92d Congress
2d Session } CONFERENCE COMMITTEE PRINT

H.R. 1

Summary of Social Security Amendments of 1972 as Approved by the Conferees

JOINT PUBLICATION

COMMITTEE ON FINANCE

OF THE

U.S. SENATE

AND

COMMITTEE ON WAYS AND MEANS

OF THE

U.S. HOUSE OF REPRESENTATIVES

OCTOBER 17, 1972

Prepared for the use of the Senate Committee on Finance and the House Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

84-969 O WASHINGTON : 1972

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price 30 cents
Stock Number 5270-01616

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I. Social Security Cash Benefit Provisions

1. Special minimum cash benefits

The bill would provide a special minimum benefit of $8.50 multiplied by the number of years in covered employment up to 30 years, producing a benefit of at least $170 a month for a worker who has been employed for 30 years under social security coverage. This benefit would be paid as an alternative to the regular benefits in cases where a higher benefit would result.

Under this provision, the new higher minimum benefit would become payable to people with 20 or more years of employment; at that point, the special minimum benefit would be more than the regular minimum—$85 as compared to the regular minimum benefit of $84.50 payable under present law. A worker with 25 years of employment under social security would thus be guaranteed a benefit of at least $127.50; while one with 30 years would receive at least $170 a month. Minimum payments to a couple would be one and one-half times these amounts.

Years of covered employment	Special minimum
19 or less	(1)
20	$85.00
21	93.50
22	102.00
23	110.50
24	119.00
25	127.50
26	136.00
27	144.50
28	153.00
29	161.50
30 or more	170.00

[1] Regular $84.50 minimum applies.

Effective date.—January 1973.

Number of people affected and dollar payments.—$150,000 people would get increased benefits on the effective date and $20 million in additional benefits would be paid in 1974.

2. Increase in widow's and widower's insurance benefits

Under present law, when benefits begin at or after age 62 the benefit for a widow (or dependent widower) is equal to 82½ percent of the amount the deceased worker would have received if his benefit had

started when he was age 65. A widow can get a benefit at age 60 reduced to take account of the additional 2 years in which she would be getting benefits.

The bill would provide benefits for a widow equal to the benefit her deceased husband would have received if he were still living. Under the bill, a widow whose benefits start at age 65 or after would receive either 100 percent of her deceased husband's primary insurance amount (the amount he would have been entitled to receive if he began his retirement at age 65) or, if his benefits began before age 65, an amount equal to the reduced benefit he would have been receiving if he were alive.

Under the bill, the benefit for a widow (or widower) who comes on the rolls between 60 and 65, would be reduced (in a way similar to the way in which widows' benefits are reduced under present law when they begin drawing benefits between ages 60 and 62) to take account of the longer period over which the benefit would be paid.

Effective date.—January 1973.

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

3. Increased benefits for those who delay retirement beyond age 65

The bill includes a provision which would provide for an increase in social security benefits of 1 percent for each year after age 65 that the individual delays his retirement.

Effective date.—For computation and recomputation after 1973 based on earnings after 1973.

4. Age 62 computation point for men

Under present law, the method of computing benefits for men and women differs in that years up to age 65 must be taken into account in determining average earnings for men, while for women only years up to age 62 must be taken into account. Also, benefit eligibility is figured up to age 65 for men, but only up to age 62 for women. Under the bill, these differences, which provide special advantages for women, would be eliminated by applying the same rules to men as now apply to women.

Effective date.—The new provision would become effective, starting January 1973 and become fully effective in January 1975.

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

5. Liberalization of the retirement test

The amount that a beneficiary under age 72 may earn in a year and still be paid full social security benefits for the year would be increased from the present $1,600 to $2,100. Under present law, benefits are reduced by $1 for each $2 of earnings between $1,680 and $2,800 and for each $1 of earnings above $2,880. The committee bill would provide for a $1 reduction for each $2 of all earnings above $2,100, there would be no $1-for-$1 reduction as under present law. Also, in the year in which a person attains age 72 his earnings in and after the month in which he attains age 72 would not be included, as they are under present law, in determining his total earnings for the year.

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

Effective date.—January 1973.

Number of people affected and dollar payments.—1.2 million beneficiaries would become entitled to higher benefit payments on the effective date and 450,000 additional people would become entitled to benefits. About $856 million in additional benefits would be paid in 1974.

6. Dependent widower's benefits at age 60

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

Effective date.—January 1973.

7. Childhood disability benefits

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

Effective date.—January 1973.

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

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

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

Effective date.—January 1973.

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

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

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

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

Effective date.—January 1973.

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

The bill would provide that a child who is entitled to benefits on the earnings record of more than one worker would get benefits based on the earnings record which results in paying him the highest amount, if the payment would not reduce the benefits of any other individual who is entitled to benefits based on that earnings record. (Entitlement of a child on the earnings record that will give the child the highest benefit could otherwise result in a reduction of the benefits for other people entitled on the same earnings record because of the family maximum limitation.)

Effective date.—January 1973.

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

Under the bill, benefits would be extended to grandchildren not adopted by their grandparents if their parents have died or are disabled and if the grandchildren were living with a grandparent at the time the grandparent qualified for benefits.

Effective date.—January 1973.

12. Nontermination of child's benefits by reason of adoption

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

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

13. Elimination of the support requirements for divorced women

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

Effective date.—January 1973.

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

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

The duration-of-marriage requirement in present law for entitlement to benefits as a worker's widow, widower, or stepchild—that is, the period of not less than 9 months immediately prior to the day on which the worker died that is now required (except where death was accidental or in the line of duty in the uniformed service in which case the period is 3 months)—would be waived in cases where the worker and his spouse were previously married, divorced, and remarried, if they were married at the time of the worker's death and if the duration-of-marriage requirement would have been met at the time of the divorce had the worker died then.

Effective date.—January 1973.

15. Reduction in waiting period for disability benefits

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

Effective date.—January 1973.

Number of people affected and dollar payments.—950 thousand beneficiaries would become entitled to additional benefit payments in 1974 and 4 thousand additional people would become entitled to benefits. About $128 million in additional benefits would be paid in 1974.

16. Disability insured status for individuals who are blind

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

Effective date.—January 1973.

