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I. SOCIAL SECURITY CASH BENEFIT PROVISIONS

1. SPECIAL MINIMUM CASH BENEFIT

The new law provides a special minimum benefit computed by multiplying $8.50 by a worker's number of years in covered employment in excess of 10 years up to 30 years. This produces a special minimum benefit of $170 a month for a worker retiring at age 65 (or disabled) who has been employed for 30 years under social security coverage. This benefit will 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 will be payable to people with 23 or more years of covered employment. A worker retiring at age 65 (or a disabled worker) with 25 years of employment under social security is guaranteed a benefit of at least $127.50; while one with 30 years will receive at least $170 a month. Minimum payments to a couple are one and one-half times these amounts. The special minimum benefit will not be increased automatically in the future.

Years of covered employment	Special minimum
22 or less	(*)
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

*The special minimum benefit will not generally be payable to workers with less than 23 years of covered employment since these workers will generally qualify for higher regular benefits.

Effective date.—January 1973.

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

2. INCREASE IN WIDOW'S AND WIDOWER'S INSURANCE BENEFITS

A widow (or dependent widower) whose benefits start at age 65 or after will 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, but not less than 82½ percent of his primary insurance amount.

The benefit for a widow (or widower) who comes on the rolls between 60 and 65 will be reduced to take account of the longer period over which the benefit will be paid. For example, a widow who becomes entitled to benefits in the month she attains age 63 will receive 88.6 percent of her husband's benefit; for a widow who applies in the month she attains age 64 the benefit will be equal to 94.3 percent of her husband's benefit. A widow's benefit after reduction for age cannot exceed the amount her deceased husband would have received, but in no case will a widow who began receiving benefits at or after age 62 get less than 82½ percent of the husband's primary insurance amount.

Effective date.—January 1973.

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

3. DELAYED RETIREMENT CREDIT

Provides for an increase in social security retirement benefits of 1 percent for each year after age 65 and before age 72 that an individual delays his retirement. Benefits of dependents and survivors will not be increased under the provision.

Effective date.—For computations and recomputations after 1972 based on earnings after 1970.

4. AGE 62 COMPUTATION POINT FOR MEN

Under prior law, the method of computing benefits for men and women differed in that years up to age 65 were taken into account in determining average earnings for men, while for women only years up to age 62 were taken into account. Also, benefit eligibility was figured up to age 65 for men, but only up to age 62 for women. Under the new law, these differences are eliminated by applying to men the rules which previously applied only to women.

Effective date.—The new provision will become effective, starting January 1973 and will be fully effective in January 1975 by reducing the age for men to 64 in 1973, to 63 in 1974 and to 62 in 1975.

Number of people affected and dollar payments.—About 190,000 people will be affected immediately and $14 million in additional benefits will 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 receive all his social security benefits for the year is increased from $1,680 to $2,100. Under prior law, benefits were reduced by $1 for each $2 of earnings between $1,680 and $2,880 and by $1 for each $1 of earnings above $2,880. The new law provides for a $1 reduction in benefits for each $2 of all earnings above $2,100; there is no $1-for-$1 reduction as under prior 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 will not be included, as they were under prior law, in determining his total earnings for the year.

The amount of exempt earnings is to be increased automatically in the future in proportion to the rise in average earnings, whenever social security benefits are increased automatically.

Effective date.—January 1973.

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

6. DEPENDENT WIDOWER'S BENEFITS AT AGE 60

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

Effective date.—January 1973.

7. CHILDHOOD DISABILITY BENEFITS

Childhood disability benefits will be paid to the disabled son or daughter of an insured retired, deceased, or disabled worker, if the child's disability began before age 22, rather than before age 18 as under prior law. In addition, a person who was entitled to childhood disability benefits will 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 will become eligible for benefits on the effective date and $17 million in additional benefits will be paid in 1974.

8. CONTINUATION OF CHILD'S BENEFITS THROUGH THE END OF A SEMESTER

Payment of benefits to a child attending school will 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. If the educational institution in which he is enrolled is not operated on a semester or quarter system, benefits will continue until the month following the completion of the course in which he is enrolled or two calendar months have elapsed after the month he reaches age 22, whichever occurs first.

Effective date.—January 1973.

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

9. ELIGIBILITY OF A CHILD ADOPTED BY AN OLD-AGE OR DISABILITY INSURANCE BENEFICIARY

The provisions of law relating to eligibility requirements for child's benefits in the case of adoption by old-age and disability insurance beneficiaries are modified to make the requirements uniform in both cases. A child adopted after a retired or disabled worker becomes entitled to benefits will 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. A child who was born in the 1-year period specified in (2) and (3) is eligible if he was living with and receiving support from the worker for substantially all of the period after he was born.

Effective date.—January 1968 and after if an application for benefits is filed within 6 months after the month of enactment; otherwise, effective for the month of enactment.

10. BENEFITS FOR A CHILD ENTITLED ON THE RECORD OF MORE THAN ONE WORKER

The new law provides that a child who is entitled to benefits on the earnings record of more than one worker will be paid 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.

Effective date.—January 1973.

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

Benefits are extended to the grandchild of a worker or his spouse if the grandchild's parents have died or are disabled and if the grandchild began living with the grandparent before age 18 and was living with and being supported by the grandparent for the year immediately before the grandparent became disabled, qualified for retirement benefits, or died.

Effective date.—January 1973.

12. NONTERMINATION OF CHILD'S BENEFITS BY REASON OF ADOPTION

Under prior law, a child's entitlement to benefits ended if he was adopted unless he was 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 was getting benefits, or (4) a stepparent, grandparent, aunt, uncle, brother, or sister after the death of the worker on whose earnings the child was getting benefits.

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

Effective date.—October 1973.

13. ELIMINATION OF SUPPORT REQUIREMENTS FOR DIVORCED WOMEN

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 under the old law a divorced woman was 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 new law eliminates these support requirements for divorced wives, divorced widows, and surviving divorced mothers.

Effective date.—January 1973.

Number of people affected and dollar payments.—10,000 additional people will become eligible for benefits on the effective date and $23 million in additional benefits will be paid in 1974.

14. WAIVER OF DURATION-OF-MARRIAGE REQUIREMENT IN CASE OF REMARRIAGE

Under the new law the duration-of-marriage requirement for entitlement to benefits as a worker's widow, widower, or stepchild—that is, the requirement that the marriage must have been in existence for not less than 9 months immediately prior to the day on which the worker died (except where death was accidental or in the line of duty in the uniformed services)—is 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 new law the period throughout which a person must be disabled before he can become eligible for disability benefits is reduced by 1 month (from 6 months to 5 months).

Effective date.—January 1973.

Number of people affected and dollar payments.—950,000 beneficiaries will become entitled to additional benefit payments in 1974 and 4,000 additional people will become entitled to benefits. About $128 million in additional benefits will be paid in 1974.

16. DISABILITY INSURED STATUS FOR INDIVIDUALS WHO ARE BLIND

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 new law eliminates 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 will become immediately eligible for benefits on the effective date, and $38 million in additional benefits will be paid in 1974.

17. DISABILITY INSURANCE APPLICATIONS FILED AFTER DEATH

Disability insurance benefits (and dependents' benefits based on a worker's entitlement to disability benefits) will 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.

Effective date.—Effective for deaths occurring after 1969.

18. DISABILITY BENEFITS AFFECTED BY THE RECEIPT OF WORKMEN'S COMPENSATION

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 are computed on two different bases and the larger amount is used. The new law 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.—40,000 people will get increased benefits on the effective date and $22 million in additional benefits will 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 new law noncontributory wage credits of $300 for each calendar quarter will 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.—130,000 people will get increased benefits on the effective date and $46 million in additional benefits will be paid in 1974.

20. OPTIONAL DETERMINATION OF SELF-EMPLOYMENT EARNINGS

Self-employed persons are permitted to elect to report for social security purposes two-thirds of their gross income from nonfarm self-employment. An individual may use this option only if his total net earnings from self-employment (farm and nonfarm) are less than $1,600 and his net self-employment earnings from his nonfarm business are less than two-thirds of his gross income from such business. (This optional method of reporting is similar to the option which has been available for farm self-employment.) A regularity of coverage requirement will have to be met and the option may be used only five times by any individual.

Effective date.—Taxable years beginning after December 31, 1972.

21. COVERAGE OF MEMBERS OF RELIGIOUS ORDERS WHO ARE UNDER A VOW OF POVERTY

Social security coverage is made available to members of religious orders who have taken a vow of poverty, if the order makes an irrevocable election to cover all of its members and lay employees.

Effective date.—October 30, 1972.

22. SELF-EMPLOYMENT INCOME OF U.S. CITIZENS LIVING TEMPORARILY OUTSIDE THE UNITED STATES AND CLERGYMEN SERVING OUTSIDE THE UNITED STATES

At present, 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 new law provides that U.S. citizens who are self-employed outside the United States and who retain their residence in the United States may not exclude the first $20,000 of earned income for social security purposes but will compute their earnings for self-employment for social security purposes in the same way as those who are self-employed in the United States. The new law also eliminates from the application of

the $20,000 exclusion provision clergymen and members of religious orders who do not maintain a residence in the United States, so that the self-employment earnings of any American clergyman serving outside the United States will be computed the same as for clergymen in the United States.

Effective date.—Taxable years beginning after December 31, 1972.

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

The new law includes a number of provisions dealing with the method of issuing social security numbers. Presently, numbers are issued upon application, often by mail.

