)(2) of the act to make it clear that a penalty for late filing will not be imposed in cases where the beneficiary files his report of earnings after the regular deadline but within the extended period of time that he was granted by the Secretary under section 203(h)(1), as amended by section 160(a) of the bill.

SECTION 161. PENALTIES FOR FAILURE TO FILE TIMELY REPORTS OF EARNINGS AND OTHER EVENTS

Failure to file timely report of earnings

Section 161(a) of the bill amends section 203(h)(2)(A) of the Social Security Act to reduce the amount of the penalty which is imposed for the first time a beneficiary fails to report, as required, his annual earnings to the Secretary of Health, Education, and Welfare within the prescribed time. Under present law, the penalty is equal to the person's benefit for the last month for which he is entitled to benefits in the year, even though the amount that is withheld under the earnings test because he has had annual earnings of above $1,500 is less than a full month's benefit; the amount of benefits required to be withheld can be as little as $1. Under the amendment, the penalty imposed for the first failure to report earnings of more than the annual ceiling (which is $1,680 for 1968 and $2,000 for 1969 and after under the amendments made by sec. 108 of the bill) within the specified time will not exceed the amount withheld under the earnings test, unless that amount is less than $10 (in which case the penalty will be $10).

Failure to file timely report of events other than earnings

Section 161(b) of the bill amends section 203(g) of the act to reduce the amount of the penalty imposed (1) for failure by a beneficiary under age 72 (or by a person getting benefits on behalf of a beneficiary) to report, within the required time, to the Secretary any month in which he engaged in 7 or more days of noncovered employment or self-employment outside the United States, and (2) for failure by a beneficiary entitled to wife's or mother's insurance benefits by reason of having in her care a child of the worker entitled to child's insurance benefits to report, within the prescribed time, to the Secretary any month in which she does not have such a child in her care. Under present law, the penalty for the first failure to report the occurrence of either one of these events is 1 month's benefit; for subsequent failures to report such events, the penalty is an amount equal to the

total amount of the benefits for all the months in which the event occurred but was not reported within the time prescribed. Under the amendment, the penalty for the first failure to report the occurrence of either event will continue to be equal to 1 month's benefit; the penalty for the second failure to report will be equal to 2 months' benefits and the penalty for the third or a subsequent failure to report will be equal to 3 months' benefits. In no case, however, will the amount of the penalty for failure to report exceed the total amount of benefits withheld. For example, if an individual failed on a third occasion to report an event that he should have reported, but only 1 month's benefit was involved, the amount of the penalty would be an amount equal to the benefit for that 1 month.

Effective date

Section 161(c) provides that the amendments made by section 161 are to be effective with respect to penalties imposed on or after the date of the enactment of the bill.

SECTION 162. AMENDMENTS TO COMPLY WITH TREATY OBLIGATIONS

Section 162(a) of the bill amends section 228(a) of the Social Security Act, which provides for benefits at age 72 for certain uninsured individuals, by adding a new sentence which would provide for an exception to clause 3(b), which requires that an alien must be a resident of the United States for 5 years, if the application of such provision would be contrary to a treaty obligation of the United States.

Section 162(b) of the bill amends section 1836 of the act, which provides for protection under the supplementary medical insurance plan of the medicare program for certain uninsured individuals, by adding a new sentence which would provide for an exception to clause (2)(A)(ii), which requires that an alien must be a resident of the United States for 5 years, if the application of such provision would be contrary to a treaty obligation of the United States

Section 162(c) of the bill amends, effective July 1, 1966, section 103(a) of the Social Security Amendments of 1965, which under a special transitional provision provides for protection under the hospital insurance plan of the medicare program for certain uninsured individuals, by adding a new sentence which would provide for an exception to clause (4)(B), which requires that an alien must be a resident of the United States for 5 years, if the application of such provision would be contrary to a treaty obligation of the United States.

SECTION 163. LIMITATION ON PAYMENT OF BENEFITS TO ALIENS OUTSIDE THE UNITED STATES

Length of time an alien is outside the United States

Section 163(a) of the bill amends section (t)(1) of section 202 of the Social Security Act to provide that after an alien has been outside the United States for 30 consecutive days he will be deemed to be outside the United States continuously until he has been in the United States for 30 consecutive days. (In general, when an alien has been outside of the United States for a period of 6 months, his benefits are suspended until the returns to the United States.) The amendment is effective with respect to 6-month periods which begin after the month of enactment of the bill.

Exceptions to suspension of benefit payments not to apply in certain cases

Section 163(b) of the bill amends paragraph (4) of section 202(t) of the act to provide that the exceptions to the suspension of benefit payments to aliens who are outside the United States that are based on the worker's having 40 quarters of coverage or 10 years residence in the United States shall not apply to any alien who is (1) a citizen of a country that has in effect a social insurance or pension system that is of general application and that does not provide benefit payments to otherwise eligible U.S. citizens who are residing outside that country, or (2) a citizen of a foreign country that has no social insurance or pension system of general application if, at any time within five years before the month the bill is enacted or, in the case of an alien whose benefits are not subject to suspension under section 202(t)(1) of the act for such month, within five years before the first month after the month of enactment for which his benefits are subject to such suspension, payment of benefits to individuals in such country is withheld by the Treasury Department under the first sentence of the act of October 9, 1949 (31 U.S.C. 123). The amendment will apply for months beginning after December 31, 1968.

Limitation on payment of benefits to aliens in certain countries

Section 163(c)(1) of the bill adds a new paragraph (10) to section 202(t) of the act to provide that no monthly social security benefits will be paid for any month beginning after December 31, 1968, to an alien who resides in a foreign country if payments to people in that country are withheld by the Treasury Department under the first section of the act of October 9, 1940 (31 U.S.C. 123). That section provides for the Department of the Treasury to withhold checks drawn on the United States from people who are in a country in which there is no reasonable assurance that an individual will receive his check or be able to negotiate it for its full value.

Subsection (c)(2) of section 163 amends subsection (t)(6) of section 202 of the act to provide that where an alien is residing in a foreign country where benefit payments are withheld by the Treasury Department under the 1940 law in the month preceding the month of his death, no lump-sum death payment may be made on the basis of his earnings record.

Subsection (c)(3) of section 163 provides that where benefits are, on December 31, 1968, being withheld by the Treasury Department under the 1940 law from an alien subsequently become payable, such benefits shall be paid only to the person from whom they were withheld or, if he has died, to a survivor entitled to a monthly benefit on the same earnings record, and that they shall be paid in an amount not in excess of the equivalent of the last twelve months' benefits that would have been payable to him.

SECTION 164. SPECIAL SAVING PROVISION FOR CERTAIN CHILDREN

Section 164 of the bill provides a special saving clause for families in which certain additional children qualified under the 1965 amendments. Section 164 provides that where the benefits of a person who was entitled to monthly benefits in August 1965 and whose benefits were reduced because of the limit on the maximum monthly benefit

payable on a worker's earnings record (or whose benefits would have been so reduced if no benefits otherwise payable on that earnings record had been withheld) because of the entitlement of one or more children who could not inherit their father's intestate property, such monthly benefit will be increased to the amount it would have been had such children not become entitled.

This section shall be effective with respect to benefits payable to such person for months after February 1968.

SECTION 165. TRANSFER TO HEALTH INSURANCE BENEFITS ADVISORY COUNCIL OF NATIONAL MEDICAL REVIEW COMMITTEE FUNCTIONS; INCREASE IN COUNCIL'S MEMBERSHIP

Section 165(a) of the bill amends section 1867 of the Social Security Act to provide for increasing the membership of the Health Insurance Benefits Advisory Council from 16 to 19 members, and for increasing from four to five the number of members at whose request it is the duty of the Secretary of Health, Education, and Welfare to call a meeting of the Advisory Council.

Section 1867 as amended includes, as an activity of the Health Insurance Benefits Advisory Council, the study of utilization of hospital and other medical care and services for which payment may be made under the health insurance program (title XVIII of the act) with a view to recommending any changes which may seem desirable in the way in which such care and services are utilized or in the administration of the title XVIII program (a function which, under present law, was to have been performed by the National Medical Review Committee). The Advisory Council is given the additional responsibility of making an annual report to the Secretary on its activities, including any recommendations it may have with respect thereto. This report is to be transmitted by the Secretary to the Congress.

Section 1867 as amended also authorizes the Advisory Council to engage such technical assistance as may be required to carry out its functions. In addition, the Secretary is to make available to the Council such secretarial, clerical, and other assistance and such pertinent data obtained and prepared by the Department of Health, Education, and Welfare as the Advisory Council may require to carry out its functions.

Section 165(b) of the bill provides that the amendment made by section 165(a) with respect to the increase in the Advisory Council membership from 16 to 19 will not affect the terms of office of the members of the Advisory Council in office on the date of enactment of the bill or their successors. The terms of office of the three additional members of the Advisory Council first appointed pursuant to the increase in the membership of such Council provided by such amendment are to expire, as designated by the Secretary at the time of the appointment, one at the end of the first year, one at the end of the second year, and one at the end of the third year after the date of appointment.

Section 165(c) of the bill repeals section 1868 of the act, which provides for the establishment of a National Medical Review Committee.

SECTION 166. ADVISORY COUNCIL ON SOCIAL SECURITY

Section 166 of the bill amends section 706 of the Social Security Act, relating to the Advisory Council on Social Security.

Section 166(a)(1) of the bill amends section 706(a) of the act to provide that an Advisory Council will be appointed after January 31 of every fourth year beginning in 1969. (Present law requires that an Advisory Council be appointed during 1968 and every fifth year thereafter.)

Section 166(a)(2) amends section 706(d) of the act to provide for inclusion in the final report of the Advisory Council of any interim reports the Council may have issued.

Section 166(b) of the bill amends section 706(b) of the act to provide that each such Council will consist of a chairman and 12 other persons, all of whom shall be appointed by the Secretary of Health, Education, and Welfare. (Present law provides that the Commissioner of Social Security serves as Chairman of the Council.)

SECTION 167. REIMBURSEMENT OF CIVIL SERVICE RETIREMENT ANNUITANTS FOR CERTAIN PREMIUM PAYMENTS UNDER SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

Section 167 of the bill amends section 1840(e)(1) of the Social Security Act to permit a plan described in section 8903 of title 5, United States Code (relating to health benefits plans under the Federal Employees Health Benefits Act of 1959), to reimburse each annuitant enrolled in such a plan and also enrolled in the supplementary medical insurance program in an amount equal to the premiums paid under the supplementary medical insurance program. Such reimbursement must be financed from funds other than the contributions made by the Federal Government and by Federal employees and annuitants under the Federal Employees Health Benefits Act of 1959.

SECTION 168. APPROPRIATIONS TO SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

Section 168(a) of the bill amends section 1844(a) of the Social Security Act to authorize the appropriation from general revenues of funds sufficient to place the Supplementary Medical Insurance Trust Fund in the same position at the end of each fiscal year after June 30, 1967, that it would be in if the Government contribution authorized under section 1844 were deposited in the trust fund at the same time as the premium being matched. Section 165(a) also authorizes the appropriation from general revenues of funds sufficient to place the trust fund in the same position it would be in at the end of any future fiscal year if that part of the Government contributions due to the trust fund for fiscal year 1967 which was not appropriated in that year had been appropriated to it on June 30, 1967.

Section 168(b) of the bill amends section 1844(b) of the act by extending from December 31, 1967, to December 31, 1969, the date of expiration of the period of availability of the contingency reserve for the medical insurance program.

SECTION 169. DISCLOSURE TO COURTS OF WHEREABOUTS OF CERTAIN INDIVIDUALS

Section 169(a) of the bill amends section 1106(c)(1) of the Social Security Act by adding a new subparagraph (B) requiring the Secretary of Health, Education, and Welfare to furnish the most recent address of an individual (or his most recent employer, or both) to a court having jurisdiction to issue orders or entertain petitions against the individual for the support and maintenance of his children if the court certifies that the information is requested for its own use in issuing or determining whether to issue such an order against such individual. In the event the individual is not within the jurisdiction of the court to which a petition for support or maintenance is filed, the information might be used to determine the court to which a petition would be forwarded under any reciprocal arrangements with other States to obtain or improve court orders for support.

Section 169(b) and (c) of the bill make conforming changes in the present provisions of section 1106(c) relating to the manner of making a request for information and to the applicability of penalties with respect to misuse of information furnished to a court.

SECTION 170. REPORTS OF BOARDS OF TRUSTEES TO CONGRESS

Section 170(a) of the bill amends sections 201(c)(2), 1817(b)(2), and 1841(b)(2) of the Social Security Act to require the Board of Trustees of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, the Board of Trustees of the Federal Hospital Insurance Trust Fund, and the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund to submit their reports on the status of each of these funds for the preceding fiscal year by April 1. These sections now require the report to be submitted by March 1.

Section 170(b) of the bill adds to section 201(c) of the act an additional requirement that the report on the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund include an actuarial analysis of the costs of the Federal Old-Age and Survivors Insurance Trust Fund of the payment of benefits to disabled beneficiaries.

SECTION 171. GENERAL SAVING PROVISION

Section 171 of the bill adds a general savings clause, applicable in certain cases where a person is made eligible for benefits by the bill.

Under section 171(a) of the bill the savings clause applies to any person (or persons) entitled to benefits for February 1968, on the basis of an application filed no later than February 1968. If another member of the person's family who was made eligible for benefits by the bill becomes entitled to benefits for March 1968, then each member of the family who was entitled to benefits for February 1968 will get the same benefit amount that he would have gotten if the newly eligible person had not become entitled to benefits, in spite of the provisions of the law (sec. 203(a)) for limiting the total amount of benefits payable to a family. The benefit amount of the newly entitled person would be determined without regard to the general savings clause.

The following example illustrates how the savings clause will operate: Assume that a man died in 1966, leaving a widow and their twin children eligible for benefits, and a stepchild who was not eligible for benefits on the earnings record of the deceased worker because the step-relationship had lasted only 11 months before the stepfather died. The widow and her twin children get benefits that are limited by the family maximum to $91.20 each—a total of $273.60 for the family. After enactment of the bill, the widow and two children have their benefit amounts increased by 15 percent, from $91.20 to $104.90 each, and the family maximum becomes $314.70. The stepchild is made eligible for benefits by another section of the bill, which would reduce the 1-year-duration-of-relationship requirements to 9 months, and becomes entitled to benefits as of March 1968. Without the general savings clause, the stepchild would merely share in the $314.70 payable to the family—the four beneficiaries would get $78.70 each. Under the savings clause, though, the widow and the two children who were getting benefits before the enactment of the bill will continue to get $104.90 each and the stepchild will be paid the $78.70 that he would have been paid without regard to the general saving clause; thus, the family will get total benefits of $393.40 a month, rather than $314.70.

Under section 171(b) of the bill the saving clause applies in the same way where any person (or persons) is entitled to benefits for November 1968, on the basis of an application filed no later than November 1968, and another member of the person's family who was made eligible for benefits by section 105 of the bill (which provides for lowering the eligibility age for retirement benefits to 60) becomes entitled to benefits for December 1968.

SECTION 172. EXPEDITED PAYMENT

Section 172 of the bill provides for expedited payment of claims for monthly retirement and survivors insurance benefits on the basis of a written request filed under certain conditions.

Section 172(a) of the bill adds a new subsection (q) to section 205 of the act, under which the Secretary of Health, Education, and Welfare would establish and put into effect procedures under which expedited payment of benefits would be made.

The new subsection 205(q) would provide that in any case in which a person alleges that a monthly payment under this title was due for a particular month but not paid to him, he could file a written request for expedited payment (1) in a case involving an initially unexplained interruption in benefit payments, when 30 days have elapsed after the 15th of the month in which the benefit payment was due, and (2) in any other case, when 90 days have elapsed after the date on which the benefit is alleged to have been due or after the date on which the claimant submitted the last information requested by the Secretary. In case such written request is filed prior to the expiration of such 30-day period the request will be deemed to have been filed upon the expiration of such period; in any other case such written request will be deemed to be filed on the day on which it was filed, or the 90th day after the first day on which the Secretary has evidence that such payment is due, whichever is later. If payments are found to be due, payment will be made within 15 days from the date of the request for expedited payment.

The new subsection 205(q) further provides that in any case where the Secretary determines there is evidence, although additional evidence might be required for a final decision, that a monthly benefit under this title is due the person for a particular month but was not paid to him, he may make payments on a preliminary basis even though the 30-day or 90-day periods described in this subsection have not elapsed.

Subsection 205(q) further provides that the certifying or disbursing officer shall not be held liable for an incorrect payment made on the basis of a preliminary certification under the subsection.

Subsection 205(q) also provides that for purposes of the subsection, benefits payable under section 228 are to be treated as monthly insurance benefits payable under title II of the Social Security Act. However, the provisions of the subsection would not apply with respect to any benefit for which a check has been negotiated or with respect to any benefit alleged to be due under either section 223 or section 202 to a wife, husband or child if a person entitled to or applying for benefits under section 223, or to a child who has attained age 18 and is under a disability or to a widow or widower on the basis of being under a disability.

Effective date

Section 172(b) of the bill provides that the amendment relating to written requests shall apply with respect to requests filed after June 30, 1968.

SECTION 173. STUDY OF PROPOSED LEGISLATION

Section 173(a) of the bill requires the Secretary of Health, Education, and Welfare to study the effects which would result from the enactment of a proposal to establish, through a formulary committee, quality and cost control standards for drugs for which payment may be made under the various Federal-State assistance programs and under the hospital insurance program established by part A of title XVIII of the Social Security Act, and the effects which would result from the enactment of a proposal to provide coverage, under the supplementary medical insurance program established by part B of title XVIII of the Social Security Act, of certain expenses incurred by insured individuals in obtaining such drugs as may be found to be qualified drugs by a formulary committee. The Secretary would be required to give consideration to the savings which might accrue to the Government from enactment of such legislation, the effects of the enactment of such legislation on the health professions and the pharmaceutical industry, including large and small manufacturers of drugs, wholesalers, and retailers of drugs, and such other medical, economic, and social factors as the Secretary shall determine to be material.

Section 173(b) of the bill would require the Secretary to report his findings of fact and conclusions to the Committee on Finance of the Senate and to the Committee on Ways and Means of the House of Representatives on or before January 1, 1969.

SECTION 174. DISABILITY BENEFITS FOR BLIND PERSONS

Section 174 of the bill provides an alternative definition of disability for blind persons and provides that an individual whose disability is

blindness and who has at least 6 quarters of coverage (earned at any time) may become entitled to disability benefits regardless of ability to engage in substantial gainful activity and that such entitlement will continue after attainment of age 65. Under present law to be entitled to disability insurance benefits, a blind individual must meet (1) the basic definition of disability—inability to engage in any substantial gainful activity, or if he is aged 55 or over, meet the occupational definition provided for the aged blind worker, and (2) the regular disability insured-status requirement or, if disabled before age 31, he must meet the alternative requirement for young blind workers. 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.

Section 174(a)(1) of the bill modifies section 223(a)(1)(B) of the act to provide that for an individual whose disability is blindness as defined in section 223(d)(1)(B) (as amended by this section) attainment of age 65 does not bar entitlement to disability benefits.

Section 174(a)(2) of the bill amends section 223(a)(1) of the act to exclude an individual whose disability is blindness from the provision which terminates disability benefits upon attainment of age 65.

Section 174(a)(3) of the bill amends section 223(a)(2) of the act to provide that the disability insurance benefit of an individual whose disability is blindness shall be equal to his primary insurance amount determined as though he were a fully insured individual in the first month of his waiting period.

Section 174(b)(1) of the bill amends section 223(c)(1) of the act to provide that an individual whose disability is blindness shall be insured for disability benefits in any month if he had not less than 6 quarters of coverage before the quarter in which such month occurs.

Section 174(b)(2) of the bill amends subsection 223(d)(1)(B) of the act (as amended by section 158 of this bill) to incorporate as an alternative definition of disability, "blindness", with blindness defined as central visual acuity of 20/200 or less in the better eye with the use of correcting lenses, or visual acuity greater than 20/200 if 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.

Section 174(b)(3) of the bill amends section 223(d)(4) of the act (as added by section 158 of this bill) to exclude the individual whose disability is blindness from the provision that an individual will be found not to be disabled if his services and earnings constitute substantial gainful activity under criteria prescribed by the Secretary. (However, the provision of section 223(a)(1) of the act that no payments will be made to an individual who qualifies by reason of the definition of blindness for any month in which he engages in substantial gainful activity has been retained.)

Section 174(c)(1) and (2) amend section 216(i)(1) of the act by eliminating the present definition of blindness and by providing (through reference to the definition of blindness in section 223(d)(1)(B) of the act as stated in section 175(b)(2) of this bill, discussed above) that central visual acuity of 20/200 or less in the better eye with the use of correcting lenses, or visual acuity greater than 20/200

if 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 meets the definition of disability for purposes of establishing a period of disability.

Section 174(d) of the bill amends section 222(b)(1) of the act to reflect that an individual whose disability is blindness will not be subject to deductions of monthly benefits if he refuses without good cause to accept rehabilitation services available to him under a State plan approved under the Vocational Rehabilitation Act.

Section 174(e) of the bill provides that the amendments are to apply only with respect to monthly benefits for months after November 1968, on the basis of applications filed after August 31, 1968.

SECTION 175. CHILDHOOD DISABILITY BENEFITS

Section 175 of the bill provides child's benefits to an otherwise qualified adult son or daughter if his disability has been continuous since before age 22 (rather than before age 18 as in present law).

Subsection (a) of section 175 of the bill amends clause (ii) of section 202(d)(1)(B) of the Social Security Act to permit the payment of child's benefits to an individual under a disability which began before he attained age 22 (rather than before age 18).

Subsection (b) of section 175 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 shall 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.

