

1987

Jerry Grandson v. Suzanne Dandoy : Brief of Respondent

Utah Court of Appeals

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BRIEF

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IN THE COURT OF APPEALS

STATE OF UTAH

DOCKET NO. 870099

JERRY GRANDSON,

Petitioner-
Appellant,

-vs-

SUZANNE DANDROY, in her capacity :
as Executive Director of the
Utah Department of Health, :

Respondent-
Appellee.

NO. 870099-CA

Category No. 14(a)

BRIEF OF RESPONDENT

**APPEAL FROM THE MEMORANDUM DECISION
AND ORDER OF THE SEVENTH JUDICIAL DISTRICT COURT
IN AND FOR SAN JUAN COUNTY, STATE OF UTAH
THE HONORABLE BOYD BUNNELL, JUDGE, PRESIDING**

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IN THE COURT OF APPEALS

STATE OF UTAH

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| JERRY GRANDSON, | : | |
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| Appellant, | : | NO. 870099-CA |
| -vs- | : | |
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| | : | |
| Respondent- | : | |
| Appellee. | : | |
| | : | |

JURISDICTIONAL STATEMENT

This is an appeal from a decision rendered by the Seventh Judicial District Court on a Petition For Review of a Final Determination made by the Director of the Utah Department of Health on a medicaid application. The Court of Appeals has jurisdiction over this appeal pursuant to Utah Code Ann. § 78-2a-3(2)(a) (1982) (Addendum 1).

STATEMENT OF ISSUES PRESENTED ON APPEAL

1. Whether federal and state statutes and regulations authorize the Utah Medicaid program to consider the income of all co-resident siblings in determining eligibility for state medical assistance.

2. Whether § 2640 of DEFRA 1984 removes the bar to the deeming of representative payee income in Medicaid cases.

STATEMENT OF THE CASE

1. MEDICAID PROGRAM: Statutory and Regulatory Background.

Title XIX of the Social Security Act, 42 U.S.C. § 1396, et seq., provides for the establishment of a cooperative federal-state program, commonly called "Medicaid," to provide payments for "necessary medical services" rendered to certain "needy individuals whose income and resources are insufficient to meet the costs of these services." 42 U.S.C. § 1396 (Addendum 2, 5); Schweiker v. Hogan, 457 U.S. 569, 102 S.Ct. 2597 (1982); Schweiker v. Gray Panthers, 453 U.S. 34, 101 S.Ct. 2633 (1981). States are not required to institute and administer a Medicaid program, but if they choose to do so, the federal government will reimburse them for a portion of the costs incurred in providing certain types of medical care and services to needy persons who are qualified recipients. 42 U.S.C. § 1396b (Addendums 2); 42 C.F.R. § 447 (Addendum 3), et seq. States who choose to participate in the program "must comply with the requirements imposed both by the Act itself and by the Secretary of the Department of Health and Human Services." Schweiker v. Gray Panthers, 453 U.S. at 37, 101 S.Ct. at 2636.

Participating states must cover as "categorically needy" all who qualify under the Aid to Families with Dependent Children (AFDC) program of Title VI-A and (subject to an exception) under the program of Supplemental Security Income for

the Aged, Blind and Disabled (SSI), Title XVI of the Social Security Act, 42 U.S.C. §1381 et seq. (Addendum 4). 42 U.S.C. § 1396a (Addendum 5).

Jerry Grandson, petitioner, herein claims to qualify for Medicaid benefits pursuant to the AFDC provisions. In such instances the law requires that:

In determining eligibility for families and children, a Medicaid agency must apply the financial eligibility requirements of the State's AFDC plan.

42 C.F.R. § 435.711 (emphasis added) (Addendum 6).

Federal statutory law requires that a State's AFDC plan must provide that, in making an eligibility determination with respect to a dependent child, the State agency shall include:

(A) any parent of such child, and

(B) any brother or sister of such child, if such brother or sister meets the conditions described in clauses (a) and (2) of section 406(a)¹, if such parent, brother or sister is living in the same home as the dependent child, and any income of or available for such parent, brother, or sister shall be included in making such determination and applying such paragraph with respect to the family (notwithstanding section 205(j), in the case of benefits provided under Title II).

¹ The referenced section 406(a) defines the term "dependent child" to be a needy child who has been deprived of parental support, lives with certain specified relatives and is under age 18 or under age 19 for certain full time students. Codified at 42 USCS § 606(a) (Addendum 8).

42 USCS § 602(a)(38) (Addendum 7). Deficit Reduction Act of 1984 and hereinafter referred to as section 2640 of DEFRA.

To further clarify, the federal position, the Department of Health and Human Services (HHS) sent Regional Identical letter #85-61 (Addendum 9) dated July 25, 1985 to all Medicaid State agencies. That letter states in part:

. . . [R]egulations at 42 CFR 435.711 require that the financial requirements and methodologies of the State's Title IV-A plan be used to determine eligibility for AFDC-related categorically needy. Similarly, Section 1902(a)(10)(c) of the Act requires the AFDC financial methodologies to be employed in determining eligibility for AFDC-related medically needy persons.

Consideration of a child's and a sibling's income when a member of the assistance unit [applies for medicaid] is not in conflict with Section 1902(a)(17) or any other Title XIX statutory provision.

. . . As Section 2640 of DRA is interpreted by the AFDC program, this provision merely specifies who must apply for assistance. It does not change the income determination methodology, which has always taken into account the income and needs of all members of the filling unit in determining the eligibility of the unit. Thus, the sibling's income is considered in determining his or her own eligibility as part of a unit and the siblings are not considered "financially responsible" for each other as that term is used in the context of Section 1902(a)(17)(D). Under this interpretation, Section 1902(a)(17)(D) does not prohibit the application of this requirement. Furthermore, Section 1902(a)(10)(C) of the act and 42 CFR 435.711 require this financial methodology of the AFDC program to be applied in determining

eligibility for the AFDC-related
categorically needy and medically needy.

Thus, the federal interpretation of the standard filing unit was made clear to the states and Utah is bound by that interpretation.

2. AGENCY ACTION

It was with this background that the District VII (B) Office of Community Operations evaluated Jerry Grandson's application for medicaid. Jerry Grandson lives in a household with his mother and three sisters. Each child receives Social Security Survivor benefits and the total income of the children in the family totals \$1,432.00 a month. This amount exceeds the basic maintenance standard (BMS) for a household of five by \$766.00 a month. Consequently, Jerry Grandson's Medicaid application was denied unless the family unit paid the \$766.00 excess. Jerry Grandson incurred over \$30,000.00 in medical expenses in June 1985 as a result of a gun shot wound. He declined to pay the \$766.00 BMS excess, however, which would have then bought him Medicaid coverage for all of June 1985 medical expenses.

Jerry Grandson requested a fair hearing to review the agency action on his application. The hearing was conducted by written briefs and letters and on December 20, 1985, the hearing officer recommended to the executive director of the Department of Health that the District Office decision be sustained.

Suzanne Dandoy, Executive Director of the Department of Health, adopted this recommended decision in her final determination dated March 14, 1986.

On May 30, 1986, Jerry Grandson filed a Petition For Review in the Seventh Judicial District Court. On February 23, 1987 the District Court entered a Memorandum Decision holding that the executive director did not act capriciously by denying Jerry Grandson Medicaid eligibility. The court reviewed the memorandum submitted and the applicable laws and regulations and concluded that the director's conclusion is not contrary to those laws and regulations.

Jerry Grandson filed his Notice of Appeal to this court on March 23, 1987.

SUMMARY OF ARGUMENT

Jerry Grandson, a minor child, applied for Medicaid benefits under Title XIX of the Social Security Act. He was denied Medicaid coverage because the total income for the family exceeded the basis maintenance standard (BMS) which governs eligibility. Mr. Grandson has challenged the calculation of his eligibility because the income of his co-resident siblings was included to determine his eligibility.