Under the new law the Secretary will be required to issue numbers to non-citizens entering the country under conditions which would permit them to work. In the case of an alien who may not legally work at the time he is admitted to the United States, the number will be issued at the time his status changes. In addition, numbers will be issued to persons who do not have them at the time they apply for benefits and to present beneficiaries under any federally financed program.

The Secretary is authorized to issue numbers to children when they enter the school system.

As a corollary to this more orderly system of issuing social security numbers, the new law provides criminal penalties for (1) knowingly and willfully furnishing false information in applying for a social security number; or (2) for the purpose of increasing a payment under social security or any other federally funded program, or for the purpose of obtaining such payment, knowingly and willfully using a social security number that was obtained with false information, falsely representing a number to be a social security number, or using someone else's social security number. The penalty involves a fine of up to $1,000 or imprisonment for up to 1 year or both.

Effective date.—October 30, 1972.

24. TRUST FUND EXPENDITURES FOR REHABILITATION SERVICES

The new law 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 is increased from 1 percent of the previous year's disability benefits to 1¼ percent for fiscal year 1973 and to 1½ percent for fiscal year 1974 and subsequent years.

Effective date.—Upon enactment for expenditures after June 30, 1972.

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

25. PAYMENTS TO SURVIVOR OR ESTATE OF FORMER EMPLOYEE AND TO DISABLED FORMER EMPLOYEE

Provides that payments will not be counted for social security benefit or tax purposes, if made by an employer to a survivor or estate of a deceased former employee after the calendar year in which the employee died or to a disabled former employee after the calendar year in which he became entitled to social security disability insurance benefits provided the disabled employee does not perform any services for that employer in the period for which the payment is made.

Effective date.—Payments made after December 1972.

26. COVERAGE OF STUDENTS AND CERTAIN PART-TIME EMPLOYEES

Permits States to modify their social security coverage agreements for State and local employees prior to January 1, 1974, so as to remove from coverage services of students employed by the public school or college they are attending, and the services of other part-time employees.

Effective date.—October 30, 1972.

27. EXCLUSION FROM COVERAGE OF STUDENTS EMPLOYED BY NON-PROFIT ORGANIZATIONS AUXILIARY TO SCHOOLS, COLLEGES, AND UNIVERSITIES

Services of a student performed in the employ of an auxiliary nonprofit organization which is organized and operated exclusively for the benefit of, and supervised or controlled by, the school, college, or university at which the student is enrolled and regularly attends classes is excluded from social security coverage. The exclusion does not apply to the services of a student for an organization connected with a public school, college, or university whose student employees are covered under social security pursuant to a State coverage agreement.

Effective date.—Applies to services performed after December 1972.

28. WAGE CREDITS FOR WORLD WAR II INTERNEES

Provides non-contributory social security credits for U.S. citizens of Japanese ancestry for the periods they were interned by the U.S. Government during World War II and were age 18 or older. The credits will be determined on the basis of the then prevailing minimum wage or the individual's prior earnings, whichever is larger.

Effective date.—January 1973.

29. DURATION-OF-RELATIONSHIP REQUIREMENTS

Amends the provision of 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 such cases if at the time of the marriage it is reasonable to expect that the deceased would have lived for at least 9 months.

Effective date.—January 1973.

30. OTHER CASH BENEFIT AMENDMENTS

Other changes in the law relate to the executive pay level of the Commissioner of Social Security; coverage of registrars of voters in Louisiana; retroactive benefits for certain disabled people; 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; recomputing benefits based on combined earnings under railroad retirement and social security; and acceptance of money gifts made unconditionally to the social security program.

II. MEDICARE-MEDICAID AMENDMENTS

1. MEDICARE COVERAGE FOR THE DISABLED

Social security disability beneficiaries will be covered under medicare after entitlement to disability benefits for not less than 24 consecutive months. Those covered 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 will be eligible initially.

Effective date: July 1973.

2. HOSPITAL INSURANCE FOR THE UNINSURED

People age 65 or over who are ineligible for part A of medicare can voluntarily enroll for hospital insurance coverage by paying the full cost of coverage (initially $33 monthly 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 is required as a condition of buying into the part A program.

Effective date: July 1973.

3. PART B PREMIUM INCREASES

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

Effective date: July 1973.

4. PART B DEDUCTIBLE

The annual part B deductible is increased from $50 to $60.

Effective date: January 1973.

5. AUTOMATIC ENROLLMENT IN PART B

The new law provides for automatic enrollment under part B for the elderly and the disabled as they become eligible for part A hospital insurance coverage (except for residents of Puerto Rico and foreign countries). People eligible for automatic enrollment must also be fully informed as to the procedure and given an opportunity to decline the coverage.

Effective date: July 1973.

6. EFFECTIVE UTILIZATION REVIEW PROGRAMS IN MEDICAID

A one-third reduction in Federal matching payments for long-term stays in hospitals, nursing homes, intermediate care facilities, and mental institutions is authorized, if States fail to have effective pro-

grams of control over the utilization of institutional services or they fail to conduct the independent professional audits of patients as required by law. The Secretary is also authorized 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.

Effective date: July 1973.

7. COST SHARING UNDER MEDICAID

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

1. States which cover the medically indigent are required to impose monthly premium charges. The premium is to 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 mandatory services required under Federal law (inpatient hospital services; outpatient hospital services; other X-ray and laboratory services; skilled nursing home services; physicians' services; screening and treatment of children; and home health services), are 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

A family eligible for assistance to needy families and to medicaid which would otherwise lose eligibility for medicaid as a result of increased earnings from employment will be continued on medicaid for a period of 4 months from the date where medicaid eligibility would otherwise terminate.

Effective date: January 1974.

9. COORDINATION BETWEEN MEDICARE AND FEDERAL EMPLOYEE PLANS

Medicare will 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 Federal employee plan 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 1975.

10. MEDICARE SERVICES OUTSIDE OF THE UNITED STATES

Payment under medicare for care in a foreign hospital of a U.S. resident is authorized where such hospital is 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, part B payments for necessary physicians' services furnished in conjunction with such hospitalization are authorized.

Medicare payments for emergency hospital and physician services needed by beneficiaries in transit between Alaska and the other continental States is also covered.

Effective date: January 1973.

11. OPTOMETRISTS UNDER MEDICAID

The new law 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: October 30, 1972.

12. BENEFICIARY LIABILITY UNDER MEDICARE

The new law will relieve beneficiaries from liability in certain situations where medicare claims are disallowed and the beneficiary is without fault.

Effective date: Claims for items and services furnished after October 30, 1972.

13. LIMITATION ON FEDERAL PAYMENTS FOR DISAPPROVED CAPITAL EXPENDITURES

Medicare and medicaid payments will not be made with respect to 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.

Effective date: January 1973, or earlier if requested by a State.

14. DEMONSTRATIONS AND REPORTS

The Secretary is authorized 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 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 and medicaid.

Effective date: October 30, 1972.

15. LIMITATION ON COVERAGE OF COSTS UNDER MEDICARE

The Secretary is authorized 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 will 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 interest in the facility).

Effective date: Accounting periods beginning after December 1972.

16. LIMITS ON PREVAILING PHYSICIAN CHARGE LEVELS

The law recognizes as reasonable, for medicare and medicaid reimbursement purposes only, those charges which fall within the 75th percentile of all charges for a similar service in an area. 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 general earnings levels in an area.

With respect to reasonable charges for medical supplies and equipment, the new law provides for recognizing only the lowest charges at which supplies and equipment of similar quality are widely and consistently available in a locality.

Effective date: July 1973 for physicians' services, and January 1973 for other items and services.

17. LIMITS ON PAYMENTS TO SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES UNDER MEDICAID

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

Effective date: January 1973.

18. PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

Medicare is authorized 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 for a comparable group of non-HMO beneficiaries in a given geographic area, and the exact amount of the incentive payment would be dependent upon the relative efficiency of the HMO.

The Secretary could make these arrangements with existing organizations 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 services of teaching physicians will be reimbursed under medicare on a costs basis unless:

(A) The patient is a bona fide private patient 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 will 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.

Effective date: July 1973.

20. ADVANCE APPROVAL OF SKILLED NURSING FACILITY AND HOME HEALTH BENEFITS

The Secretary is authorized to establish, by diagnosis, minimum periods during which the posthospital patient would be presumed to be eligible for skilled nursing facility and home health benefits.

Effective date: January 1973.

21. TERMINATION OF PAYMENT TO SUPPLIERS OF SERVICE

The Secretary is authorized to suspend or terminate medicare payments to a provider found to have abused the program. Further, there will be no Federal participation in medicaid payments which might be made subsequently to such a provider.

Effective date: Medicaid, January 1973; medicare, October 30, 1972.

22. ELIMINATION OF REQUIREMENT THAT STATES MOVE TOWARD COMPREHENSIVE MEDICAID PROGRAM

Section 1903(e) of prior law, 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, is repealed.

Effective date: October 30, 1972.

23. ELIMINATION OF MEDICAID MAINTENANCE OF EFFORT

Section 1902(d) of prior law, under which a State could not reduce its aggregate expenditures for the State share of its medicaid program from one year to the next, is repealed.

Effective date: October 30, 1972.

24. DETERMINATION OF REASONABLE COST OF INPATIENT HOSPITAL SERVICES UNDER MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

States are allowed, 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 cannot exceed reasonable cost reimbursement as provided for under medicare.