Number of people affected and dollar payments.—30,000 additional people would become immediately eligible for benefits on the effective date, and $38 million in additional benefits would be paid in 1974.

17. Disability insurance benefits applications filed after death

Disability insurance benefits (and dependents' benefits based on a worker's entitlement to disability benefits) would be paid to the disabled worker's survivors if an application for benefits is filed within 3 months after the worker's death, or within 3 months after enactment of the provision. It would be effective for deaths occurring after 1969.

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

Under present law, social security disability benefits must be reduced when workmen's compensation is also payable if the combined payments exceed 80 percent of the worker's average current earnings

before disablement. Average current earnings for this purpose can be computed on two different bases and the larger amount will be used. The bill adds a third alternative base, under which a worker's average current earnings can be based on the 1 year of his highest earnings in a period consisting of the year of disablement and the 5 preceding years.

Effective date.—January 1973.

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

19. Wage credits for members of the uniformed services

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

Effective date.—January 1973.

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

20. Optional determination of self-employment earnings

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

Effective date.—January 1973.

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

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

Effective date.—January 1973.

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

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

would compute their earnings for self-employment for social security purposes in the same way as those who are self-employed in the United States.

Effective date.—January 1973.

23. Issuance of social security numbers and penalty for furnishing false information to obtain a number

The bill includes a number of provisions dealing with the method of issuing social security account numbers. Under present law, numbers are issued upon application, often by mail, upon the individual's motion.

Under the bill the Secretary would be required to issue numbers to non-citizens entering the country under conditions which would permit them to work. In the case of a person who may not legally work at the time he is admitted to the United States, the number would be issued at the time his status changes. In addition to these general rules, numbers would be issued to persons who do not have them at the time they apply for benefits under any federally financed program.

The Secretary would be authorized to issue numbers to individuals when they enter the school system.

As a corollary to this more orderly system of issuing social security account numbers, the bill would provide criminal penalties for (1) furnishing false information in applying for a social security number; (2) knowingly and willfully using a social security number that was obtained with false information or (3) using someone else's social security number. The penalty would involve a fine of up to $1,000 or imprisonment for up to 1 year or both.

Effective date.—January 1973.

24. Trust fund expenditures for rehabilitation services

The bill provides an increase in the amount of social security trust fund moneys that may be used to pay for the costs of rehabilitating social security disability beneficiaries. The amount would be increased from 1 percent of the previous year's disability benefits (as under present law) to 1¼ percent for fiscal year 1973 and to 1½ percent for fiscal year 1974 and subsequent years.

Dollar expenditures.—$28 million in additional expenditures for vocational rehabilitation would be made in 1974.

25. Recomputation of benefits based on combined railroad and social security earnings

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

26. Payments to disabled former employee

Provides that payments made by an employer to a former disabled employee will not be counted for social security benefit or tax pur-

poses if the payment is made after the calendar year in which the former employee became entitled to social security disability insurance benefits.

27. Social security coverage for foreign missionaries

Eliminates for certain foreign ministers the $20,000 exclusion from earned income earned abroad in the case of a minister or a member of a religious order.

28. Coverage of students and certain part-time employees

Permits States to modify their social security coverage agreements for State and local employees so as to remove from coverage services of students employed by the public school or college they are attending, and the services of part-time employees.

29. Wage credits for World War II internees

Provides non-contributory social security credits for U.S. citizens of Japanese ancestry who were interned by the U.S. Government during World War II. In order to qualify for the wage credits an individual must have been age 18 or older at the time he was interned and the credits will be determined on the basis of the then prevailing minimum wage or the individual's prior earnings, whichever is larger.

30. Duration-of-relationship requirements

Amends the provision of present law which reduces from 9 months to 3 months the duration-of-relationship requirement when death is accidental or in line of duty in the Armed Forces so that there would be no duration-of-relationship requirement in cases of an accidental death if it is reasonable to expect that the deceased would have lived for at least 9 months.

31. Other Cash Benefit Amendments

Other amendments included in the committee bill relate to the executive pay level of the Commissioneer of Social Security; coverage of registrars of voters in Louisiana; coverage of certain policemen and firemen in West Virginia and Idaho and certain hospital employees in New Mexico; coverage of certain employees of the Government of Guam; coverage of Federal Home Loan Bank employees; and acceptance of money gifts made unconditionally to social security.

II. Medicare-Medicaid Amendments

1. Medicare coverage for the disabled

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

2. Hospital insurance for the uninsured

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

Effective date: July 1, 1973.

3. Part B premium increases

The bill will limit part B premium increases for fiscal years 1974 and thereafter to not more than the percentage by which the Social Security cash benefits had been generally increased since the last part B premium adjustment. Costs above those met by such premium payments would be paid out of general revenues in addition to the regular general revenue matching.

Effective date: July 1, 1973.

4. Part B deductible

Beginning with calendar year 1973, the bill increases the annual part B deductible from $50 to $60.

5. Automatic enrollment in part B

Effective July 1, 1973, the bill provides (except for residents of Puerto Rico and foreign countries) for automatic enrollment under part B for the elderly and the disabled as they become eligible for part A hospital insurance coverage. Persons eligible for automatic enrollment must also be fully informed as to the procedure and given an opportunity to decline the coverage.

6. Effective utilization review programs in medicaid

Effective July 1, 1973, the bill authorizes a one-third reduction in Federal matching payments for long-term stays in hospitals, nursing homes, intermediate care facilities, and mental institutions, if States fail to have effective programs of control over the utilization of institutional services or where they fail to conduct the independent professional audits of patients as required by law. The bill also authorizes the Secretary, after June 30, 1973, to compute a reasonable differential between the cost of skilled nursing facility services and intermediate care facility services provided in a State to medicaid patients.

7. Cost sharing under medicaid

The bill made the following changes with respect to premiums, copayments, and deductibles under medicaid.

1. It requires States which cover the medically indigent to impose monthly premium charges. The premium would be graduated by income in accordance with standards prescribed by the Secretary.

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

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

Effective date: January 1973.

8. Protection against loss of medicaid because of increased earnings

An individual or member of a family eligible for cash public assistance and medicaid who would otherwise lose eligibility for medicaid as a result of increased earnings from employment would be continued on medicaid for a period of 4 months from the date where medicaid eligibility would otherwise terminate.