Section 1902(a)(10) of the Medicaid statute and attendant regulations clearly require that in determining Medicaid eligibility for families and children the financial eligibility requirements of the States AFDC plan must be applied.

Section 2640 of DEFRA is an AFDC financial eligibility requirement which requires the counting of income of parents and all minor children in one filing unit. A minor child can not file separately but must file as part of an AFDC filing unit.

Although a very strict construction of subsection 17(D) of the 1965 Medicaid Act says that states should not take into account the financial responsibility of any individual for the applicant except the spouse or child who is under 21, the Congressional record shows that Subsection 17(D) was not intended to prevent the inclusion of all members of a nuclear family household from being considered as one filing unit when determining eligibility.

Furthermore, Subsection 17(B) of the same statute granted authority to the Secretary of the U.S. Department of Health and Human Services (hereinafter "Secretary") to determine when income was considered "available" for eligibility determination purposes. The Secretary has informed the all states and specifically, Utah Department of Health that the income of parents and minor children living together should be counted as "available" to that filing unit. This direction is not only within the Secretary's authority but also mandated by Congress. The Secretary's determination is also entitled to great deference if not legislative effect.

The 1984 Congress was aware that Medicaid eligibility is governed by AFDC financial eligibility requirements and intended to impact both programs by amending those requirements with the DEFRA provisions. Though this retargeting of scarce public resources results in some individuals, including Jerry Grandson, being ineligible to receive Medicaid benefits without paying the BMS excess, others that were previously ineligible will now be eligible, and a net increase in those eligible for Medicaid is expected. This "retargeting" is clearly within the authority of Congress.

In addition, Section 2640 DEFRA removes the bar prohibiting Social Security benefits which are paid to a representative payee from being counted as available to the AFDC unit. Because Medicaid eligibility is tied to the AFDC filing unit, the bar is also removed for calculating Medicaid eligibility.

The issues in this case have been carefully considered by a hearing office for the Department of Health and his decision was affirmed by the Executive Director. In addition, Judge Bunnell of the the 7th District reviewed the Final Determination pursuant to Utah Code Ann. § 26-23-2 (1953) and affirmed the decision because he found that the final determination was not capricious and supported by the evidence.

ARGUMENT

POINT I

SECTION 17(D), THE MEDICAID FINANCIAL RESPONSIBILITY PROVISION, WAS NOT INTENDED TO PREVENT CONSIDERATION OF INCOME OF ALL MEMBERS OF A NUCLEAR FAMILY HOUSEHOLD IN DETERMINING MEDICAID ELIGIBILITY.

Jerry Grandson argues that DEFRA Section 2640(a), as set forth above should not apply to Medicaid eligibility determinations because of a provision in the Medicaid statute which provides that a state Medicaid plan must include reasonable standards for determining eligibility which

do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under 21 . . .

42 U.S.C. § 1396a(a)(17)(D) (Addendum 5). (Hereafter referred to as "Section 17(D)").

Petitioner also cites the regulation promulgated pursuant to that provision which reiterates that prohibition.

In order to properly interpret Section 17(D) it is necessary to understand why it became part of the Medicaid statute passed by Congress in 1965. For the first time in 1960 Congress enacted federal medical assistance legislation, Pub. L. 86-778, which became commonly known as the "Kerr-Mills" program. Kerr-Mills made federal matching grants available to states which chose to develop a medical assistance program for needy elderly

persons who could not afford necessary medical care. By the time of Congress' action on the Social Security Amendments of 1965 which included Medicaid, the proponents of that legislation (and even many of its opponents) agreed that a more effective medical assistance program was needed than Kerr-Mills had shown itself to be. Title XIX, or Medicaid, was established "to provide a more effective Kerr-Mills medical assistance program for the aged and to extend its provisions to additional needy persons . . ." H.R. Rep. No. 213, 89th Cong., 1st Sess. 9, 63-64 (March 29, 1965) (Addendum 11).

One of the major problems with Kerr-Mills was that several states had passed financial responsibility laws that placed financial responsibilities for the care, including medical care, of needy elderly persons upon relatives such as brothers, sisters, children and grandchildren. Hence, if an elderly person was in need of medical care for which he was not able to pay, he was required to first turn to his relatives for assistance. Because Kerr-Mills was a program for the elderly, the relatives were, almost without exception, adults who had their own households to maintain. Rather than placing an additional burden on their relatives or facing the humiliation of calling on them for help, many of the needy elderly chose to forego needed medical care. For those needy elderly who did receive assistance under Kerr-Mills the burden on family members was often extreme.

Additionally, in cases where emergency care was rendered to the needy, hospital collection departments sought satisfaction from the relatives listed in the particular statute.

Senator McNamara's Subcommittee on Health of the Elderly had reported in 1963:

The aged applicant filing for MAA [Medical Assistance for the Aged] in a State which utilizes family responsibility provisions, thereby, in effect, may subject members of his family to a means test -- apart from himself.

In all probability, no other condition attached to application for MAA is as upsetting as the requirement that relatives be investigated and interviewed to determine their ability to contribute toward the health expenses of the applicant for MAA. It is not that families are unwilling to take care of their own. Relatives of the applicant may have already been paying a substantial part of the living expenses of their older relative(s). In some instances, MAA help is requested because the applicant knows that the finances of his family are already under heavy strain. When the older person learns that additional financial aid may be demanded on his family, frequently at what he knows will mean severe hardship, he may well and very often does, withdraw or refuse to make application and let his health needs go unmet.

"Medical Assistance for the Aged, the Kerr-Mills Program 1960 - 1963, " Report by the Subcommittee on Health of the Elderly to the Special Committee on Aging (Committee Print 1963), at 31 (Addendum 12). The subcommittee also noted the heavy administrative costs, in which the federal government participated in pursuing collection of the hospital bills from legally responsible relatives. Id. at 32. As a result, the sub-

committee concluded that "a rather persuasive case has been made for congressional consideration of an amendment to the Kerr-Mills Act which would confine the application of family responsibility provision, in those states using such provisions, to the applicant and/or his spouse." *Id.* at 32-33 (emphasis added).

When the Medicaid bill was debated upon the floor of the House, members consistently reiterated that the "financial responsibility" limitation on considering income from relatives, as well as the entire program of Medicare and Medicaid, was intended to preclude states shifting the financial burden of helping the elderly poor to their adult children who had families of their own to support. *See* , *e.g.* , 111 Cong. Rec. H7201 et. seq. daily ed. April 7, 1965 (Addendum 13).

For example, Congressman Secrest indicated that under the expanded Kerr-Mills each "indigent old person will be judged by his own resources. The income of his children will no longer bar him from benefits." *Id.* at H7244.

The House Ways and Means Committee report to the House indicated:

Your committee has heard of hardship on certain individuals by requiring them to provide support and to pay for the medical care needed by relatives. Your committee believes it is proper to expect spouses to support each other and parents to be held accountable for the support of their minor children. . . Such requirements for support may reasonably include the payment by such relative, if able, for medical care. Beyond such degree of relationship, however, requirements

imposed [by some states under Kerr-Mills] are often destructive and harmful to the relationship among members of the family group. Thus, States, may not include in their plans provisions for requiring contributions from relatives other than a spouse or the parent of a minor child . . . Any contributions actually made by relatives or friends, or from other sources will be taken into account by the State in determining whether the individual applying for medical assistance is, in fact, in need of such assistance.

H.R. Rep. No. 213 89th Cong. 1st Sess. p. 68, March 29, 1965
(Addendum 11).

Similar comments were made when the bill came before the Senate.

From the foregoing it is clear that Section 17(D) was intended to lift the burden of medical care expenses from adult relatives, and that the Congress intended that those beyond the degree of relationship of spouse or of parents and minor children should not be called upon to expend their resources to satisfy that burden before a needy person could qualify for Medicaid. There is no indication that Congress ever considered the income of minor children.