Effective date: July 1972.

25. CUSTOMARY CHARGES LESS THAN REASONABLE COSTS

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 provision will 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: Accounting periods beginning after December 1972.

26. INSTITUTIONAL PLANNING UNDER MEDICARE

All providers of services, as a condition of medicare participation, are required to have a written overall plan and budget reflecting an operating budget and a capital expenditures plan which would be updated at least annually.

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

Effective date: Fiscal years of providers beginning after March 1973.

27. COST DETERMINATION SYSTEMS UNDER MEDICAID

The law 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 1971.

28. PROHIBITION AGAINST REASSIGNMENT OF CLAIMS FOR BENEFITS

Payment under medicare and medicaid cannot be made 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.

Effective date: October 30, 1972, for medicare and January 1973 for medicaid.

29. UTILIZATION REVIEW REQUIREMENTS UNDER MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

Hospitals and skilled nursing facilities participating in medicaid are required to use the same utilization review committees and procedures now required under medicare, with certain exceptions approved by the Secretary. This requirement is in addition to any other requirements imposed by Federal or State governments.

Effective date: January 1973.

30. NOTIFICATION OF UNNECESSARY HOSPITAL AND SKILLED NURSING FACILITY ADMISSIONS

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

Effective date: January 1973.

31. USE OF STATE HEALTH AGENCY TO PERFORM CERTAIN FUNCTIONS UNDER MEDICAID

The same State health agency (or other appropriate State medical agency) must certify facilities for participation under both medicare and medicaid. Federal participation in medicaid payments is contingent upon the State health agency establishing a plan for statewide review of appropriateness and quality of services rendered.

Effective date: January 1973.

32. RELATIONSHIP BETWEEN MEDICAID AND COMPREHENSIVE HEALTH PROGRAMS

States are permitted 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.

Effective date: October 30, 1972.

33. PROFICIENCY TESTING

The new law provides for proficiency testing of paramedical personnel under medicare and medicaid until December 31, 1977.

34. PENALTY FOR FRAUDULENT ACTS AND FALSE REPORTING

Penalties for soliciting, offering or accepting bribes or kickbacks, or for concealing events affecting a person's rights to benefits 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 may be imposed. Additionally, false reporting of a material fact as to conditions or operations of a health care facility is a misdemeanor and is subject to up to 6 months' imprisonment, a fine of $2,000, or both.

Effective date: For acts occurring on or after October 30, 1972.

35. PROVIDER REIMBURSEMENT REVIEW BOARD

A Provider Reimbursement Review Board to hear cases involving an issue of $10,000 or more is established under medicare. 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.

Effective date: Accounting periods ending on or after June 30, 1973.

36. VALIDATION OF JOINT COMMISSION ON ACCREDITATION OF HOSPITALS SURVEYS

The State health certification agencies, as directed by the Secretary, will survey on a selective sample basis (or where substantial allegations of noncompliance have been made) hospitals accredited by the Joint Commission on Accreditation of Hospitals. The Secretary is also authorized to promulgate health and safety standards without being restricted to JCAH standards.

Effective date: October 30, 1972.

37. PAYMENT FOR DURABLE MEDICAL EQUIPMENT UNDER MEDICARE

The Secretary is authorized 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.

Effective date: October 30, 1972.

38. CONFORMING STANDARDS FOR EXTENDED CARE AND SKILLED NURSING FACILITIES

A single definition and set of standards for extended care facilities under medicare and skilled nursing homes under medicaid is established. The provision creates a single category of "skilled nursing facilities" which will be eligible to participate in both health care programs. A "skilled nursing facility" is defined as an institution meeting the prior definition of an extended care facility and which also satisfies certain other medicaid requirements.

Effective date: July 1973.

39. "SKILLED CARE" DEFINITION FOR MEDICARE AND MEDICAID

The definition of care requirements with respect to entitlement for extended care benefits under medicare and with respect to skilled nursing care under medicaid is made the same. Prior law is 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 will also be continued during short-term periods (e.g., a day or two) when no skilled services are actually provided but when discharge from a skilled facility for such brief period is neither desirable nor practical.

Effective date: January 1973.

40. 14-DAY TRANSFER REQUIREMENT FOR EXTENDED CARE BENEFITS

Under prior law, medicare beneficiaries were entitled to extended care benefits only if they transferred to an extended care facility within 14 days following discharge from a hospital. Under the new law an interval of more than 14 days is authorized for patients whose conditions do not permit immediate provision of skilled services

within the 14-day limitation. An extension not to exceed 2 weeks beyond the 14 days is also authorized in those instances where an admission to a skilled nursing facility is prevented because of the non-availability of appropriate bed space in facilities ordinarily utilized by patients in a geographic area.

Effective date: October 30, 1972.

41. REIMBURSEMENT RATES FOR CARE IN SKILLED NURSING FACILITIES

States will be required to reimburse skilled nursing and intermediate care facilities on a reasonable cost-related basis under medicaid, using acceptable cost-finding techniques and methods approved and validated by the Secretary of HEW. Cost reimbursement methods which the Secretary finds 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.

Effective date: July 1976.

42. SKILLED NURSING FACILITY CERTIFICATION PROCEDURES

Facilities which participate in both medicare and medicaid will be certified by the Secretary of HEW. The Secretary will make that determination, based principally upon the appropriate State health agency evaluation of the facilities.

Effective date: October 30, 1972.

43. FEDERAL FINANCING OF NURSING HOME INSPECTIONS

Federal reimbursement for the survey and inspection costs of skilled nursing facilities and intermediate care facilities under medicaid are 100 percent from October 1, 1972, through June 30, 1974.

44. DISCLOSURE OF INFORMATION CONCERNING MEDICARE AGENTS AND PROVIDERS

The Department of Health, Education, and Welfare must 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 evaluations of the performance of contractors—including comparisons of either overall performance or of any particular contractor operation: (3) program validation survey reports—with the names of individuals deleted.

Effective date: Reports completed after January 1973.

45. PROHIBITION AGAINST INSTITUTIONAL MEDICAL CARE PAYMENTS UNDER CASH WELFARE PROGRAMS

Federal matching for that portion of any money payment to a cash public assistance recipient which is related to institutional medical or remedial care will not be made.

Effective date: October 30, 1972.

46. DETERMINING ELIGIBILITY FOR MEDICAID FOR CERTAIN INDIVIDUALS

Individuals eligible for cash public assistance in August 1972 will not lose their eligibility to medicaid benefits because of the 20-percent social security benefit increase first paid in October 1972. The provision will expire in October 1974.

Those people who do not receive cash assistance or who are eligible under a State medicaid program for the medically indigent are not affected by this provision.

47. PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

The new law provides for the establishment of professional standards review organizations (PSRO's) 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 will 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. 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.

Effective date: October 30, 1972.

48. PHYSICAL THERAPY SERVICES AND OTHER SERVICES UNDER MEDICARE

(1) Physical therapy provided in the therapist's office pursuant to a physician's written plan of treatment is covered under Part B of medicare. Benefit payments in one year for services by an independent practitioner in his office or the patient's home cannot be based on more than $100 of incurred expenses.

(2) A hospital or skilled nursing facility could provide covered outpatient physical therapy services to its inpatients, so that an inpatient could conveniently receive his part B benefits after his inpatient benefits have expired.

(3) Reimbursement for services provided by physical and other therapists in health institutions will generally be limited to a reasonable salary-related basis rather than fee-for-service basis.

Effective date: (1) July 1973, (2) October 30, 1972, and (3) January 1973.

49. COVERAGE OF SUPPLIES RELATED TO COLOSTOMIES

Medicare coverage of the costs of supplies directly related to the care of a colostomy is provided.

Effective date: October 30, 1972.

50. COVERAGE PRIOR TO APPLICATION FOR MEDICAID

All States are required 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-month retroactive coverage requirement are deceased individuals whose fatal condition prevented them from applying for medicaid coverage but who would have been eligible if application had been made.

Effective date: July 1973.

51. HOSPITAL ADMISSIONS FOR DENTAL SERVICES UNDER MEDICARE

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

Effective date: January 1973.

52. EXTENSION OF GRACE PERIOD FOR TERMINATION OF SUPPLEMENTARY MEDICAL INSURANCE COVERAGE WHERE FAILURE TO PAY PREMIUMS IS DUE TO GOOD CAUSE

The 90-day grace period can be extended for an additional 90 days where the Secretary finds that there was good cause for failure to pay the medical Part B premium before the expiration of the initial 90-day grace period.

Effective date: October 30, 1972 (and premiums due 90 days before October 30, 1972).

53. EXTENSION OF TIME FOR FILING CLAIM FOR SUPPLEMENTARY MEDICAL INSURANCE BENEFITS WHERE DELAY IS DUE TO ADMINISTRATIVE ERROR

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.

Effective date: October 30, 1972.

54. WAIVER OF ENROLLMENT PERIOD REQUIREMENTS WHERE INDIVIDUAL'S RIGHTS WERE PREJUDICED BY ADMINISTRATIVE ERROR OR INACTION

The Secretary is authorized to provide such equitable relief as may be necessary to correct or eliminate the effects of situations where an individual's rights were prejudiced by administrative error or inaction, 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.

Effective date: October 30, 1972, for all cases arising since the beginning of medicare.