9. Coordination between medicare and Federal employee plans

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

Effective date: January 1974.

10. Medicare services outside of the United States

Effective January 1, 1973, the bill authorizes use of a foreign hospital by a U.S. resident where such hospital was closer to his residence or more accessible than the nearest suitable United States hospital.

Such hospitals must be approved under an appropriate hospital approval program.

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

The bill also authorizes medicare payments for emergency hospital and physician services needed by beneficiaries in transit between Alaska and the other continental States.

11. Optometrists under medicaid

The bill requires States, which had previously covered optometric services under medicaid and which, in their State plans, specifically provided for coverage for eye care under "physicians' services," which an optometrist is licensed to provide, to reimburse for such care whether provided by a physician or an optometrist.

Effective date: Enactment.

12. Beneficiary liability under medicare

The bill would, with respect to claims for services provided after the date of enactment, relieve beneficiaries from liability in certain situations where medicare claims are disallowed and the beneficiary is without fault.

13. Limitation on Federal payments for disapproved capital expenditures

The bill would preclude medicare and medicaid payments for certain disapproved capital expenditures (except for construction toward which preliminary expenditures of $100,000 or more had been made in the 3-year period ending December 17, 1970) which are specifically determined to be inconsistent with State or local health facility plans. The provision would become effective after December 31, 1972 or earlier, if requested by a State.

14. Demonstrations and reports

The bill authorizes the Secretary to undertake studies, experiments or demonstration projects with respect to: various forms of prospective reimbursement of facilities; ambulatory surgical centers; intermediate care and homemaker services (with respect to the extended care benefit under medicare); elimination or reduction of the three-day prior hospitalization requirement for admission to a skilled nursing facility; determination of the most appropriate methods of reimbursing for the services of physicians' assistants and nurse practitioners; provision of day care services to older persons eligible under medicare and medicaid; and, possible means of making the services of clinical psychologists more generally available under medicare.

Effective date: Enactment.

15. Limitation on coverage of costs under medicare

The bill authorizes the Secretary to establish limits on overall direct or indirect costs which will be recognized as reasonable for comparable services in comparable facilities in an area. He may also establish maximum acceptable costs in such facilities with respect to items or

groups of services (for example, food costs, or standby costs). The beneficiary would be liable (except in the case of emergency care) for any amounts determined as excessive (except that he may not be charged for excessive amounts in a facility in which his admitting physician has a direct or indirect ownership in the facility.

Effective date: January 1973.

16. Limits on prevailing physician charge levels

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

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

17. Limits on payments to skilled nursing facilities and intermediate care facilities under medicaid

Effective January 1, 1973, Federal financial participation in reimbursement for skilled nursing facility care and intermediate care per diem costs would not be available to the extent such costs exceed 105 percent of prior year levels of payment under the provision (except for those costs attributable to any additional required services). The provision would except increased payment resulting from increases in the Federal minimum wage or other new Federal laws.

18. Payments to health maintenance organizations

Authorizes medicare to make a single combined Part A and B payment, on a capitation basis, to a "Health Maintenance Organization," which would agree to provide care to a group not more than one-half of whom are medicare beneficiaries who freely choose this arrangement. Such payments may not exceed 100 percent of present Part A and B per capita costs in a given geographic area, and the exact amount of the payment would be dependent on the efficiency of the HMO.

The Secretary could make these arrangements with existing prepaid groups and foundations, and with new organizations which eventually meet the broadly defined term "Health Maintenance Organization."

Effective date: July 1973.

19. Payments for the services of teaching physicians

The bill provides that, for accounting periods beginning after June 30, 1973, services of teaching physicians would be reimbursed on a costs basis unless:

(A) The patient is bona fide private or;

(B) The hospital has charged all patients and collected from a majority on a fee-for-service basis.

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

20. Advance approval of ECF and home health coverage

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

Effective date: January 1973.

21. Termination of payment to suppliers of service

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

Effective date: January 1973.

22. Elimination of requirement that States move toward comprehensive medicaid program

The bill repeals Section 1903(e) which required each State to show that it was making efforts in the direction of broadening the scope of services in its medicaid program and liberalizing eligibility requirements for medical assistance.

23. Elimination of medicaid maintenance of effort

The bill repeals Section 1902(d). Under Section 1902(d) a State could not reduce its aggregate expenditures for the State share of its medicaid program from one year to the next.

Effective date: Enactment.

24. Determination of reasonable cost of inpatient hospital services under medicaid and maternal and child health programs

The bill would allow States, with the advance approval of the Secretary, to develop their own methods and standards for reimbursement of the reasonable costs of inpatient hospital services. Reimbursement by the States would in no case exceed reasonable cost reimbursement as provided for under medicare.

25. Customary charges less than reasonable costs under medicare

Effective for accounting periods beginning after December 31, 1972, the bill provides that reimbursement for services under medicaid and medicare cannot exceed the lesser of reasonable costs determined under medicare, or the customary charges to the general public. The provisions would not apply to services furnished by public providers free of charge or at a nominal fee. In such cases reimbursement would be based on those items included in the reasonable cost determination which would result in fair compensation.

Effective date: January 1973.

26. Institutional planning under medicare

The bill would require all providers, as a condition of medicare participation, to have a written overall plan and budget reflecting an operating budget and a capital expenditures plan which would be updated at regular intervals.

The required annual operating budget would not have to be a detailed item budget.

Effective date: Fiscal years after March 1973.

27. Cost determination systems under medicaid

The bill provides for Federal matching for the cost of designing, developing, and installing mechanized claims processing and information retrieval systems at 90 percent and 75 percent for the operation including contract operation (of such systems).

Effective Date: July 1972.

28. Prohibition against reassignment of claims for benefits

Effective January 1, 1973, the bill prohibits payment to anyone other than the physician or other person who provided the service, unless such person is required as a condition of his employment to turn his fees over to his employer.

29. Utilization review requirements under medicaid and maternal and child health programs

Effective January 1973, the bill requires hospitals and skilled nursing homes participating in titles 5 and 19 to use the same utilization review committees and procedures now required under title 18 for those programs with certain exceptions approved by the Secretary. This requirement is in addition to any other requirements now imposed by the Federal or State governments.