POINT II

THE SECRETARY'S DIRECTIVE THAT THE INCOME OF ALL MEMBERS OF THE HOUSEHOLD FILING UNIT SHOULD BE CONSIDERED TO BE "AVAILABLE" FOR MEDICAID ELIGIBILITY PURPOSES WAS WITHIN THE BOUNDS OF HER AUTHORITY AND IN ACCORD WITH APPLICABLE LAW.

In the above-cited report the House Ways and Means Committee set forth a further reason for not counting assets of

relatives who are beyond the degree of spouse or of parent to minor child. At p. 67 of that report the Committee indicated:

. . . These provisions are designed so that the States will not assume the availability of income which may not, in fact, be available. Examples of income assumed include support orders from absent fathers, which have not been paid, or contributions from relatives which are not in reality received by the needy individual. . .

P. 67 (Emphasis added.)

Realizing the Congressional concern of not counting income which may not, in fact, be "available" it is significant to note that Congress placed the responsibility of determining when income and resources are to be considered "available" upon the Secretary of the U.S. Department of Health and Human Services. Section 1902(a)(17)(B) enacted in 1965 as a part of the same Title XIX Medicaid Section upon which Petitioner relies (i.e. 17(D)), explicitly authorizes that "such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient" shall be taken into account in determining Medicaid eligibility. Section 1902(a)(17)(B) of the Social Security Act -- now codified as 42 U.S.C. 1396a(a)(17)(B), and hereafter referred to as "17(B)".

In relation to the Secretary's authority to determine when income and resources are "available" the Supreme Court has stated:

The Social Security Act is among the most intricate ever drafted by Congress. Its Byzantine construction . . . makes the Act "almost unintelligible to the uninitiated." [citation omitted] Perhaps appreciating the complexity of what it had wrought, Congress conferred on the Secretary exceptionally broad authority to prescribe standards for applying certain sections of this Act. . .

In view of [the] explicit delegation of substantive authority [to prescribe standards under section 1902(a)(17)(B)], the Secretary's definition of the term "available" is "entitled to more than mere deference or weight." [citing Batterton v. Francis]. Rather, the Secretary's definition is entitled to "legislative effect" because, "[i]n a situation of this kind, Congress entrusts to the Secretary, rather than to the courts, the primary responsibility for interpreting the statutory term."

Schweiker v. Gray Panthers, 101 S.Ct. at 2640. The Gray Panthers court declared that, unless the Secretary exceeded her statutory authority or is arbitrary and capricious, her promulgation of standards with respect to section 17(B) must be upheld. Here, the Medicaid standard as interpreted by the Secretary is that income available to any member of the public assistance filing unit is "available" for purposes of section 17(B).

In the present case, not only has the Secretary determined that the income and resources of brothers and sisters of a dependent child who live in the same household should be counted as "available"; the Congress itself has also expressed that intention. After proposing DEFRA §2640 which effected that intent, the Senate Finance Committee explained that provision as follows:

This change . . . will ensure that the income of family members who live together and share expenses is recognized and counted as available to the family as a whole.

S. Rep. No. 300, 98th Cong., 2d Sess. 165 (1983) (emphasis added) (Addendum 14); Senate Committee Print 98-169, Vol. I, "Deficit Reduction Act of 1984, Explanation of Provisions Approved by the Committee on March 21, 1984" (Senate Committee on Finance, April 2, 1984), at pp. 980-981.

Thus Congress concluded that the income of those family members living together and sharing expenses should be counted as available in assessing the financial condition of that family unit. Congress recognized the reality that the income of a particular sibling member of that family unit is used by the head of household for necessities, many of which are of direct benefit to all members of the family unit, including important contributions to the shelter cost of rent, food costs, utility costs and other household expenses. The sibling with income lives with the family and receives the benefit of his income in the family household. In addition, the sibling with income does not merely contribute such income to the unit, but becomes an added member of the unit for purposes of determining its level of need based upon family size. Thus, the sibling child brings with him or her into the unit both his or her income and resources and his or her needs which must be met. Congress directed that states should assess both for all mandated members of the filing

unit, parent, child and siblings, as a realistic family household.

Therefore, the decision of the Utah Department of Health that the income of Jerry Grandson's sisters who reside in the same household should be considered to be "available" for Medicaid eligibility determination purposes was in accord with the mandate of the Secretary. The Secretary's mandate was pursuant to a power that was specifically authorized, and a duty that was specifically assigned, by Congress. The Supreme Court has indicated that the Secretary's determination as to availability is entitled to legislative effect. Furthermore the Secretary's determination relative to the instant case can hardly be considered beyond her statutory authority since it is exactly what Congress itself has required. Hence the Final Determination of the Executive Director is not capricious and the 7th District correctly affirmed her decision.

POINT III

THE DEFRA PROVISION WAS INTENDED TO AFFECT MEDICAID ELIGIBILITY DETERMINATIONS.

Petitioner argues that the DEFRA provision set forth above applies only to AFDC eligibility determination and not to Medicaid. Section 1902(a)(10) of the Medicaid Act and the regulations enacted pursuant to it require that the eligibility of the Medicaid categorically needy be determined by application of the financial eligibility requirements of AFDC. Section

1902(a)(17)(B) requires that income available to a Medicaid claimant, as determined under standards prescribed by the Secretary, be counted in determining eligibility for Medicaid.

The DEFRA provision provides that the financial eligibility of a child for AFDC whose siblings are dependent children living in the same home must be determined by including the parent and such siblings of the child in the public assistance filing unit and considering as available the income of each members of the household unit.

To argue that DEFRA does not apply to Medicaid is to argue that either Congress is oblivious to the interrelation of AFDC and Medicaid or that Congress, being fully aware of the requirement that Medicaid eligibility is determined using AFDC eligibility standards, enacted a provision amending those AFDC standard and without mentioning that the amendment was not intended to affect Medicaid, yet somehow assumed that such would be the case.

A brief look at the legislative history will show that neither was the case. In 1965 Congress passed many of the President's "Great Society" programs which had an expansive perspective. Congress enacted the above referenced subsections 17(B) and 17 (D) of Medicaid to preclude states from limiting Medicaid public assistance by considering income that was not "available" to claimants or by assuming the financial

responsibility of persons outside the filing unit other than a spouse or parent of a child. (As mentioned above, the power to determine what was "available" was granted to the Secretary rather than to the states). In 1984, however, Congress had a deficit-conscious perspective which sought substantial cuts in federal spending on domestic programs and retargeting scarce public resources.

The 1984 attempts to bring the deficit under control were preceded by earlier attempts. In 1981 Congress passed the Omnibus Budget Reconciliation Act (OBRA) and in 1982 the Tax Equity and Fiscal Responsibility Act P.L. 97-24B (TEFRA). In explaining savings effected under OBRA the Secretary indicated:

These savings arise primarily from retargeting scarce resources on [those] most in need and restricting eligibility to the truly needy.

47 Fed. Reg. at 5648 (1982) (emphasis added) (Addendum 15).

This is precisely the retargeting of scarce public resources to those poor families most in need which Congress explicitly intended with its 1984 DEFRA program improvements. When introducing the Senate Finance Committee amendment, Senator Dole explained that the bill's health program proposals reflected "the committee's concern for directing spending to where it is most needed, including modest increases where appropriate." 130 Cong. Rec. S4097, S4099 (April 9 1984) (emphasis added) (Addendum 16).

Prior to 1984, there was no requirement that all co-resident family members be included in the filing unit for AFDC purposes. A family applying for AFDC assistance could therefore exclude from the filing unit those family members with income that, if counted in the overall family income, would reduce or terminate the amount of the family's AFDC benefits. In anticipation of the prospective receipt of additional income (such as Social Security benefits), a family member could also be selectively, voluntarily removed from the AFDC rolls at any time. Thus many who were not those most in need were able to qualify for AFDC and thus for Medicaid.