Subsection (c) of section 175 of the bill further amends section 202(d)(1) of the act by adding a new sentence at the end which provides that child's insurance benefits will not be payable 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 (as amended by the sections of this bill relating to the definition of disability and to disability benefits for the blind).

Subsection (d) of this section of the bill amends subsection 202(d)(7) of the act (redesignated as par. (6) by sec. 151 of this bill) to provide that (1) a child whose benefits are terminated at or after age 18 can be reentitled to child's benefits if he is disabled before age 22, and (2) such reentitlement shall end 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.

Subsection (e) of section 175 of the bill makes two changes in section 202(s) of the act. One change amends paragraph (1) of section 202(s) of the act to provide mother's insurance benefits to an individual who has in her care a child entitled to child's benefits on the basis of a disability that began before age 22, instead of age 18 as under present law. The second change amends paragraphs (2) and (3) of section 202(s) of the act which permit a childhood disability beneficiary to continue to get benefits when he marries another beneficiary, and which permit such a beneficiary to continue to get benefits when he marries a childhood disability beneficiary, so that benefits will not be termi-

nated if the child was under a disability which began before he attained age 22, instead of age 18 as under present law, or had been under such a disability in the third month before the month in which such marriage occurred. The change also extends to the child entitled on the basis of a disability that began after age 18 and 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 the benefits of a beneficiary married to a male disability beneficiary when his benefits terminate because he is no longer disabled; (3) the provisions of present law that exempt a disabled 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.

Subsection (f) of section 175 of the bill provides that the amendments made by this section are to apply with respect to monthly benefits for and after March 1968; except that in the case of an individual who is not entitled to benefits under such section for February 1968; such amendments shall apply only on the basis of an application filed in or after February 1968.

TITLE II—PUBLIC WELFARE AMENDMENTS

PART 1—PUBLIC ASSISTANCE AMENDMENTS

SECTION 201. PROGRAMS OF SERVICES FURNISHED TO FAMILIES WITH DEPENDENT CHILDREN

Section 201(a)(1) of the bill amends section 402(a) of the Social Security Act (as amended by sec. 202(a) of this bill) by striking out clause (14) thereof, by inserting therein a new clause (14), and by adding thereto four clauses (clauses (15) through (18)) imposing new requirements for a State plan for the aid to families with dependent children program.

Clause (14) requires such a plan to proivde for the development and application of a program for such family services, as defined in section 406(d) of the act (added by sec. 201(f) of the bill), and child-welfare services, as defined in section 425 of the act (added to title IV of the act by sec. 235(c) of the bill), for each child and relative receiving aid, and each appropriate individual (living in the same home with such a recipient) whose needs are taken into account in determining eligibility for and the amount of the aid, as may be necessary in the light of the particular home conditions and other needs of such child, relative, and individual.

Clause (15) requires such a plan to provide (1) for the development of a program for each appropriate relative and child recipient of aid, and each appropriate individual (living in the home with such a recipient) whose needs are taken into account in determining eligibility for and the amount of the assistance payments, with the objective of assuring, to the maximum extent possible, that such persons will become self-sufficient wage earners, and of preventing or reducing the incidence of births out of wedlock and otherwise strengthening family life; (2) for the implementation of such programs by assuring that such relatives, children, and individuals who are referred to the Secretary of Labor pursuant to clause (19) of

section 402(a) of the act (added by sec. 204(b) of the bill) are furnished child-care services and that in all appropriate cases family planning services are offered to them, and when appropriate that aid in the form of protective or vendor payments authorized under section 406(b)(2) of the act are provided; (3) that the acceptance by each such person of family planning services provided under the plan shall be voluntary on his part and shall not be a prerequisite to eligibility for or the receipt of any other service or aid under the plan; (4) for review as necessary of each program (as often as necessary but at least once a year) to insure its effective implementation; (5) for furnishing the Secretary with reports of the results of the programs; and (6) to the extent that such programs are developed and implemented by services furnished by the staff of the State agency, for the establishment in the State of a single organizational unit responsible for furnishing the services.

Clause (16) requires the State plan to provide that where the State agency has reason to believe that the home is unsuitable for a recipient child residing therein because of the neglect, abuse, or exploitation of the child this condition (and data the agency has about the situation) will be brought to the attention of the appropriate court or law enforcement agency.

Clause (17) requires the plan to provide (1) for the development and implementation of a program by the State agency for establishing the paternity of a child recipient born out of wedlock and securing support for him, and for securing support for a child recipient deserted or abandoned by his parent from such parent (or another person legally liable for such support), utilizing any reciprocal arrangements adopted with other States to obtain or enforce court orders for support, and (2) for the establishment of a single organizational unit in the State or local agency administering the State plan which is to be responsible for the administration of such program for the support of such child recipients.

Clause (18) requires the plan to provide for entering into cooperative arrangements with appropriate courts and law enforcement officials (1) to assist the State agency in administering its program referred to in clause (17) for obtaining support for child recipients, including entering into financial arrangements with such courts and officials to assure optimum results under this program, and (2) with respect to any other matters of concern common to such courts or officials and the agency.

Section 201(b) of the bill adds a new subsection (c) to section 402 of the act. This subsection provides that on the basis of his review of reports received from the States as provided for under new clause (15) of section 402(a) (as added by sec. 201(a)(1) of the bill) the Secretary is to compile the necessary data and from time to time publish his findings as to the effectiveness of the State programs undertaken pursuant to such clause. The Secretary will also report annually with respect to such programs to the Congress (with the first report due by July 1, 1970).

Section 201(c) of the bill strikes out subparagraphs (A) and (B) of section 403(a)(3) of the act and inserts a new subparagraph (A) relating to Federal participation in certain administrative costs. The Federal share is 75 percent of such costs as are for (1) the services

which are furnished to recipients or to certain other individuals (living in the same home with such recipients) pursuant to clauses (14) and (15) of section 402(a) of the act (as added by sec. 201(a)(1) of the bill); (2) any of the services described in such clauses (14) and (15), such as child-welfare services, family services, child care services, and family planning services, which are provided to a child or relative who is an applicant for aid, or is a former or potential applicant or recipient; or (3) the training of personnel employed or preparing for employment with the State or local agency.

Section 201(d) of the bill makes certain technical changes and adds a provision within such section 403(a)(3) of the act that, to the extent specified by the Secretary, child-welfare services, family planning services, and family services may be obtained by the agency from sources other than those State agencies specified in or under section 403(a)(3)(D) and (E) of the act.

Section 201(e) of the bill makes certain technical changes in sections 403(a)(3) and 408(d), and repeals section 403(a)(4) and (c), of the act.

Section 201(f) of the bill adds to section 406 of the act a new subsection (d) defining the term "family services."

Section 201(g)(1) of the bill provides that the new requirements for approval of a State plan under section 402 of the act (added by sec. 201(a) of the bill) and the various amendments made by subsections (b), (d), (e), and (f) of section 201 of the bill become effective July 1, 1968, except that, if on the date this bill is enacted the State agency responsible for such State plan is different from the State agency responsible for the State's child-welfare services plan under part 3 of title V of the act, the new requirement in section 402(a)(15)(E) of the act (added by such sec. 201(a) of the bill) shall not apply to such State but only so long as such agencies of the State are different.

Section 201(g)(2) of the bill provides that the amendments made by section 201(c) of the bill will be applicable with respect to services furnished after June 30, 1968.

Section 201(h) of the bill provides that, notwithstanding section 403(a)(3)(A) of the act (as amended by sec. 201(c) of the bill), the rate specified therein shall be 85 percent (rather than 75 percent) with respect to expenditures, for services furnished by a State pursuant to section 402(a)(14) and (15) of the act (as added by sec. 201(a)(1) of the bill), made during the period beginning October 1, 1967, and ending with the close of June 30, 1969.

SECTION 202. EARNINGS EXEMPTION FOR PUBLIC ASSISTANCE RECIPIENTS

Section 202(a)(1) of the bill redesignates clauses (8) through (13) of section 402(a) of the Social Security Act as clauses (9) through (14), respectively.

Section 202(a)(2) of the bill strikes out clause (7) of such section 402(a) and inserts, effective July 1, 1969, clauses (7) and (8) changing requirements for a State plan for dependent children with respect to the determination of need. The new clause (7) provides that, with the exceptions set forth in the new clause (8), the State agency shall, in determining need, take into account any other income and resources of any child or relative claiming aid under the plan, or that of any other

individual living in the same home whose needs the State takes into account in determining whether such child or relative is needy, as well as any expenses reasonably attributable to the earning of such income.

The new clause (8) requires a State plan to provide that, in making the determination under the new clause (7), the State agency shall with respect to any month disregard all of the earnings of each child receiving aid for any month in which he is a full-time student attending a school, college, or university, or a vocational or technical training course designed to fit him for gainful employment.

In addition, it provides that in the case of earnings of a dependent child not included in the previous paragraph, a relative receiving aid, and any other individual (living in the same home as such relative and child) whose needs are considered in making such determination, the State agency shall disregard the first $50 of the total earned income of such persons for such month plus one-half of the remainder thereof. This clause also incorporates present provisions of law under which a State agency may, subject to limitations prescribed by the Secretary, permit all or any portion of the earned or other income to be set aside for future identifiable needs of a dependent child, and may, before disregarding any of the preceding amounts, disregard not more than $5 per month of any income. The clause further provides that, with respect to any month, the State agency shall not disregard any earned income of any one of the persons specified above (other than children in school) if such person left work or reduced his earnings without good cause within such period (of not less than 30 days) preceding such month as may be prescribed by the Secretary, or refused without good cause, within such period preceding such month as may be prescribed by the Secretary, to accept work he is able to perform which is offered under certain conditions; nor shall the State agency disregard the earned income of any of the persons specified above (other than children in school) for a month if with respect to such month the income of such persons exceeded their need as determined by the agency pursuant to clause (7) (without regard to clause (8)), unless, for any one of the preceding 4 months, the needs of such persons were met by aid furnished under the plan.

Section 202(a)(3) of the bill provides that a State with a plan approved under section 402 of the act will not be deemed to have failed to comply substantially with the requirements of section 402(a)(7) of the act (as in effect prior to July 1, 1969) for any period beginning after 1967, and ending prior to July 1, 1969, if for such period the State agency disregards earned income in accordance with the requirements of section 402(a)(7) and (8) of the act as amended by section 202 of the bill.

Section 202(b)(1) of the bill amends clauses (i) and (ii) of section 2(a)(10)(A) of the act, effective July 1, 1969, which currently give the State the options to disregard not more than $5 per month of any income of an individual and a maximum of $50 per month of his earned income in determining need for old-age assistance. The amendment makes mandatory the disregard of the first $50 of his total earned income for a month plus one-half the remainder thereof, and leaves it optional with the State whether, before it effectuates such mandatory disregard, to disregard not more than $5 per month of any income.

Section 202(b)(2) of the bill provides that a State with an approved title I plan shall not be deemed to have failed to comply substantially with the requirements of section 2(a)(10)(A) of the act (as in effect before July 1, 1969) for any period beginning after 1967 and ending before July 1, 1969, if for such period the State agency disregards earned income in accordance with the requirements of clause (i) of such section 2(a)(10)(A) of the act as amended by section 202(b) of the bill.

Amendments similar to those made by section 202(b) of the bill with respect to the old-age assistance program under title I of the act are also made by section 202(c) of the bill with respect to needy disabled individuals under title XIV of the act and by section 202(d) of the bill with respect to needy aged or disabled individuals (who are not blind) under title XVI of the act.

Section 202(e) of the bill provides that in determining the need of individuals claiming aid or assistance under a State plan approved under title I, XIV, or XVI, or part A of title IV of the Social Security Act which provides for making such a determination under the provisions of such title or such part as amended by section 202 of the bill, the State shall apply such provisions notwithstanding any other statutory requirement that the State disregard earned income of such individuals in making such a determination under such State plan.

SECTION 203. DEPENDENT CHILDREN OF UNEMPLOYED FATHERS

Section 203(a) of the bill amends in its entirety section 407 of the Social Security Act, which now provides for aid to families with dependent children with respect to a needy child who is deprived of parental support or care because of the unemployment (as defined by the State) of a parent and who meets certain other eligibility conditions.

The new section 407(a) of the act redefines a "dependent child" for purposes of such section 407 as one whose deprivation results from the unemployment (as determined in accordance with standards prescribed by the Secretary) of his father and who meets the other eligibility conditions.

The new section 407(b) of the act applies the above definition to a State if its plan approved under section 402 of the act—

(1) Requires the payment of aid with respect to a child within such definition when his father has been unemployed for a minimum period of 30 days before receipt of aid and has not without good cause within such period refused a bona fide offer of employment or training, and

(2) Provides for assurances that will satisfy the Secretary that fathers of children within the above definition will be referred to the Secretary of Labor as provided in section 402(a)(19) of the act (added by sec. 204 (b) of the bill) within 30 days after receiving aid; for cooperative arrangements with the State vocational education agency to encourage retraining; and for denial of aid if and for as long as such a father is not currently registered with the public employment offices in the State.

The new section 407(c) of the act provides that, notwithstanding other provisions of such section 407—

(1) The State may provide in its plan for denial of all (or any part) of the aid under the plan with respect to a child within the above definition to which any child or relative might otherwise be entitled for any month if the father of such child receives unemployment compensation under a State or Federal law for any week any part of which is included in such month; and

(2) Federal sharing in expenditures pursuant to the section will not be available where such expenditures are made, with respect to a child within the above definition, for any part of the 30-day period referred to in section 407(b)(1)(A) or for any period before his father meets the conditions of section 407(b)(1)(B), and will not be available if and for as long as no action is taken (after the 30-day period referred to in the new sec. 407(b)(2)(A) of the act) to make the referral to the Secretary of Labor provided for in section 402(a)(19) of the act (added by sec. 204(b) of the bill).

Section 203(b) of the bill provides that section 407 of the act (as amended by sec. 203(a) of the bill) will be effective January 1, 1968; except that no State which had in operation an approved unemployed parents program under section 407 of the act (as in effect before enactment of sec. 203(a) of the bill) in the calendar quarter commencing October 1, 1967, will be required before July 1, 1969, to include any additional child or family under its approved plan for dependent children by reason of the enactment of section 203(a) of the bill.

SECTION 204. WORK INCENTIVE PROGRAM FOR RECIPIENTS OF AID UNDER PART A OF TITLE IV

Section 204(a) of the bill adds a new part C to title IV of the Social Security Act. The new part describes the employment, training, and special work programs which States are required to establish for recipients of aid under State plans approved under part A of title IV. The new part C consists of the following sections:

Section 430 states the purpose of the part to encourage and require (1) the employment of welfare recipients in the regular economy, (2) their training for work in the regular economy, and (3) their participation in special work projects, and give to such individuals a new sense of dignity and self-worth.

Section 431 authorizes appropriation to the Secretary of Health, Education, and Welfare for each fiscal year a sum sufficient to carry out this part. Amounts so appropriated shall be transferred to the Secretary of Labor.

Section 432(a) requires the Secretary of Labor to establish work incentive programs in each political subdivision of a State in which he determines there is a significant number of individuals who have attained age sixteen years and are receiving aid under title IV. In other political subdivisions he shall use his best efforts to provide such programs or arrange for transportation outside the political subdivision.

Section 432(b) requires the Secretary to establish the following types of programs: (1) placement in regular employment and on-the-job training, (2) institutional and work experience training, and (3) special work projects for individuals for whom a job in the regular economy cannot be found.

Section 432(c) authorizes the work incentive program to be undertaken through grants or agreements with public or private agencies

or organizations, including Indian tribes, except that no grants or agreements may be made with a private for profit employer to undertake a work experience project.

Section 432(d) authorizes use of the Secretary of Labor's authority under the Manpower Development and Training Act of 1962, the Wagner-Peyser Act of 1933, and other acts, to the extent such authority is not inconsistent with this act.

Section 432(e) requires the Secretary of Labor to maintain the present level of manpower services available under authority of other statutes to recipients of aid under this title IV.

Section 433(a) requires the Secretary of Labor to provide a program of testing and counseling for all recipients of aid under title IV referred to him by State welfare agencies and to assign all such persons to one of the three types of work incentive programs except when he finds there is good cause for any person's nonparticipation.

Section 433(b) requires the Secretary of Labor to develop for each suitable person an employability plan describing the education, work experience, and orientation which will enable each person to become self-supporting.

Section 433(c) requires the Secretary of Labor to make maximum use of services available from other Federal and State agencies and authorizes reimbursement of such other agencies for services rendered.

Section 433(d) describes the scope of services, including counseling, training, education, and placement, which may be made available under this part.

Section 433(e) describes the special work projects for those not found immediately employable or referrable to institutional or work experience training. The program is described in the following paragraphs:

(1) authorizes agreements with public agencies or private nonprofit organizations for work which serves a useful public purpose and would not otherwise be performed by regular employees;

(2) provides for the terms of such agreements which include provision for the payment by the Secretary of Labor to each employer of a portion of the wages to be paid by the employer to the individuals for the work performed and specification of the hourly wage rate and number of hours per week of work to be performed;

(3) requires the Secretary of Labor to establish one or more accounts into which amounts paid by the State welfare agencies under section 402(a) shall be paid and which amounts shall be available for the payment of wages on special work projects; and

(4) requires compliance with any applicable minimum wage laws.

Section 433(f) prescribes the standard provisions for special work project agreements designed to protect the welfare of individuals assigned to such projects including safety standards and workmen's compensation and provides that the work performed must not result in the displacement of employed workers.

Section 433(g) provides that where the Secretary of Labor finds after an opportunity for fair hearing that an individual refuses without good cause to accept employment or participate in a project under a program established by this part he shall notify the State agency which referred the individual to him.

Section 433(h) requires the Secretary of Labor to review at least every 6 months the employment record of all individuals in special work projects and determine whether it is feasible to place such individuals in regular employment or in institutional or work experience training.

Section 434 authorizes payment of an incentive payment not to exceed $20 per week to all persons enrolled in projects of institutional or work experience training.

Section 435 provides that Federal assistance under this part shall not exceed 90 percent of the costs of carrying out this part, that non-Federal contributions may be in cash or in kind, and defines the items which must be included and excluded in determining cost.

Section 436 requires the Secretary of Labor to design all institutional and work experience training under this part so that the average period of enrollment in each area of the country will not exceed 1 year, and provides that assistance under this part may continue as long as deemed necessary after an individual ceases to qualify for money assistance payments under this title.

Section 437 authorizes a program of financial assistance to participants in programs under this part to relocate their place of residence when the wage rates at their place of relocation will at least equal their full need as determined by the State to which they will be relocated.

Section 438 provides that participants under this part shall be deemed not to be Federal employees.

Section 439 authorizes the Secretary of Labor to issue such rules and regulations as he finds necessary to carry out the purposes of this part and requires consultation with the Secretary of Health, Education, and Welfare in developing policies for programs established by this part.

Section 440 requires the Secretary of Labor to file an annual report with Congress on the work incentive programs established by this part.

Section 441 requires the Secretary of Labor and the Secretary of Health, Education, and Welfare to jointly provide for the continuing evaluation of projects under this part. The Secretary of Labor is authorized to conduct research regarding ways to increase the effectiveness of programs under this part. The Federal Government pays all of the costs of evaluation and research.

Section 442 authorizes States to establish one or more review panels which shall have final authority to approve agreements for special work projects with private employees under section 433(e)(1).

Section 443 authorizes the Secretary of Health, Education, and Welfare to withhold from any State in which the required non-Federal contribution of 10 percent of the cost of programs under this part is not made amounts due under other specified titles of the Social Security Act until amounts so withheld together with the amount of non-Federal contributions within the State equals 10 percent of the costs. Amounts so withheld are paid over to the Secretary of Labor and considered non-Federal contributions for the purposes of section 435.