30. Notification of unnecessary hospital and skilled nursing facility admissions

The bill requires notification to patient and physician and a payment cut-off after 3 days, in those cases where unnecessary utilization is discovered during a sample review of admissions to medicare hospitals or skilled nursing facilities.

31. Use of State health agency to perform certain functions under medicaid

Effective January 1973, the bill requires that the same State health agency (or other appropriate State medical agency) certify facilities for participation under both medicare and medicaid. The bill also requires that Federal participation in medicaid payments be contingent upon the State health agency establishing a plan for statewide review of appropriateness and quality of services rendered.

32. Relationship between medicaid and comprehensive health programs

The bill permits States to waive Federal statewideness and comparability requirements in medicaid with approval of the Secretary if a State contracts with an organization which has agreed to provide

health services in excess of the State plan to eligible recipients who reside in the area served by the organization and who elect to receive services from such organization. Payment to such organizations could not be higher on a per-capita basis than the per-capita medicaid expenditures in the same general area.

33. Proficiency testing

The bill provides for proficiency testing of paramedical personnel under medicaid until December 31, 1977.

34. Penalty for fraudulent acts and false reporting

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

35. Provider Reimbursement Review Board

The bill establishes a Provider Reimbursement Review Board to hear cases involving an issue of $10,000 or more. Groups of providers can appeal where the amounts at issue on a common matter aggregate $50,000 or more. Any provider which believes that its fiscal intermediary has failed to make a timely cost determination on its annual cost report or timely determination on a supplemental filing can appeal to the Board where the amount involved is $10,000 or more. The change is effective for accounting periods ending on or after June 30, 1973.

36. Validation of Joint Commission on Accreditation of Hospitals Surveys

The bill provides that State certification agencies, as directed by the Secretary, would survey on a selective sample basis (or where substantial allegations of noncompliance have been made) hospitals accredited by the JCAH. The bill also authorizes the Secretary to promulgate health and safety standards without being restricted to JCAH standards.

37. Payment for durable medical equipment under medicare

The bill authorizes the Secretary to experiment with reimbursement approaches which are intended to eliminate unreasonable expenses resulting from prolonged rentals of durable medical equipment and then to implement the approaches found effective.

38–42. Skilled Nursing Facilities under medicare and medicaid

38. Conforming standards for extended care and skilled nursing home facilities.—The bill would establish a single definition and set of standards for extended care facilities under medicare and skilled nursing homes under medicaid. The provision creates a single category of "skilled nursing facilities" which would be eligible to partici-

pate in both health care programs. A "skilled nursing facility" would be defined as an institution meeting the present definition of an extended care facility and which also satisfies certain other medicaid requirements set forth in the Social Security Act.

Effective date: July 1973.

39. "Skilled care" definition for medicare and medicaid.—The bill would change the definition of care requirements with respect to entitlement for extended care benefits under medicare and with respect to skilled nursing care under medicaid. Present law would be amended to authorize skilled care benefits for individuals in need of "skilled nursing care and/or skilled rehabilitation services on a daily basis in a skilled nursing facility which it is practical to provide only on an inpatient basis." Coverage would also be continued during short-term periods (e.g. a day or two) when no skilled services were actually provided but when discharge from a skilled facility for such brief period was neither desirable nor practical.

Effective date: January 1973.

40. 14-Day transfer requirement for extended care benefits.—Under existing law, medicare beneficiaries are entitled to extended care benefits only if they are transferred to an extended care facility within 14 days following discharge from a hospital. Under the bill an interval of more than 14 days would be authorized for patients whose conditions did not permit immediate provision of skilled services within the 14-day limitation. An extension not to exceed 2 weeks beyond the 14 days would also be authorized in those instances where an admission to an ECF is prevented because of the non-availability of appropriate bed space in facilities ordinarily utilized by patients in a geographic area. *Effective date:* Enactment.

41. Reimbursement rates for care in skilled nursing facilities.—The bill amends title 19 to require States, by July 1, 1976, to reimburse skilled nursing and intermediate care facilities on a reasonable cost-related basis, using acceptable cost-finding techniques and methods approved and validated by the Secretary of HEW. Cost reimbursement methods which the Secretary found to be acceptable for a State's medicaid program could be adapted, with appropriate adjustments, for purposes of medicare skilled nursing facility reimbursements in that State.

42. Skilled nursing facility certification procedures.—Under the bill, facilities which participate in both medicare and medicaid would be certified by Secretary of HEW. The Secretary would make that determination, based principally upon the appropriate State health agency evaluation of the facilities.

43. Federal financing of nursing home inspections

The bill authorizes 100% Federal reimbursement for the survey and inspection costs of skilled nursing facilities and intermediate care facilities under medicaid, from October 1, 1972, through July 1, 1974.

44. Disclosure of information concerning medicare agents and providers

The bill provides that DHEW regularly make public the following types of evaluations and reports with respect to the medicare and medicaid programs: (1) individual contractor performance reviews and other formal evaluations of the performance of carriers, intermediaries, and State agencies including the reports of follow-up reviews: (2) comparative explanations of the performance of contractors—including comparisons of either overall performance or of any particular contractor operation: (3) program validation survey reports—with the names of individuals deleted.

45. Prohibition against institutional medical care payments under cash welfare programs

The bill precludes Federal matching for that portion of any money payment which is related to institutional medical or remedial care.

46. Determining eligibility for medicaid for certain individuals

Individuals eligible for medicaid in September 1972 could not lose their eligibility because of the recent 20% social security benefit increase until October 1973.

47. Professional standards review organizations

The bill provides for the establishment of professional standards review organization consisting of substantial numbers of practicing physicians (usually 300 or more) in local areas to assume responsibility for comprehensive and on-going review of services covered under the medicare and medicaid programs. Until January 1, 1976 only such qualified physician-sponsored organizations may be designated as PSRO's. Subsequent to that date priority will be given to such organizations but where they do not choose to or do not qualify to assume such responsibilities in an area, the Secretary may designate another organization having professional medical competence as the PSRO for the area. The PSRO would be responsible for assuring that institutional services were (1) medically necessary and (2) provided in accordance with professional standards. A PSRO, at its option, and with the approval of the Secretary, may also assume responsibility for the review of non-institutional care and services provided under medicare and Medicaid. PSRO's would not be involved with reasonable charge determinations. The provision is designed to assure proper utilization of care and services provided under medicare and medicaid utilizing a formal professional mechanism representing the broadest possible cross-section of practicing physicians in an area. Safeguards are included, designed to protect the public interest, including appeals procedures, and to prevent pro forma assumption in carrying out review responsibilities. The provision requires recognition of and use by the PSRO of utilization review committees in hospitals and medical organizations to the extent they are determined to be effective.