It is precisely that problem that Congress sought to correct by enacting Section 2640 of DEFRA, as is indicated by the following excerpt from the House Conference Report:

Present Law

There is no requirement in present law that parents and all siblings be included in the AFDC filing unit. Families applying for assistance may exclude from the filing unit certain family members who have income which might reduce the family benefit.

Senate Amendment

Require States to include in the filing unit the parents and all minor siblings living with a dependent child who applies for or receives AFDC.

Conference Agreement

The conference agreement follows the Senate amendment

House Conference Report No. 98-861, 98th Cong., 2d Sess. 1407 (June 23, 1984) (Addendum 17), reprinted in 1984 U.S. Code Cong. and Admin. News, Pamphlet 6B, at 751, 1401.

That "filing unit" provision was proposed as part of the Senate Finance Committee amendment, which formed the primary basis of the Senate's position in conference with the house.

The Committee explanation of the provision included estimated cost savings under the AFDC program of \$455 million for fiscal years 1984-1987. Senate Committee Print 98-169 at p. 981 (See Addendum 14). This estimate was taken from the Congressional Budget Office (CBO) report to the committee, dated March 30, 1984, which indicated that amount of savings for those years. Id., at pp. 1007-09, particularly 1008. See Addendum, Item 18. The CBO also reported that the AFDC filing unit provision would result in increased costs under the Medicaid program for the federal government, although the balance between the financial impact in AFDC and in Medicaid would be a significant savings to the federal government. Id. at p. 1008. In addition, concerning estimated costs to state and local governments, the CBO stated:

Changing the AFDC filing unit would result in state savings in AFDC and state costs in Medicaid.

Id., p. 1009.

The reason for the anticipated cost increase in Medicaid was that there would be more claimants eligible after enactment of the DEFRA filing unit provision. Prior to DEFRA when a sibling was not included in the AFDC unit, he was generally not a claimant for Medicaid either. After DEFRA, it could be anticipated that the addition of the sibling to the public assistance unit would mean potential new claims for Medicaid as well. In some cases, the income of the added sibling would result in a lower AFDC benefit for the household, but they would still remain eligible for AFDC and, therefore, all, including the newly added sibling, would be eligible as categorically needy Medicaid claimants. Thus the DEFRA family filing unit provision would have precisely that "retargeting of scarce resources to those most in need" effect that was intended by Congress and it would affect both the AFDC and Medicaid.

It should not be granting too much deference to Congress to presume that at least the committees that dealt with Health and Human Services issues, if not the whole Congress, understood the very basics of the dependence of Medicaid eligibility on AFDC financial requirements. The legislative history of § 2640 of DEFRA is replete with references to the impact that changing the AFDC filing unit would have on Medicaid eligibility. One finance committee report states:

Impact of changes in other program -
The Administration budget is proposing a

number of changes in AFDC which will reduce AFDC caseloads. Since medicaid eligibility is linked to eligibility for AFDC, medicaid savings are also anticipated The Administration estimates reductions in outlays for fiscal year 1984 of \$93 million due to AFDC changes.

S.PRT. 98-13, Senate Committee on Finance, 98th Cong., 1st Sess, Data and Materials for the Fiscal Year Finance Committee Report Under the Congressional Budget Act. at p. 76 (Addendum 19).

Hence it was known by the Congress that Medicaid eligibility is governed by AFDC financial eligibility requirements and that by changing the AFDC financial eligibility requirements by enacting the DEFRA filing unit provision, that a change would also result in the Medicaid program. Indeed that was the intent in an effort to retarget the use of scarce resources to those most in need.

In the present case, the Department of Health was therefore justified in applying the DEFRA requirements to Jerry Grandson's eligibility determination. The Executive Director's ruling upholding that determination was therefore not capricious, and Judge Bunnell's review of that determination found that the Director was not acting capriciously.

POINT IV

DEFRA SPECIFICALLY REMOVES THE BAR TO CONSIDERING SOCIAL SECURITY BENEFITS WHICH ARE PAID TO A REPRESENTATIVE PAYEE AS AVAILABLE TO THE AFDC FILING UNIT.

Jerry Grandson argues that Title II survivors benefits, such as those paid to his sisters, can be paid to a representative payee but that the payee is compelled to allocate the payments for the sole use and benefit of the beneficiary and that they are therefore not "available" and should not be counted. Petitioner cites 42 U.S.C. § 405(j), (which was originally designated as section 205(j) of Title II) in support of this contention. 42 U.S.C. § 602, however, provides that in determining the eligibility of an individual the state agency shall include:

(A) any parent of such child, and

(b) any brother or sister of such child, if such brother or sister meets the conditions described in clauses (1) and (2) of section 406(a) [42 USCS § 606(a)], if such parent, brother, or sister is living in the same home as the dependent child, and any income of or available for such parent, brother, or sister shall be included in making such determination and applying such paragraph with respect to the family (notwithstanding section 205(j) [42 USCS § 405(j)], the case of benefits provided under title II [42 USCS § § 401 et seq.]);

42 USCS § 602(a)(38) (emphasis added) (Addendum 7).

Most all courts which have examined DEFRA § 2640 have held that the express statutory language of this section removes

the bar to the deeming of representative payee income in AFDC cases. Ardister v. Mansour, 627 F.Supp. 641 (W.D. Mich. 1986); Whitehorse v. Heckler, 809 F.2d 529 (8th Cir. 1987); Showers v. Cohen, 645 F.Supp. 217 (M.D. Pa. 1986); Gorrie v. Bowen, 809 F.2d 508 (8th Cir. 1987).

Because the Medicaid agency must apply the financial eligibility requirements of the AFDC program 42 C.F.R. § 435.711 (Addendum 6), the removal of this bar logically extends to the Medicaid program as well.

POINT V

THE SECRETARY'S CONTEMPORANEOUS CONSTRUCTION
OF A NEW PROVISION IN A COMPLICATED STATUTE
SHE IS CHARGED WITH ADMINISTERING, IF
REASONABLE AND CONSISTENT WITH THE STATUTE,
IS ENTITLED TO GREAT DEFERENCE.

The principle is well settled that, where there is some ambiguity in interpreting a statute, the interpretation of the agency charged with administering it is entitled to great deference. The Supreme Court has admonished that a reviewing court must

[show] great deference to the interpretation given the statute by the officers or agency charged with its administration. "To sustain the Commission's application of the statutory terms, we need not find that its construction is the only reasonable one, or even that it is the result we would have reached had the question arisen in the first instance in judicial proceedings
. . . .

"Particularly is this respect due when the administrative practice at stake 'involves a contemporaneous construction of a statute by the men charged with the responsibility of setting its machinery in motion; of making the parts work efficiently and smoothly while they are yet untried and new.'"

Udall v. Talman, 380 U.S. 1, 16, 85 S.Ct. 792, 801 (1965)

(emphasis added). In interpreting the Medicaid provisions of the Social Security Act, the Supreme Court has specifically found that Congress has entrusted the Secretary with an exceptionally broad delegation of authority to define its terms. As previously noted in Schwieker v. Gray Panthers, 453 U.S. 34 (1981), the Court found the Secretary's definition of the term "available" is entitled to 'legislative effect' because '[i]n a situation of this kind, Congress entrusts to the Secretary, rather than to the courts, the primary responsibility for interpreting the statutory term. Id. at 44 (citations omitted). See also Schweiker v. Hogan, 457 U.S. 569, 102 S.Ct. 2597, 2609 (1982) (Medicaid); Blum v. Bacon, 457 U.S. 132, 141-142, 102 S.Ct. 2355, 2361 (1982) (AFDC); Connecticut Dept. of Income Maint. v. Heckler, 471 U.S. 524, 105 S.Ct. 2210 (1985) (Medicaid) (Citing Blum).

This deference is all the more appropriate and decisive where the agency's interpretation is contemporaneous with the statute and where

the administrators participated in drafting and directly made known their views to Congress in Committee hearings.

[citations omitted] In such circumstances, absent any indication that Congress differed with the responsible department, a court should resolve any ambiguity in favor of the administrative construction, if such construction enhances the general purposes and policies underlying the legislation.