55. ELIMINATION OF PROVISIONS PREVENTING ENROLLMENT IN SUPPLEMENTARY MEDICAL INSURANCE PROGRAM MORE THAN 3 YEARS AFTER FIRST OPPORTUNITY

The prior 3-year limit with respect to both initial enrollment and reenrollment after an initial termination is removed.

Effective date: October 30, 1972, for all those who could not enroll.

56. WAIVER OF RECOVERY OF INCORRECT MEDICARE PAYMENTS FROM SURVIVOR WHO IS WITHOUT FAULT

Any individual who is liable for repayment of a medicare overpayment can 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.

Effective date: October 30, 1972.

57. REQUIREMENT OF MINIMUM AMOUNT OF CLAIM TO ESTABLISH ENTITLEMENT TO HEARING UNDER SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

A minimum amount of $100 must be at issue before an enrollee in the supplementary medical insurance program can be granted a fair hearing by the carrier.

Effective date: October 30, 1972.

58. COLLECTION OF SUPPLEMENTARY MEDICAL INSURANCE PREMIUMS FROM INDIVIDUALS ENTITLED TO BOTH SOCIAL SECURITY AND RAILROAD RETIREMENT BENEFITS

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

Effective date: October 30, 1972.

59. SERVICES OF OPTOMETRISTS IN FURNISHING PROSTHETIC LENSES NOT TO REQUIRE A PHYSICIAN'S ORDER

An optometrist can attest to a beneficiary's need for prosthetic lenses under medicare.

Effective date: October 30, 1972.

60. PROHIBITION AGAINST REQUIRING PROFESSIONAL SOCIAL SERVICES IN SKILLED NURSING FACILITIES UNDER MEDICARE

The provision of medical social services will no longer be required as a condition of participation for a skilled nursing facility under medicare.

Effective date: October 30, 1972.

61. REFUND OF EXCESS PREMIUMS UNDER MEDICARE

The Secretary is authorized to dispose of excess supplementary medical insurance premiums and excess hospital insurance premiums in the same manner as unpaid medical insurance benefits are treated.

Effective date: October 30, 1972.

62. WAIVER OF REQUIREMENT OF REGISTERED PROFESSIONAL NURSES IN SKILLED NURSING FACILITIES IN RURAL AREAS

A special waiver of the R.N. nursing requirement for skilled nursing facilities in rural areas can be granted provided that a registered nurse is absent from the facility for not more than two day-shifts (if the facility employes 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.

Effective date: October 30, 1972.

63. EXEMPTION OF CHRISTIAN SCIENCE SANATORIUMS FROM CERTAIN NURSING HOME REQUIREMENTS UNDER MEDICAID

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

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Such sanatoriums must continue to meet all applicable safety standards.

Effective date: October 30, 1972.

64. LICENSURE REQUIREMENT FOR NURSING HOME ADMINISTRATORS

States are permitted 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.

Effective date: October 30, 1972.

65. INCREASE IN MAXIMUM FEDERAL MEDICAID AMOUNT FOR PUERTO RICO AND THE VIRGIN ISLANDS

The Federal ceiling on medicaid payments to Puerto Rico is increased to $30 million. The 50 percent Federal matching rate remains unchanged. The annual medicaid amount for the Virgin Islands is increased from $650,000 to $1,000,000.

Effective date: Fiscal year 1972.

66. MEDICAID: FREEDOM OF CHOICE IN PUERTO RICO, THE VIRGIN ISLANDS, AND GUAM

The requirement that Puerto Rico, the Virgin Islands and Guam implement the "freedom of choice" provision, under which medicaid recipients can choose providers or practitioners in the medicaid program, will apply on July 1, 1975, rather than July 1972 as under prior law.

Effective date: July 1972.

67. INCLUSION OF AMERICAN SAMOA AND THE TRUST TERRITORY OF THE PACIFIC ISLANDS UNDER TITLE V

Eligibility under maternal and child health programs for Samoa and the Trust Territory of the Pacific Islands is authorized.

Effective date: October 30, 1972.

68. COVERAGE OF CHIROPRACTIC SERVICES UNDER PART B OF MEDICARE

The definition of the term "physician" in title XVIII (medicare) includes a licensed chiropractor who also meets uniform minimum standards promulgated by the Secretary.

The services furnished by chiropractors are 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.

Effective date: July 1973.

69. CHIROPRACTORS' SERVICES UNDER MEDICAID

The coverage of chiropractic under medicaid is conformed with the provisions conditioning eligibility of such services included under part B of medicare except for the requirement that an X-ray show the existence of a subluxation.

Effective date: July 1973.

70. SERVICES OF PODIATRIC INTERNS AND RESIDENTS UNDER PART A OF MEDICARE

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 are included within the definition of approved hospital teaching programs.

Effective date: January 1973.

71. USE OF CONSULTANTS FOR SKILLED NURSING FACILITIES

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

Effective date: October 30, 1972.

72. DIRECT LABORATORY BILLING OF PATIENTS

With respect to diagnostic laboratory tests for which payment is to be made to a laboratory, the Secretary is authorized to negotiate a payment rate with a 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 must be limited to an amount not to exceed the total payment that would have been made in the absence of such rate.

Effective date: October 30, 1972.

73. CLARIFICATION OF MEANING OF "PHYSICIANS' SERVICES" UNDER MEDICAID

A physician, under title XIX (medicaid), for purposes of the mandatory provision of physicians' services, is a duly licensed doctor of medicine or osteopathy only.

Effective date: October 30, 1972.

74. LIMITATION ON ADJUSTMENT OR RECOVERY OF INCORRECT PAYMENTS UNDER THE MEDICARE PROGRAM

The new law limits medicare's right of recovery of overpayments to a 3-year period (or as short as one year if the Secretary so decides) from the date of payment where the beneficiary acted in good faith. The law also permits the Secretary to set a time between 1 and 3 years within which claims for underpayments have to be made.

Effective date: October 30, 1972.

75. SPEECH PATHOLOGY SERVICES 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, are covered under medicare.

Effective date: January 1973.

76. TERMINATION OF MEDICAL ASSISTANCE ADVISORY COUNCIL

The new law terminates the medicaid advisory council.

Effective date: October 30, 1972.

77. MODIFICATION OF ROLE OF HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

The new law provides for modification of the role of the health insurance benefits advisory council so that its role would be that of offering suggestions for the consideration of the Secretary on matters of general policy in the medicare and medicaid programs.

Effective date: October 30, 1972.

78. AUTHORITY OF SECRETARY TO ADMINISTER OATHS IN MEDICARE PROCEEDINGS

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

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

Effective date: October 30, 1972.

79. WITHHOLDING MEDICAID PAYMENTS TO TERMINATED MEDICARE PROVIDERS

The Secretary, upon 60-days' notice, is authorized 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.

Effective date: October 30, 1972.

80. INTERMEDIATE CARE IN STATES WITHOUT MEDICAID

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

Effective date: October 30, 1972.

81. REQUIRED INFORMATION RELATING TO EXCESS MEDICARE TAX PAYMENTS BY RAILROAD EMPLOYEES

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

Effective date: Remuneration paid after 1971.

82. APPOINTMENT AND CONFIRMATION OF ADMINISTRATOR OF SOCIAL AND REHABILITATION SERVICE

Appointments 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.

Effective date: October 30, 1972.

83. REPEAL OF SECTION 1903(b)(1)

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

Effective date: October 30, 1972.

84. COVERAGE UNDER MEDICAID OF INTERMEDIATE CARE FURNISHED IN MENTAL AND TUBERCULOSIS INSTITUTIONS

Intermediate care must be covered for individuals age 65 or older in mental institutions if such individuals are also covered when in mental hospitals or skilled nursing facilities for mental care.

Effective date: January 1973.

85. INDEPENDENT REVIEW OF INTERMEDIATE CARE FACILITY PATIENTS

Independent professional review to determine proper patient placement and care of medicaid patients is made mandatory in all intermediate care facilities.

Effective date: January 1972.

86. INTERMEDIATE CARE MAINTENANCE OF EFFORT IN PUBLIC INSTITUTIONS

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 is the four

calendar quarters immediately preceding the quarter in which the State elected to make such services available.

Effective date: January 1972.

87. DISCLOSURE OF OWNERSHIP OF INTERMEDIATE CARE FACILITIES

Intermediate care facilities not otherwise licensed as skilled nursing homes by a State must make ownership information available to the State licensing agency.

Effective date: January 1973.

88. TREATMENT IN MENTAL HOSPITALS FOR MEDICAID ELIGIBLES UNDER AGE 21

Coverage of inpatient care (under specific conditions) in mental institutions for medicaid eligibles under age 21 is authorized.

Effective date: January 1973.

89. PUBLIC DISCLOSURE OF INFORMATION CONCERNING SURVEY REPORTS OF AN INSTITUTION

The Secretary is required 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 must be available for inspection within 90 days of completion of the survey.

Effective date: May 1, 1973.

90. FAMILY PLANNING SERVICES MANDATORY UNDER MEDICAID

(1) Federal funding for the costs of family planning services under medicaid and aid to families with dependent children (AFDC) is set at the 90 percent rate.

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

(3) The Federal share of AFDC funds must be reduced by 1%, 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.

Effective dates: (1) January 1973, (2) October 30, 1972, and (3) fiscal year 1974.

91. PENALTY FOR FAILURE TO PROVIDE CHILD HEALTH SCREENING SERVICES UNDER MEDICAID

The Federal share of AFDC matching funds would be reduced by 1% if a State—

(a) fails to inform the adults in AFDC 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.