Section 204(b) of the bill amends section 402(a) of the Social Security Act by adding (after the new clause (18) added to such section 402(a) of the act by sec. 201(a) of the bill) a new clause (19) which requires a State plan for the dependent children program under part A of the title IV of the act to provide—

(1) for the prompt referral to the Secretary of Labor or his representative for participation under a work incentive program established by part C of title IV of the act (added by sec. 204(a) of the bill) of—

(a) each appropriate child and relative who has attained age 16 and is a recipient of aid;

(b) each appropriate individual (living in the same home as such a recipient) who has attained such age and whose needs are considered in determining eligibility for and the amount of the aid; and

(c) any other person claiming aid under the plan (who is not described in (a) or (b), above) who, after being informed of such work incentive programs, requests such a referral unless the State agency determines that his participation in any such program would be inimical to him or the family;

except that the State agency shall not refer a child, relative, or individual described in (a) or (b), above, if such person is—

(d) a person with illness, incapacity, or advanced age;

(e) so remote from any of the projects under such work incentive programs that he cannot effectively participate under any of them;

(f) a child attending school full time;

(g) a person needed in the home on a substantially continuous basis because of the illness or incapacity of another member of the home;

(h) a mother who is actually caring for at least one child of preschool age and whose presence at home is necessary and in the best interest of such children; or

(i) a person with respect to whom the State agency finds that participation under such work incentive programs would be not in the best interests of such child, relative, or individual and inconsistent with the objectives of such programs;

(2) that aid under the plan will not be denied because of such referral or of an individual's participation on a project under the program established by section 432(b) (2) or (3) of the act (added by sec. 204(a) of the bill);

(3) for arrangements to assure that a non-Federal contribution will be made to such work incentive programs by appropriate State agencies or private organizations of 10 percent of their cost, as specified in section 435(b) of the act (added by sec. 204(a) of the bill);

(4) that—

(a) training incentives authorized under section 434 of the act (added by sec. 204(a) of the bill), and income derived from a special work project under the program established by section 432(b)(3) of the act (added by sec. 204(a) of the bill) shall be disregarded in determining needs of an individual under section 402(a)(7) of the act; and

(b) in determining such individual's needs the additional expenses attributable to his participation in a program established by section 432(b)(2) or (3) of the act (added by sec. 204(a) of the bill) shall be taken into account;

(5) that, with respect to any individual referred pursuant to subparagraph A of the new clause (19) (described in item (1)

above) who is participating in a special work project under the program established by section 432(b)(3) of the act (added by sec. 204(a) of the bill);

(a) the State agency, after proper notification by the Secretary of Labor, will pay to such Secretary (at such times and in such manner as the Secretary of Health, Education, and Welfare prescribes) the money payments such State would otherwise make to or on behalf of such individual (including such money payments for his family) or 80 percent of his earnings under such program, whichever is less; and

(b) the State agency will supplement his earnings by payments to him (which payments shall be considered aid under the plan) in an amount which when added to his earnings from his participation in such special work project, will equal the aid that the State agency would have paid with respect to his family had he not participated therein, plus 20 percent of his earnings from such project;

(6) that if and for so long as any child, relative, or other individual (referred to the Secretary of Labor as described in item (1)(a) and (b), above) has been found by such Secretary under section 433(g) of the act (added by sec. 204(a) of the bill) to have refused without good cause to participate under such a work incentive program with respect to which such Secretary has determined his participation is consistent with the purposes of part C of title IV of the act (added by sec. 204(a) of the bill), or to have refused without good cause to accept employment in which he is able to engage which is offered through the public employment offices of the State or by an employer whose offer is determined, after notification by such employer, to be a bona fide offer—

(a) in the case of refusal by the relative, his needs shall not be considered in making the determination under section 402(a)(7) of the act, and aid for any dependent child in the family will be made in the form of payments described in section 406(b)(2) of the act (which may be made in such case without regard to some of the conditions set forth therein) or aid in the form of foster care under section 408 of the act,

(b) in the case of refusal by a child who is the only child recipient in the family, no aid will be furnished the family,

(c) if more than one child in the family is a recipient, aid will be denied for any child who makes such refusal (and his needs shall not be considered in making the determination under section 402(a)(7) of the act), and

(d) if such individual makes such refusal, his needs shall not be considered in making the determination under such section 402(a)(7);

except that the State agency shall, for a period of 60 days, make the payments of the type described in such section 406(b)(2) of the act (without regard to some of the conditions set forth therein) on behalf of the relative described in (a) of this item (6) or continue aid in the case of a child specified in (b) or (c) of this item (6) but only if during such period such child, relative, or individual accepts counseling or other services (which the State agency shall make available

to him) aimed at persuading such relative, child, or individual, as the case may be, to participate in such program in accordance with the determination of the Secretary of Labor.

Section 204(c)(1) of the bill provides that such new clause (19) shall in the case of any State be effective, July 1, 1968, or if a statute of such State prevents it from complying with the requirements of such clause (19) on such date, such requirements shall with respect to such State be effective on July 1, 1969; except that they shall be effective earlier (in the case of any State) than either such date if a modification of the State plan to comply with such requirements is approved on an earlier date.

Section 204(c)(2) of the bill provides that the provisions of section 409 of the act (relating to community work and training programs) shall not apply to any State with respect to any quarter beginning after the first quarter in which it is not prohibited by a State statute from complying with the requirements of such new clause (19).

Section 204(d) of the bill provides that during the fiscal year 1969 the Secretary of Labor may, notwithstanding the provisions of section 433(e)(2)(A) of the act (added by sec. 204(a) of the bill), pay all of the wages to be paid by the employer to the individuals for work performed for public agencies (including Indian tribes with respect to Indians on a reservation) under special work projects established as provided for under section 432(b)(3) of the act (added by sec. 204(a) of the bill) and may transfer into accounts established pursuant to section 433(e)(3) of the act (added by sec. 204(a) of the bill) such amounts as he finds necessary in addition to amounts paid into such accounts pursuant to section 402(a)(19)(E) of the act (added by sec. 204(b) of the bill).

Section 204(e) of the bill amends clause (ii) of section 402(a)(8)(A) of the act (added by sec. 202(b) of the bill) to provide that the provisions of such clause (ii) will not apply to earned income derived from participation on a project maintained under the programs established by section 432(b)(2) and (3) of the act (added by sec. 204(a) of the bill).

SECTION 205. FEDERAL PARTICIPATION IN PAYMENTS FOR FOSTER CARE OF CERTAIN DEPENDENT CHILDREN

Section 205(a) of the bill adds to section 402(a) of the Social Security Act a new requirement that a State plan must, effective July 1, 1969, provide for aid to families with dependent children in the form of foster care in accordance with section 408 of the act.

Section 205(b) of the bill amends section 403(a)(1)(B) of the act by increasing the maximum average amount per month in which the Federal Government will share in expenditures for aid to families with dependent children in the form of foster care for such month. (Under present law such maximum is $32 per month for all recipients of aid to families with dependent children in any form.)

Section 205(c) of the bill amends section 408(a) of the act so as to extend aid to families with dependent children in the form of foster care to additional children. Under the proposed amendment, aid in such form will be available to a child who meets the conditions in

clauses (1), (2), and (3) of such section 408(a) and who, although he did not receive aid to families with dependent children in or for the month in which court proceedings leading to his removal from his home were initiated as required in present clause (4) of such section 408(a), would have received such aid in or for such month upon application therefor, or, if he had lived with a relative specified in section 406(a) of such act within 6 months before the month in which such proceedings were initiated, would upon application have received such aid in or for such month if in that month he had been living with (and removed from the home of) such a relative.

Section 205(d) of the bill makes permanent the provision in section 408(a)(2)(B) of the act that the condition regarding responsibility for placement and care of the child is met where such responsibility, even though it is not in the State or local agency administering the State plan approved under section 402 of the act, is in another public agency and such other agency meets certain conditions. Section 205(d) of the bill also makes permanent the provision in section 408(a)(3) of the act under which a child who has been placed in a child-care institution, and who meets the other conditions of eligibility, is considered a dependent child for purposes of aid to families with dependent children in the form of foster care.

Section 205(e) of the bill provides that the amendments made by subsections (b) and (c) will be applicable only with respect to foster care provided after December 1967.

SECTION 206. EMERGENCY ASSISTANCE FOR CERTAIN NEEDY FAMILIES WITH CHILDREN

Section 206(a) of the bill amends section 403(a) of the Social Security Act (as amended by sec. 201(e) of the bill) so as to provide for Federal participation in expenditures for "emergency assistance to needy families with children" under the State plan approved under section 402 of the act. The Federal share will be 50 percent of the total expenditures under such plan for such assistance in the form of payments or care and 75 percent of the total expenditures for such assistance in the form of services.

Section 206(b) of the bill adds a new subsection (e) to section 406 of the act (as amended by sec. 201(f) of the bill). Under paragraph (1) of the new subsection (e), "emergency assistance to needy families with children" is defined to mean, but only with respect to a State whose State plan approved under section 402 of such act provides for furnishing such assistance, (1) money payments, payments in kind, or such other payments as the State agency may specify with respect to, or medical or remedial care recognized under State law on behalf of, an eligible child or any other member of household in which such child is living, and (2) such services as the Secretary may specify. Emergency assistance may be given for a period not in excess of 60 days in any 12-month period in the case of a needy child under age 21 who is (or, within a period specified by the Secretary, has been) living with any of the relatives specified in section 406(a)(1) of the act in a place of residence maintained by such a relative as his home, but only where such child is without available resources, the payments, care, or services involved are necessary to avoid destitution of the child or to provide

living arrangements in a home for such a child, and such destitution or need for living arrangements did not arise because such child or relative refused without good cause to accept employment or training for employment. Under paragraph (2) of such new subsection (e), emergency assistance may also be provided under the conditions specified in such subsection to migrant workers with families in the State or in such part or parts thereof designated by the State.

SECTION 207. PROTECTIVE PAYMENTS AND VENDOR PAYMENTS WITH RESPECT TO DEPENDENT CHILDREN

Sections 207(a)(1) and (2) and 207(c) of the bill amend and make permanent the protective payments provisions in section 406(b)(2) of the Social Security Act. As amended, section 406(b)(2) (in addition to continuing the authority for Federal sharing, where certain conditions are met, in protective payments made to an individual interested in or concerned with the welfare of the family with dependent children) will authorize Federal participation, where the same conditions are met, in payments made on behalf of such family directly to a person furnishing food, living accommodations, or other goods, services, or items to or for such family. This amendment also deletes the requirement in present law that the State provide for meeting all of the need of individuals for whom protective or vendor payments are made.

Section 207(a)(3) of the bill further amends section 406(b) of the act by providing that, in the case of a refusal to take certain steps leading to self-sufficiency through employment (as described in section 402(a)(20) of the act as amended by section 204(b) of the bill), protective payments and vendor payments which are made under section 406(b)(2) of the act (as amended by section 207(a) of the bill) without regard to the specified conditions therein shall be included as assistance expenditures.

Section 207(b) of the bill further amends section 403(a) of the act by increasing to 10 percent the limitation on the number of recipients with respect to whom protective payments may be made with Federal participation, and by adding a provision that in computing such 10 percent there shall not be taken into account individuals with respect to whom such payments are made for any month in accordance with section 402(a)(19)(F) of the act (added by sec. 204(b) of the bill).

SECTION 208. FEDERAL PARTICIPATION IN PAYMENTS FOR REPAIRS TO HOME OWNED BY RECIPIENT OF AID OR ASSISTANCE

Section 208(a) of the bill adds a new section 1119 to the Social Security Act. Such section 1119 provides that where an expenditure is made for repairing the home owned by a recipient of old-age assistance, aid to families with dependent children, aid to the blind, aid to the permanently and totally disabled, or aid to the aged, blind, or disabled under a State plan approved under title I, X, XIV, or XVI, or part A of title IV of the act, the Federal payments to the State under section 3(a), 403(a), 1003(a), 1403(a), or 1603(a) of such act for any quarter will be increased by 50 percent of such expenditures, except that amounts in excess of $500 for any one home

shall be excluded in determining such expenditures. In order to claim the Federal share of such expenditures, the public assistance agency is required to make a finding (prior to making the expenditure) that the home is so defective that continued occupancy is unwarranted, that unless repairs are made rental quarters will be necessary for the recipient, and that the cost of rental quarters needed for the individual (including his spouse living with him in the home and any other person whose needs are taken into account in determining the recipient's need) will exceed (over such time as the Secretary may specify) the cost of repairs necessary to make the home habitable and other costs attributable to its continued occupancy. It is also required that there had been no expenditures for repairing the home pursuant to any prior finding under this provision.

Subsection (b) makes this amendment applicable with respect to expenditures made after September 30, 1967.

SECTION 209. USE OF SUBPROFESSIONAL STAFF AND VOLUNTEERS IN PROVIDING SERVICES TO INDIVIDUALS APPLYING FOR AND RECEIVING ASSISTANCE

Section 209(a) of the bill amends sections 2(a)(5), 402(a)(5), 1002(a)(5), 1402(a)(5), 1602(a)(5), and 1902(a)(4) of the Social Security Act by adding a new requirement to each of such sections of the act. Under these amendments, each State plan for public assistance or medical assistance must provide for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients of public assistance and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to public assistance applicants and recipients and in assisting any advisory committees established by the State agency.

Subsection (b) provides that each of these amendments shall become effective July 1, 1969, or, with respect to any approved public assistance or medical assistance plan of a State, on such earlier date as of which the modification of such plan to comply with such amendment is approved.

SECTION 210. SIMPLICITY OF ADMINISTRATION

Subsections (a), (b), (c), (d), and (e) of section 210 of the bill amend sections 2(a)(5), 402(a)(5), 1002(a)(5), 1402(a)(5), and 1602(a)(5) of the Social Security Act, respectively, effective July 1, 1969, by adding a new requirement to each of such sections of the act. Under these amendments, each State plan for public assistance must provide such methods of administration as are found by the Secretary to be necessary to assure that eligibility for and the extent of aid or assistance under the plan will be determine in a manner consistent with simplicity of administration and the best interests of the recipients.

SECTION 211. LOCATION OF CERTAIN PARENTS WHO DESERT OR ABANDON DEPENDENT CHILDREN; ESTABLISHMENT AND COLLECTION OF LIABILITY TO THE UNITED STATES

Subsection (a) of section 211 of the bill amends section 402(a) of the Social Security Act (as amended by other provisions of this bill) by adding three new clauses imposing new requirements for a State plan for the dependent children program.

The first of these new clauses (clause 21)) is part of the scheme to locate absent parents of children with respect to whom AFDC payments are being made where a court order for the support of the dependent children has been issued against a parent and the parent is not complying with such order, or a petition for such support has been filed. Under this clause, the State welfare agency is to report to HEW the name and social security account number, if known, of the parent, the last known address, and any other information the State agency has with respect to the date on which the parent could be located at that address. In addition, the State agency is to furnish such other information as the Secretary of HEW requires.

The second of these new clauses (clause (22)) provides for the cooperation of the welfare agency of one State with such agency of another State in locating a parent residing in the first State, in cases where a petition for support of a child (with respect to whom AFDC payments are being provided) of such parent has been filed in the other State. In addition, the State agencies are to cooperate in securing compliance, or good faith partial compliance, by a parent residing in their State with a court order for support of such a child.

The third of these new clauses (clause (23)) provides that a State welfare agency is to report to HEW the name and social security account number of certain parents. This information is to be reported with respect to a parent against whom a court order has been issued for the support of a child of the parent with respect to whom AFDC payments are being made, if the parent is not making payments in compliance, or good faith partial compliance with the order and, if the parent is residing in another State. In these cases, the State agency is also to report to HEW—

(1) The amount of AFDC aid furnished under the State plan after March 31, 1968, or after the date of the court order whichever is later;

(2) The amount of payments by the parent for the support of the child (or children) specified in the court order;

(3) All available information concerning the ability of the parent to make payments in compliance with the court order; and

(4) Such other information as the Secretary requires.

These three new clauses are effective January 1, 1969.

Subsection (b) of section 211 of the bill amends title IV of the Social Security Act by adding new sections 410 and 411. The new section 410 provides for the assistance of the Internal Revenue Service in locating parents who have abandoned dependent children. Under the new section 410 the Department of HEW, upon receiving a report from a State welfare agency pursuant to the new clause (21) of section 402(a) of the Social Security Act, is to furnish the Secretary of the Treasury or his delegate the names and social security account numbers

of the parents contained in the report and the name of the State agency which submitted the report. The Secretary of the Treasury or his delegate is then to endeavor to ascertain the address of these parents from the master file of the Internal Revenue Service, and is to furnish the addresses so ascertained to the State agency which submitted the report.

The new section 411 relates to the establishment and collection of liability to the United States. Under subsection (a) of the new section 411, if a State agency reports to HEW pursuant to the new clause (23) of section 402(a) of the Social Security Act that a parent residing in another State is not making payments in compliance with, or good faith partial compliance with, a court order for the support of dependent children with respect to whom the State is making AFDC payments, HEW is to determine whether the parent is able to make payments in full or partial compliance (in amounts larger than he is making) with the court order. This determination is to be made on the basis of the information reported by the State agency and any other information that HEW may obtain. In making this determination HEW is to take into consideration the income of the parent, his current obligations and such other factors as HEW considers proper.

Subsection (b)(1) of the new section 411 provides that if the Secretary of HEW determines that a parent described in subsection (a) of such section is able to make payments in full compliance with the court support order, or to make payments in partial compliance with the order in amounts larger than he is making, the parent is to become liable to the United States (as provided in subsec. (c) of the new sec. 411) for the lower of the following amounts:

(A) The Federal share of the AFDC payments made with respect to the child of the parent, or

(B) The amount of payments required for the parent to be in full compliance with the court order (for the period with respect to which the computation under par. 2 of new sec. 411(b) is made) reduced by the amount of payments made in partial compliance with the order for that period.

Paragraph (2) of the new section 411(b) provides that the Federal share referred to in paragraph (1)(A) of such section is to be computed by the Secretary of HEW. For this purpose the Federal share is to be an amount equal to the Federal share of the amounts expended under the AFDC program with respect to the child (or children) of the parent during the period beginning on April 1, 1968, on the date of the court order, or on the first day after the close of any period for which a prior computation is made under this provision with respect to the parent, whichever is later, and ending with the close of the calendar quarter preceding the day on which the computation is made. The period, however, is not to include any portion thereof during which the parent made payments in compliance, or good faith partial compliance, with the court order. If at any time after the close of the period the parent makes payments attributable to the period, HEW is to recompute the amount under this provision.

Paragraph (1) of the new section 411(C) provides that HEW is from time to time (but not more often than quarterly) to determine with respect to each parent with respect to whom it has made a de-

termination under subsection (b)(1) of new section 411, the portion of the applicable amount described in subsection (b)(1)(A) or (B) of the new section 411 with respect to the parent which in its judgment the parent is able to pay. The determination is to be made on the basis of information furnished by the State agency which submitted the report under subsection (a) of the new 411 and such other information as HEW may obtain. In making this determination HEW is to take into consideration the income of the parent, his current obligations, and such other factors as it considers proper. The Department of HEW is to certify the amount so determined to the Treasury Department together with the social security account number, if known, of the parent and his last known address, and such other information as the Treasury Department considers necessary to assist in the collection of the amount certified.

Paragraph (2) of the new section 411(c) provides that the certification under paragraph (1) of such section is not to be made with respect to any parent who is making payments in compliance, or good faith partial compliance, with the court support order issued against him, or after the obligation of the parent to make payments under the court order terminates.

Paragraph (3) of the new section 411(c) provides that upon certification by HEW with respect to a parent under paragraph (1) of such section, the parent becomes liable to the United States for the amount certified.

Subsection (d) of the new section 411 provides that the Treasury Department upon receiving a certification from HEW under subsection (c) of such section with respect to a parent is to assess and collect the amount certified as it would a tax imposed by subtitle C of the Internal Revenue Code of 1954. However, no interest or penalties are to be assessed or collected.

Subsection (e) of the new section 411 provides for the payment of the cost to the Internal Revenue Service of the expense it incurs performing the functions and duties required of it under the new sections 410 and 411. Paragraph (1) of such subsection (e) provides that there is authorized to be appropriated such sums as are necessary to carry out the purposes of these two new sections. Paragraph (2) of such subsection (e) provides that HEW is to transfer to the Treasury Department from time to time sufficient amounts out of the moneys appropriated pursuant to paragraph (1) of new section 411(e) to enable it to perform its functions and duties under these two new sections.

Subsection (c)(1) of section 211 of the bill adds a new section to subchapter A of chapter 64 of the Internal Revenue Code of 1954. The new section, section 6305, provides that, upon receiving a certification from HEW under section 411(c) of the Social Security Act (as added by this bill) with respect to any parent, the Treasury Department is to assess and collect the amount certified in the same manner, with the same power, and subject to the same limitations and restrictions, as if the amount certified were a tax imposed by subtitle C of the Internal Revenue Code of 1954, except that no interest or penalties are to be assessed or collected.

Subsection (c)(2) of section 212 of the bill makes a clerical amendment to the Internal Revenue Code of 1954.

SECTION 212. PROVISION OF SERVICES BY OTHERS THAN A STATE

Section 212 (a), (b), (c), and (d) of the bill amends sections 3(a)(4), 1003(a)(3), 1403(a)(3), and 1603(a)(4) of the Social Security Act, respectively, to authorize the State agency, to the extent specified by the Secretary, to obtain certain services which are offered to individuals under the State plans from sources other than those State agencies specified in or under subparagraphs (D) and (E) of each such section of the act.

Section 212(e) of the bill makes these amendments effective on January 1, 1968.

SECTION 213. INCREASING INCOME OF RECIPIENTS OF PUBLIC ASSISTANCE

Section 213(a)(1) of the bill amends section 2(a)(10) of the Social Security Act by adding thereto a new subparagraph (D) which requires a State plan for old-age assistance, effective July 1, 1968, to provide that the standards used for determining the need of applicants and recipients for and the extent of such assistance under the plan, and any maximum on the amount of assistance, will be so modified that an increase in the amount of assistance and other income will not be less than $7.50 per month per individual (determined on an average per individual in accordance with standards prescribed by the Secretary) above such amount of assistance and other income available under the standards and maximum applicable under the plan on December 31, 1966.

Paragraphs (2), (3), and (4) of section 213(a) of the bill amend sections 1002(a), 1402(a), and 1602(a) of the act, respectively, by adding to such sections of the act a comparable new requirement, effective July 1, 1968, for increasing the amount of aid and other income of recipients of aid to the blind, aid to the permanently and totally disabled, or aid to the aged, blind, or disabled.

Paragraph (5) of section 213(a) of the bill amends section 402(a) of the act by adding (after the new clause (23) added to such sec. 402(a) of the act by sec. 211(a) of the bill) a new clause (24) which requires a State plan for the dependent children program to provide that by July 1, 1969, and at least annually thereafter, the amounts used by the State to determine the needs of individuals will be adjusted to reflect fully changes in living costs since such amounts were established, and that any maximums that the State imposes on the amount of aid paid to families will be proportionately adjusted.

Section 213(b)(1) of the bill requires the Secretary, in the case of any State, to determine the expenditures made during the period July 1, 1968–June 30, 1970, under the State's plan approved under title I, X, XIV, or XVI of the act which are necessitated by compliance with the new requirements under such title imposed by section 215 of the bill.

Section 213(b)(2) of the bill authorizes the Secretary to pay any State the expenditures determined pursuant to section 213(b)(1) of the bill.