Zuber v. Allen, 396 U.S. 168, 90 S.Ct. 314, 327-328 (1969).

(Emphasis added). Both the Social Security Medicaid Amendment of 1965 and the sibling provision and other amendments to AFDC in DEFRA of 1984 arose from legislative proposals developed by the respective Secretaries of the U.S. Department of Health and Human Services. See, for 1965, "Social Security Amendments of 1965: Summary and Legislative History" by the Undersecretary of HEW and the Commissioner of Social Security (Addendum 21), at p. 3, concerning the introduction of H.R.1, the Administration's proposals leading to the Social Security Amendments; and, for 1984, the Secretary's May 25, 1983 letter to President of the Senate Bush, with attachments, including section 102, the definition of the family filing unit, at p. 1-2 of section-by-section analysis (Addendum 22).

The Zuber principle of deference to the agency which participated in drafting and hearings has been confirmed consistently. See United States v. Vogel Fertilizing Co., 455 U.S. 16, 102 S.Ct. 821, 830-831 (1982); Central Lincoln Peoples' Utility Dist. v. Johnson, 686 F.2d 708, 710-711 (9th Cir. 1982); Frank Diehl Farms v. Sec'y of Labor, 697 F.2d 13236, 1329-1330

(11th Cir. 1983); International Nutrition v. U.S. Dept. of Health and Human Services, 676 F.2d 338, 342 (8th Cir. 1982); Meade Township, et al. v. Andrus, et al., 695 F.2d 1006, 1011 (6th Cir. 1982) and Pfeiffer v. Essex Wire Corp., 682 F.2d 684, 687 (7th Cir. 1982) (both citing Zuber with approval as to the weight of the congressional drafters' report).

The Executive Director does not contend that the rendering of the Secretary's interpretation dispenses with the role of a federal court. The Court assuredly does have a role in evaluating her interpretation and deciding whether it is a reasonable one. However, if her interpretation is reasonable and consistent with the statutory purpose, the established standard of appropriate judicial deference does mean that the Court is not empowered to substitute its own judgment, or a plaintiff's judgment, as to the "better" reading of the law.

Based upon the foregoing authority, the Secretary's interpretation of the interrelation between the AFDC and Medicaid statutes here is entitled to great weight and substantial deference, if not "legislative effect." As the experienced administrator delegated exceptionally broad authority by Congress to define the terms and implement the mandates of the Medicaid statute, the Secretary has taken a reasonable position which comfortably, smoothly accommodates both the older and the newer provisions of two very complex, interrelated statutes.

CONCLUSION

For the foregoing reasons, we respectfully request this court to affirm the decision of the district court.

DATED this June²² day of _____, 1987.

Brian L. Farr
BRIAN L. FARR
Assistant Attorney General

Ruth Lybbert Renlund
RUTH LYBBERT RENLUND
Assistant Attorney General

CERTIFICATE OF MAILING

This is to certify that I mailed four copies of the foregoing BRIEF OF RESPONDENT to the following this 22nd day of June, 1987:

STEVEN BOOS
DNA-PEOPLE'S LEGAL SERVICES, INC.
Attorneys for Appellant
Post Office Box 488
Mexican Hat, Utah 84531

Burt Lyndert Reinhard

Addendum 1

78-2a-3. Court of Appeals jurisdiction [Effective until January 1, 1988].

(1) The Court of Appeals has jurisdiction to issue all extraordinary writs and to issue all writs and process necessary to carry into effect its judgments, orders, and decrees or in aid of its jurisdiction.

(2) The Court of Appeals has appellate jurisdiction, including jurisdiction of interlocutory appeals, over:

(a) the final orders and decrees of state and local agencies or appeals from the district court review of them, except the Public Service Commission, State Tax Commission, Board of State Lands, Board of Oil, Gas, and Mining, and the state engineer, notwithstanding any other provision of law;

(b) appeals from the juvenile courts;

(c) appeals from the circuit courts;

(d) interlocutory appeals from any court of record in criminal cases except those involving a charge of a first degree or capital felony;

(e) appeals from district court in criminal cases except those involving a conviction of a first or capital degree felony;

(f) appeals from orders on petitions for extraordinary writs involving a criminal conviction, except those involving a first degree or capital felony;

(g) appeals from district court involving domestic relations cases including, but not limited to, divorce, annulment, property division, child custody, support and visitation, adoption, and paternity; and

(h) cases transferred to the Court of Appeals from the Supreme Court.

(3) The Court of Appeals, upon its own motion only and by the vote of four judges of the court, may certify to the Supreme Court for original appellate review and determination any matter over which the Court of Appeals has original appellate jurisdiction.

Court of Appeals jurisdiction [Effective January 1, 1988].

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(b) appeals from the juvenile courts;

(c) appeals from the circuit courts;

(d) interlocutory appeals from any court of record in criminal cases, except those involving a charge of a first degree or capital felony;

(e) appeals from district court in criminal cases, except those involving a conviction of a first or capital degree felony;

(f) appeals from orders on petitions for extraordinary writs involving a criminal conviction, except those involving a first degree or capital felony;

Addendum 2

ter) resulting from enactment of Pub. L. 92-336 (see Tables volume) not been applicable to such individual."

NURSING HOMES ELIGIBLE FOR MATCHING FUNDS FOR HOME SERVICES WHEN MEETING STATE LICENSURE REQUIREMENTS AFTER JUNE 30, 1968

Section 334(c) of Pub. L. 90-248 provided that: "Notwithstanding any other provision of law, after June 30, 1968, no Federal funds shall be paid to any State as Federal matching under title I, X, XIV, XVI, or XIX of the Social Security Act (subchapter I, X, XIV, XVI, or XIX of this chapter) for payments made to any nursing home or on account of any nursing home services provided by such nursing home for any period during which such nursing home is determined not to meet fully all requirements of the State for licensure as a nursing home, except that the Secretary may prescribe a reasonable period or periods of time during which a nursing home which has formerly met such requirements will be eligible for payments which include Federal participation if during such period or periods such home promptly takes all necessary steps to again meet such requirements."

DISTRICT OF COLUMBIA: PLAN FOR MEDICAL ASSISTANCE

Pub. L. 90-227, § 1, Dec. 27, 1967, 81 Stat. 744, provided:

"That (a) the Commissioner of the District of Columbia (now Mayor) (hereafter in this Act (enacting this note and material set out as a note under section 1395v of this title) referred to as the 'Commissioner') may submit under title XIX of the Social Security Act (this subchapter) to the Secretary of Health, Education, and Welfare (hereafter in this Act referred to as the 'Secretary') a plan for medical assistance (and any modifications of such plan) to enable the District of Columbia to receive Federal financial assistance under such title for a medical assistance program established by the Commissioner under such plan.

"(b)(1) Notwithstanding any other provision of law, the Commissioner may take such action as may be necessary to submit such plan to the Secretary and to establish and carry out such medical assistance program, except that in prescribing the standards for determining eligibility for and the extent of medical assistance under the District of Columbia's plan for medical assistance, the Commissioner may not (except to the extent required by title XIX of the Social Security Act) (this subchapter)—

"(A) prescribe maximum income levels for recipients of medical assistance under such plan which exceed (i) the title XIX maximum income levels if such levels are in effect, or (ii) the Commissioner's maximum income levels for the local medical assistance program if there are no title XIX maximum income levels in effect, or

"(B) prescribe criteria which would permit an individual or family to be eligible for such assistance if such individual or family would be ineligible, solely by reason of his or its resources, for medical assistance both under the plan of the State of Maryland approved under title XIX of the Social Security Act (this subchapter) and under the plan of the State of Virginia approved under such title.