48. Physical therapy services and other services under medicare

Effective July 1973, the bill would include as covered services under part B, physical therapy provided in the therapist's office pursuant to a physician's written plan of treatment.

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

Benefit payments in one year for services by an independent practitioner in his office or the patient's home could not exceed $100. Effective January 1973, reimbursement for services provided by physical and other therapists would generally be limited to a reasonable salary-related basis rather than fee-for-service basis.

49. Coverage of supplies related to colostomies

The bill provides for medicare coverage of the costs of supplies directly related to the care of a colostomy.

50. Coverage prior to application for medicaid

The bill requires, effective July 1, 1973, all States to provide medicaid coverage for care and services furnished in or after the third month prior to application to those individuals who were otherwise eligible when the services were received. Included as eligible under the three-months retroactive coverage requirement would be deceased individuals whose fatal condition prevented them from applying for medicaid coverage but who would have been eligible if application had been made.

States are expected to modify their provider agreements where applicable so as to permit the application of appropriate utilization control procedures retroactively in these cases to assure that appropriate and necessary care was delivered.

51. Hospital admissions for dental services under medicare

The bill authorizes the dentist who is caring for a medicare patient to make the certification of the necessity for inpatient hospital admission for noncovered dental services under the above circumstances without requiring a corroborating certification by a physician.

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

52. Extension of grace period for termination of supplementary medical insurance coverage where failure to pay premiums is due to good cause

The bill extends the 90-day grace period for an additional 90 days where the Secretary finds that there was good cause for failure to pay the premium before the expiration of the initial 90-day grace period.

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

53. Extension of time for filing claim for supplementary medical insurance benefits where delay is due to administrative error

The bill provides that where a claim under supplementary medical insurance is not filed timely due to error of the Government or one of

its agents, the claim may nevertheless be honored if filed as soon as possible after the facts in the case have been established.

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

54. Waiver of enrollment period requirements where individual's rights were prejudiced by administrative error or inaction

The bill authorizes the Secretary to provide such equitable relief as may be necessary to correct or eliminate the effects of these situations, including (but not limited to) the establishment of a special initial or subsequent enrollment period, with a coverage period determined on the basis thereof and with appropriate adjustments of premiums.

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

55. Elimination of provisions preventing enrollment in supplementary medical insurance program more than 3 years after first opportunity

The bill eliminates the 3-year limit with respect to both initial enrollment and reenrollment after an initial termination. Enrollment periods would remain as presently defined and the restriction limiting individuals who terminate enrollment to reenroll only once would be retained.

This provision would apply to all those who are ineligible to enroll because of the 3-year limit in effect under present law.

56. Waiver of recovery of incorrect medicare payments from survivor who is without fault

The bill permits any individual who is liable for repayment of a medicare overpayment to qualify for waiver of recovery of the overpaid amount if he is without fault and if such recovery would defeat the purpose of title II or would be against equity and good conscience.

57. Requirement of minimum amount of claim to establish entitlement to hearing under supplementary medical insurance program

The bill requires that a minimum amount of $100 be at issue before an enrollee in the supplementary medical insurance program will be granted a fair hearing by the carrier.

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

58. Collection of supplementary medical insurance premiums from individuals entitled to both social security and railroad retirement benefits

The bill provides that the Railroad Retirement Board shall be responsible for collection of supplementary medical insurance premiums for all enrollees who are entitled under that program.

59. Provide that services of optometrists in furnishing prosthetic lenses not require a physician's order

The bill would recognize the ability of an optometrist to attest to a beneficiary's need for prosthetic lenses by amending the definition of

the term "physician" in title XVIII to include a doctor of optometry authorized to practice optometry by the State in which he furnishes services. An optometrist would be recognized as a "physician" only for the purpose of attesting to the patient's need for prosthetic lenses. (Of course, neither the physician nor the optometrist would be paid by medicare for refractive services when the beneficiary has been given a prescription by a physician for the necessary prosthetic lenses.) This change would not provide for coverage of services performed by optometrists other than those covered under present law, nor would it permit an optometrist to serve as a "physician" on a professional standards review organization.

60. Prohibition against requiring professional social workers in ECF's under medicare

The bill specifies that the provision of medical social services will not be required as a condition of participation for an extended care facility under medicare.

61. Refund of excess premiums under medicare

The bill provides authority for the Secretary to dispose of excess supplementary medical insurance premiums and excess hospital insurance premiums in the same manner as unpaid medical insurance benefits are treated.

62. Waiver of requirement of registered professional nurses in skilled nursing facilities in rural areas

The bill authorizes the granting of a special waiver of the R.N. nursing requirement for skilled nursing facilities in rural areas provided that a registered nurse is absent from the facility for not more than two day-shifts (if the facility employs one full-time registered nurse) and the facility is making good faith efforts to obtain another on a part-time basis.

In addition, this special waiver may be granted only if (1) the facility is caring only for patients whose physicians have indicated (in written form on order sheet and admission note) that they could go without a registered nurse's services for a 48-hour period or (2) if the facility has any patients for whom physicians have indicated a need for daily skilled nursing services, the facility has made arrangements for a registered nurse or a physician to spend such time as is necessary at the facility to provide the skilled nursing services required by patients on the uncovered day.

63. Exemption of Christian Science sanatoriums from certain nursing home requirements under medicaid

The bill exempts Christian Science sanatoriums from the requirements for a licensed nursing home administrator, requirements for medical review, and other inappropriate requirements of the medicaid program.

Such sanatoriums will be expected to continue to meet all applicable safety standards.

64. Licensure requirement for nursing home administrators

The bill permits States to establish a permanent waiver from licensure requirements for those persons who served as nursing home administrators for the three-year period prior to the establishment of the State's licensing program.