PART 2—MEDICAL ASSISTANCE AMENDMENTS

SECTION 220. LIMITATION ON FEDERAL PARTICIPATION IN MEDICAL ASSISTANCE

Section 220(a) of the bill amends section 1903(a)(1) of the Social Security Act which currently provides that the Federal share of a State's medical assistance expenditures under its plan approved under title XIX of the act shall be an amount equal to the Federal medical assistance percentage (as defined in sec. 1905(b) of the act) of the total of such expenditures with respect to all individuals who received medical assistance. Under the amendment, the Federal payment to the State will continue to be based on such Federal medical assistance percentage but only with respect to the total of the medical assistance expenditures for individuals who—

(1) Are recipients of money payments under a plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, of the act,

(2) Are not eligible for money payments under one of such plans but would be eligible therefor if they met the durational residence requirements for eligibility imposed thereunder.

(3) Are children under age 21 who are not, but would be (except for age and school attendance requirements), eligible for aid to families with dependent children under the State's plan approved under such part A of title IV of the act, or

(4) Are in medical institutions and are not, but would be (if they were not in such institutions), eligible for money payments under one of the plans referred to in item (1), above.

The amendment provides, however, that the Federal payment will be limited to an amount equal to the square of the fraction which is equivalent to the Federal medical assistance percentage of the total medical assistance expenditures for individuals who are not described in items (1)–(4), above.

Section 220(b) of the bill amends section 1903 of the act by adding thereto a new subsection (f). Paragraph (1) of such new subsection (f) prohibits payment of the Federal share, as determined under such section 1903, with respect to any medical assistance expenditure by a State for any individual whose income exceeds the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 150 percent of the amount, applicable in the States for determining need, for determining eligibility for aid or assistance in the form of money payments under the State's plan approved under title I or XVI (as the case may be) of the act, or if more than one such individual lives in the same home, the amount so determined for one such individual plus additional amounts for each other individual in the home as may be determined in accordance with such standards prescribed by the Secretary. The total so determined, if it is not a multiple of $100, may be rounded to the next higher multiple of $100.

(Paragraph (2) of such new subsection (f) provides for the exclusion, in computing an individual's (or family's) income for purposes of paragraph (1) thereof, of any costs (whether for insurance premiums or otherwise) incurred by him (or the family) for medical or remedial care.

Section 220(c) of the bill provides that, except in the cases of Puerto Rico, the Virgin Islands, and Guam, such new subsection (f) of section 1903 of the act shall apply with respect to calendar quarters beginning after June 30, 1968, and that the amendments made by subsection (a) of this section of the bill shall apply with respect to calendar quarters beginning after June 30, 1969.

SECTION 221. MAINTENANCE OF STATE EFFORT

Section 221(a) of the bill amends section 1117(a) of the Social Security Act (1) to provide States the option, for any fiscal year ending on or after June 30, 1967, and before July 1, 1968, to have the "maintenance of State effort" requirements of section 1117 of the act applied on a fiscal year basis rather than on a quarterly basis, and (2) to provide, if a State exercises this option, that it will have to choose, as the base period against which its effort is to be measured, either the fiscal year ending June 30, 1965, or the fiscal year ending June 30, 1964. (Subsec. (b) and (c) of such sec. 1117 (relating to the manner of determining expenditures and reductions) would also be applied on a fiscal year basis to the State.)

Section 221(b) of the bill adds to section 1117 of the act a new subsection (d) allowing any State at its option, for the quarters in any fiscal year ending before July 1, 1968, to have the reduction (if any) of the Federal share due to the application of the "maintenance of State effort" requirements determined—

(1) On the basis of aid or assistance in the form of money payments alone under its public assistance plans approved under titles I, IV, X, XIV, and XVI of the act rather than, as currently required, by taking into account, in addition to such money payments, all aid or assistance in the form of medical vendor payments under such plans or medical assistance payments under its approved title XIX plan;

(2) On the basis of expenditures for child-welfare services under sections 523 and 422 of the act in conjunction with money payments, medical vendor payments, and medical assistance payments under all of its approved public assistance plans; or

(3) On the basis of expenditures for child-welfare services under such sections 523 and 422 in conjunction with aid or assistance in the form of money payments alone under its approved public assistance plans.

Section 221(c) of the bill further amends section 1117(a) of the act so that the maintenance of State effort provisions thereof are applicable to quarters beginning after June 30, 1966, rather than December 31, 1965.

Section 221(d) of the bill repeals section 1117 of the act, effective July 1, 1968.

SECTION 222. COORDINATION OF TITLE XIX AND THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

Subsections (a) and (b) of section 222 of the bill amend section 1843 of the Social Security Act, which provides for agreements between States and the Secretary of Health, Education, and Welfare for the enrollment under the supplementary medical insurance program

(established under part B of title XVIII of the act) of individuals eligible therefor who are receiving money payments under approved public assistance plans, so as to permit a State to include in an agreement under section 1843 (or modify its existing agreement under such section to include), on substantially the same conditions as money payment recipients except for a 2-month waiting period, aged individuals who are eligible to receive medical assistance under the State's plan approved under title XIX of the act.

Subsections (c) and (d) of section 222 of the bill amend section 1903 of the act to prohibit, with respect to quarters beginning after 1967, Federal financial participation under a State plan approved under title XIX of the act, with respect to individuals age 65 or over, in medical assistance expenditures which would have been paid under the supplementary medical insurance program if the individuals involved had been enrolled in that program or in expenditures for other health insurance premiums for individuals who are not enrolled under that program. (These amendments would not change the equal matching of supplementary medical insurance premiums from general funds as presently provided under sec. 1844 of the act, or affect Federal financial participation in expenditures for such premiums for money payment recipients.)

Subsection (e) of section 222 of the bill amends section 1843(a) of the act, which requires that the buy-in agreement be requested by the State before 1968, to allow the State to request the agreement before 1970. (Sec. 222(b)(3) of the bill amends section 1843(g)(1) of the act to allow the State to request a modification of such an agreement before 1970.) It also amends section 1843 (c) and (d) of the act to permit a State to provide coverage for an individual under the supplementary medical insurance program through the buy-in agreement regardless of when the individual becomes eligible for coverage through such agreement, instead of only if he becomes eligible for such coverage before 1968 as provided by existing law.

SECTION 223. MODIFICATION OF COMPARABILITY PROVISIONS

Section 223(a) of the bill amends section 1902(a)(10) of the Social Security Act to provide exceptions to the requirement for comparability of treatment of individuals with respect to medical assistance made available by a State under its plan approved under title XIX of the act. Under the amendment, the fact that the State (1) makes available to individuals age 65 or older the benefits of the supplementary medical insurance program under part B of title XVIII of the act (either pursuant to a "buy-in" agreement under sec. 1843 or by State payment of the premiums due under such part B on their behalf), or (2) provides for meeting part or all of the cost of the deductibles, cost sharing, or similar charges under such part B for individuals eligible for supplementary medical insurance benefits, does not require the State to make available any such benefits, or services of the same amount, duration, and scope, to any other individuals.

Subsection (b) makes this amendment applicable with respect to calendar quarters beginning after June 30, 1967.

SECTION 224. REQUIRED SERVICES UNDER STATE MEDICAL ASSISTANCE PLAN

Section 224(a) of the bill amends section 1902(a)(13) of the Social Security Act which currently includes a requirement in clause (A) thereof that a State plan for medical assistance provide for inclusion of at least the first five items of medical care and services listed in section 1905(a) of the act. This amendment, in additon to making technical redesignations of existing provisions of such section 1902(a)(13), makes this requirement (which would be designated as clause (B) of such section 1902(a)(13)) applicable only in the case of recipients of aid or assistance under another of the State's approved public assistance plans. Under the new clause (C) of such section 1902(a)(13), the State would have the option, in the case of individuals who are not such recipients, to make available at least (1) such first five items or (2) any seven of the first fourteen items listed in section 1905(a) of the act and, if hospital or skilled nursing home services are included in the plan, physicians' services to an individual in a hospital or skilled nursing home during any period he is receiving hospital services from such hospital or skilled nursing home services from such home.

Section 224(b) of the bill makes the amendment made by subsection (a) applicable with respect to calendar quarters beginning after December 31, 1967.

Section 224(c)(1) of the bill further amends section 1902(a)(13)(A) of the act (as amended by subsec. (a) of this section of the bill) to add a requirement that the State plan provide for the inclusion of home health services for any individual who, under such plan, is entitled to skilled nursing home services.

Section 224(c)(2) of the bill makes the amendment made by subsection (c)(1) applicable with respect to calendar quarters beginning after June 30, 1970.

SECTION 225. EXTENT OF FEDERAL FINANCIAL PARTICIPATION IN CERTAIN ADMINISTRATIVE EXPENSES

Section 225(a) of the bill amends section 1903(a)(2) of the Social Security Act to authorize 75-percent Federal financial participation in expenses attributable to the compensation of training of skilled medical personnel and directly supporting staff engaged in the administration of an approved title XIX plan without regard to whether such personnel are employees of the single State agency responsible for administration of the plan or of some other public agency participating in the administration of the plan.

Subsection (b) makes this amendment applicable with respect to expenditures made after December 31, 1967.

SECTION 226. ADVISORY COUNCIL ON MEDICAL ASSISTANCE

Section 226 of the bill adds to title XIX of the Social Security Act a new section 1906 providing for the establishment of a Medical Assistance Advisory Council of 21 members, appointed by the Secretary without regard to the civil-service laws, to advise the Secretary on matters of general policy in the administration of medical assistance

(including the relationship of titles XIX and XVIII) and make recommendations for improvements in such administration. Such members, who hold office for a term of 4 years on a rotating basis, will include representatives of State and local agencies and other groups concerned with health, and consumers of health services, with a majority of the membership consisting of representatives of consumers. The Secretary may also appoint special advisory professional or technical committees. Members of the Advisory Council and of such special committees are entitled to compensation at rates not exceeding $100 per day, including travel time, plus travel expenses and per diem in lieu of subsistence. The Advisory Council will hold meetings as frequently as called by the Secretary, and upon the request of five or more members the Secretary must call a meeting of the Advisory Council.

SECTION 227. FREE CHOICE BY INDIVIDUALS ELIGIBLE FOR MEDICAL ASSISTANCE

Section 227(a) of the bill adds to section 1902(a) of the Social Security Act a new requirement that a State plan for medical assistance must provide that any individual eligible for such assistance is free to choose to obtain the services he requires from any institution, agency, or person qualified to perform the required services (including a prepayment plan which provides such services or arranges for their availability) and which undertakes to provide such services to him.

Subsection (b) makes this amendment applicable with respect to calendar quarters beginning after June 30, 1969, in the case of the States and the District of Columbia, and with respect to calendar quarters beginning after June 30, 1972, in the case of Puerto Rico, the Virgin Islands, and Guam.

SECTION 228. UTILIZATION OF STATE FACILITIES TO PROVIDE CONSULTATIVE SERVICES TO INSTITUTIONS FURNISHING MEDICAL CARE

Section 228(a) of the bill amends section 1902(a) of the Social Security Act by adding thereto a new requirement that a State plan for medical assistance must, effective July 1, 1969, provide for consultative services by health agencies and other appropriate State agencies to hospitals, nursing homes, home health agencies, clinics, laboratories, and other institutions specified by the Secretary in order to assist them with respect to (1) qualifying for payments under the act, (2) establishing and maintaining fiscal records necessary for the proper and efficient administration of the act, and (3) providing information needed to determine payments due under the act on account of care and services furnished to individuals. (Under sec. 1903(a) of the act, the State could receive 75 percent Federal matching toward the cost of providing these consultative services.)

Section 228(b) of the bill provides that, effective July 1, 1969, the last sentence of section 1864(a) of the act, which includes State consultative services among the services for which reimbursement on a 100-percent basis is made from the hospital insurance trust fund, is repealed.

SECTION 229. PAYMENTS FOR SERVICES AND CARE BY A THIRD PARTY

Section 229(a) of the bill adds to section 1902(a) of the Social Security Act a new requirement that a State plan for medical assistance must provide (1) that the State or local agency will take all reasonable measures to ascertain whether third parties are legally liable to pay for care and services (available under the plan) arising out of injury, disease, or disability, (2) that where the agency knows that a third party has such legal liability it will treat such legal liability as a resource of the individual for whom care and services are made available in its consideration of whether income and resources are available to him, and (3) that in any case where it is found that such legal liability exists after medical assistance has been provided tothe individual, the agency will seek reimbursement for such medical assistance to the extent of such legal liability.

Section 229(b) of the bill provides that the amendments made by section 229(a) will be applicable with respect to legal liabilities of third parties arising after March 31, 1968.

Section 229(c) of the bill amends section 1903(d)(2) of the act by adding thereto a new sentence which provides that expenditures for which the State received payments under section 1903(a) of the act shall be treated as an overpayment to the extent the State or local agency is reimbursed for such expenditures by a third party pursuant to the provisions of its plan that comply with the requirements added to section 1902(a) of the act by section 229(a) of the bill.

SECTION 230. DIRECT PAYMENTS TO CERTAIN RECIPIENTS OF MEDICAL ASSISTANCE

Section 230 of the bill amends section 1905(a) of the Social Security Act to provide that in the case of physicians' or dentists' services provided under a State plan approved under title XIX to an individual, the term "medical assistance" includes payments for such services regardless of whether the State makes such payments directly to such individual or on his behalf to the provider of such services. Payments for such services made directly to an individual must be made under such safeguards as the Secretary prescribes to assure the quality thereof and the reasonableness of any charge therefor.

SECTION 231. DATE ON WHICH STATE PLANS UNDER TITLE XIX MUST MEET CERTAIN FINANCIAL PARTICIPATION REQUIREMENTS

Section 231 of the bill amends section 1902(a)(2) of the Social Security Act to advance to July 1, 1969, the date on which State plans for medical assistance must meet the requirements for State financial participation.

SECTION 232. OBSERVANCE OF RELIGIOUS BELIEFS

Section 232 of the bill adds to title XIX of the Social Security Act a new section 1907 which provides that title XIX shall not be construed to require a State with an approved title XIX plan to compel any person to undergo any medical screening, examination, diagnosis, or treatment or to accept health care or services for any purpose (other

than for the purposes of discovering and preventing the spread of infection or contagious disease or of protecting environmental health), if such person (or his parent or guardian in the case of a child) objects thereto on religious grounds.

SECTION 233. COVERAGE UNDER TITLE XIX OF CERTAIN SPOUSES OF INDIVIDUALS RECEIVING CASH WELFARE AID OR ASSISTANCE

Section 233(a) of the bill amends section 1905(a) of the Social Security Act to add a new group of individuals to those for whom payment for medical care and services may be made by a State under its title XIX plan with Federal financial participation. Such group consists of persons essential (as described below) to individuals who are recipients of aid or assistance under the public assistance plan of the State approved under title I, X, XIV, or XVI of the act.

Section 233(b) of the bill further amends section 1905(a) of the act by adding a provision that for purposes of the above amendment a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, such person's needs are taken into account in determining such individual's assistance payment (under the public assistance plan of the State approved under titles I, X, XIV, or XVI of the act), and such person is determined, under such a plan, to be essential to the well being of such individual.

SECTION 234. INSPECTION OF RECORDS AND PREMISES OF PROVIDERS OF CARE AND SERVICES UNDER PUBLIC ASSISTANCE AND MEDICAL ASSISTANCE

Subsections (a), (b), (c), (d), (e), and (f) of section 234 of the bill amend sections 2(a)(6), 402(a)(6), 1002(a)(6), 1402(a)(6), 1602(a)(6), and 1902(a)(6) of the Social Security Act, respectively, effective July 1, 1968, by adding a new requirement to each of such sections of the act. Under these amendments, each State plan for public assistance or medical assistance must provide for having in effect agreements or other arrangements with institutions and, to the extent prescribed by the Secretary, persons furnishing medical or remedial care and services under the plan under which the Secretary and the General Accounting Office will be afforded such access to the records and premises of such suppliers as may be necessary to assure that payments under the plan are proper and, otherwise to carry out the purposes of the assistance programs, except that such agreements or arrangements may limit such access to audits on a sample or similar basis with respect to those suppliers whose records and premises may be selected for inspection and to situations in which the Secretary or General Accounting Office has reason to believe that payments under the plan to such a supplier are erroneous as a result of fraud.

SECTION 234a. STANDARDS FOR SKILLED NURSING HOMES FURNISHING SERVICES UNDER STATE PLANS APPROVED UNDER TITLE XIX

Section 234a(a) of the bill amends section 1902(a) of the Social Security Act (as amended by the preceding provisions of the bill) by adding thereto three paragraphs (pars. (25), (26), and (27)) imposing new requirements for a State plan for medical assistance.

Paragraph (25) requires such a plan, effective July 1, 1969, to provide for—

(1) A regular program of medical review (including evaluation of each patient's need for skilled nursing home care) or (in the case of individuals eligible therefor under the plan) need for mental hospital care, a written plan of care, and, where applicable, a plan of rehabilitation prior to admission to a skilled nursing home;

(2) Periodic inspections of all skilled nursing homes and mental institutions (if the plan includes care in such institutions) within the State by at least one medical review team (composed of physicians and other appropriate health and social service personnel) of (*a*) the care provided in such homes (and such institutions, if the plan provides for care therein) to recipients under the plan, (*b*) with respect to each patient receiving such care, the adequacy of services available in particular nursing homes (or mental institutions) to meet the current health needs and promote the maximum physical well-being of patients therein, (*c*) the necessity and desirability of their continued placement in such homes (or mental institutions), and (*d*) the feasibility of meeting their health care needs through alternative institutional or noninstitutional services; and

(3) The making by such a team of full and complete reports of the findings resulting from its inspections and any recommendations to the State agency.

Paragraph (26) requires such a plan to provide for agreements with every supplier of services under the plan under which such supplier agrees to keep full records of the services provided to recipients under the plan, and to furnish the State agency such information about any payments it claimed for providing services under the plan as the agency may request.

Paragraph (27) requires such a plan to provide that any skilled nursing home receiving payments under the plan must—

(1) Supply the State licensing agency with full and complete information as to the identity of each person having a direct or indirect ownership interest of at least 10 percent in such home, and if it is a corporation or partnership the names of the officers and directors partners; and report promptly any changes which would affect the current accuracy of the required information;

(2) Have and maintain an organized nursing service for its patients, which is directed by a professional registered nurse employed full time by such home and composed of sufficient nursing and auxiliary personnel to provide adequate and properly supervised nursing services during all hours of each day and all days of each week;

(3) Provide for professional planning and supervision of menus and meal service for patients for whom special diets or dietary restrictions are medically prescribed;

(4) Have satisfactory policies and procedures for maintenance of medical records on each of its patients, for dispensing and administering drugs and biologicals, and for assuring that each patient is under a physicians care and will be provided medical attention during emergencies;

(5) Have arrangements with at least one general hospital under which the hospital will provide needed diagnostic and other services to patients of such home and agree to timely admission of acutely ill patients of the home who need hospital care; except that the State agency may waive this requirement in whole or in part with respect to any nursing home meeting all the other requirements and which, because of its remote location or other good and sufficient reason, is unable to effect such an arrangement with a hospital; and

(6) (*a*) Meet (after December 31, 1969, provisions of the Life Safety Code of the National Fire Production Association (21st edition, 1967) applicable to nursing homes; except that the State agency may waive, for periods it deems appropriate, specific provisions of such code which, if rigidly applied, would cause unreasonable hardship to a nursing home, where the agency makes a determination (and keeps a written record of the basis thereof) that such waiver will not adversely affect the health and safety of the patients of such home; and except that the requirements described in this item (6) (*a*) shall not apply in any State if the Secretary finds that such State has in effect a fire and safety code, imposed by State law, which adequately protects patients in nursing homes; and (*b*) meet conditions relating to environment and sanitation applicable to extended care facilities under title XVIII of the act; except that any requirement described in this item (6) (*b*) may be waived by the State agency in situations and under conditions comparable to those described in item (6) (*a*), above.

Section 234a(b) of the bill provides that the amendments made by subsection (a) of this section of the bill (except as specified in such amendments) shall take effect on January 1, 1969.

Section 234a(c) of the bill provides that notwithstanding any other provisions of law, after June 30, 1968, no Federal matching payments shall be made to any State under title I, X, XIV, XVI, or XIX of the act for payments made to any nursing home for or on account of any of its nursing home services provided during any period during which it is determined not to meet fully all State requirements for licensure as a nursing home, except that the Secretary may prescribe a reasonable period or periods of time during which a nursing home which formerly met such requirements will be eligible for payments subject to Federal matching if during such period or periods such home promptly takes all necessary steps to again meet such requirements.

SECTION 234b. COST SHARING AND SIMILAR CHARGES WITH RESPECT TO INPATIENT HOSPITAL SERVICE FURNISHED UNDER TITLE XIX

Section 234b(a)(1) of the bill amends section 1902(a)(14)(A) of the Social Security Act which currently requires, as a condition of approval of a title XIX plan, that the plan provide that no deduction, cost sharing, or similar charges will be imposed on any individual covered under the plan with respect to inpatient hospital services furnished him under the plan. Under this amendment, this requirement would apply only in the case of individuals receiving aid or assistance

under a plan of the State approved under the other public assistance titles.

Section 234b(a)(2) of the bill amends section 1902(a)(14)(B) of the act to make clear that any deduction, cost sharing, or similar charge imposed under the plan with respect to inpatient hospital services, as well as other medical assistance, furnished under the plan to any individual, whether he is a recipient of assistance under another approved public assistance plan of the State, must be reasonably related to his income or his income and resources.

Section 2346(a)(3) of the bill amends section 1902(a)(15) by deleting subparagraph (A) thereof and by amending subparagraph (B) by referring to title XVIII rather than part B of title XVIII. The effect of the change would be to no longer require that a State plan meet the cost of deductibles imposed under Part A of title XVIII and to require that the plan relate any deductibles imposed under the hospital insurance program, as well as the supplementary medical insurance program, of the XVIII to the income of the individuals covered under the plan.

Section 234b(b) of the bill makes these amendments effective in the case of calendar quarters beginning after December 31, 1967.