"(2) For purposes of subparagraph (A) of paragraph (1) of this subsection—

"(A) the term 'title XIX maximum income levels' means any maximum income levels which may be specified by title XIX of the Social Security Act (this subchapter) for recipients of medical assistance under State plans approved under that title,

"(B) the term 'the Commissioner's maximum income levels for the local medical assistance program' means the maximum income levels prescribed for recipients of medical assistance under the District of Columbia's medical assistance program in effect in the fiscal year ending June 30, 1967, and

"(C) during any of the first four calendar quarters in which medical assistance is provided under such plan there shall be deemed to be no title XIX maxi-

mum income levels in effect if the title XIX maximum income levels in effect during such quarter are higher than the Commissioner's maximum income levels for the local medical assistance program."

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 1315, 1395v, 1396b, 1396d, 1396g, 1396i, 4725 of this title; title 21 section 1173.

SECTION REFERRED TO IN D.C. CODE

This section is referred to in section 22-801 of the District of Columbia Code.

§ 1396b. Payment to States

(a) Computation of amount

From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this subchapter, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1396d(b) of this title, subject to subsections (g) and (h) of this section) of the total amount expended during such quarter as medical assistance under the State plan (including expenditures for premiums under part B of subchapter XVIII of this chapter, for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title, and, except in the case of individuals sixty-five years of age or older and disabled individuals entitled to hospital insurance benefits under subchapter XVIII of this chapter who are not enrolled under part B of subchapter XVIII of this chapter, other insurance premiums for medical or any other type of remedial care or the cost thereof, plus

(2) an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel, of the State agency or any other public agency; plus

(3) an amount equal to—

(A) 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such mechanized claims processing and information retrieval systems as the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of subchapter XVIII of this chapter, including the State's share of the

cost of installing such a system to be used jointly in the administration of such State's plan and the plan of any other State approved under this chapter, and

(ii) 90 per centum of so much of the sums expended during any such quarter in the fiscal year ending June 30, 1972, or the fiscal year ending June 30, 1973, as are attributable to the design, development, or installation of cost determination systems for State-owned general hospitals (except that the total amount paid to all States under this clause for either such fiscal year shall not exceed \$150,000), and

(B) 75 per centum of so much of the sums expended during such quarter as are attributable to the operation of systems (whether such systems are operated directly by the State or by another person under a contract with the State) of the type described in subparagraph (A)(i) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by the plan of the specific services so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services; plus

(4) an amount equal to 100 per centum of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) which are attributable to compensation or training of personnel (of the State agency or any other public agency) responsible for inspecting public or private institutions (or portions thereof) providing long-term care to recipients of medical assistance to determine whether such institutions comply with health or safety standards applicable to such institutions under this chapter; plus

(5) an amount equal to 90 per centum of the sums expended during such quarter which are attributable to the offering, arranging, and furnishing (directly or on a contract basis) of family planning services and supplies;

(6) an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b) Quarterly expenditures beginning after December 31, 1969

(1) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) of this section for any State for any quarter beginning after December 31, 1969, shall not take into account any amounts expended as medical assistance with respect to individuals aged 65 or over and disabled individuals entitled to hospital insurance benefits under subchapter XVIII of this chapter which would not have been so expended if the individuals involved had been enrolled in the insurance program established by part B of sub-

chapter XVIII of this chapter, other than amounts expended under provisions of the plan of such State required by section 1396a(a)(24) of this title.

(2) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1320a-1 of this title.

(c) Repealed. Pub. L. 92-233, § 18(y)(1)(A), Dec. 31, 1973, 87 Stat. 973

(d) Estimates of amount of State entitlement; installments; adjustments; overpayment; obligated appropriations

(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsections (a) and (b) of this section for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection. Expenditures for which payments were made to the State under subsection (a) of this section shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1396a(a)(25) of this title.

(3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

(4) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

(e) Repealed. Pub. L. 92-603, title II, § 236, Oct. 30, 1972, 86 Stat. 1410

(f) Limitation on Federal participation in medical assistance

(1)(A) Except as provided in paragraph (4), payment under the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds

the applicable income limitation determined under this paragraph.

(B)(1) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133% percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under Part A of subchapter IV of this chapter.

(ii) If the Secretary finds that the operation of a uniform maximum limits payments to families of more than one size, he may adjust the amount otherwise determined under clause (i) to take account of families of different sizes.

(C) The total amount of any applicable income limitation determined under subparagraph (B) shall, if it is not a multiple of \$100 or such other amount as the Secretary may prescribe, be rounded to the next higher multiple of \$100 or such other amount, as the case may be.

(2) In computing a family's income for purposes of paragraph (1), there shall be excluded any costs (whether in the form of insurance premiums or otherwise) incurred by such family for medical care or for any other type of remedial care recognized under State law.

(3) For purposes of paragraph (1)(B), in the case of a family consisting of only one individual, the "highest amount which would ordinarily be paid" to such family under the State's plan approved under part A of subchapter IV of this chapter shall be the amount determined by the State agency (on the basis of reasonable relationship to the amounts payable under such plan to families consisting of two or more persons) to be the amount of the aid which would ordinarily be payable under such plan to a family without any income or resources) consisting of one person if such plan (without regard to section 608 of this title) provided for aid to such a family.

(4) The limitations on payment imposed by the preceding provisions of this subsection shall not apply with respect to any amount expended by a State as medical assistance for any individual—

(A) who is receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV or XVI, or part A of subchapter IV, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or

(B) who is not receiving such aid or assistance and with respect to whom such benefits are not being paid, but (i) is eligible to receive such aid or assistance, or to have such benefits paid with respect to him, or (ii) would be eligible to receive such aid or assistance, or to have such benefits paid with respect to him if he were not in a medical institution, or

(C) with respect to whom there is being paid, or who is eligible, or would be eligible if he were not in a medical institution, to have paid with respect to him, a State supplementary payment and is eligible for medical assistance equal in amount, duration, and scope

to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title, but only if the income of such individual (as determined under section 1382a of this title, but without regard to subsection (b) thereof) does not exceed 300 percent of the supplemental security income benefit rate established by section 1382(b)(1) of this title.

at the time of the provision of the medical assistance giving rise to such expenditure.

(g) Decrease in Federal medical assistance percentage of amounts paid for services furnished under State plan after June 30, 1973

(1) With respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1395mm of this title), the Federal medical assistance percentage shall be decreased as follows: After an individual has received care as an inpatient in a hospital (including an institution for tuberculosis), skilled nursing facility or intermediate care facility on 60 days, or in a hospital for mental diseases on 90 days (whether or not such days are consecutive), during any fiscal year, which for purposes of this section means the four calendar quarters ending with June 30, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual in the same fiscal year shall be decreased by 33% per centum thereof unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services (including tuberculosis hospitals), skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), there is in operation in the State an effective program of control over utilization of such services; such a showing must include evidence that—

(A) in each case for which payment is made under the State plan, a physician certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and recertifies, where such services are furnished over a period of time, in such cases, at least every 60 days, and accompanied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services; and

(B) in each such case, such services were furnished under a plan established and periodically reviewed and evaluated by a physician;

(C) such State has in effect a continuous program of review of utilization pursuant to section 1396a(a)(30) of this title whereby each admission is reviewed or screened in accordance with criteria established by medical and other professional personnel who are not

themselves directly responsible for the care of the patient involved, and who do not have a significant financial interest in any such institution and are not, except in the case of a hospital, employed by the institution providing the care involved; and the information developed from such review or screening, along with the data obtained from prior reviews of the necessity for admission and continued stay of patients by such professional personnel, shall be used as the basis for establishing the size and composition of the sample of admissions to be subject to review and evaluation by such personnel, and any such sample may be of any size up to 100 per centum of all admissions and must be of sufficient size to serve the purpose of (i) identifying the patterns of care being provided and the changes occurring over time in such patterns so that the need for modification may be ascertained, and (ii) subjecting admissions to early or more extensive review where information indicates that such consideration is warranted; and

(D) such State has an effective program of medical review of the care of patients in mental hospitals, skilled nursing facilities, and intermediate care facilities pursuant to section 1396a(a) (26) and (31) of this title whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams.