Effective date: July 1974.

92. HOME HEALTH COINSURANCE

The coinsurance payment under Part B of medicare for home health services is eliminated.

Effective date: January 1973.

93. LONG-TERM CARE INSTITUTIONS ON INDIAN RESERVATIONS

The Secretary, rather than the States only, may certify institutions on Indian reservations as intermediate care facilities or skilled nursing facilities.

Effective date: October 30, 1972.

94. MEDICARE APPEALS

The new law makes clear 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.

Effective date: October 30, 1972.

95. MEDICARE: COVERAGE OF PERSONS NEEDING KIDNEY TRANSPLANTATION OR DIALYSIS

The new law 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. Institutional care will be covered only in institutions which meet a minimum utilization rate requirement and which provide for a medical review board to screen the appropriateness of patients for proposed treatment procedures. About 180 million people under age 65 are protected under this provision.

Effective date: July 1973.

III. SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

The new law replaces (except in Puerto Rico, the Virgin Islands, and Guam), 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 (social services for the aged, blind and disabled as well as all the programs for aid to the families with dependent children will continue as State programs).

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

Under the law, about 5 million aged, blind, and disabled persons with no other income will be guaranteed a monthly income of at least $130 for an individual or $195 for a couple. In addition the law provides that the first $20 of social security or any other earned or unearned income (other than income which is based on need) will 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 is not need-related) of at least $20 will be assured total monthly income of at least $150 for for an individual or $215 for a couple.

Individuals in an institution where care is paid for under medicaid will be eligible for a benefit of $25 monthly (less countable income).

EARNED INCOME DISREGARD

In addition to a monthly disregard of $20 of social security or other income, there will be disregarded $65 of earned income plus one-half of any remaining earnings. 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 prior law, any amount reasonably attributable to the earning of income would be disregarded for the blind and any income necessary for the fulfillment of a plan for achieving self-support will be disregarded for persons qualifying on the basis of blindness or disability. A savings clause assures that blind persons, who were recipients of aid to the blind in December 1973 and met the definition of blindness under the State plan in effect as of October 1972, will not receive any reduction in benefits due to these provisions.

DEFINITIONS OF BLINDNESS AND DISABILITY

Each State has been 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 will be uniform definition of "disability" and "blindness."

The term "disability" is 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 used in the social security disability insurance program. Children under 18 with disabilities of comparable severity will be eligible.

No disabled person will be eligible if he is medically determined to be a drug addict or an alcoholic unless such individual is undergoing appropriate treatment, if available. Payments for addicts or alcoholics will be made only as protective payments to third parties.

The term "blindness" is defined as central visual acuity of 20/200 or less in the better eye with the use of correcting lens. Also included in this definition is the particular sight limitation 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 as of October 1972 will be considered blind or disabled for purposes of this program so long as he continues to be blind or disabled as defined in such State plan.

OTHER FEDERAL ELIGIBILITY STANDARDS

Eligibility for supplemental security income will be open to an aged, blind or disabled individual if his resources are 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, an automobile, and property needed for self support will, if found to be reasonable, be excluded. Life insurance policies will not be counted if the face value of all policies is less than $1,500. (Current recipients under State programs with higher resource limits will retain their eligibility.)

An individual receiving supplemental security income will not be considered a member of a family receiving aid under a plan approved under title IV, nor will his income or resources be considered available to such a family (also applicable to title XVI of current law, effective January 1, 1973).

STATE SUPPLEMENTATION

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

INELIGIBILITY FOR FOOD STAMPS

Individuals eligible for benefits under the supplemental security income program (or who upon application would be eligible) will not be eligible for food stamps or surplus commodities.

SAVINGS CLAUSE

The law provides no direct Federal participation in the costs of State supplemental payments. However, a savings clause is included under which the Federal Government will, if it administers the State payments, 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 will apply only to State supplementation needed to maintain the State's assistance levels in effect as of January 1972. The savings clause will, however, also cover an upward adjustment over the January 1972 levels to the extent necessary to offset the elimination of food stamp eligibility.

MEDICAID COVERAGE

States are now required to cover all cash assistance recipients under the medicaid program. The new law exempts 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 after 1973.

SOCIAL SERVICES

States are 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 will be replaced by the new Federal supplemental security income program. There will be 75 percent Federal matching for the services provided (90 percent for family planning), subject to the overall limitations established by the State and Local Fiscal Assistance Act.

AMENDMENTS TO CURRENT LAW FOR AID TO AGED, BLIND, AND DISABLED PERSONS (EFFECTIVE UPON ENACTMENT AND 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 law 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 law 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 new law 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

Prior 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 is at least $4 higher as a result of the 1969 social security benefit increase. The new law adds an additional $4 "passalong" related to this year's 20 percent social security increase and makes 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)

Annual authorization for Federal grants to the States for child welfare services is increased 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 cost of providing foster care which now represents the largest single item of child welfare expenditure on the county level. The law, however, does not earmark amounts specifically for foster care so that wherever possible the State and counties can 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

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

V. STATISTICAL MATERIAL

TABLE 1.—SOCIAL SECURITY TAX RATES FOR EMPLOYERS AND EMPLOYEES AND SELF-EMPLOYED UNDER PRIOR LAW AND UNDER P. L. 92-603

[In percent]

Calendar year	OASDI		HI		Total	
	Prior law	New schedule	Prior law	New schedule	Prior law	New schedule
	Employer-employee, each					
1972.....	4.60	4.60	0.60	0.60	5.20	5.20
1973-77....	4.60	4.85	0.90	1.00	5.50	5.85
1978-80....	4.50	4.80	1.00	1.25	5.50	6.05
1981-85....	4.50	4.80	1.00	1.35	5.50	6.15
1986-92....	4.50	4.80	1.10	1.45	5.60	6.25
1993-97....	4.50	4.80	1.20	1.45	5.70	6.25
1998-2010..	4.50	4.80	1.20	1.45	5.70	6.25
2011+	5.35	5.85	1.20	1.45	6.55	7.30
	Self-employed					
1972.....	6.90	6.90	0.60	0.60	7.50	7.50
1973-77....	6.90	7.00	0.90	1.00	7.80	8.00
1978-80....	6.70	7.00	1.00	1.25	7.70	8.25
1981-85....	6.70	7.00	1.00	1.35	7.70	8.35
1986-92....	6.70	7.00	1.10	1.45	7.80	8.45
1993-97....	6.70	7.00	1.20	1.45	7.90	8.45
1998-2010..	6.70	7.00	1.20	1.45	7.90	8.45
2011+	7.00	7.00	1.20	1.45	8.20	8.45

NOTE.—Under both prior 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.—ALLOCATION TO DISABILITY INSURANCE TRUST FUND

	Percent of wages		Percent of self-employment income	
	Prior law	New schedule	Prior law	New schedule
1973-77.....	1.00	1.10	0.750	0.795
1978-2010.....	1.10	1.15	.825	.840
2011+.....	1.40	1.50	.915	.895

TABLE 3.—OPERATIONS OF THE OLD-AGE AND SURVIVORS INSURANCE AND THE DISABILITY INSURANCE TRUST FUNDS, COMBINED, CALENDAR YEARS 1965–77

[In millions]

Calendar year	Transactions during period											
	Income					Disbursements						
			Reimbursements from general fund of Treasury for costs of—									
	Total	Contributions, less refunds	Noncontributory credits for military service	Payments to noninsured persons aged 72 and over	Interest on investments	Total	Benefit payments	Payments for vocational rehabilitation services	Administrative expenses	Transfers to railroad retirement account	Net increase in fund
1965	$17,857	$17,205	.....	.....	$651	$19,187	$18,311	.....	$418	$459	—$1,331
1966	23,381	22,585	$94	.....	702	20,913	20,048	$3	393	469	2,467
1967	26,413	25,424	94	.....	896	22,471	21,406	11	515	539	3,942
1968	28,493	27,034	188	$226	1,045	26,015	24,936	17	603	458	2,479
1969	33,346	31,546	94	364	1,342	27,892	26,751	16	612	513	5,453

1970.....	36,993	34,737	94	371	1,791	33,108	31,863	20	635	589	3,886
1971.....	40,908	38,343	187	351	2,027	38,542	37,171	26	719	626	2,366
Estimated future experience:											
1972...	46,163	43,399	189	337	2,238	43,236	41,607	36	844	749	2,927
1973...	54,730	51,927	191	301	2,311	53,650	51,885	59	877	829	1,080
1974...	61,045	58,048	192	322	2,483	56,710	54,733	77	907	993	4,335
1975...	66,005	62,726	212	297	2,770	62,031	59,950	85	951	1,045	3,974
1976...	69,734	66,107	333	261	3,033	65,132	63,002	92	991	1,047	4,602
1977...	75,387	71,591	338	229	3,229	71,537	69,335	99	1,038	1,065	3,850

NOTE: Under the automatic increase provisions, the following changes are assumed to occur on January 1 of the stated year:

Year	General benefit increase (percent)	Contribution and benefit base	Annual exempt amount under the retirement test
1975.....	5.1	$12,600	$2,280
1977.....	5.5	14,100	2,520

TABLE 4.—OPERATIONS OF THE OLD-AGE AND SURVIVORS INSURANCE TRUST FUND, CALENDAR YEARS 1965–77

[In millions]