SECTION 234C. STATE PLAN REQUIREMENTS REGARDING LICENSING OF ADMINISTRATORS OF SKILLED NURSING HOMES FURNISHING SERVICES UNDER STATE PLANS APPROVED UNDER TITLE XIX

Section 234c(a) of the bill amends section 1902(a) of the Social Security Act (as amended by the preceding sections of the bill) by adding thereto a new paragraph (28) which requires a State plan for medical assistance to include a State program which meets the requirements set forth in section 1907 of the act (added by sec. 234c(b) of the bill) for the licensing of administrators of nursing homes.

Section 234c(b) of the bill amends title XIX of the act (as amended by sec. 226 of the bill) by adding thereto a new section 1907 under the heading "State Programs for Licensing of Administrators of Nursing Homes."

Section 1907(a) states that for purposes of the new paragraph (28) such a State licensing program is one which provides that no nursing home within the State may operate except under the supervision of an administrator who is licensed as provided in section 1907.

Section 1907(b) requires licensing of nursing home administrators to be carried out by the State agency responsible for licensing under the State's Healing Arts Licensing Act or, if there is no such act or agency, a board representative of the professions and institutions concerned with care of chronically ill and infirm aged patients and established to carry out the purposes of section 1907.

Section 1907(c) provides that it shall be the function and duty of such agency or board to—

> (1) Develop, impose, and enforce standards, to be met as a condition of receiving a license as a nursing home administrator, designed to insure that such an administrator will be of good character and otherwise suitable, and, by training or experience in the field of institutional administration, will be qualified to serve as such an administrator;

(2) Develop and apply appropriate techniques, including examinations and investigations, for determining whether an individual meets such standards;

(3) Issue licenses to individuals who meet such standards, and revoke or suspend licenses in any case of substantial failure to conform to such standards;

(4) Establish and carry out procedures designed to insure that such licensees will, during any period that they serve as such administrators, comply with such standards;

(5) Receive, investigate, and take appropriate action with respect to any charge or complaint filed with the agency or board to the effect that any such licensee has failed to comply with such standards; and

(6) Conduct a continuing study and investigation of nursing homes and administrators of nursing homes within the State with a view to the improvement of such licensing standards and of procedures and methods for the enforcement of such standards.

Section 1907(d) provides that no State shall be considered to have failed to comply with the new paragraph (28) because the agency or board of such State (established pursuant to sec. 1907(b)) granted any waiver, with respect to any individual who, during all of the calendar year immediately preceding the calendar year in which the requirements prescribed in such new paragraph (28) are first met by the State, has served as a nursing home administrator, of any of the standards developed, imposed, and enforced by such board pursuant to section 1907(c)(1) other than such standards as relate to good character or suitability if—

(1) such waiver is for a period which ends after being in effect for 2 years or on December 31, 1971, whichever is earlier, and

(2) there is provided in the State (during all of the period for which waiver is in effect), a program of training and instruction designed to enable all individuals, with respect to whom any such waiver is granted, to attain the qualifications necessary to meet such standards.

Section 1907(e)(1) authorizes the appropriation for fiscal year 1968 and the 4 succeeding fiscal years of such sums as may be necessary to enable the Secretary to make grants to States to assist them in programs of training and instruction of the type referred to in section 1907(d)(2).

Section 1907(e)(2) limits the grant for any such program to 75 percent of the reasonable and necessary cost, as determined by the Secretary, of instituting and conducting such program.

Section 1907(f)(1) creates, for the purpose of advising the Secretary and the States in carrying out the provisions of section 1907, a National Advisory Council on Nursing Home Administration of nine persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the civil service laws. The members shall include, but not be limited to, representatives of State health officers, State welfare directors, nursing home administrators, and university programs in public health or medical care administration.

Section 1907(f)(2) specifies additional functions and duties of the Council with respect to the field of nursing home administration and

the training and qualifications of nursing home administrators, and provides that the Council shall complete certain of its functions by July 1, 1969, and submit a written report to the Secretary for submission to the States.

Section 1907(f)(3) provides that members of the Council are entitled to compensation at rates not exceeding $100 per day, including traveltime, plus travel expenses and per diem in lieu of subsistence.

Section 1907(f)(4) authorizes the Secretary, at the request of the Council, to engage technical assistance needed to carry out its functions; and he shall also provide the Council with secretarial and other assistance and data of the Department of Health, Education, and Welfare needed by the Council.

Section 1907(f)(5) requires the Secretary to appoint the Council before July 1, 1968, and provides that it shall cease to exist as of December 31, 1971.

Section 1907(g) contains definitions of the terms "nursing home" and "nursing home administrator" as they are used in section 1907.

Section 234c(c) of the bill provides that, except as otherwise specified in the text of the amendments made by section 234c of the bill, such amendments shall take effect on July 1, 1970.

PART 3—CHILD-WELFARE SERVICES AMENDMENTS

SECTION 235. INCLUSION OF CHILD-WELFARE SERVICES IN TITLE IV

Subsections (a), (b), and (c) of section 235 of the bill incorporate into title IV as a new part B the present provisions for child-welfare services now appearing in part 3 of title V. Subsection (c), in addition, adds a new clause (vi) to the plan requirements in section 422(a)(1)(B) of the new part B requiring that the plan provide for the development and implementation of arrangements for the more effective involvement of the parent or parents in the appropriate care of the child and the improvement of his health and development. The present title IV, including the amendments thereto made by the bill, becomes part A of title IV.

Part B of title IV, in addition to incorporating all the provisions of title V, part 3, makes the following changes in such part 3: (1) The authorization for appropriations is changed to $125 million for the fiscal year ending June 30, 1969, and $160 million for each fiscal year thereafter; and (2) the provision relating to research, training and demonstration projects (sec. 426) is amended to authorize projects for the demonstration of the utilization of research in the field of child welfare in order to encourage experimental and special types of welfare services and to authorize contracts and jointly financed cooperative arrangements for research, special projects, or demonstration projects.

Subsection (d)(2) of section 235 of the bill adds a provision requiring the State plan for child-welfare services to provide that the State agency administering or supervising the administration of the plan of the State approved under part A of title IV will administer or supervise the administration of the plan under part B of title IV and that those child-welfare services which are furnished by the staff of the State agency will be the responsibility of the organizational unit in the State agency established under section 402(a)(15)(E) of the act.

Subsection (d)(3) of section 235 of the bill amends section 422(a)(1) of the act (added by sec. 235(c) of the bill) by adding a new requirement for State plans for child-welfare services concerning the use of subprofessional staff and volunteers similar to the new requirement for State plans for public assistance or medical assistance added to various titles of the act by section 210(a) of the bill.

Subsections (e), (f), and (g) of section 235 of the bill contain a number of provisions effectuating the transfer of the child-welfare provisions from title V, part 3 to part B of title IV:

(1) title V, part 3 is repealed on enactment of the bill;

(2) part B of title IV becomes effective at that time;

(3) a plan developed under title V, part 3, is treated as a plan developed under part B of title IV;

(4) appropriations, allotments, or reallotments under title V, part 3, is deemed such under part B of title IV;

(5) overpayments and underpayments under title V, part 3, are treated as such under part B of title IV; and

(6) grants and appropriations under section 526 of the act are deemed to be such under section 426.

Subsection (e) of section 235 of the bill also provides that subsection (d)(2) of such section (relating to the State agency and the organizational unit responsible for furnishing child-welfare services) will be effective July 1, 1969, except that if on the date this bill is enacted the State agency responsible for the State's child-welfare services plan under part 3 of title V of the act is different from the State agency responsible for the public assistance plan of the State approved under section 402 of the act, the provisions of section 422(a)(1)(A) of the act (added by section 235(d)(2) of the bill) shall not apply to such State but only so long as such agencies of the State are different.

Subsection (e) of section 235 of the bill further provides that section 422(a)(1)(C) of the act (added by sec. 235(d)(3) of the bill) shall become effective July 1, 1969, or, with respect to a State, on such earlier date as of which the modification of the State plan to comply with such section 422(a)(1)(C) of the act is approved.

SECTION 236. CONFORMING AMENDMENTS

Section 236 of the bill makes a series of conforming amendments to provisions of titles II, IV, XI, XVI, XVIII, and XIX of the Social Security Act which are necessary to reflect the transfer of the child-welfare provisions from title V to title IV of the act by section 235 of the bill.

PART 4—MISCELLANEOUS AND TECHNICAL AMENDMENTS

SECTION 245. PARTIAL PAYMENTS TO STATES

Section 245 of the bill amends sections 4, 404(a), 1004, and 1404 of the Social Security Act so that, where the Secretary finds after notice and opportunity for hearing to a State that its plan approved under section 2, 402, 1002, or 1402 of the act fails to comply with the provisions of such section, the Secretary will have discretion (similar to the authority now in secs. 1604 and 1904 of the act) to limit the

withholding of Federal payments to the State to categories under or parts of the plan not affected by such failure, rather than withhold total payments to the State.

SECTION 246. COOPERATIVE RESEARCH OR DEMONSTRATION PROJECTS

Sectioon 246(a) of the bill amends section 1110(a)(1) of the Social Security Act by making a technical change therein, and section 246(b) of the bill further amends such section 1110(a)(1) of the act to provide clarification that the grants authorized under present law for research and demonstration projects will help improve the administration and effectiveness of Federal-State programs (not all programs) carried on or assisted under the Social Security Act.

Section 246(c) of the bill adds a new provision to section 1110(a)(1) of the act to authorizes grants for projects such as those relating to the causes of economic insecurity, methods of meeting risks to family income, costs of health care, and improvements in the effectiveness of the social security programs.

Section 246(d) of the bill amends section 1110(a)(2) of the act to authorize contracts or jointly financed cooperative arrangements for research or demonstration projects with private organizations and agencies (as well as with States and public and other nonprofit organizations and agencies, to which the present authority is limited).

SECTION 247. PERMANENT AUTHORITY TO SUPPORT DEMONSTRATION PROJECTS

This section of the bill amends section 1115 of the Social Security Act to make permanent the authority to pay the State's share of the cost of demonstration projects to promote the objectives of the public assistance titles of the act, and to increase the funds available for such purposes for any fiscal year beginning after June 30, 1967, from $2 million to $10 million.

SECTION 248. SPECIAL PROVISIONS RELATING TO PUERTO RICO, THE VIRGIN ISLANDS, AND GUAM

Section 248(a) of the bill amends section 1108 of the Social Security Act in its entirety and makes the amendment applicable with respect to fiscal years beginning after June 30, 1967.

Under section 1108(a) of the act as so amended, the present $9.8 million limit for Federal financial participation in the public assistance programs (other than the medical assistance program) of Puerto Rico would be raised to $12.5 million for fiscal year 1968 and further increases would be made in each succeeding fiscal year to a maximum of $24 million for fiscal year 1972 and each fiscal year thereafter. Similarly, there would be proportionate increases in the dollar maximums for the Virgin Islands and Guam—from the present $330,000 to $800,000 for fiscal year 1972 and thereafter in the case of the Virgin Islands, and from the present $450,000 to $1.1 million for fiscal year 1972 and thereafter in the case of Guam. These limits do not apply to payments which are subject to the limits imposed by section 1108(b) (discussed below).

Section 1108(b) of the act as amended authorizes payment, in addition to the amounts stated in section 1108(a), on account of family planning services and services and items referred to in section 403(a)(3)(B) of the act (as added by sec. 204(c) of the bill), with respect to any fiscal year, of not more than $2 million for Puerto Rico, $65,000 for the Virgin Islands, and $90,000 for Guam.

Section 1108(c) of the act as amended imposes a maximum on Federal payments for the medical assistance program under title XIX of the act, with respect to any fiscal year, of $20 million for Puerto Rico, $650,000 for the Virgin Islands, and $900,000 for Guam. In addition to this limitation, section 248(e) of the bill, by an amendment to section 1905(b) of the act, reduces the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, and Guam from 55 to 50 percent, effective with respect to quarters after 1967. Section 248(d) of the bill makes inapplicable to these three jurisdictions the limitation on Federal participation in medical assistance expenditures that is applicable to the States and the District of Columbia under section 1903(f)(1) of the act as added by section 220(b) of the bill.

Section 1108(d) of the act as amended (substantially restating existing law) provides that, notwithstanding sections 502(a) and 512(a) of the present Social Security Act, and sections 421, 503(1), and 504(1) of the act as amended by the bill, and until the Congress may by appropriation or other law otherwise provide, the Secretary shall, in lieu of the initial allotment specified in such sections, allot such smaller amounts to Guam as he may deem appropriate.

Section 248(b) of the bill provides that, notwithstanding section 403(a)(3)(A) of the act (as amended by sec. 201(c) of the bill), the rate specified in such provisions shall, in the case of Puerto Rico, the Virgin Islands, and Guam, be 60 percent (rather than 75 or 85 percent).

Section 248(c) of the bill provides, effective July 1, 1969, that neither the disregards or set-aside of income authorized under section 402(a)(7) of the present Social Security Act nor the disregards or set-aside of income provided for in section 402(a)(8) of the act as amended by section 202(b) of the bill will apply in the case of Puerto Rico, the Virgin Islands, and Guam. It further requires, effective not later than July 1, 1972, that their State plans approved under section 402 of the act provide for disregarding of income of dependent children in making the determination under such section 402(a)(7) in amounts (agreed to between the Secretary and the State agencies involved) sufficiently lower than the amounts specified in such section 402(a)(8) to reflect appropriately the applicable differences in income levels.

SECTION 249. APPROVAL OF CERTAIN PROJECTS

This section of the bill adds to title XI of the Social Security Act a new section 1120. Subsection (a) of such section 1120 would prohibit any payment under the Social Security Act with respect to any experimental, pilot, demonstration, or other project where any part of such a project is wholly financed with Federal funds made available under such act (without any non-Federal financial participation)

unless the Secretary or Under Secretary of Health, Education, and Welfare has personally approved such project. Section 1120(b) would require the Secretary to submit to the Congress, as soon as possible after the approval of any such project, a description thereof together with a statement of its purpose, probable cost, and expected duration.

SECTION 250. STUDY TO DETERMINE WAYS OF ASSISTING RECIPIENTS OF AID OR ASSISTANCE IN SECURING PROTECTION OF CERTAIN LAWS

Section 250 of the bill requires the Secretary to make a study of and recommendations concerning the means by which and the extent to which State public welfare agencies may better serve, advise, and assist public assistance applicants or recipients in securing the full protection of local, State, and Federal health, housing, and related laws and in helping them to use most effectively public assistance and other community programs, and the extent to which the State public assistance, medical assistance, or related programs may be used as a means of enforcing such health, housing, and related laws. By July 1, 1969, the Secretary must report to the Congress the results of the study and make recommendations, including the necessary changes in the Social Security Act.

SECTION 251. ASSISTANCE IN THE FORM OF INSTITUTIONAL SERVICES IN INTERMEDIATE CARE FACILITIES

Section 251(a) of the bill amends title XI of the Social Security Act (as amended by secs. 209 and 249 of the bill) by adding thereto a new section 1121.

Section 1121(a) authorizes any State which has in effect an approved State plan for old-age assistance, aid to the blind, aid to the permanently and totally disabled, or aid to the aged, blind, or disabled, to modify such plan on or after January 1, 1968, to include therein payments for institutional services in intermediate care facilities for individuals who are or would be (if not receiving institutional services in intermediate care facilities) entitled to assistance under such plan in the form of money payments.

Section 1121(b) requires any modification pursuant to section 1121(a) to provide that benefits in the form of institutional services in intermediate care facilities will be provided only to individuals who—

(1) Are or would be (if not receiving institutional services in intermediate care facilities) entitled to receive aid or assistance under the State plan in the form of money payments;

(2) Because of their physical or mental condition (or both), require living accommodations and care which, as a practical matter, can be made available to them only through institutional facilities; and

(3) Do not have such an illness, disease, injury, or other condition as to require the high degree of care and treatment which a hospital or skilled nursing home (as that term is employed in title XIX of the act) is designed to provide.

Section 1121(c) provides that payments to any State which modifies its approved State plan (referred to in sec. 1121(a)) to provide recipients thereunder with benefits in the form of institutional serv-

ices in intermediate care facilities shall be made in the same manner and from the same appropriation as payments made with respect to expenditures under the State plan so modified, except that, with respect to the State's expenditures for the cost of benefits in the form of institutional services in intermediate care facilities for any quarter, the Secretary shall if the State so elects pay the State an amount equal to the Federal medical assistance percentage (as defined in sec. 1905(b) of the act).

Section 1121(d) provides that except when inconsistent with the purposes, or contrary to any provision, of section 1121, any modification, pursuant to section 1121, of an approved State plan shall be subject to the same conditions, limitations, rights, and obligations as obtain with respect to such approved State plan.

Section 1121(e) defines the term "intermediate care facility" as an institution which (1) is licensed, under State law, to provide the patients or residents thereof, on a regular basis, the range or level of care and services which is suitable to the needs of individuals described in section 1121(b) (2) and (3), but which does not provide the degree of care required to be provided by a skilled nursing home furnishing services under a State plan approved under title XIX of the act, and (2) meets such standards of safety and sanitation as are applicable under State law; except that in no case shall such term include an institution which does not regularly provide a level of care and service beyond room and board.

TITLE III. IMPROVEMENT OF CHILD HEALTH

SECTION 301. CONSOLIDATION OF SEPARATE PROGRAMS UNDER TITLE V OF THE SOCIAL SECURITY ACT

Section 301 of the bill amends title V of the Social Security Act, effective with respect to the fiscal years beginning after June 30, 1968, by substituting a new title V for parts 1, 2, 4, and 5 of the present title V as follows:

TITLE V—MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES

Section 501. Authorization of Appropriations

The new section 501 combines the purpose clauses of existing sections 501 and 511, adds reduction of infant mortality to the purpose clause, and incorporates into a single authorization for appropriations the authorizations in existing parts 1, 2, and 4 of title V. The combined authorization is for $250 million for the fiscal year ending June 30, 1969, $305 million for fiscal year 1970, $360 million for fiscal year 1971, $385 million for fiscal year 1972, and $410 million for the fiscal year ending June 30, 1973, and for each fiscal year thereafter.

Section 502. Purposes for Which Funds Are Available

The new section 502 makes the appropriation pursuant to new section 501 available as follows: For fiscal years 1969 through 1972, 50 percent is allotted for maternal and child health services and services for

crippled children, 40 percent for special project grants for maternity and infant care, health of school and preschool children, and dental health of children, and 10 percent for grants for research and training; for the fiscal year ending June 30, 1973, and each year thereafter, 90 percent of the appropriation is allotted for the maternal and child health and crippled children's services program under new sections 503 and 504 which will, after June 30, 1972, include the special projects relating to such services under new sections 508, 509, and 510, and 10 percent is allotted for training and research under new sections 511 and 512. The Secretary may transfer not to exceed 5 percent of the appropriation from one of the purposes specified to another and of the appropriations available for sections 503 and 504 shall determine the portion to be available for allotment under each section. The new section 502 further provides that notwithstanding preceding provisions therein, of the amount appropriated for any fiscal year pursuant to the new section 501, not less than 6 percent of the appropriation for fiscal year 1969, 15 percent of the appropriation for fiscal year 1970, and 20 percent of the appropriation for each fiscal year thereafter, shall be available for payments for family planning services from allotments under the new section 503 and for payments for family planning services under projects under the new section 508.

Section 503. Allotments to States for Maternal and Child Health Services

The new section 503 replaces, and makes no substantive change in, the provisions of existing section 502.

Section 504. Allotments to States for Crippled Children's Services

The new section 504 replaces, and makes no substantive change in, the provisions of existing section 512.

Section 505. Approval of State Plans

The new section 505 requires a single State plan for maternal and child health services and services for crippled children. It combines the provisions of existing sections 503 and 513 and adds new plan requirements as follows:

(1) Provision for early identification and treatment of children in need thereof with respect to the portion of the plan relating to crippled children;

(2) Special attention to dental care for children and family planning services for mothers in the development of demonstration projects;

(3) Effective July 1, 1972, provision of a program of projects which offer reasonable assurance of helping reduce the incidence of mental retardation and other handicapping conditions caused by complications associated with childbearing and of helping to reduce infant and maternal mortality, and which offer reasonable assurance of promoting the health of children of school and preschool age and of promoting the dental health of such children;

(4) Where payment is authorized under the plan for services which an optometrist is licensed to perform and such services are

not to be rendered either in a clinic or in another appropriate institution which has an arrangement with optometrists to render such services, the individual for whom such payment is authorized may, to the extent practicable, obtain such services from any optometrist licensed to perform such service.

Section 505 also provides that in the event different agencies administered (or supervised) the plans under existing sections 503 and 513 on July 1, 1967, each such agency can continue to administer (or supervise) its respective portion of the new combined plan.

Section 506. Payments

The new section 506 replaces, and makes no substantive change in, the provisions of subsections (a), (b), and (c) of existing sections 504 and 514. However, this section adds as a condition of payment maintenance of State and local fiscal effort at least at the 1968 level and adds to the existing other conditions of payment (which require that States make a satisfactory showing of extension of maternal and child health services and services to crippled children) extension of the provision of dental care and family planning services. It also includes a provision on payment of grants under other provisions of title V.

Section 507. Operation of State Plans

The new section 507 (which replaces the existing secs. 505 and 515) empowers the Secretary, in the event of a State's failure to comply with all or any of the State's plan requirements, to withhold payment or limit payment to categories under parts of the plan not affected by such failure until he is satisfied that there is no longer failure to comply.

Section 508. Special Project Grants for Maternity and Infant Care

The new section 508 (which replaces the existing sec. 531) adds reduction of infant and maternal mortality to the purpose clause of the authorization for special project grants for maternity and infant care, authorizes health care for mothers and infants in circumstances which increase hazards to their health, authorizes grants for projects for provision of health care for infants and for projects for family planning services, adds any public or nonprofit private agency, institution, or organization as a potential grantee for these purposes, and extends the authorization for projects under this section for 4 additional years, through June 30, 1972.