In determining the number of days on which an individual has received services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under section 1395d of this title.

(2) The Secretary shall, as part of his validation procedures under this subsection, conduct sample onsite surveys of private and public institutions in which recipients of medical assistance may receive care and services under a State plan approved under this subchapter, and his findings with respect to such surveys (as well as the showings of the State agency required under this subsection) shall be made available for public inspection.

(h) Reduction by Secretary of amount otherwise considered as expenditures under State plan where reasonable cost differential between statewide average cost of skilled nursing facility services and statewide average cost of intermediate care facility services does not exist for any calendar quarter beginning after June 30, 1973

(1) If the Secretary determines for any calendar quarter beginning after June 30, 1973, with respect to any State that there does not exist a reasonable cost differential between the statewide average cost of skilled nursing facility services and the statewide average cost of intermediate care facility services in such State, the Secretary may reduce the amount which would otherwise be considered as expenditures under the State plan by any amount which in his judgment is a reasonable equivalent of the difference between the amount of the expenditures by such State for intermediate care facility services and the amount that would have

been expended by such State for such services if there had been a reasonable cost differential between the cost of skilled nursing facility services and the cost of intermediate care facility services.

(2) In determining whether any such cost differential in any State is reasonable the Secretary shall take into consideration the range of such cost differentials in all States.

(3) For the purposes of this subsection, the term "cost differential" for any State for any quarter means, as determined by the Secretary on the basis of the data for the most recent calendar quarter for which satisfactory data are available, the excess of—

(A) the average amount paid in such State (regardless of the source of payment) per inpatient day for skilled nursing facility services, over

(B) the average amount paid in such State (regardless of the source of payment) per inpatient day for intermediate care facility services.

(4) For purposes of this subsection, the term "cost" shall mean amounts reimbursable by the State under a State plan approved under this subchapter.

(i) Payment for services performed after December 31, 1972; restrictions

Payment under the preceding provisions of this section shall not be made—

(1) with respect to any amount paid for items or services furnished under the plan after December 31, 1972, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under the fourth and fifth sentences of section 1395u(b)(3) of this title; or

(2) with respect to any amount paid for services furnished under the plan after December 31, 1972, by a provider or other person during any period of time, if payment may not be made under subchapter XVIII of this chapter with respect to services furnished by such provider or person during such period of time solely by reason of a determination by the Secretary under section 1395y(d)(1) of this title or under clause (D), (E), or (F) of section 1395cc(b)(2) of this title; or

(3) with respect to any amount expended for inpatient hospital services furnished under the plan to the extent that such amount exceeds the hospital's customary charges with respect to such services or (if such services are furnished under the plan by a public institution free of charge or at nominal charges to the public) exceeds an amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such payment which the Secretary finds will provide fair compensation to such institution for such services; or

(4) with respect to any amount expended for care or services furnished under the plan by a hospital or skilled nursing facility unless such hospital or skilled nursing facility has in effect a utilization review plan which meets the requirements imposed by section 1395x(k) of this title for purposes of subchapter XVIII of this chapter; and if such hospital or skilled

nursing facility has in effect such a utilization review plan for purposes of subchapter XVIII of this chapter, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this subchapter, the Secretary is authorized to waive the requirements of this paragraph if the State agency demonstrates to his satisfaction that it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under section 1395x(k) of this title.

(j) Order by Secretary for suspension of payment; grounds for issuance; procedure; effective date and duration of order

(1) Notwithstanding the preceding provisions of this section, no payment shall be made to a State (except as provided under this subsection) with respect to expenditures incurred by it for services provided by any institution during any period that an order for suspension of payment (as authorized by this subsection) is effective with respect to such institution.

(2) The Secretary may issue a suspension of payment order with respect to any institution if—

(A) such institution (i) does not (at the time such order is issued) have in effect an agreement with the Secretary which is entered into pursuant to section 1395cc of this title; and (ii) did (prior to the time such order is issued) have in effect such an agreement; and

(B)(i) the Secretary has been unable to collect (or make satisfactory arrangement for the collection of) amounts due on account of overpayments made to such institution under subchapter XVIII of this chapter; or

(ii) the Secretary has been unable to obtain from such institution the data and information necessary to enable him to determine the amount (if any) of the overpayments made to such institution under subchapter XVIII of this chapter.

(3) Whenever the Secretary issues any order for suspension of payment under this subsection with respect to any institution, he shall submit a notice of such order to the single State agency (referred to in section 1396a(a)(5) of this title) of each State which he has reason to believe does or may utilize the services of such institution in providing medical assistance under a plan approved under this subchapter.

(4) Any order for suspension of payment issued with respect to any institution under this subsection shall become effective, in the case of any state plan approved under this subchapter, on the 60th day after the date the State agency (referred to in section 1396a(a)(5) of this title) administering or supervising the administration of such plan receives notice of such order submitted pursuant to paragraph (3). Any such order shall cease to be effective at such time as the Secretary is satisfied that the institution is participating in substantial negotiations which seek to remedy the conditions which gave rise to his order of suspension of payments, or that the amounts (referred to in paragraph (2)) are no longer due from such institution or that a satisfactory arrangement has

been made for the payment by such institution of any such amounts. Upon the determination of the Secretary that any such order with respect to any such institution shall cease to be effective, he shall forthwith notify each State agency to which he has theretofore submitted notice under paragraph (3) with respect to such institution.

(5) Whenever any order which has been issued by the Secretary under the preceding provisions of this subsection with respect to an institution ceases to be effective, any payment to which any State would (except for the preceding provisions of this subsection) have been entitled under this section on account of services provided by such institution shall be made to such State for the month in which such order ceases to be effective.

(k) Technical assistance to states

The Secretary is authorized to provide at the request of any State (and without cost to such State) such technical and actuarial assistance as may be necessary to assist such State to contract with any health maintenance organization which meets the requirements of section 1395mm of this title for the purpose of providing medical care and services to individuals who are entitled to medical assistance under this subchapter.

(l) Repealed. Pub. L. 94-552, § 1, Oct. 18, 1976, 90 Stat. 2540

(m) Definition; duties and functions of Secretary; payments to States; provisional determination of status by State

(1)(A) The term "health maintenance organization" means a legal entity which provides health services to individuals enrolled in such organization and which—

(i) provides to its enrollees who are eligible for benefits under this subchapter the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1396d of this title, and, to the extent required by section 1396a(a)(13)(A)(ii) of this title to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1396d(a) of this title;

(ii) provides such services and benefits in the manner prescribed in section 300e(b) of this title (except that, solely for purposes of this paragraph, the term "basic health services" and references thereto, when employed in such section, shall be deemed to refer to the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1396d(a) of this title, and, to the extent required by section 1396a(13)(A)(ii) of this title to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1396d(a) of this title); and

(iii) is organized and operated in the manner prescribed by section 300e(c) of this title (except that solely for purposes of this paragraph, the term "basic health services" and references thereto, when employed in such section shall be deemed to refer to the services and benefits described in section 1396d(a)(1), (2), (3), (4)(C), and (5) of this title, and to the extent required by section 1396a(a)(13)(A)(ii) of this title, to be provided

under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1396d(a) of this title).

(B) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a health maintenance organization within the meaning of subparagraph (A), shall be administered through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and the administration of such duties and functions shall be integrated with the administration of section 300e-11(a) and (b) of this title.

(2)(A) Except as provided in subparagraphs (B) and (C), no payment shall be made under this subchapter to a State with respect to expenditures incurred by it for payment for services provided by any entity—

(i) which is responsible for the provision of—

(I) inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1396d(a) of this title, or

(II) any three or more of the services described in such paragraphs,

when payment for such services is determined under a prepaid capitation risk basis or under any other risk basis;

(ii) which the Secretary (or the State as authorized by paragraph (3)) has not determined to be a health maintenance organization as defined in paragraph (1); and

(iii) more than one-half of the membership of which consists of individuals who are insured under parts A and B of subchapter XVIII or recipients of benefits under this subchapter.