Calendar year	Transactions during period										
	Income					Disbursements					
			Reimbursements from general fund of Treasury for costs of—								
	Total	Contributions, less refunds	Noncontributory credits for military service	Payments to noninsured persons aged 72 and over	Interest on investments	Total	Benefit payments	Payments for vocational rehabilitation services	Administrative expenses	Transfers to railroad retirement account	Net increase in fund
1965	$16,610	$16,017	.....	.....	$593	$17,501	$16,737	.....	$328	$436	—$890
1966	21,302	20,580	$78	.....	644	18,967	18,267	(1)	256	444	2,335
1967	24,034	23,138	78	.....	818	20,382	19,468	(1)	406	508	3,652
1968	25,040	23,719	156	$226	939	23,557	22,642	$1	476	438	1,483
1969	29,554	27,947	78	364	1,165	25,176	24,209	1	474	491	4,378

1970.....	32,220	30,256	78	371	1,515	29,848	28,796	2	471	579	2,371
1971.....	35,877	33,723	137	351	1,667	34,542	33,413	2	514	613	1,335
Estimated future experience:											
1972...	40,503	38,210	138	337	1,818	38,465	37,115	2	623	725	2,038
1973...	48,326	46,018	139	301	1,868	47,485	46,036	3	641	805	841
1974...	53,942	51,465	140	322	2,015	50,063	48,439	4	659	961	3,879
1975...	58,328	55,612	146	297	2,273	54,737	53,027	5	690	1,015	3,591
1976...	61,616	58,610	231	261	2,514	57,444	55,702	5	717	1,020	4,172
1977...	66,636	63,472	233	229	2,702	63,089	61,297	6	750	1,036	3,547

[1] Less than $500,000.

NOTE: Under the automatic increase provisions, the following changes are assumed to occur on January 1 of the stated year:

Year	General benefit increase (percent)	Contribution and benefit base	Annual exempt amount under the retirement test
1975.....	5.1	$12,600	$2,280
1977.....	5.5	14,100	2,520

TABLE 5.—OPERATIONS OF THE DISABILITY INSURANCE TRUST FUND, CALENDAR YEARS 1965–77

[In millions]

Calendar year	Transactions during period									
	Income				Disbursements					
	Total	Contributions, less refunds	Reimbursements from general fund of Treasury for costs of noncontributory credits for military service	Interest on investments	Total	Benefit payments	Payments for vocational rehabilitation services	Administrative expenses	Transfers to railroad retirement account	Net increase in fund
1965.....	$1,247	$1,188	.....	$59	$1,687	$1,573	.....	$90	$24	—$440
1966.....	2,079	2,006	$16	58	1,947	1,781	$3	137	25	133
1967.....	2,379	2,286	16	78	2,089	1,939	11	109	31	290
1968.....	3,454	3,316	32	106	2,458	2,294	16	127	20	996
1969.....	3,792	3,599	16	177	2,716	2,542	15	138	21	1,075

1970.....	4,774	4,481	16	277	3,259	3,067	18	164	10	1,514
1971.....	5,031	4,620	50	361	4,000	3,758	24	205	13	1,031
Estimated future experience:										
1972...	5,660	5,189	51	420	4,771	4,492	34	221	24	889
1973...	6,404	5,909	52	443	6,165	5,849	56	236	24	239
1974...	7,103	6,583	52	468	6,647	6,294	73	248	32	456
1975...	7,677	7,114	66	497	7,294	6,923	80	261	30	383
1976...	8,118	7,497	102	519	7,688	7,300	87	274	27	430
1977...	8,751	8,119	105	527	8,448	8,038	93	288	29	303

NOTE: Under the automatic increase provisions, the following changes are assumed to occur on January 1 of the stated year:

Year	General benefit increase (percent)	Contribution and benefit base	Annual exempt amount under the retirement test
1975.....	5.1	$12,600	$2,280
1977.....	5.5	14,100	2,520

TABLE 6.—ESTIMATED OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND, UNDER PUBLIC LAW 92-603, CALENDAR YEARS 1972-77

[In millions]

	1972	1973	1974	1975	1976	1977
Income:						
Contributions	$5,576	$10,347	$11,816	$12,770	$13,460	$14,586
Reimbursement for uninsured persons	468	556	582	585	585	576
Reimbursement for military service wage credits	48	48	48	48	48	48
Transfers from railroad retirement account	65	96	125	132	135	135
Interest on investments	147	213	371	513	625	702
Total income	6,304	11,260	12,942	14,048	14,853	16,047
Disbursements:						
Benefit payments	6,615	8,222	10,084	11,468	12,986	14,603
Administrative expenses	165	203	248	287	325	365
Total disbursements	6,780	8,425	10,332	11,755	13,311	14,968
Fund at end of year	2,558	5,393	8,003	10,296	11,838	12,917

TABLE 7.—ESTIMATED OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, P.L. 92-603, CALENDAR YEARS 1972-77

[In millions]

	1972	1973	1974	1975	1976	1977
Income:						
Premiums	$1,392	$1,561	$1,725	$1,788	$1,852	$1,915
General revenue	1,406	1,619	2,155	2,569	3,023	3,519
Interest	31	42	55	67	80	94
Total income	2,829	3,222	3,935	4,424	4,955	5,528
Disbursements:						
Benefits	2,340	2,629	3,267	3,715	4,153	4,629
Administrative costs	330	369	456	502	564	636
Total disbursements	2,670	2,998	3,723	4,217	4,717	5,265
Fund at end of year	609	833	1,045	1,252	1,490	1,753

TABLE 8.—INCREASE IN EXPENDITURES UNDER SOCIAL SECURITY AMENDMENTS OF 1972, CALENDAR YEAR 1974

[In billions]

Trust funds:	
Social security cash benefits	$2.3
Hospital insurance	1.6
Supplementary medical insurance	.1
Total	4.0
General revenues:	
Supplemental security income	1.9
Food stamp cash-out	—.3
Child welfare services	.2
Medicaid	—.8
Supplementary medical insurance	.4
Total	1.4
Grand total	5.4

TABLE 9.—SOCIAL SECURITY PROGRAMS: FIRST FULL-YEAR COST OF P.L. 92-603

[Amounts in millions]

Provision	Additional benefit payments in calendar year 1974
Total	$4,372
Social security cash benefit program:	
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	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 22	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 chronic kidney disease patients	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 chronic kidney disease patients	52
Eliminate coinsurance on home health services	8
Subtotal, supplementary medical insurance program	393

Source: Department of Health, Education, and Welfare.

TABLE 10.—CHANGES IN ESTIMATED MEDICAID COSTS (+) AND SAVINGS (—) UNDER P.L. 92-603

[In millions of dollars]

	Calendar year 1974
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 P.L. 92-603	—790

[1] The prior 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 11.—CALENDAR YEAR 1974 FEDERAL COSTS OF SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED, AND CHILD WELFARE SERVICES

[Dollars in billions]

	Gross costs	Prior 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] Prior law cost is $46,000,000.

Source: Department of Health, Education, and Welfare.

TABLE 12.—ESTIMATED AMOUNT OF COMBINED TOTAL BENEFIT PAYMENTS UNDER THE OASDI AND MEDICARE PROGRAMS AND, SEPARATELY, TOTAL BENEFIT PAYMENTS UNDER THE MEDICARE PROGRAM, CALENDAR YEAR 1974, BY STATE

[In millions]

Beneficiary's State of residence	Total benefit payments in calendar year 1974 under the OASDI and medicare programs			Benefit payments in calendar year 1974 under the medicare program				
	Total benefit payments under the amended programs	Additional benefit payments resulting from the amendments	Benefits that would have been paid under the programs as in effect before the amendments	Total benefit payments under the amended program	Additional benefit payments resulting from the amendments			Benefits that would have been paid under the program as in effect before the amendments
					Net total [1]	Payments for disabled persons	Net payments resulting from other changes	
Total [2]	$68,161	$4,362	$63,799	$13,351	$2,015	$1,795	$220	$11,336
Alabama	1,001	68	933	173	36	33	3	137
Alaska	28	1	26	5	1	1	(3)	4
Arizona	577	36	542	107	18	17	2	89
Arkansas	668	41	628	115	22	20	2	93
California	6,618	460	6,158	1,581	256	232	24	1,325
Colorado	613	36	576	134	18	16	2	116
Connecticut	1,039	63	975	211	27	23	4	184
Delaware	160	10	150	29	5	4	(3)	24
District of Columbia	199	14	185	50	8	7	1	42
Florida	3,091	169	2,921	620	84	75	9	536
Georgia	1,124	76	1,048	192	42	39	3	149
Hawaii	162	9	153	29	5	4	(3)	25
Idaho	230	14	217	40	6	5	1	34
Illinois	3,695	230	3,465	735	95	82	13	640

Indiana	1,699	103	1,596	287	41	36	5	247
Iowa	1,065	63	1,002	200	22	19	4	177
Kansas	797	49	748	157	17	15	3	139
Kentucky	1,016	64	953	175	33	30	3	142
Louisiana	931	65	867	168	35	32	3	133
Maine	372	23	349	68	10	9	1	58
Maryland	989	64	925	185	28	25	3	157
Massachusetts	2,134	139	1,995	491	59	51	9	432
Michigan	2,959	192	2,768	547	88	79	9	459
Minnesota	1,289	72	1,217	282	30	25	5	251
Mississippi	619	41	578	116	24	22	2	92
Missouri	1,726	105	1,621	342	48	42	6	294
Montana	235	15	219	43	7	6	1	37
Nebraska	528	30	498	102	11	9	2	91
Nevada	122	8	114	27	5	4	(3)	22
New Hampshire	263	14	249	43	5	5	1	38
New Jersey	2,493	161	2,332	475	65	58	7	410
New Mexico	244	16	229	43	8	8	1	35
New York	7,132	501	6,631	1,608	220	193	27	1,388
North Carolina	1,350	92	1,258	235	50	46	4	185
North Dakota	209	14	195	47	6	5	1	41
Ohio	3,387	212	3,175	604	88	78	11	516
Oklahoma	900	59	840	190	30	27	3	160
Oregon	792	46	746	139	21	19	2	118
Pennsylvania	4,333	281	4,052	754	112	100	12	642
Puerto Rico	409	21	387	49	13	12	1	37
Rhode Island	368	25	343	84	12	11	1	72
South Carolina	645	46	600	104	26	24	2	78
South Dakota	236	14	222	45	5	5	1	39
Tennessee	1,135	73	1,062	194	36	33	3	158
Texas	3,042	192	2,850	641	96	86	10	545
Utah	254	14	240	37	5	4	1	32
Vermont	162	11	151	36	5	5	1	31

See footnotes at end of table.