Section 509. Special Project Grants for Health of School and Preschool Children

The new section 509 replaces the existing section 532 without substantial change in the program content and extends the authorization for special project grants for health of school and preschool children for 2 additional years, through June 30, 1972.

Section 510. Special Project Grants for Dental Health of Children

The new section 510 adds to title V a new authorization for project grants to promote the dental health of children and youth of school or preschool age, particularly in areas with concentrations of low income families. The Secretary is authorized to make grants to the State health agency and (with the consent of the State health agency) to the health agency of any political subdivision of the State, and to any other public or nonprofit private agency, institution, or organization, to pay not to exceed 75 percent of the cost of projects of a comprehensive nature for dental care and services for children and youth of school age or preschool children. Treatment, correction of defects, or aftercare is available only to children who would not otherwise receive it because they are from low income families or because of other reasons beyond their control. Such preventive services, treatment, correction of defects, and aftercare for such age groups as may be provided in regulations of the Secretary must be available through the project. Projects may include research or demonstrations. No grant may be made for any project under this section for any period after June 30, 1972.

Section 511. Training of Personnel

The new section 511 replaces and broadens the training authorization in existing section 516 to include training of any personnel for health care and related services for mothers and children and to give special attention to training at the undergraduate level.

Section 512. Research Projects Relating to Maternal and Child Health Services and Crippled Children's Services

The new section 512 replaces existing section 533 and requires that special emphasis be accorded to projects which will help in studying the need for, feasibility, costs, and effectiveness of comprehensive health care programs making maximum use of health personnel with varying levels of training, and in studying methods of training for such programs. Grants authorized under this section for such projects will include funds for training personnel for work in such projects.

Section 513. Administration

The new section 513 replaces existing section 541 and adds a new provision to make available up to one-half of 1 percent of the appropriation for grants under title V for evaluation of programs and reduces the amount available for allotments accordingly. The Secretary is authorized to carry out such evaluation directly, or by grants or contracts. This section also adds, as a condition of receipt of grants under title V by any agency, institution, or organization, a requirement for cooperation (to the extent specified by the Secretary) with the agency administering or supervising the administration of the State's plan approved under title XIX.

Section 514. Definition

The new section 514 defines a crippled child for purposes of title V.

Section 515. Observance of Religious Beliefs

The new section 515 adds a new provision which prohibits title V from being construed to require a State with a plan or program approved under, or receiving financial support under, title V to compel any person to undergo any medical screening, examination, diagnosis, or treatment or to accept health care or services for any purpose (other than for the purposes of discovering and preventing the spread of infection or contagious disease or of protecting environmental health), if such person (or his parent or guardian in the case of a child) objects thereto on religious grounds.

SECTION 302. CONFORMING AMENDMENTS

Section 302 of the bill amends title XIX of the act, effective July 1, 1969, to list, among the described care and services which are included by section 1905(a)(4) of the act under "medical assistance," such screening, diagnosis, and treatment of children as are prescribed in regulations by the Secretary, and to require, by an amendment to section 1902(a)(11) of the act, that State plans under title XIX must provide for utilization and appropriate reimbursement of the agencies, institutions, and organizations providing services under title V for the cost of such services furnished to any individual for which payment would otherwise be made to the State with respect to him under section 1903.

SECTION 303. 1968 AUTHORIZATION FOR MATERNITY AND INFANT CARE PROJECT

Section 303 of the bill amends section 531 of the existing title V of the act by increasing the authorization for special project grants for maternity and infant care from $30 to $35 million for the fiscal year ending June 30, 1968.

SECTION 304. USE OF SUBPROFESSIONAL STAFF AND VOLUNTEERS

Section 304(a) of the bill amends section 505(a)(3) of the Social Security Act (added by sec. 301 of the bill) to add a new requirement for State plans for maternal and child health services and services for crippled children concerning the use of subprofessional staff and volunteers similar to the new requirement for State plans for public assistance or medical assistance added to various titles of the act by section 210(a) of the bill.

Subsection (b) provides that this amendment shall become effective July 1, 1969, or, with respect to a State, on such earlier date as of which the State plan modification to comply with the amendment is approved.

SECTION 305. ADMINISTRATION OF THE PROGRAM FOR SERVICES FOR CRIPPLED CHILDREN

Section 305 of the bill provides that the Secretary shall administer the program for services for crippled children as established by title III of the bill through the Children's Bureau of the Department of Health, Education, and Welfare

SECTION 306. SHORT TITLE

Section 306 authorizes citing title III of the bill as the "Child Health Act of 1967."

TITLE IV—GENERAL PROVISIONS

SECTION 401. SOCIAL WORK MANPOWER AND TRAINING

This section of the bill adds a new section 707 to title VII of the Social Security Act. The new section authorizes an appropriation of $5 million for the fiscal year ending June 30, 1969, and $5 million for each of the 3 succeeding fiscal years for grants by the Secretary to public or nonprofit private colleges and universities and to accredited graduate schools of social work or an association of such schools. The grants are to be made to meet part of the cost of development, expansion, or improvement of undergraduate programs in social work and programs for the graduate training of professional social work personnel, including the costs of compensation of additional faculty, administrative personnel, and minor improvements of existing facilities. No less than half the amount appropriated for any fiscal year may be used for grants for undergraduate programs. In making grants, the Secretary is to take into account the relative need in the States for personnel trained in social work and the effect of the grants thereon.

The term "graduate school of social work" means a department, school, division, or other administrative unit, in a public or private college or university, which provides, primarily or exclusively, a program of education in social work and allied subjects leading to a graduate degree in social work. The term "accredited" as applied to a graduate school of social work refers to a school accredited by a body or bodies approved by the Commissioner of Education or with respect to which there is evidence satisfactory to the Secretary that it will be accredited within a reasonable time. The term "nonprofit" is used in the sense that no part of the net earnings derived from the operation of a college or university inures to the benefit of any private shareholder or individual.

SECTION 402. INCENTIVE FOR ECONOMY WHILE MAINTAINING QUALITY IN OR IMPROVING THE PROVISION OF HEALTH SERVICE

Section 402(a) of the bill authorizes the Secretary to develop and engage in experiments under which, and pursuant to their selection by the Secretary in accordance with regulations, physicians who would otherwise receive payment on the basis of reasonable charge, and organizations and institutions which would otherwise be reimbursed on the basis of reasonable cost, for services under (1) title XVIII of the Social Security Act (health insurance for the aged), (2) title XIX of the act (grants to States for medical assistance programs), or (3) title V of the act (grants to States for maternal and child welfare) will be reimbursed or paid in any manner mutually agreed upon by the Secretary and the physician, institution, or organization. The method of payment (in the case of physicians) or reimbursement (in the case of an organization or institution) which will be applied in

such experiments will be such as the Secretary may select, may be based on charges or costs adjusted by incentive factors, and may include specific incentive payments or reductions of payments for the performance of specific actions, but in any case shall be such as he determines may, through experiment, be demonstrated to have the effect of increasing the efficiency and economy of health services through the creation of additional incentives to these ends without adversely affecting the quality of such services.

Section 402(b) of the bill provides that in the case of any such experiment, the Secretary may waive compliance with the requirements of titles XVIII, XIX, and V of the act insofar as they require payment of physicians on the basis of reasonable charge or reimbursement or payment for certain services to be made on the basis of reasonable cost (including physicians' services and other medical services which a group practice prepayment plan elects to have reimbursed on a cost basis in accordance with sec. 1833(a)(1) of such act). Costs incurred in such experiments which would not otherwise be reimbursed or paid under such titles for such services may nevertheless be paid to the extent that the waiver applies to them, and in such cases the Secretary will bear the excess costs.

Section 402(c) of the bill amends section 1875(b) of the act to provide that the Secretary's annual report to the Congress concerning the operation of the health insurance program will include a report on the experimentation authorized by section 402 of the bill.

SECTION 403. CHANGES TO REFLECT CODIFICATION OF TITLE 5, UNITED STATES CODE

Section 403 of the bill amends various provisions of the Social Security Act, and of certain other related laws, to correct references which were rendered obsolete or erroneous by the enactment into positive law of title 5 of the United States Code on September 6, 1966 (Public Law 89-554).

SECTION 404. MEANING OF SECRETARY

Section 404 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 amendments made by the bill.

TITLE V—MISCELLANEOUS PROVISIONS

SECTION 501. INCOME TAX DEDUCTION FOR INDIVIDUALS WHO WAIVE ENTITLEMENT TO MEDICARE

Section 501 of the bill amends section 213 of the Internal Revenue Code of 1954 (relating to a deduction for medical, dental, etc., expenses) to allow certain individuals who waive entitlement to medicare benefits to deduct medical expenses without regard to the 3-percent and 1-percent limitations of present law.

Section 501(a) of the bill amends section 213(a) of the code to restate as section 213(a)(1) of the code the provisions presently contained in paragraphs (1) and (2) of section 213(a). A new section

213(a)(2) is added which allows a taxpayer to deduct without regard to the 3-percent floor the amount of expenses (not compensated for by insurance or otherwise) which he pays during the taxable year for his own medical care, his spouse's medical care, and the medical care of certain dependents, if specified conditions are satisfied. Expenses for the taxpayer's medical care and for the medical care of the taxpayer's spouse may be deducted in full (1) if the taxpayer or his spouse has attained the age of 65 before the close of the year, and (2) the taxpayer and his spouse, respectively, have filed a waiver of entitlement to benefits under title XVIII of the Social Security Act (relating to hospital insurance and supplementary medical insurance for the aged) which is effective for the year. The waiver is to be filed pursuant to new section 1876 of the Social Security Act which is added by section 501(d) of the bill. Where either the taxpayer or his spouse has attained the age of 65 before the close of the taxable year and one, but not both of them, has filed the waiver referred to above, only the medical expenses of the one filing the waiver may be deducted in full. Expenses for medical care of a dependent also may be deducted in full if the dependent (1) is the father or mother of the taxpayer or his spouse, (2) has attained the age of 65 before the close of the year, and (3) has filed a waiver of entitlement to benefits under title XVIII of the Social Security Act which is effective for the year. Medical expenses of an individual who qualifies for the deduction of these expenses without regard to the 3-percent and 1-percent limitations of present law are not also to be taken into account for purposes of the limited deduction provided by present law (restated as sec. 213(a)(1)).

Section 501(b) of the bill amends section 213(b) of the code to provide that the present 1-percent floor on amounts paid for medicine and drugs is not applicable in the case of any individual who qualifies for the full medical expense deduction provided by the new code section 213(a)(2).

Section 501(c) of the bill amends section 213(e) of the code (relating to definitions for purposes of the medical expense deduction) to add a new paragraph (5) which provides rules regarding the effective date of the waiver which must be filed under new section 1876 of the Social Security Act to qualify for the deduction provided by section 501(a) of the bill. A waiver is to be effective for a taxable year only if the waiver is filed before the close of the taxable year or on or before the time prescribed by law (including extensions of time) for filing the income tax return for that year. In addition, a waiver with respect to a taxable year beginning in 1967 will be effective for that and subsequent years if filed on or before June 30, 1968. In either case, evidence of the waiver must be furnished in such form as the Secretary of the Treasury or his delegate prescribes by regulations. A waiver which is effective to allow the deduction of medical expenses without regard to the 3-percent and 1-percent limitations of present law for a taxable year is to be effective for this purpose for all subsequent taxable years.

Section 501(d) of the bill amends title XVIII of the Social Security Act by adding a new section 1876 which provides that an individual over age 65 (or within four months of attaining that age) or an individual under age 65 who is the spouse of an individual over age 65 (or within four months of attaining that age), may waive all

entitlement, present and future, to hospital insurance benefits and supplementary medical insurance benefits for the aged under title XVIII. The waiver may be made whether or not the individual is, or may become, entitled to these benefits.

A waiver may not be made after June 30, 1968, by an individual who becomes 65 on or before that date, if any services have been furnished to him after that date for which he is entitled to payment, or to have payment made on his behalf under title XVIII of the Social Security Act.

A waiver may not be made by an individual who becomes 65 after June 30, 1968, if any services have been furnished to him for which he is entitled to payment or to have payment made on his behalf under title XVIII of the Social Security Act.

A waiver made under new section 1876 is irrevocable and constitutes a permanent debarment of the individual with respect to any insurance benefits under title XVIII for any period on or after the date of the waiver.

A waiver may be filed by a fiduciary acting for an individual's estate or by an individual's survivor (within the meaning of section 205(c)(1)(C) of the Social Security Act) if the individual was eligible to file a waiver on the date of his death, or if he died before the effective date of the new section, would have been eligible to file a waiver if he had died on that effective date.

The amendments made by subsections (a), (b) and (c) of section 501 of the bill are to apply with respect to taxable years beginning after December 31, 1966. The amendment made by subsection (d) of section 501 of the bill is to take effect upon the date of enactment.

SECTION 502. TAX-EXEMPT STATUS OF CERTAIN HOSPITAL SERVICE ORGANIZATIONS

Subsection (a) of section 502 of the bill amends section 501 of the Internal Revenue Code of 1954 (relating to exemption from tax on corporations, etc.) by redesignating subsection (e) as subsection (f) of section 501 and inserting a new subsection (e). The new subsection (e) provides that, for purposes of the Internal Revenue Code of 1954, an organization is to be treated as one organized and operated exclusively for charitable purposes if the organization satisfies the following three conditions.

The first condition is that the organization must be organized and operated exclusively to perform services of a type which, if performed on its own behalf by a hospital described in section 501(c)(3) of the code, and exempt from taxation under section 501(a) thereof, would constitute an integral part of the hospital's exempt activities. In addition, the organization must perform the described services solely for hospitals, each of which is any one of the following: an organization described in section 501(c)(3) of the code and exempt from taxation under section 501(a) thereof; a constituent part of an organization described in section 501(c)(3) which constituent part, if organized and operated as a separate entity, would itself constitute an organization described in such section; or a hospital owned and operated by the United States, a State, the District of Columbia, a possession of the United States, or a political subdivision or instrumentality of any one of the foregoing.

The second condition which an organization must satisfy in order to be treated as one organized and operated exclusively for charitable purposes under the new subsection (e) is that the organization must be organized and operated on a cooperative basis and allocate or pay, within 8½ months of the close of its taxable year, all its net earnings (or margins) to its patrons on the basis of services performed for them.

The third and last condition is that, if such organization has capital stock, all such stock outstanding must be owned by its patrons.

For purposes of the Internal Revenue Code, any organization which satifies the preceding three conditions and, by reason thereof, is an organization described in section 501(c)(3) of the code, and exempt from taxation under section 501(a) thereof, is to be treated as a hospital and as an organization referred to in section 503(b)(5) of the code.

Subsection (b) of section 502 of the bill provides that the amendments made by subsection (a) of such section are to apply to taxable years ending after the date of enactment.

SECTION 503. EXTENSION OF PERIOD FOR FILING APPLICATION FOR EXEMPTION BY MEMBERS OF RELIGIOUS GROUPS OPPOSED TO INSURANCE

Section 503(a) of the bill amends paragraph (2) of section 1402(h) of the Internal Revenue Code of 1954 (relating to the time in which members of certain religious faiths may file applications for exemption from tax on self-employment income) by extending the time in which these members may file exemption applications. The amendment applies only with respect to members of recognized religious sects or divisions who, in adhering to established tenets or teachings thereof, conscientiously oppose acceptance of certain public or private insurance. In the case of such a member who has self-employment income (determined without regard to the exclusion provided therefor in subsection (h) of section 1402 and subsection (c)(6) of such section) for any taxable year ending before December 31, 1967, the time for filing the exemption application is not to expire on or before December 31, 1968.

In any other case, the time for filing the exemption application is not to expire until the time prescribed for filing the self-employment tax return (including any extension thereof) for the first taxable year ending on or after December 31, 1967, in which the member has self-employment income (as determined above). However, an application filed after the filing date prescribed in the preceding sentence is to be considered timely if filed on or before the last day of the third calendar month following the calendar month in which the Secretary of the Treasury first notifies a member of the specified type of religious sect that he has not filed a timely application of exemption from self-employment tax.

Section 503(b) provides that the amendments made by section 503 of the bill are to apply with respect to taxable years beginning after December 31, 1950. For this purpose, the self-employment tax provisions of the Internal Revenue Code of 1954 are to be treated as applying to all taxable years beginning after that date.

Section 503(c) provides that any refund or credit of any overpayment resulting from enactment of this section which is prevented on the date of enactment of the bill or at any time on or before December

31, 1968, by the operation of any law or rule of law, is nevertheless to be made or allowed if claim for such refund or credit is filed on or before such date. However, no interest is to be allowed or paid on any overpayment resulting from the enactment of this section.

SECTION 504. COVERAGE STATUS OF FISHERMEN AND TRUCK LOADERS AND UNLOADERS

Section 504 of the bill amends those provisions of the Social Security Act and the Internal Revenue Code of 1954 which relate to the coverage status of fishermen and truck loaders and unloaders for purposes of social security benefits, the Federal Insurance Contributions Act tax, and income tax withholding. The amendments made to the Social Security Act for social security benefit purposes conform to the amendments made to the Internal Revenue Code for FICA tax and income tax withholding purposes (except with respect to the effective date.)

Amendments to Title II of the Social Security Act

Subsection (a)(1) of section 504 of the bill amends section 210(j) of the Social Security Act (relating to the definition of the term "employee") by adding new paragraphs (4) and (5). New paragraph (4) identifies captains and crew members of fishing vessels as employees for purposes of title II of the Social Security Act (relating to social security benefits irrespective of the common law status of these persons. The amendment thus makes it unnecessary to determine the status of these persons under the common law rules applicable to an employer-employee relationship. The amendment applies to all services performed by captains or crew members for remuneration in connection with their catching, taking, harvesting, cultivating, or farming of any fish, shellfish, crustacea, sponges, seaweeds, etc., including services incident to such activities. Thus, for example, the amendment applies to services performed in loading or unloading a fishing vessel, or in preparing the catch for market. The amendment does not apply to partners who are performing services for a bona fide partnership.

An exception is provided at the end of the new paragraph (4) of section 210(j) of the Social Security Act in order to exclude from employee status for social security benefit purposes anyone who himself is deemed to be an employer of any officer or other member of a crew under the new subsection (p) of section 210 as added by section 504(a)(2) of the bill. The exception may apply, for example, in a case where the captain of a vessel has the sole interest in a catch as owner or charterer. Under such circumstances, the captain is classified as an employer under the new subsection (p) of section 210. The exception at the end of paragraph (4) thus applies so that the captain is not classified both as an employer and as an employee for social security benefit purposes.

New paragraph (5) of section 210(j) of the Social Security Act identifies a person who loads or unloads the contents of a truck, truck or tractor trailer, or similar conveyance for remuneration as an employee for social security benefit purposes irrespective of the person's common law status. The amendment thus makes it unnecessary to determine the status of such a person under the common law rules applicable to an employer-employee relationship.

Subsection (a)(2) of section 504 of the bill further amends section 210 of the Social Security Act (relating to definition of employment) by adding new subsections (p) and (q). New subsection (p) (relating to owners and lessees of vessels) establishes as a basic rule that for social security benefits purposes, the owner of a vessel is deemed to be the employer of persons who are designated as employees (as described above) under the new paragraph (4) of section 210(j) as added by section 504(a)(1) of the bill.

An exception to the basic rule provided in the new subsection (p) of section 210 provides that an individual described in new paragraph (4) of section 210(j) of the Social Security Act is to be considered as an employee of one other than the owner of a vessel (as provided above) for social security benefit purposes where two conditions are met. The first condition is that the owner has chartered or leased his vessel in such a way as to have retained no interest of any kind in the catch. The second is that the charterer or lessee of the vessel has an interest in the catch. If both these conditions are met, then the charterer or lessee, rather than the owner, is deemed to be the employer of the individual. (As noted above, therefore, in some circumstances, an individual who otherwise might be deemed to be an employee under new paragraph (4) of sec. 210(j) of the act, as added by sec. 504(a)(1) of the bill, under this exception may himself be deemed to be an employer of others and, hence, self-employed.) If one or both of the conditions set forth in this exception are not met, then the individual comes within the basic rule and is deemed to be an employee of the owner.

The last sentence of the new subsection (p) of section 210 provides a special rule for an individual performing services on a vessel where a person who has leased or chartered the vessel from the owner then charters the vessel to a captain or similar individual. (In the maritime industry, a lessee often charters a vessel to a captain who actually operates the vessel.) In such an instance, if both the lessee and the captain have an interest in the catch (and the owner does not), then the individual is deemed to be an employee of the charterer or lessee who is not an officer or member of the crew (the so-called "land-based charterer") for social security benefit purposes.

The term "interest" as used in the context of new subsection (p) is intended to have a very broad meaning. For example, if the owner of a vessel charters the vessel to a captain for a flat rental fee, it might appear that the owner has retained no interest in the catch. If, however, the owner also requires the catch to be sold to him (or, perhaps, a third person), and if the price paid is less than the prevailing market price, it is apparent that the owner is getting a share of the catch through a bargain purchase. In such a case it is intended that the owner be deemed to have an interest in the catch even though the formal arrangement may appear otherwise. Moreover, in these cases, even if the sales price is at the prevailing market price, it is intended that the owner be deemed to have an interest in the catch where, for example, an assured source of supply is vital. In any situation where the owner retains control over the disposition of the catch, it is intended that he be deemed to have an interest in the catch. This expansive meaning of the term "interest" thus is to apply to both the social security benefit provisions and the Federal Insurance Contributions Act provisions.