65. Increase in maximum Federal medicaid amount for Puerto Rico and the Virgin Islands

The bill provides that the Federal ceiling on title XIX payments to Puerto Rico be increased to $30 million effective with fiscal year 1972 and fiscal years thereafter. The 50 percent Federal matching rate would remain unchanged. The annual medicaid amount for the Virgin Islands would be increased from $650,000 to $1,000,000.

66. Medicaid: Freedom of choice in Puerto Rico

The bill delays, until June 30, 1975, the requirement that Puerto Rico implement the "freedom of choice" provision, under which medicaid recipients can choose providers or practitioners in its medicaid program.

67. Inclusion of American Samoa and the Trust Territory of the Pacific Islands under title V

The bill authorizes eligibility under title V for Samoa and the Trust Territory of the Pacific Islands.

68. Coverage of chiropractic services under part B of medicare

The bill broadens the definition of the term "physician" in title XVIII to include a licensed chiropractor who also meets uniform minimum standards to be promulgated by the Secretary.

The services furnished by chiropractors would be covered under the program as "physicians' services," but only with respect to treatment of the spine by means of manual manipulation which the chiropractor is legally authorized to perform. Claims for such treatment must be verifiable with a satisfactory X-ray indicating the existence of a subluxation of the spine.

The amendment would become effective with respect to services provided on or after July 1, 1973.

69. Chiropractors' services under medicaid

The bill conforms the coverage of chiropractic under medicaid with the provisions conditioning eligibility of such services included in the amendment adding chiropractic coverage to Part B of medicare except for the requirement that an X-ray show the existence of a subluxation.

70. Services of podiatric interns and residents under part A of medicare

Effective January 1973, the bill includes within the definition of approved hospital teaching programs services furnished by an intern

or resident-in-training in the field of podiatry under a teaching program approved by the Council on Podiatry Education of the American Podiatry Association.

71. Use of consultants for extended care facilities

The bill allows those State agencies which are capable of and willing to provide specialized consultative services for medicare patients in a skilled care facility which requests them, to do so, subject to approval of the State's arrangements by the Secretary.

72. Direct laboratory billing of patients

The bill provides that, with respect to diagnostic laboratory tests for which payment is to be made to a laboratory, the Secretary would be authorized to negotiate a payment rate with the laboratory which would be considered the full charge for such tests, and for which reimbursement would be made at 100% of such negotiated rate. Such negotiated rate would be limited to an amount not to exceed the total payment that would have been made in the absence of such rate.

73. Clarification of meaning of "physicians' services" under title XIX

The bill defines a physician, under Title XIX, for purposes of the mandatory provision of physicians' services as being a duly licensed doctor of medicine or osteopathy.

74. Limitation on adjustment or recovery of incorrect payments under the medicare program

The bill would limit medicare's right of recovery of overpayments to a 3-year period (or a 1-year period) from the date of payment where the beneficiary acted in good faith; would permit the Secretary to set a time between 1 and 3 years within which claims for underpayment would have to be made.

75. Speech pathology services under medicare

The bill would cover under medicare the costs of speech pathology services where such services are provided in clinics participating in the program as providers of covered physical therapy services.

76. Termination of medical asistance advisory council

The bill terminates the medicaid advisory council.

77. Modification of role of health insurance benefits advisory council

The bill provides for modification of the role of HIBAC so that its role would be that of offering suggestions for the consideration of the Secretary on matters of general policy in the medicare and medicaid programs.

78. Authority of Secretary to administer oaths in medicare proceedings

The bill authorizes the Secretary, in carrying out his responsibility for administration of the medicare program, to administer oaths and

affirmations in the course of any hearing, investigation, or other proceeding.

79. Withholding medicaid payments to terminated medicare providers

The bill authorizes the Secretary upon 60-days' notice to withhold Federal participation in medicaid payments by States with respect to institutions which have withdrawn from medicare without refunding medicare overpayments or submitting medicare cost reports.

80. Intermediate care in States without medicaid

The bill allows Federal matching for intermediate care in States which, on January 1, 1972, did not have a medicaid program in operation.

81. Required information relating to excess medicare tax payments by railroad employees

The bill deletes the requirement that railroads include amount of hospital insurance tax withheld on W–2 forms. Employees would be notified, however, that those with dual employment may be entitled to a refund of excess hospital insurance tax paid.

82. Appointment and confirmation of Administrator of Social and Rehabilitation Service

The bill provides that appointments made on or after the enactment of this bill to the office of the Administrator of the Social and Rehabilitation Service will be made by the President, by and with the advice and consent of the Senate.

83. Repeal of section 1903(b)(1)

The bill deletes the requirement that States spend at least as much for care of individuals age 65 or over in mental hospitals as in fiscal year 1965.

84. Coverage under medicaid of intermediate care furnished in mental and tuberculosis institutions

The bill provides that intermediate care can be covered for individuals age 65 or older in mental institutions if such individuals could also be covered when in mental hospitals for hospital or skilled nursing facility care. Effective date: Services furnished after December 31, 1972.

85. Independent review of intermediate care facility payments

The bill provides that independent professional review to determine proper patient placement and care of Title XIX patients is mandatory in all intermediate care facilities.

86. Intermediate care maintenance of effort in public institutions

The bill provides that the designation of the base period for the maintenance of effort requirement pertaining to non-Federal expenditures with respect to patients in public institutions for the mentally

retarded to be the four quarters immediately preceding the quarter in which the State elected to make such services available.

87. Disclosure of ownership of intermediate care facilities

The bill requires that intermediate care facilities not otherwise licensed as skilled nursing homes by a State make ownership information available to the State licensing agency. Effective date: January 1, 1973.

88. Treatment in mental hospitals for medicaid eligibles under age 21

The bill authorizes coverage of inpatient care (under specific conditions) in mental institutions for medicaid eligibles under age 21. *Effective date:* January 1973.

89. Public disclosure of information concerning survey reports of an institution

The bill requires the Secretary to make reports of an institution's significant deficiencies or the absence thereof (such as in the areas of staffing, fire safety, and sanitation) a matter of public record readily and generally available. Such information would be available for inspection within 90 days of completion of the survey.