TABLE 12.—ESTIMATED AMOUNT OF COMBINED TOTAL BENEFIT PAYMENTS UNDER THE OASDI AND MEDICARE PROGRAMS AND, SEPARATELY, TOTAL BENEFIT PAYMENTS UNDER THE MEDICARE PROGRAM, CALENDAR YEAR 1974, BY STATE—Continued

[In millions]

Beneficiary's State of residence	Total benefit payments in calendar year 1974 under the OASDI and medicare programs			Benefit payments in calendar year 1974 under the medicare program				
	Total benefit payments under the amended programs	Additional benefit payments resulting from the amendments	Benefits that would have been paid under the programs as in effect before the amendments	Total benefit payments under the amended program	Additional benefit payments resulting from the amendments			Benefits that would have been paid under the program as in effect before the amendments
					Net total [1]	Payments for disabled persons	Net payments resulting from other changes	
Virgin Islands, Guam, and American Samoa...	$9	(3)	$9	$1	(3)	(3)	(3)	$1
Virginia.....	1,161	$79	1,081	192	$37	$34	$3	155
Washington.....	1,113	66	1,047	190	26	23	3	164
West Virginia.....	695	49	646	101	24	22	2	77
Wisconsin.....	1,610	95	1,515	308	39	34	5	269
Wyoming.....	98	6	92	17	2	2	(3)	14

[1] Estimates in this column represent payments on behalf of disabled persons under age 65 plus an additional amount totaling $220 million resulting from the net effect of other changes in the medicare program, i.e., $220 million in additional payments due to changes in the hospital insurance plan and no net additional payments resulting from changes in the supplementary medical insurance plan (see footnote 2 of table 14).

[2] Totals include OASDI benefits to beneficiaries residing abroad. No medicare payments are included for beneficiaries residing abroad, because medicare payments for such beneficiaries are payable only under conditions that are expected to occur rarely.

[3] Less than $500,000.

NOTE.—Totals do not necessarily equal the sum of rounded components.

TABLE 13.—ESTIMATED NUMBER OF PERSONS WITH HOSPITAL INSURANCE PROTECTION ON JULY 1, 1973, AND ESTIMATED AMOUNT OF HOSPITAL INSURANCE BENEFIT PAYMENTS, CALENDAR YEAR 1974, BY STATE

[Numbers in thousands; amounts in millions]

Insured person's State of residence	Number of persons with hospital insurance protection on July 1, 1973			Benefit payments under the hospital insurance plan in calendar year 1974				
	Total	Disabled persons under age 65 who gain hospital insurance protection immediately, as a result of the amendments [1]	Persons aged 65 and over with hospital insurance protection under the program as in effect before the amendments	Total benefit payments under the amended program	Additional benefit payments resulting from the amendments			Benefits that would have been paid under the program as in effect before the amendments
					Total additional benefit payments	Payments for disabled persons [1]	Payments resulting from other changes	
Total	22,800	1,700	21,100	$10,084	$1,598	$1,378	$220	$8,486
Alabama	381	40	341	131	28	25	3	103
Alaska	8	1	7	3	1	1	(2)	3
Arizona	174	15	159	75	14	12	2	62
Arkansas	274	26	247	85	17	15	2	68
California	2,029	163	1,866	1,111	191	167	24	920
Colorado	210	13	197	101	14	12	2	87
Connecticut	321	19	303	168	22	19	4	145
Delaware	51	4	47	23	4	3	(2)	19
Dist. of Columbia	75	6	69	39	6	6	1	33
Florida	995	65	930	426	62	53	9	364
Georgia	429	50	380	141	32	30	3	109
Hawaii	51	4	46	22	3	3	(2)	18

See footnotes at end of table.

TABLE 13.—ESTIMATED NUMBER OF PERSONS WITH HOSPITAL INSURANCE PROTECTION ON JULY 1, 1973, AND ESTIMATED AMOUNT OF HOSPITAL INSURANCE BENEFIT PAYMENTS, CALENDAR YEAR 1974, BY STATE—Continued

[Numbers in thousands; amounts in millions]

Insured person's State of residence	Number of persons with hospital insurance protection on July 1, 1973			Benefit payments under the hospital insurance plan in calendar year 1974				
	Total	Disabled persons under age 65 who gain hospital insurance protection immediately, as a result of the amendments [1]	Persons aged 65 and over with hospital insurance protection under the program as in effect before the amendments	Total benefit payments under the amended program	Additional benefit payments resulting from the amendments			Benefits that would have been paid under the program as in effect before the amendments
					Total additional benefit payments	Payments for disabled persons [1]	Payments resulting from other changes	
Idaho	78	6	72	$30	$5	$4	$1	$25
Illinois	1,223	72	1,151	596	81	67	13	515
Indiana	556	37	519	233	34	29	5	199
Iowa	391	19	372	156	19	15	4	138
Kansas	293	14	279	123	14	12	3	108
Kentucky	391	37	354	138	27	24	3	111
Louisiana	354	37	317	132	28	25	3	104
Maine	135	9	126	56	8	7	1	47
Maryland	327	24	303	148	23	20	3	124
Massachusetts	704	39	666	382	49	40	9	333
Michigan	878	69	809	426	72	63	9	354
Minnesota	455	22	434	224	26	21	5	198
Mississippi	260	27	233	87	19	17	2	68
Missouri	627	42	586	267	39	34	6	228
Montana	79	6	73	34	5	5	1	29

Nebraska	202	9	192	79	9	7	2	70
Nevada	35	3	32	20	4	3	[3]	17
New Hampshire	90	5	85	34	4	4	1	29
New Jersey	778	51	727	335	49	42	7	286
New Mexico	83	8	75	32	6	6	1	25
New York	2,219	143	2,076	1,212	175	149	27	1,037
North Carolina	488	54	434	182	40	36	4	142
North Dakota	75	4	71	38	5	4	1	33
Ohio	1,122	77	1,044	482	73	63	11	408
Oklahoma	336	26	310	141	24	21	3	118
Oregon	255	18	237	107	17	14	2	90
Pennsylvania	1,437	102	1,334	561	88	75	12	473
Puerto Rico	210	29	180	36	10	9	1	26
Rhode Island	118	8	110	65	10	9	1	55
South Carolina	231	31	201	80	20	19	2	60
South Dakota	90	5	85	37	5	4	1	32
Tennessee	445	42	403	149	29	26	3	120
Texas	1,109	81	1,027	456	73	63	10	383
Utah	86	6	80	27	4	3	1	23
Vermont	56	4	52	29	4	4	1	25
Virgin Islands, Guam, and American Samoa	4	[2]	4	1	[3]	[3]	[3]	1
Virginia	419	41	378	148	30	27	3	118
Washington	361	23	337	140	20	17	3	119
West Virginia	237	30	208	80	20	18	2	61
Wisconsin	532	31	501	244	33	27	5	211
Wyoming	34	2	32	13	2	2	[3]	11

[1] Under the amendments, hospital insurance protection is provided beginning July 1, 1973, for certain disabled persons who are under age 65. This protection would not have been available to these disabled persons under the program as in effect prior to the amendments.

[2] Less than 500.

[3] Less than $500,000.

NOTE.—Totals do not necessarily equal the sum of rounded components.