New subsection (q) of section 210 of the Social Security Act (relating to truck loaders and unloaders), as added by subsection (a)(2) of section 504 of the bill, establishes as a basic rule that for social security benefit purposes, an individual who is deemed to be an employee under the provisions of new paragraph (5) of section 210(j), as added by section 504(a)(1) of the bill, is to be deemed to be an employee of the driver in charge of the truck or conveyance. Where the truck driver is himself the employee of another person, however, then such other person is to be deemed to be the employer of the individual who does the loading or unloading.

The last sentence of the new subsection (q) of section 210 of the Social Security Act provides an exception to the basic rule stated above. The exception applies in instances where a third person acknowledges that he is responsible for collecting and paying Federal Insurance Contributions Act taxes with respect to loading or unloading services performed by an individual specified in paragraph (5) of section 210(j). For example, where a truck driver obtains individuals to load or unload the contents of his truck from either a business establishment to or from which such contents are assigned, or from another trucking company which makes available to him certain of its regular employees, or by arrangements with a person who acts as a middleman between the truck driver and the individuals (described in paragraph (5) of sec. 210(j)) who do the work, then such individuals are not to be deemed the employees of the truck driver (or his employer). This exception applies only where the consignee or the trucking company or middleman acknowledges (in a form to be prescribed by the Secretary of the Treasury) his responsibility for collecting and paying Federal Insurance Contributions Act taxes with respect to the services performed in the loading or unloading of the truck.

Subsection (a)(3) of section 504 of the bill provides that the amendments made by paragraphs (1) and (2) of section 504(a) of the bill ~~are to apply~~ for social security benefit purposes with the same effect as if included in the Social Security Act on and after January 1, 1951.

Amendments to the Internal Revenue Code of 1954

Subsection (b)(1) of section 504 of the bill amends section 3121(d) of the Internal Revenue Code of 1954 (relating to the definition of the term "employee") by adding new paragraphs (4) and (5). New paragraph (4) identifies captains and crew members of fishing vessels as employees for purposes of the Federal Insurance Contributions Act irrespective of their common law status. The amendment thus makes it unnecessary to determine the status of these persons under the common law rules applicable to an employer-employee relationship. The amendment applies to all services performed by captains or crew member for remuneration in connection with their catching, taking, harvesting, cultivating, or farming of any fish, shellfish, crustacea, sponges, seaweed, etc., including services incident to such activities. Thus, for example, the amendment applies to services performed in loading or unloading a fishing vessel, or in preparing the catch for market. The amendment does not apply to partners who are performing services for a bona fide partnership.

An exception is provided at the end of the new paragraph (4) of section 3121(d) of the code in order to exclude from employee status for purposes of the Federal Insurance Contributions Act anyone who

himself is deemed to be an employer of any officer or other member of the crew under the new subsection (r) of section 3121, as added by section 504(b)(2) of the bill. The exception may apply, for example, in a case where the captain of a vessel has the sole interest in a catch as owner or charterer. Under such circumstances the captain is classified as an employer under the new subsection (r) of section 3121. The exception at the end of paragraph (4) thus applies so that the captain is not classified both as an employer and as an employee for Federal Insurance Contributions Act purposes.

New paragraph (5) of section 3121(d) of the code identifies a person who loads or unloads the contents of a truck, truck or tractor trailer, or similar conveyance for remuneration as an employee for purposes of the Federal Insurance Contributions Act irrespective of the person's common law status. The amendment thus makes it unnecessary to determine the status of such a person under the common law rules applicable to an employer-employee relationship.

Subsection (b)(2) of section 504 of the bill further amends section 3121 of the code (relating to definitions) by adding new subsections (r) and (s). New subsection (r) (relating to owners and lessees of vessels) establishes as a basic rule that for Federal Insurance Contributions Act purposes, the owner of a vessel is deemed to be the employer of persons who are designated as employees (as described above) under the new paragraph (4) of section 3121(d) as added by section 504(b)(1) of the bill.

An exception to the basic rule provided in the new subsection (r) of section 3121 of the code relieves owners from employer responsibility for Federal Insurance Contributions Act purposes (as described above) where two conditions are met. The first condition is that the owner has chartered or leased his vessel in such a way as to have retained no interest of any kind in the catch. The second is that the charterer or lessee of the vessel has an interest in the catch. If both these conditions are met, the charterer or lessee, rather than the owner, is deemed to be the employer of the individuals specified in new paragraph (4) of section 3121(d) as added by section 504(b)(1) of the bill. If one or both of these conditions is not met, however, the owner retains full employer responsibilities with respect to the individuals specified in paragraph (4).

The last sentence of the new subsection (r) of section 3121 provides a special rule for those cases where a person who has leased or chartered a vessel from an owner then charters the vessel to a captain or similar individual. (In the maritime industry, a lessee often charters a vessel to a captain who actually operates the vessel.) In such an instance, if both the lessee and the captain have an interest in the catch (and the owner does not), the charterer or lessee who is not an officer or member of the crew (the so-called "land based charterer") is, under such last sentence, deemed to be the employer of the individuals specified in new paragraph (4) of section 3121(d) for Federal Insurance Contributions Act purposes.

The term "interest" as used in the context of new subsection (r) is intended to have a very broad meaning. For example, if the owner of a vessel charters the vessel to a captain for a flat rental fee, it might appear that the owner has retained no interest in the catch. If, however, the owner also requires the catch to be sold to him (or perhaps, a third

person) and if the price paid is less than the prevailing market price, it is apparent that the owner is getting a share of the catch through a bargain purchase. In such a case it is intended that the owner be deemed to have an interest in the catch even though the formal arrangement may appear otherwise. Moreover, in these cases even if the sales price is at the prevailing market price, it is intended that the owner be deemed to have an interest in the catch where, for example, an assured source of supply is vital. In any situation where the owner retains control over the disposition of the catch, it is intended that he be deemed to have an interest in the catch.

New subsection (s) of section 3121 of the Code (relating to truck loaders and unloaders), as added by subsection (b)(2) of section 504 of the bill, establishes as a basic rule that for Federal Insurance Contributions Act purposes, the driver in charge of a truck or other conveyance is deemed to be the employer of the persons who are designated as employees (as described above) under new paragraph (5) of section 3121(d) as added by section 504(b)(1) of the bill. Where the truck driver is himself the employee of another person, however, then such other person is deemed to be the employer of both the truck driver and the individual who does the loading and unloading.

The last sentence of the new subsection (s) of section 3121 of the Code provides an exception to the basic rule stated above. The exception applies in instances where a third person acknowledges (in a form to be prescribed by the Secretary of the Treasury) that he is responsible for collecting and paying Federal Insurance Contributions Act taxes with respect to the loading or unloading services performed by an individual specified in paragraph (5) of section 3121(d). For example, where a truck driver obtains individuals to load or unload the contents of his truck from either a business establishment to which such contents are consigned, or from another trucking company which makes available to him certain of its regular employees, or by arrangement with a person who acts as a middleman between the truck driver and the individuals who do the work, then the truck driver (or his employer) is not to be deemed to be the employer of the loaders or unloaders, provided that the consignee, other trucking company, or middleman acknowledges his responsibility for collecting and paying Federal Insurance Contributions Act taxes with respect to the services performed in the loading or unloading of the truck.

The exception contained in the last sentence of the new subsection (s) of section 3121 is intended to provide for those situations where a regular employer-employee relationship has already been established between truck loaders or unloaders, on the one hand, and shippers, consignees, other trucking companies, or middlemen, on the other hand.

Subsection (b)(3) of section 504 of the bill provides that the amendments made by paragraphs (1) and (2) of section 504(b) (as described above) are to apply for Federal Insurance Contributions Act purposes with respect to remuneration paid after December 31, 1967, for services performed after that date. It is not intended that the amendments made by paragraphs (1) and (2) of section 504(b) be taken into account in connection with the determination of Federal Insurance Contributions Act tax liabilities for periods prior to Janu-

ary 1, 1968. Such liabilities are to be determined on the basis of prior law, without reference to the enactment of paragraphs (1) and (2).

Subsection (c)(1) of section 504 of the bill amends section 3401(c) of the Internal Revenue Code of 1954 (relating to the definition of employee). This amendment conforms (with one exception) the definition of the term "employee" for purposes of income tax withholding to the definition of that same term as set forth in the amended subsection (d) of section 3121 of the Internal Revenue Code for Federal Insurance Contributions Act purposes. The exception excludes from the definition of employee under subsection (c) of section 3401 for income tax withholding purposes the persons identified in existing paragraph (3) of section 3121(d) (relating to agent-drivers, life insurance salesmen, etc.).

The principal purpose of the amendment to section 3401(c) is to specifically identify captains and crew members of fishing vessels, and truck loaders and unloaders, as employees for purposes of income tax withholding.

Subsection (c)(2) of section 504 of the bill provides that the amendments made by paragraph (1) of section 504(c) of the bill are to apply for income tax withholding purposes with respect to remuneration paid after December 31, 1967, for services performed after such date. No inference with respect to prior law is intended.

SECTION 505. REFUND OF CERTAIN OVERPAYMENTS BY EMPLOYEES OF HOSPITAL INSURANCE TAX

Subsection (a) of section 505 of the bill amends section 6413(c) of the Internal Revenue Code of 1954 (relating to special refunds of overpayments of certain employment taxes) by adding a new paragraph (3), which is to be applicable with respect to compensation of employees subject to the Railroad Retirement Tax Act. Paragraph (3) provides that in the case of any individual who receives wages from one or more employers during any calendar year after 1967, and also receives compensation subject to the tax imposed by section 3201 or 3211 of the code (Railroad Retirement Act taxes) the compensation is to be treated as wages received from an employer with respect to which the tax imposed by section 3101(b) was deducted, for purposes of applying paragraph (1) of section 6413(c) with respect to the tax imposed by section 3101(b) (FICA hospital insurance tax on employees).

Subsection (b)(1) of section 505 of the bill amends the second sentence of section 1402(b) of the code (relating to definition of self-employment income), and provides that for purposes of paragraph (1) of section 1402(b), but solely with respect to the hospital insurance tax imposed by section 1401(b), the term "wages" includes compensation which is subject to the tax imposed by section 3201 or 3211.

Subsection (b)(2) of section 505 of the bill provides that the amendment made by subsection (b)(1) of such section applies only with respect to taxable years ending on or after December 31, 1968.

Subsection (c)(1) of section 505 of the bill amends section 6051(a) of the code (relating to the furnishing of W-2 forms by employers)

to provide that every person required to deduct and withhold from an employee a Railroad Retirement Act tax under section 3201, is to furnish to each such employee a written statement (Form W-2), such as is presently required by section 6051(a) of every person required to deduct and withhold from an employee a tax under section 3101 or 3402. In addition, such subsection (c)(1) adds, after paragraph (6) of section 6051(a), new paragraphs (7) and (8) which provide that the written statement required by section 6051(a) must show (A) the total amount of compensation with respect to which the tax imposed by section 3201 was deducted, and (B) the total amount deducted as tax under section 3201.

Subsection (c)(2) of section 505 of the bill amends section 6051(c) of the code to provide that the statements required under section 6051 must also show the proportion of the total amount withheld as tax under section 3201 which is for financing the cost of hospital insurance benefits under part A of title XVIII of the Social Security Act.

Subsection (c)(3) of section 505 of the bill provides that the amendments made by paragraphs (1) and (2) of subsection (c) of section 505 of the bill are to apply in respect of remuneration paid after December 31, 1967.

SECTION 506. JOINT EMPLOYEES OF CERTAIN TAX-EXEMPT ORGANIZATIONS

Section 506 of the bill provides that for purposes of the Internal Revenue Code of 1954 in cases where an individual is an employee of two or more tax-exempt organizations, described in section 501(c)(4) of the code, which provide hospital or medical insurance and one of the organizations pays all the remuneration to the employee for his employment by the organizations, then that organization which pays the remuneration will, with the consent of the other organizations, be treated as the employer of the individual with respect to his employment by the organizations. The consent of an organization, as mentioned above, shall be made according to regulations prescribed by the Secretary of the Treasury or his delegate.

SECTION 507. EXTENSION OF TIME TO PROVIDE ASSISTANCE FOR UNITED STATES CITIZENS RETURNED FROM FOREIGN COUNTRIES

Section 507 of the bill amends section 1113(d) of the Social Security Act to authorize continuation of the program of temporary assistance under section 1113 of the act until the close of June 30, 1969.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE AND BASIC HOSPITAL INSURANCE TAX LIABILITY OF EMPLOYEES UNDER PRESENT LAW [1] AND UNDER SENATE FINANCE COMMITTEE BILL [2]

SELECTED LEVELS OF WAGE OR SALARY INCOME, 1968

Wage or salary income	OASDI and HI tax liability			
	Under present law	Under Finance Committee bill	Increase, Finance Committee bill over present law	
			Amount	Percent
$1,000	$44.00	$44.00	.....	.....
2,000	88.00	88.00	.....	.....
4,000	176.00	176.00	.....	.....
5,000	220.00	220.00	.....	.....
6,000	264.00	264.00	.....	.....
6,600	290.40	290.40	.....	.....
7,500	290.40	330.00	$39.60	13.6
7,600	290.40	334.40	44.00	15.2
8,000	290.40	352.00	61.60	21.2
8,800	290.40	352.00	61.60	21.2
10,000	290.40	352.00	61.60	21.2
10,800	290.40	352.00	61.60	21.2
12,500	290.40	352.00	61.60	21.2
15,000	290.40	352.00	61.60	21.2
20,000	290.40	352.00	61.60	21.2
25,000	290.40	352.00	61.60	21.2
35,000	290.40	352.00	61.60	21.2

[1] A tax rate of 4.4 percent and maximum earnings subject to tax of $6,600.
[2] A tax rate of 4.4 percent and maximum earnings subject to tax of $8,000.

Source: Staff of Joint Committee on Internal Revenue Taxation.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE AND BASIC HOSPITAL INSURANCE TAX LIABILITY OF THE SELF-EMPLOYED UNDER PRESENT LAW [1] AND UNDER SENATE FINANCE COMMITTEE BILL [2]

SELECTED LEVELS OF SELF-EMPLOYMENT INCOME, 1968

Self-employment income	OASDI and HI tax liability			
	Under present law	Under Finance Committee bill	Increase, Finance Committee bill over present law	
			Amount	Percent
$1,000	$64.00	$64.00	.....	.....
2,000	128.00	128.00	.....	.....
4,000	256.00	256.00	.....	.....
5,000	320.00	320.00	.....	.....
6,000	384.00	384.00	.....	.....
6,600	422.40	422.40	.....	.....
7,500	422.40	480.00	$57.60	13.6
7,600	422.40	486.40	64.00	15.2
8,000	422.40	512.00	89.60	21.2
8,800	422.40	512.00	89.60	21.2
10,000	422.40	512.00	89.60	21.2
10,800	422.40	512.00	89.60	21.2
12,500	422.40	512.00	89.60	21.2
15,000	422.40	512.00	89.60	21.2
20,000	422.40	512.00	89.60	21.2
25,000	422.40	512.00	89.60	21.2
35,000	422.40	512.00	89.60	21.2

[1] A tax rate of 6.4 percent and maximum self-employment income subject to tax of $6,600.
[2] A tax rate of 6.4 percent and maximum self-employment income subject to tax of $8,000.

Source: Staff of the Joint Committee on Internal Revenue Taxation.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE AND BASIC HOSPITAL INSURANCE TAX LIABILITY OF EMPLOYEES UNDER PRESENT LAW [1] AND UNDER SENATE FINANCE COMMITTEE BILL [2]

SELECTED LEVELS OF WAGE OR SALARY INCOME, 1969

Wage or salary income	OASDI and HI tax liability			
	Under present law	Under Finance Committee bill	Change, Finance Committee bill over present law	
			Amount	Percent
$1,000	$49.00	$48.00	−$1.00	−2.0
2,000	98.00	96.00	−2.00	−2.0
4,000	196.00	192.00	−4.00	−2.0
5,000	245.00	240.00	−5.00	−2.0
6,000	294.00	288.00	−6.00	−2.0
6,600	323.40	316.80	−6.60	−2.0
7,500	323.40	360.00	+36.60	+11.3
7,600	323.40	364.80	+41.40	+12.8
8,000	323.40	384.00	+60.60	+18.7
8,800	323.40	422.40	+99.00	+30.6
10,000	323.40	422.40	+99.00	+30.6
10,800	323.40	422.40	+99.00	+30.6
12,500	323.40	422.40	+99.00	+30.6
15,000	323.40	422.40	+99.00	+30.6
20,000	323.40	422.40	+99.00	+30.6
25,000	323.40	422.40	+99.00	+30.6
35,000	323.40	422.40	+99.00	+30.6

[1] A tax rate of 4.9 percent and maximum earnings subject to tax of $6,600.
[2] A tax rate of 4.8 percent and maximum earnings subject to tax of $8,800.

Source: Staff of Joint Committee on Internal Revenue Taxation.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE AND BASIC HOSPITAL INSURANCE TAX LIABILITY OF THE SELF-EMPLOYED UNDER PRESENT LAW [1] AND UNDER SENATE FINANCE COMMITTEE BILL [2]

SELECTED LEVELS OF SELF-EMPLOYMENT INCOME, 1969

Self-employment income	OASDI and HI tax liability			
	Under present law	Under Finance Committee bill	Change, Finance Committee bill over present law	
			Amount	Percent
$1,000	$71.00	$69.00	−$2.00	−2.8
2,000	142.00	138.00	−4.00	−2.8
4,000	284.00	276.00	−8.00	−2.8
5,000	355.00	345.00	−10.00	−2.8
6,000	426.00	414.00	−12.00	−2.8
6,600	468.60	455.40	−13.20	−2.8
7,500	468.60	517.50	+48.90	+10.4
7,600	468.60	524.40	+55.80	+11.9
8,000	468.60	552.00	+83.40	+17.8
8,800	468.60	607.20	+138.60	+29.6
10,000	468.60	607.20	+138.60	+29.6
10,800	468.60	607.20	+138.60	+29.6
12,500	468.60	607.20	+138.60	+29.6
15,000	468.60	607.20	+138.60	+29.6
20,000	468.60	607.20	+138.60	+29.6
25,000	468.60	607.20	+138.60	+29.6
35,000	468.60	607.20	+138.60	+29.6

[1] A tax rate of 7.1 percent and maximum self-employment income subject to tax of $6,600.
[2] A tax rate of 6.9 percent and maximum self-employment income subject to tax of $8,800.

Source: Staff of the Joint Committee on Internal Revenue Taxation.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE AND BASIC HOSPITAL INSURANCE TAX LIABILITY OF EMPLOYEES UNDER PRESENT LAW[1] AND UNDER SENATE FINANCE COMMITTEE BILL[2]

SELECTED LEVELS OF WAGE OR SALARY INCOME, 1972

Wage or salary income	OASDI and HI tax liability			
	Under present law	Under Finance Committee bill	Increase, Finance Committee bill over present law	
			Amount	Percent
$1,000	$49.00	$52.00	$3.00	6.1
2,000	98.00	104.00	6.00	6.1
4,000	196.00	208.00	12.00	6.1
5,000	245.00	260.00	15.00	6.1
6,000	294.00	312.00	18.00	6.1
6,600	323.40	343.20	19.80	6.1
7,500	323.40	390.00	66.60	20.6
7,600	323.40	395.20	71.80	22.2
8,000	323.40	416.00	92.60	28.6
8,800	323.40	457.60	134.20	41.5
10,000	323.40	520.00	196.60	60.8
10,800	323.40	561.60	238.20	73.7
12,500	323.40	561.60	238.20	73.7
15,000	323.40	561.60	238.20	73.7
20,000	323.40	561.60	238.20	73.7
25,000	323.40	561.60	238.20	73.7
35,000	323.40	561.60	238.20	73.7

[1] A tax rate of 4.9 percent and maximum earnings subject to tax of $6,600.
[2] A tax rate of 5.2 percent and maximum earnings subject to tax of $10,800.

Source: Staff of the Joint Committee on Internal Revenue Taxation.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE AND BASIC HOSPITAL INSURANCE TAX LIABILITY OF THE SELF-EMPLOYED UNDER PRESENT LAW[1] AND UNDER SENATE FINANCE COMMITTEE BILL[2]

SELECTED LEVELS OF SELF-EMPLOYMENT INCOME, 1972

Self-employment income	OASDI and HI tax liability			
	Under present law	Under Finance Committee bill	Increase, Finance Committee bill over present law	
			Amount	Percent
$1,000	$71.00	$75.00	$4.00	5.6
2,000	142.00	150.00	8.00	5.6
4,000	284.00	300.00	16.00	5.6
5,000	355.00	375.00	20.00	5.6
6,000	426.00	450.00	24.00	5.6
6,600	468.60	495.00	26.40	5.6
7,500	468.60	562.50	93.90	20.0
7,600	468.60	570.00	101.40	21.6
8,000	468.60	600.00	131.40	28.0
8,800	468.60	660.00	191.40	40.8
10,000	468.60	750.00	281.40	60.1
10,800	468.60	810.00	341.40	72.9
12,500	468.60	810.00	341.40	72.9
15,000	468.60	810.00	341.40	72.9
20,000	468.60	810.00	341.40	72.9
25,000	468.60	810.00	341.40	72.9
35,000	468.60	810.00	341.40	72.9

[1] A tax rate of 7.1 percent and maximum self-employment income subject to tax of $6,600.
[2] A tax rate of 7.5 percent and maximum self-employment income subject to tax of $10,800.