90. Family planning services mandatory under medicaid

(1) The bill authorizes 90% Federal funding for the costs of family planning services under medicaid and title IV.

(2) Provision requires States to make available on a voluntary and confidential basis such counseling, services and supplies, directly and/or on a contract basis with family planning organizations throughout the State, to present, former, or likely recipients who are of childbearing age and who express a desire for such services.

(3) The Federal share of AFDC funds would be reduced by 1%, beginning in fiscal 1974, if a State in the prior year fails to inform the adults in AFDC families of the availability of family planning services or if the State fails to actually provide or arrange for such services for persons desiring to receive them who are applicants or recipients of cash assistance.

91. Penalty for failure to provide child health screening services under medicaid

The bill would reduce the Federal share of AFDC matching funds by 1%, beginning in fiscal 1975, if a State—

(a) fails to inform the adults in FDC families of the availability of child health screening services;

(b) fails to actually provide or arrange for such services; or

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

92. Home health coinsurance

Effective January 1973, the bill eliminates requirement of coinsurance payment under Part B of medicare for home health services.

93. Long-term care

The bill includes as intermediate care facilities or skilled nursing facilities under medicaid long-term institutions certified by the Secretary on Indian reservations.

94. Medicare appeals

The bill clarifies present law that there is no authorization for an appeal to the Secretary or for judicial review on matters solely involving amounts of benefits under part B, and that insofar as part A amounts are concerned, appeal is authorized only if the amount in controversy is $100 or more and judicial review only if the amount in controversy is $1,000 or more.

95. Medicare: Coverage of persons needing kidney transplantation or dialysis

The bill provides that fully or currently insured workers under social security and their dependents with chronic renal disease would be deemed disabled for purposes of coverage under parts A and B of medicare. Coverage would begin 3 months after a course of renal dialysis is begun.

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

The bill would replace the present State programs of aid to the aged, blind, and disabled, effective January 1, 1974, with a new wholly Federal program of supplemental security income.

National supplemental security income; disregard of social security or other income

Under the bill, aged, blind, and disabled persons with no other income would be guaranteed a monthly income of at least $130 for an individual or $195 for a couple. In addition the bill would provide that the first $20 of social security or any other income would not cause any reduction in supplemental security income payments.

As a result, aged, blind, and disabled persons who also have monthly income from social security or other sources (which are not need-related) of at least $20 would, be assured total monthly income of at least $150 for individual or $215 for a couple.

Earned income disregard

In addition to a monthly disregard of $20 of social security or other income, there would be an additional disregard of $65 of earned income plus one-half of any earnings above $65. This will enable those aged, blind, and disabled individuals who are able to do some work to do so and in the process give them a higher income in addition to supplemental security income.

In addition, as under present law, any income necessary for the fulfillment of a plan for achieving self-support would be disregarded for persons qualifying on the basis of blindness. A savings clause would assure that blind persons would not receive any reduction in benefits due to these provisions.

Definitions of blindness and disability

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

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

The term "disability" would be defined as "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months." This definition is the same as that now used in the Social Security disability insurance program.

The term "blindness" would be defined as central visual acuity of 20/200 or less in the better eye with the use of correcting lens. Also in-

cluded in this definition is the particular sight limitation which is referred to as "tunnel vision."

A blind or disabled person who was on the rolls in December 1973 and met the State definition for blindness or disability as defined in the State plan in effect October 1972 would be considered blind or disabled for purposes of this title so long as he continues to be blind or disabled.

No disabled person would be eligible if the disability is medically determined to be due solely to drug addiction or alcoholism unless such individual is undergoing appropriate treatment, if available. Payments for addicts or alcoholics would only be made to third parties as protective payments.

Other Federal eligibility standards

Eligibility for supplemental security income would be open to an aged, blind or disabled individual if his resources were less than $1500 (or $2250 for a couple). In determining the amount of his resources, the value of the home (including land surrounding home), household goods, personal effects, including an automobile, and property needed for self support would, if found to be reasonable, be excluded. Life insurance policies would not be counted if the face value of all policies was less than $1,500. (Current recipients under State programs with higher resource limits would retain their eligibility.)

State supplementation

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

Ineligibility for food stamps

Individuals in the Supplemental Security Income program would not be eligible for food stamps or surplus commodities.

Savings clause

The bill provides no direct Federal participation in the costs of State supplemental payments. However, a savings clause is included under which the Federal Government would assume all of a State's costs of supplemental payments which exceed its calendar year 1972 share of the costs of aid to the aged, blind, and disabled. This savings clause would apply only to State supplementation needed to maintain the State's assistance levels in effect as of January 1972. The savings clause would, however, also cover an upward adjustment over the January levels to the extent necessary to offset the elimination of food stamp eligibility.

Medicaid coverage

Under present law, the States are required to cover all cash assistance recipients under the medicaid program. The bill would exempt from this requirement newly eligible recipients who qualify because of the new provision for a $130 minimum benefit with a disregard of $20 of social security or other income.

Social services

States would be authorized to continue programs providing social services to aged, blind, and disabled persons. These services are currently provided under the welfare programs for the aged, blind, and disabled which would be replaced by the new Federal supplemental security income program. There would be 75 percent Federal matching for the services provided, subject to the overall limitations established by the State and Local Fiscal Assistance Act.

AMENDMENTS TO PRESENT LAW FOR AID TO AGED, BLIND, AND DISABLED PERSONS (EFFECTIVE UNTIL JANUARY 1, 1974):

Separation of social services not required

Separation of social services and eligibility determination is specifically not required.

Cost for providing manuals

At its option, the State may require a charge for reasonable cost of providing manuals and other policy issuances.

Appeals process

The bill provides that the decision of the local agency on the matter considered at an evidentiary hearing may be implemented immediately.

Absence from State for 90 days

The bill provides that the State may make any person ineligible for money payments who has been absent from the State over 90 consecutive days until such person has been present in the State for 30 consecutive days in the case of an individual who has maintained his residence in the State during such period or 90 days in the case of any other individual.

Rent payments for public housing

Permits the States, if they elect to do so, to make rent payments directly to a public housing agency on behalf of a recipient or a group or groups of recipients.

Safeguarding information

The bill permits the use or disclosure of information concerning applicants or recipients to public officials who require such information in connection with their official duties.