TABLE 14.—ESTIMATED NUMBER OF PERSONS WITH SUPPLEMENTARY MEDICAL INSURANCE PROTECTION ON JULY 1, 1973, AND ESTIMATED AMOUNT OF SUPPLEMENTARY MEDICAL INSURANCE BENEFIT PAYMENTS, CALENDAR YEAR 1974, BY STATE

[Numbers in thousands; amounts in millions]

Insured person's State of residence	Number of persons with supplementary medical insurance protection on July 1, 1973			Benefit payments under the supplementary medical insurance plan in calendar year 1974		
	Total	Disabled persons under age 65 who become eligible for supplementary medical insurance protection immediately, as a result of the amendments [1]	Persons aged 65 and over with supplementary medical insurance protection under the program as in effect before the amendments	Total benefit payments under the amended program	Additional benefit payments, for disabled persons under age 65, resulting from the amendments [1,2]	Benefits that would have been paid under the program as in effect before the amendments
Total	22,400	1,700	20,700	$3,267	$417	$2,850
Alabama	376	40	336	42	8	35
Alaska	6	1	6	1	(4)	1
Arizona	171	15	156	32	5	27
Arkansas	269	26	242	31	5	26
California	2,016	163	1,853	470	65	405
Colorado	208	13	195	33	4	30
Connecticut	320	19	301	44	4	39
Delaware	50	4	46	6	1	5
District of Columbia	73	6	68	11	2	10
Florida	986	65	921	194	22	172
Georgia	423	50	374	50	10	40
Hawaii	50	4	46	7	1	6

Idaho	76	6	71	10	1	8
Illinois	1,207	72	1,134	139	15	125
Indiana	544	37	507	54	6	48
Iowa	387	19	368	44	4	40
Kansas	289	14	274	34	3	31
Kentucky	388	37	351	37	6	31
Louisiana	334	37	297	36	7	29
Maine	134	9	125	13	2	11
Maryland	316	24	293	38	5	33
Massachusetts	700	39	661	110	11	99
Michigan	867	69	799	121	16	104
Minnesota	452	22	430	58	5	53
Mississippi	252	27	225	29	5	24
Missouri	618	42	576	75	9	66
Montana	78	6	72	9	1	8
Nebraska	199	9	189	23	2	21
Nevada	35	3	32	7	1	6
New Hampshire	88	5	83	10	1	9
New Jersey	773	51	722	141	16	124
New Mexico	79	8	71	11	2	9
New York	2,185	143	2,042	396	45	351
North Carolina	479	54	425	54	10	44
North Dakota	74	4	70	9	1	8
Ohio	1,102	77	1,025	122	15	107
Oklahoma	333	26	307	48	7	42
Oregon	249	18	230	32	4	28
Pennsylvania	1,409	102	1,307	193	24	169
Puerto Rico	130	29	101	13	3	10
Rhode Island	117	8	108	19	2	17
South Carolina	225	31	195	24	5	19
South Dakota	89	5	84	8	1	7
Tennessee	439	42	397	45	7	38
Texas	1,102	81	1,021	185	24	162
Utah	84	6	78	10	1	9
Vermont	55	4	51	7	1	6

See footnotes at end of table.

TABLE 14.—ESTIMATED NUMBER OF PERSONS WITH SUPPLEMENTARY MEDICAL INSURANCE PROTECTION ON JULY 1, 1973, AND ESTIMATED AMOUNT OF SUPPLEMENTARY MEDICAL INSURANCE BENEFIT PAYMENTS, CALENDAR YEAR 1974, BY STATE—Continued

[Numbers in thousands; amounts in millions]

Insured person's State of residence	Number of persons with supplementary medical insurance protection on July 1, 1973			Benefit payments under the supplementary medical insurance plan in calendar year 1974		
	Total	Disabled persons under age 65 who become eligible for supplementary medical insurance protection immediately, as a result of the amendments [1]	Persons aged 65 and over with supplementary medical insurance protection under the program as in effect before the amendments	Total benefit payments under the amended program	Additional benefit payments, for disabled persons under age 65, resulting from the amendments [1] [2]	Benefits that would have been paid under the program as in effect before the amendments
Virgin Islands, Guam, and American Samoa	3	([3])	3	([4])	([4])	([4])
Virginia	409	41	367	$44	$8	$37
Washington	357	23	333	51	6	45
West Virginia	234	30	204	20	4	16
Wisconsin	528	31	496	64	7	58
Wyoming	34	2	32	4	([4])	3

[1] Under the amendments, supplementary medical insurance protection is available beginning July 1, 1973, for certain disabled persons who are under age 65. This protection would not have been available to these disabled persons under this program as in effect prior to the amendments.

[2] A reduction in benefit payments, totaling $115 million, that results from the increase in the supplementary medical insurance deductible from $50 to $60, beginning January 1, 1973, is offset by additional benefit payments totaling an equal amount—$115 million—that results from all other changes, except for the extension of protection to disabled persons under age 65.

[3] Less than 500.

[4] Less than $500,000.

NOTE.—Totals do not necessarily equal the sum of rounded components.

TABLE 15.—ESTIMATED NUMBER OF BENEFICIARIES ON JAN. 1, 1973, ESTIMATED NUMBER OF PERSONS AFFECTED BY SELECTED PROVISIONS, AND ESTIMATED AMOUNT OF BENEFIT PAYMENTS, CALENDAR YEAR 1974, BY STATE

[Numbers in thousands; amounts in millions]

Beneficiary's State of residence	Number of persons receiving monthly benefits, Jan. 1, 1973	Number of beneficiaries affected by selected provisions		OASDI benefit payments in calendar year 1974 [1]		
		Increased benefits for widows and widowers [2]	Retirement test changes [3]	Total benefit payments under the amended program	Additional benefit payments resulting from the amendments	Benefits that would have been paid under the program as in effect before the amendments
Total [4]	28,400	3,800	1,660	$54,810	$2,347	$52,463
Alabama	510	57	20	829	33	796
Alaska	14	1	1	24	1	23
Arizona	242	25	12	470	17	453
Arkansas	356	34	11	553	19	535
California	2,484	305	145	5,039	204	4,835
Colorado	253	31	13	479	18	460
Connecticut	375	58	26	828	37	791
Delaware	65	9	4	131	6	126
Dist. of Columbia	83	9	6	149	6	142
Florida	1,266	146	57	2,470	85	2,386
Georgia	574	59	20	933	34	899
Hawaii	73	6	3	133	4	129

See footnotes at end of table.

TABLE 15.—ESTIMATED NUMBER OF BENEFICIARIES ON JAN. 1, 1973, ESTIMATED NUMBER OF PERSONS AFFECTED BY SELECTED PROVISIONS, AND ESTIMATED AMOUNT OF BENEFIT PAYMENTS, CALENDAR YEAR 1974, BY STATE—Continued

[Numbers in thousands; amounts in millions]

Beneficiary's State of residence	Number of persons receiving monthly benefits, Jan. 1, 1973	Number of beneficiaries affected by selected provisions		OASDI benefit payments in calendar year 1974 [1]		
		Increased benefits for widows and widowers [2]	Retirement test changes [3]	Total benefit payments under the amended program	Additional benefit payments resulting from the amendments	Benefits that would have been paid under the program as in effect before the amendments
Idaho	101	12	7	$191	$8	$183
Illinois	1,423	216	96	2,960	135	2,825
Indiana	694	103	43	1,412	62	1,349
Iowa	448	65	32	865	41	824
Kansas	334	47	27	640	31	609
Kentucky	507	58	17	842	31	810
Louisiana	469	55	16	764	30	734
Maine	163	21	11	304	13	291
Maryland	408	60	24	804	36	768
Massachusetts	785	119	66	1,643	79	1,563
Michigan	1,141	175	60	2,413	104	2,309
Minnesota	533	70	33	1,007	41	966
Mississippi	352	29	11	504	17	486
Missouri	736	97	41	1,384	57	1,327
Montana	100	12	7	192	9	183
Nebraska	228	30	16	426	19	407
Nevada	47	5	3	95	4	92

New Hampshire	108	14	7	219	9	211
New Jersey	929	150	68	2,018	96	1,922
New Mexico	122	11	5	201	7	194
New York	2,559	379	232	5,525	280	5,244
North Carolina	678	72	29	1,115	42	1,073
North Dakota	92	11	8	162	8	154
Ohio	1,361	221	73	2,783	124	2,660
Oklahoma	399	49	21	710	29	681
Oregon	322	38	20	653	25	628
Pennsylvania	1,714	298	111	3,579	169	3,410
Puerto Rico	354	10	5	359	9	351
Rhode Island	138	20	10	284	13	271
South Carolina	335	33	12	541	20	521
South Dakota	108	14	7	191	8	183
Tennessee	576	62	25	941	37	904
Texas	1,390	168	69	2,400	95	2,305
Utah	110	14	7	217	9	208
Vermont	66	9	4	126	6	120
Virgin Islands, Guam, and American Samoa	6	(5)	(5)	8	(6)	8
Virginia	553	68	29	969	42	927
Washington	449	58	32	923	40	882
West Virginia	326	47	11	594	25	569
Wisconsin	647	92	41	1,302	56	1,246
Wyoming	42	5	3	81	3	78

[1] Includes payments for vocational rehabilitation services.
[2] Represents persons who will receive larger benefits for January 1973.
[3] Represents persons who will receive either additional benefits, or some benefits (where they would have received none under prior law), for months in the first full year.
[4] Numbers of persons residing abroad, and amounts of benefit payments to them, are included in totals.
[5] Less than 500.
[6] Less than $500,000.

NOTE.—Totals do not necessarily equal the sum of rounded components.

TABLE 16.—DOLLAR AMOUNT OF EMPLOYEE SOCIAL SECURITY CONTRIBUTIONS FOR CALENDAR YEARS 1973 AND 1974 FOR SELECTED LEVELS OF ANNUAL EARNINGS

	Contribution rate (percent)	Maximum covered earnings ($10,800 for 1973; $12,000 for 1974)	Median earnings (male) ($7,433 for 1973; $7,804 for 1974)	Minimum wage earner $3,328 earnings
1973:				
Prior law	5.5	$594.00	$408.82	$183.04
New schedule	5.85	631.80	434.83	194.69
1974:				
Prior law	5.5	660.00	429.22	183.04
New schedule	5.85	702.00	456.53	194.69