Source: Staff of the Joint Committee on Internal Revenue Taxation.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE AND BASIC HOSPITAL INSURANCE TAX LIABILITY OF EMPLOYEES UNDER PRESENT LAW [1] AND UNDER SENATE FINANCE COMMITTEE BILL [2]

SELECTED LEVELS OF WAGE OR SALARY INCOME, 1987

Wage or salary income	OASDI and HI tax liability			
	Under present law	Under Finance Committee bill	Increase, Finance Committee bill over present law	
			Amount	Percent
$1,000	$56.50	$58.00	$1.50	2.7
2,000	113.00	116.00	3.00	2.7
4,000	226.00	232.00	6.00	2.7
5,000	282.50	290.00	7.50	2.7
6,000	339.00	348.00	9.00	2.7
6,600	372.90	382.80	9.90	2.7
7,500	372.90	435.00	62.10	16.7
7,600	372.90	440.80	67.90	18.2
8,000	372.90	464.00	91.10	24.4
8,800	372.90	510.40	137.50	36.9
10,000	372.90	580.00	207.10	55.5
10,800	372.90	626.40	253.50	68.0
12,500	372.90	626.40	253.50	68.0
15,000	372.90	626.40	253.50	68.0
20,000	372.90	626.40	253.50	68.0
25,000	372.90	626.40	253.50	68.0
35,000	372.90	626.40	253.50	68.0

[1] A tax rate of 5.65 percent and maximum earnings subject to tax of $6,600.
[2] A tax rate of 5.8 percent and maximum earnings subject to tax of $10,800.

Source: Staff of the Joint Committee on Internal Revenue Taxation.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE AND BASIC HOSPITAL INSURANCE TAX LIABILITY OF THE SELF-EMPLOYED UNDER PRESENT LAW [1] AND UNDER SENATE FINANCE COMMITTEE BILL [2]

SELECTED LEVELS OF SELF-EMPLOYMENT INCOME, 1987

Self-employment income	OASDI and HI tax liability			
	Under present law	Under Finance committee bill	Change, Finance Committee bill over present law	
			Amount	Percent
$1,000	$78.00	$77.50	−$.50	−0.6
2,000	156.00	155.00	−1.00	−0.6
4,000	312.00	310.00	−2.00	−0.6
5,000	390.00	387.50	−2.50	−0.6
6,000	468.00	465.00	−3.00	−0.6
6,600	514.80	511.50	−3.30	−0.6
7,500	514.80	581.25	+66.45	+12.9
7,600	514.80	589.00	+74.20	+14.4
8,000	514.80	620.00	+105.20	+20.4
8,800	514.80	682.00	+167.20	+32.5
10,000	514.80	775.00	+260.20	+50.5
10,800	514.80	837.00	+322.20	+62.6
12,500	514.80	837.00	+322.20	+62.6
15,000	514.80	837.00	+322.20	+62.6
20,000	514.80	837.00	+322.20	+62.6
25,000	514.80	837.00	+322.20	+62.6
35,000	514.80	837.00	+322.20	+62.6

[1] A tax rate of 7.8 percent and maximum self-employment income subject to tax of $6,600.
[2] A tax rate of 7.75 percent and maximum self-employment income subject to tax of $10,800.

Source: Staff of the Joint Committee on Internal Revenue Taxation.

SUMMARY TABLE OF FULL-YEAR BENEFIT COSTS, NUMBER OF PERSONS AFFECTED, AND EFFECTIVE DATE OF ITEMS WITH COST IMPORTANCE IN H.R. 12080, FINANCE COMMITTEE VERSION *

Item	Trust fund (millions)	General Treasury (millions)	Number of persons affected	Effective date
HEALTH CARE PROGRAMS (1969)				
Basic hospital	(1)	(1)	17,800,000 insured, plus 1,900,000 uninsured.	April 1968.
Voluntary supplementary medical	.....	[2] $62	18,000,000	Do.
Medicaid changes	.....	−375	No estimate available	July 1968.
Health care, total	.....	−313	.....	
OASDI AMENDMENTS (1ST 12 MONTHS OF OPERATION)				
Benefit increase for insured persons	$4,128	.....	23,135,000	March 1968.
Benefit increase for uninsured persons	.....	178	925,000	Do.
Disabled widows and widowers	71	.....	70,000	Do.
Workers disabled before age 31	72	.....	100,000	Do.
Dependents of women workers	88	.....	180,000	Do.
Children disabled before age 22	8	.....	10,000	Do.
Modification of earnings test [3]	175	.....	760,000	January 1968.
Reduced benefits at age 60	555	.....	775,000	December 1968.
Disability benefits for the blind	165	.....	205,000	Do.
OASDI, total	5,262	178	.....	.....
PUBLIC ASSISTANCE AND CHILD HEALTH (FISCAL YEAR 1969)				
Work training	.....	190	No estimate available	On enactment.
Earnings exemptions	.....	35	....do	January 1968.
Day care	.....	55	....do	On enactment.
Other welfare costs	.....	181	....do	
Savings from work training	.....	−41	....do	July 1968.
Other welfare savings	.....	−56	....do	
Child health	.....	40	....do	Do.
Total	.....	404	.....	
Grand total	5,262	269	.....	

[1] The changes made have relatively little net cost effect.
[2] This figure represents half the additional cost of the benefit changes, since the cost of the program is borne on a 50–50 basis by the enrollees and the General Treasury.
[3] The corresponding figures for the 1st 12 months of operation when the $2,000 annual exempt amount becomes effective (calendar year 1969) are $500,000,000 and 840,000 persons.

*The data on this table is based upon 12 months of operation measured from the effective date of the various provisions. The table does not reflect calendar year data.

COMPARISON OF CONTRIBUTION INCOME AND BENEFIT OUTGO UNDER PRESENT LAW, HOUSE BILL, AND FINANCE COMMITTEE BILL, 1967–72

[In billions of dollars]

Calendar year	Present law	House bill	Finance committee bill
	Contribution income		
1967	28.5	----------	----------
1968	29.6	30.8	31.2
1969	33.7	34.9	36.3
1970	35.2	36.5	38.3
1971	36.2	40.3	42.5
1972	37.2	42.0	46.0
	Benefit outgo		
1967	24.2	----------	----------
1968	25.5	[1] 28.7	[2] 29.0
1969	26.9	30.3	32.7
1970	28.2	31.7	34.4
1971	29.4	33.1	35.9
1972	30.8	34.6	37.4
	Excess of contributions over benefits		
1967	4.3	----------	----------
1968	4.1	2.1	2.2
1969	6.8	4.6	3.6
1970	7.0	4.8	3.9
1971	6.8	7.2	6.6
1972	6.4	7.4	8.6

[1] Assumes that increased benefits will be payable for all 12 months of 1968 (as would have been the case if bill had been enacted when it passed the House).

[2] Based on effective date of March (payable at beginning of April) for increased benefits.

Note: Benefit outgo data include increase in HI benefit-cost estimates made following passage of House bill.

V. 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 law made by the bill, as reported).

VI. MINORITY VIEWS

Need for Social Security Legislation

We of the minority feel that there should be a social security bill raising benefits. This is necessary in order to bring the level of benefits up to meet the needs caused by the rising cost of living. We favor such action and fully supported it in committee.

There are other features of H.R. 12080 which also are timely and desirable. These include corrective amendments relating to the old-age and survivors programs and corrective amendments relating to medicare.

Further we support the objective of the House of Representatives relating to work and training programs and incentives designed to get individuals on public welfare into productive activity. We believe that the Senate Committee on Finance has improved this part of the House bill, particularly in reference to spelling out guidelines as to who is an appropriate person among the recipients of aid to families of dependent children (AFDC) to be required to take training or work, or both.

The Level of Benefits and Financing

In determining the level of social security benefits, consideration should be given to—

(1) The need for an increase by reason of inequities in the present schedule.

(2) Higher living costs.

(3) Such other factors as the tax burden that will fall upon present and future social security taxpayers.

(4) The long-term as well as the short-term inflationary effect.

One of the paramount needs of all people, but more especially the needs of social security recipients, is a stable currency. Social security benefits to have real meaning must be paid in dollars having real purchasing power. Our present social security beneficiaries are in distress not because the designated number of dollars of their benefit has been reduced but because the dollars they receive buy less and less. The real friend of the social security program is he who also takes into account the soundness of the financing, and the effect of the financing arrangements on the purchasing power of the beneficiaries

The Operation of the Social Security System

In considering benefits, tax rates, and the wage base, it is important that we review the manner in which the social security program operates.

The social security system is not a system wherein the social security taxpayer pays into the fund an amount which together with interest accumulations will provide his benefits. It is rather a system that keeps going and meets its obligations only by reason of the taxes

paid by present and future employees, self-employed persons, and employers.

It is not a program that is fully funded in which there are sufficient reserves in the trust fund to meet the accrued and accruing obligations. For instance, the amount of money in the trust fund reserve at the present time would pay the present benefits to those now on the benefit rolls for only 1 year. The reserve does not contain sufficient funds to pay present beneficiaries beyond this 12-month period or to pay anything to those who become beneficiaries next month or any time in the future.

According to the Social Security Administration, the reserve in the trust fund has consistently gone down in terms of the time over which the reserve would pay benefits. The following table is significant:

COMPARISON OF OASDI TRUST FUND BALANCES AND BENEFIT OUTGO

[Balance in fund and benefit outgo in millions]

Calendar year	Balance in fund at beginning of year	Benefit outgo in year	Ratio of fund to benefit outgo	
			In years	In months
1940	$1,724	$35	49.3	591.6
1941	2,031	88	23.1	277.2
1942	2,762	131	21.1	253.2
1943	3,688	166	22.2	266.4
1944	4,820	209	23.1	277.2
1945	6,005	274	21.9	262.8
1946	7,121	378	18.8	225.6
1947	8,150	466	17.5	210.0
1948	9,360	556	16.8	201.6
1949	10,722	667	16.1	193.2
1950	11,816	961	12.3	147.6
1951	13,721	1,885	7.3	87.6
1952	15,540	2,194	7.1	85.2
1953	17,442	3,006	5.8	69.6
1954	18,707	3,670	5.1	61.2
1955	20,576	4,968	4.1	49.2
1956	21,663	5,715	3.8	45.6
1957	22,519	7,404	3.0	36.0
1958	23,042	8,576	2.7	32.4
1959	23,243	10,299	2.3	27.6
1960	21,966	11,245	2.0	24.0
1961	22,613	12,749	1.8	21.6
1962	22,162	14,461	1.5	18.0
1963	20,705	15,427	1.3	15.6
1964	20,715	16,223	1.3	15.6
1965	21,172	18,310	1.2	14.4
1966	19,841	20,048	1.0	12.0
1967	22,309	[1] 21,549	1.0	12.0

[1] Estimated.

Many of the early retirees under social security made only a token payment for the benefits they received. For instance, at the end of 1966 there were still 4,500 individuals drawing benefits who started to draw benefits in 1940, the first year monthly benefits were payable. The maximum amount that any employee could have paid into the fund if he retired in January 1940, was a total of $90. Such an individual would have drawn from January 1940, through September 1967, benefits totaling $22,458.90.

Many other individuals who have become beneficiaries in the past have likewise paid only small amounts in total social security taxes. Other individuals who have gone on the benefit rolls have paid a greater sum in taxes but still an amount far short of providing for their own benefits. The following figures in reference to beneficiaries who retire this year at age 65 illustrate that the major costs of the social security

program continue to be borne by future taxpayers who pay as employees, self-employed persons, and employers.

The person who has paid the maximum tax as an employee during the period 1937 through 1966 has paid the total sum of $3,449 including accumulated interest at 3¾ percent. If such person has a spouse who is also 65 years of age, the present value of the couple's future benefits is $26,844.

The person who as an employee has paid the average amount of tax—that is, on the earnings equal to the median earnings of all wage and salary workers, in each year during the period 1937 through 1966—has paid a total in taxes of $2,564 including accumulated interest. If such a person has a spouse who is also 65 years of age, the present value of the couple's future benefits amounts to $23,901.

It is possible for an employee who retired this year at age 65 to have qualified for the minimum benefits by the payment of total social security taxes of $16 including accumulated interest. If that individual has a spouse living who is also 65, the present value of the couple's future benefits is $9,022.

The figures in the foregoing hypothetical cases are cited to illustrate the nature of the operation of the social security program and to point out the need for concern for present social security taxpayers, particularly the young [ones] and for those who will join the work force in future years.

What Are the Inflationary Pressures?

The policies of the Federal Government determine whether or not we are to experience more and more inflation—whether price rises will get out of control, and create additional hardships, or whether the purchasing power of the dollar will stabilize. The total expenditures under all titles of the Social Security Act, if the committee bill is passed, are estimated for calendar year 1969 to be $40.8 billion. By reason of the very size of the social security program, the financial management of that program becomes of great importance in the fight against inflation.

The failure of proper financial management of the social security system can add to inflation in at least three ways:

(1) By pumping more money into our economic system in benefits in a given year than is taken out in taxes.

(2) By a commitment for future expenditures at a level that can only be maintained by further inflating the economy.

(3) When the social security tax burden itself becomes inflationary.

In 1968, 1969, and 1970 the extra benefits provided under the Senate Finance Committee-approved bill exceed the extra taxes levied in the same years by $1.9 billion, $3.2 billion, and $3.1 billion, respectively.

This represents a total of over $8 billion extra money being pumped into the economy at a time when we are already threatened with another disastrous round of inflation.

When the social security law was first enacted, the maximum amount of annual tax imposed on any employee was $30. A like amount was imposed upon his employer. Thus, the businessman who employed 10 such workers paid a social security tax of $300 per year. The ultimate maximum tax under the Finance Committee proposal on an

employee in the year 1980 will be $626.40 with a like amount to be paid by the employer. Thus, when the maximum tax recommended by the majority members of the Finance Committee becomes effective, it will cost an employer of 10 such employees in social security taxes alone the sum of $6,264 per year. (This is more than 20 times what it was the first year of the social security program.) If any business is to succeed and stay in business, all items of cost including social security taxes must be passed on to the consumer. Thus, the size of the tax burden becomes a direct cause in raising the price of the necessities of life.

It must also be borne in mind that a portion of our self-employed social security taxpayers will be able to pass on and must pass on their increased social security tax burden to the consumers. Neither can it be argued that a portion of the employees' social security tax is not actually passed on to the consumer. Employees must and do think in terms of take-home pay. Added social security taxes and any other factor that affects take-home pay have a bearing on wage demands and wage contracts.

The Tax Burden

There are two factors to be considered in determining the social security tax burden in dollars. One is the rate of tax and the other is the wage base to which the tax is applied. In the early years of the program the tax was 1 percent on the employee and 1 percent on the employer, and it was applied on the first $3,000 of wages. At the present time, the tax rate is 4.4 percent on the employee's first $6,600 of wages. The tax and wage base are similar for the employer. The tax burden on the self-employed is with certain limitations roughly 1½ times the burden on an employee.

Under the present law the wage base—the maximum amount of wages or self-employed earnings subject to the tax—remains at $6,600 a year. Under present law the employee rate will ultimately go up to 4.9 percent in 1969, to 5.4 percent in 1973, to 5.45 percent in 1976, to 5.55 percent in 1980, and to 5.65 percent in 1987.

Under H.R. 12080, as passed by the House of Representatives, the tax burden is increased over the present law. Under the House bill the employee rate is increased to 4.8 percent for 1969, to 5.2 percent for 1971, to 5.65 percent in 1973, to 5.7 percent in 1976, to 5.8 percent in 1980, and to 5.9 percent in 1987. The wage base is increased to $7,600 for 1968 and thereafter.

Under the bill as recommended by the majority members of the Finance Committee, the tax rate will be the same as the House-passed bill up to 1980 but the wage base is greatly increased. The wage base will be $8,000 in 1968, $8,800 in 1969 and $10,800 in 1972.

Under existing law the maximum in employee tax which will be reached in 1987 amounts to $372.90 annually. Under the provisions of H.R. 12080, as passed by the House, the maximum employee tax which will be reached in 1987 amounts to $448.40, and the maximum employee tax under the bill as recommended by the majority members of the Finance Committee which will be reached in 1980 amounts to $626.40. Similar burdens are carried by employers and a proportionate increase will follow upon the self-employed.

This increased burden comes about not only by reason of the growing tax rate which affects all, but by reason of the increase in the wage base.

Any person whose wages exceed $6,600 per year will have his tax burden increased. We take note of the fact that an ever-increasing percentage of the workers and self-employed persons will have wages or self-employed earnings reaching or nearing the maximum wage base. As this happens, the social security tax burden on employers also increases and for the reasons earlier set forth, this means an increase in the burdens of the consuming public.

The financial burden of a social security system—including the tax rate and the wage base necessitated by the level of benefits—should not reach the point where it provides an undue hardship on the low income earners of the future nor should it destroy the incentive of the young to advance and earn more, nor discourage company pension plans, nor destroy the incentive for all people to save individually and accumulate for their own old age to add to their standard of living.

Adverse Effects on Young and Middle Income Employees

The Finance Committee tax and financing amendments are especially discriminatory against young and middle income employees. In fact, they go so far that they may undermine the foundations on which the great popularity of the social security program has been built. They may also stunt the growth of what has been one of the most promising developments for the welfare of employees in recent years—private pension plans.

Discrimination Against Young and Middle Income Employees

As a result of the committee's action the additional taxes, over and above those provided for in present law, would be imposed solely on wages and self-employment income in excess of $6,600 until the year 1971. This follows from reliance on raising the taxable wage base from the present $6,600 per employee to $8,000 in 1968, to $8,800 in 1969, to $10,800 in 1972 to finance the benefit increases recommended by the committee. Today, when we speak of salaries and wages in these ranges, we are referring to the middle income employees.

These middle income employees will pay $352 in social security taxes in 1968 if they earn as much as $8,000. This compares with the present $290.40, which resulted from previous tax increases in both 1966 and 1967. The employee tax would jump by 21.2 percent in 1968 from the present amount—by 45.5 percent in 1969 for those earning at least $8,800—and 93.4 percent in 1972 for salary and wage earners of $10,800 and over.

Employers would be required to pay equal amounts to that paid by their employees. This additional burden could well make it difficult for many employers, especially smaller ones, either to initiate pension programs or to continue to liberalize pension benefits.

But the most serious burden will be placed on younger employees both in the long run and immediately. Even if they made as much as $8,000, young families can ill afford the immediate tax. In the long run, the benefit and tax schedules proposed by the committee, become a very poor bargain indeed.

This can be illustrated by taking a wage earner age 21 in 1972 with annual earnings of at least $10,800 throughout his 44-year career. Even after the 28 percent of OASDI costs that the Social Security

Administration says goes for disability and survivorship is subtracted, the combined employer-employee tax increase imposed by H.R. 12080, as recommended by the Finance Committee, would amount to $16,528.[1] This would accumulate at 4-percent interest to $43,494.96 by the year 2016. This accumulation would provide the following private annuities:

(1) A single life annuity at age 65 of $354 per month (contrasted with $120 from social security under the committee proposal), or

(2) A joint and survivor annuity for a man and wife both age 65 of $312 per month during their joint lives (contrasted with $141 per month from social security) and $171 per month for the surviving spouse (contrasted with $99 from social security).

These figures illustrate why we need to be concerned for the future acceptance of social security if we adopt the benefit and tax recommendation of the Finance Committee.

UNDERMINES "INSURANCE" CONCEPTS AND THREATENS PRIVATE PENSIONS

The president of the AFL–CIO, George Meany, showed at least some indirect recognition of the tax burden being imposed on wage earners, in appearing before the Finance Committee in support of the Administration benefit increase proposals, when he said:

> We do wish to point out, however, that these increases in the rates are probably the maximum workers should be expected to pay. Therefore, you can expect us to urge the next time we come before you gradual introduction of a contribution from general revenues to the social security trust fund. * * * (Hearings, p. 1418.)

When the Administration submitted its 1967 social security proposals to Congress, the Under Secretary of HEW, Wilbur J. Cohen, was quoted in the Washington Post of January 24, that it is "good speculation" that any further improvements beyond those being proposed would have to be financed out of general revenues.

Resort to extensive use of general revenues to finance social security will sweep away the last pretense that social security is a form of "insurance." The great popularity of the social security program is built on the self-financed, contributory and wage related principles that are basic to the American "social insurance" system.

Once social security is freed from relying almost exclusively on direct taxation of employees and employers, benefits would of course no longer be restricted by the practical limits of payroll taxation.

The Benefit Increases

Under the House bill, the benefits for the retired and their survivors are increased by 12½ percent. The increase recommended by the Senate Committee on Finance is 15 percent with a minimum benefit of $70 per month. The long-range cost of benefits under the Finance Committee recommendation is considerably more than 15 percent because the benefit formula will be applied to the increased wage base.

[1] The Social Security Administration contends that the employer tax should not be considered, but both the employee and the employer generally consider this as a wage cost which might otherwise have gone to the employee in increased wages or other fringe benefit.

Expenditures From the General Fund

Many of the programs which comprise the social security system are financed by general revenues. If the recommendations of the majority members of the Finance Committee become law, the increase in expenditures for calendar year 1968 from the general fund over present expenditures will be an estimated $325 million.

Departure From a Principle

The principle of fiscal responsibility demands that at the time increased benefits are paid which would require an ultimate increase in scheduled taxes there should be an increase in taxes.

To depart from this principle adds to the burdens on future taxpayers. A departure from this principle postpones a greater portion of the needed taxes. A departure from this principle draws attention away from the fact that benefits are possible only because taxes are paid and similarly that increases in benefits are possible only because increases in taxes are paid. If the recommendations of the majority members of the Senate Finance Committee are followed, all beneficiaries will receive an increase in benefits in the calendar year 1968 with no increase in the tax rate for 1968 and no increase in the dollar amount of taxes paid in 1968 for an estimated two-thirds of the taxpayers. This might be branded by some as political chicanery. We say it is misleading and places an added burden on the future social security taxpayers.

Conclusions

We who have joined in this report believe that the tax rate, wage base, and level of benefits provided in the House bill are more appropriate and are more in accord with the economic future well-being of our citizens of all ages than are the revisions recommended by the Senate Finance Committee.

John J. Williams.
Frank Carlson.
Wallace F. Bennett.
Carl T. Curtis.
Thruston B. Morton.
Everett McKinley Dirksen.

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