Passalong of social security increases

Present law requires State programs of aid to the aged, blind, and disabled to assure that the total income of recipients who also get social security are at least $4 higher as a result of the 1969 social security benefit increase. The bill would add an additional $4 "passalong" related to this year's 20 percent social security increase and would make both "passalong" provisions applicable until January 1974.

IV. Child Welfare Services and Social Services

Grants to States for child welfare services (including foster care and adoptions)

The committee adopted an amendment increasing the annual authorization for Federal grants to the States for child welfare services to $196 million in fiscal year 1973, rising to $266 million in 1977 and thereafter. For fiscal year 1973, this is $150 million more than the $46 million which has been appropriated every year since 1967. It is anticipated that a substantial part of any increased appropriation under this higher authorization will go toward meeting the costs of providing foster care which now represents the largest single item of child welfare expenditure on the county level. The bill, however, avoided earmarking amounts specifically for foster care so that wherever possible the State and counties could use the additional funds to expand preventive child welfare services with the aim of helping families stay together and thus avoiding the need for foster care. The additional funds can also be used for adoption services, including action to increase adoptions of hard-to-place children.

Social Services

Provides a saving provision to the limitation on expenditures for social services contained in the State and Local Assistance Act of 1972 so that States for the first quarter of fiscal 1973 will be reimbursed as they would have been under previous laws. This saving provision would be applicable only to the extent that the resultant Federal funding for this quarter does not exceed $50 million.

TABLE 1.—SOCIAL SECURITY TAX RATES FOR EMPLOYERS AND EMPLOYEES UNDER PRESENT LAW AND UNDER H.R. 1

[In percent]

Calendar year	OASDI		HI		Total	
	Present law	New schedule	Present law	New schedule	Present law	New schedule
1973 to 1977.....	4.60	4.85	0.9	1.0	5.50	5.85
1978 to 1980.....	4.50	4.80	1.0	1.25	5.50	6.05
1981 to 1985.....	4.50	4.80	1.0	1.35	5.50	6.15
1986 to 1992.....	4.50	4.80	1.1	1.45	5.60	6.25
1993 to 1997.....	4.50	4.80	1.2	1.45	5.70	6.25
1998 to 2010.....	4.50	4.80	(1.2)	(1.45)	(5.70)	(6.25)
2011+.....	5.35	5.85	(1.2)	(1.45)	(6.55)	(7.3)

Note: Under both present law and the new schedule, the contribution and benefit base would be $10,800 in 1973 and $12,000 in 1974, with automatic adjustment thereafter.

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

[Amounts in millions]

Provision	Additional benefit payments in calendar year 1974
Total	$4,372
Social security cash benefit programs:	
Earnings in year of attainment of age 72	14
Retirement test at $2,100	842
Special minimum at $170 for 30 years	20
Credit for delayed retirement prospectively	27
Liberalized disability provision for blind (House)	38
Reduction in disability waiting period to 5 months	128
Increased benefits for widows and widowers	1,109
Eliminate support requirement for divorced wives	23
Student child benefits payable after 22 to end of semester	19
Age 62 computation point for men	14
Liberalized workmen's compensation offset	22
Children disabled at ages 18 to 21	17
Increased allowance for vocational rehabilitation expenses	28
Military wage credit	46
Subtotal, cash benefits	2,347
Hospital insurance program:	
Coverage of the disabled	1,412
Liberalized definition of skilled nursing facility care	110
Waiver of beneficiary liability for disallowed claims	35
Coverage of renal dialysis and transplantation	75
Subtotal, hospital insurance	1,632
Supplementary medical insurance program (general revenues):	
Coverage of the disabled	365
Increase in part B deductible	−58
Coverage of chiropractors' services	17
Coverage of speech pathologist services	9
Coverage of renal dialysis and transplantation	52
Eliminate coinsurance on home health services	8
Subtotal, supplementary medical insurance program	393

Source: Department of Health, Education, and Welfare.

TABLE 3.—CHANGES IN ESTIMATED MEDICAID COSTS (+) AND SAVINGS (—) UNDER H.R. 1

[In millions of dollars]

	Calendar year 1974
Changes in H.R. 1:	
Coverage of the disabled under Medicare	—70
Increase in Medicare pt. B deductible from $50 to $60	+8
Reduction in Medicaid matching if States fail to perform required utilization review	—162
Imposition of premium, copayment and deductible requirements on Medicaid recipients	—89
Families with earnings under Medicaid: Eligibility extended 4 months	+33
Limitation on nursing home and intermediate care facility reimbursement to 105 percent of last year's payment	—22
Elimination of requirement that States move toward comprehensive Medicaid program by 1977	(1)
Elimination of requirement that States maintain their year to year fiscal efforts in Medicaid	—640
Payments to States under Medicaid for installation and operation of claims processing and information retrieval systems	+10
Increased Medicaid matching for Puerto Rico and the Virgin Islands	+10
More specific requirements as to eligibility for skilled nursing level of care	—14
100 percent reimbursement for the cost of certifying skilled nursing homes under Medicaid	+10
Expansion of Medicaid coverage to include inpatient care for mentally ill children	+120
90 percent Federal funding of family planning services	+36
Coverage of persons needing renal dialysis or transplantation under Medicare	—20
Preserving Medicaid eligibility for social security beneficiaries	
Total estimated reduction in Medicaid costs under H.R. 1	—790

[1] The current law estimates take no account of the effect of the requirement that States move toward comprehensive medicaid programs by 1977; therefore, no savings are attributed to the repeal of this requirement.

Source: Department of Health, Education, and Welfare.

TABLE 4.—CALENDAR YEAR 1974 FEDERAL COSTS OF SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED, AND CHILD WELFARE SERVICES

[Dollars in billions]

	Gross costs	Current law	Amount of increase
Aged, blind, and disabled:			
Benefit payments	$3.5	$2.1	$1.4
Savings clause for State supplementation	.3	.....	.3
Food programs	.....	.3	—.3
Administrative costs	.4	.2	.2
Subtotal, aged, blind, and disabled	4.2	2.6	1.6
Child welfare services	.2	(1)	.2
Total	4.4	2.6	1.8

[1] Current law cost is $46 million.

Source: Department of Health, Education, and Welfare.

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