(B) Subparagraph (A) does not apply with respect to payments under this subchapter to a State with respect to expenditures incurred by it for payment for services provided by an entity which—

(i)(I) received a grant of at least \$100,000 in the fiscal year ending June 30, 1976, under section 247d(d)(1)(A) or 254c(d)(1) of this title, and (II) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this subchapter has been the recipient of a grant under either such section; and

(II) provides to its enrollees, on a prepaid capitation risk basis or on any other risk basis, all of the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1396d(a) of this title and, to the extent required by section 1396a(a)(13)(A)(ii) of this title to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of such section; or

(ii) is a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

(I) which received in the fiscal year ending June 30, 1976, at least \$100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965, and

(II) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this subchapter either has been the recipient of a grant, subgrant, or subcontract under such Act or has provided services under a contract (initially entered into during a year in which the entity was the recipient of such a grant, subgrant, or subcontract) with a State agency under this subchapter on a prepaid capitation risk basis or on any other risk basis; or

(iii) which has contracted with the single State agency for the provision of services (but not including inpatient hospital services) to persons eligible under this subchapter on a prepaid risk basis prior to 1970.

(C) Subparagraph (A)(iii) shall not apply with respect to payments under this subchapter to a State with respect to expenditures incurred by it for payment for services by an entity during the three-year period beginning on October 8, 1976, or beginning on the date the entity enters into a contract with the State under this subchapter for the provision of health services on a prepaid risk basis, whichever occurs later, but only if the entity demonstrates to the satisfaction of the Secretary by the submission of plans for each year of such three-year period that it is making continuous efforts and progress toward achieving compliance with subparagraph (A)(iii).

(3) A State may, in the case of an entity which has submitted an application to the Secretary for determination that it is a health maintenance organization within the meaning of paragraph (1) and for which no such determination has been made within 90 days of the submission of the application, make a provisional determination for the purposes of this subchapter that such entity is such a health maintenance organization. Such provisional determination shall remain in force until such time as the Secretary makes a determination regarding the entity's qualification under paragraph (1).

(Aug. 14, 1935, ch. 531, title XIX, § 1903, as added July 30, 1965, Pub. L. 89-97, title I, § 121(a), 79 Stat. 349, and amended Jan. 2, 1968, Pub. L. 90-248, title II, §§ 220(a), 222(c), (d), 225(a), 229(c), 241(f)(5), 81 Stat. 898, 901, 902, 904, 917; June 28, 1968, Pub. L. 90-364, title III, § 303(a)(1), 82 Stat. 274; Aug. 9, 1969, Pub. L. 91-56, § 2(a), 83 Stat. 99; Oct. 30, 1972, Pub. L. 92-603, title II, §§ 207(a), 221(c)(6), 224(c), 225, 226(e), 229(c), 230, 233(c), 235(a), 237(a)(1), 249B, 278(b)(1), (5), (16), 290, 295, 299E(a), 86 Stat. 1379, 1380, 1389, 1395, 1396, 1404, 1410, 1411, 1414, 1415, 1453, 1454, 1457, 1459, 1462; July 9, 1973, Pub. L. 93-66, title II, § 234(a), 87 Stat. 160; Dec. 31, 1973, Pub. L. 93-233, § 13(a)(11), (12), 18(r)-(v), (x)(5), (6), (y)(1), 87 Stat. 963, 971-973; Dec. 31, 1975, Pub. L. 94-182, title I, §§ 110(a), 111(b), 89 Stat. 1054; Oct. 8, 1976, Pub. L. 94-460, title II, § 202(a), 90 Stat. 1957; Oct. 18, 1976, Pub. L. 94-552, § 1, 90 Stat. 2540.)

REFERENCES IN TEXT

The Appalachian Regional Development Act of 1965, referred to in subsec. (m)(2)(B)(ii), is Pub. L. 89-4.

Mar. 9, 1965, 79 Stat. 8, as amended, which is set out in the Appendix to Title 40, Public Buildings, Property, and Works. For complete classification of this act to the Code, see Tables volume.

AMENDMENTS

1976—Subsec. (f). Pub. L. 94-552 repealed subsec. (f) provisions for reduction of amount of payments to States found not to be in compliance with section 1396a(g) of this title.

Subsec. (m). Pub. L. 94-460 added subsec. (m).

1975—Subsec. (g)(1)(C). Pub. L. 94-182, § 110(a), added provisions specifying the method by which the size and composition of the sample of admissions subject to review is to be established.

Subsec. (f). Pub. L. 94-182, § 111(b), added subsec. (f).

1973—Subsec. (a). Pub. L. 93-233, § 18(x)(5), struck out reference to section 1317 of this title in introductory parenthetical phrase.

Subsec. (a)(1). Pub. L. 93-233, §§ 13(a)(11), 18(r)(1), substituted "individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title" for "individuals who are recipients of money payments under a State plan approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter" and inserted after "individuals sixty-five years of age or older" text reading "and disabled individuals entitled to hospital insurance benefits under subchapter XVIII of this chapter," respectively.

Subsec. (a)(4). Pub. L. 93-233, § 18(s), substituted "sums expended with respect to costs incurred" for "sums expended".

Subsec. (a)(5). Pub. L. 93-233, § 18(t), struck out after "such quarter" parenthetical text reading "(as found necessary by the Secretary for the proper and efficient administration of the plan)".

Subsec. (b). Pub. L. 93-233, §§ 18(r)(2), (u), (x)(6), inserted in par. (2) after "individuals sixty-five years of age or older" text reading "and disabled individuals entitled to hospital insurance benefits under subchapter XVIII of this chapter" and end text reading "other than amounts expended under provisions of the plan of such State required by section 1396a(a)(34) of this title," and redesignated pars. (2) and (3) as (1) and (2), respectively.

Subsec. (c). Pub. L. 93-233, § 18(y)(1)(A), struck out subsec. (c) providing for Federal medical assistance percentage and Federal share of State medical expenses during fiscal year ending June 30, 1965.

Subsec. (d)(1). Pub. L. 93-233, § 18(y)(1)(B), struck out reference to subsec. (c) of this section.

Subsec. (f)(4). Pub. L. 93-233, § 13(a)(12), in subpar. (A), made payment limitations inapplicable to individual with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter; in subpar. (B), made payment limitations inapplicable to individual with respect to whom such benefits are not being paid, and in cls. (i) and (ii) inserted phrase "to have such benefits paid with respect to him", and added subpar. (C).

Subsec. (g)(1)(C). Pub. L. 93-233, § 18(v), substituted "directly responsible for the care of the patient or financially interested in any such institution or, except in the case of hospitals, employed by the institution" for "directly responsible for the care of the patient and who are not employed by or financially interested in any such institution".

Subsec. (j). Pub. L. 93-66 struck out provisions respecting skilled nursing facility services and intermediate care facility services.

1972—Subsec. (a)(1). Pub. L. 92-603, § 207(a)(2), added reference to subsecs. (g) and (h) and of this section.

Subsec. (a)(3) to (6). Pub. L. 92-603, §§ 235(a), 249B, 299E(a), added pars. (3) to (6). Former subsec. (a)(3) redesignated (a)(6).

Subsec. (b)(1). Pub. L. 92-603, § 295, struck out subsec. (b)(1), which related to the amount of quarterly expenditures exceeding the average of total expenditures for each quarter of fiscal year ending June 30, 1965.

Subsec. (b)(3). Pub. L. 92-603, § 221(c)(6), added par. (3).

Subsec. (e). Pub. L. 92-603, § 230, repealed subsec. (e), which related to furnishing for comprehensive care and services by July 1, 1977.

Subsec. (g). Pub. L. 92-603, §§ 207(a)(1), 278(b)(1), added subsec. (g) and substituted "skilled nursing facility" for "skilled nursing home" and "skilled nursing facilities" for "skilled nursing homes" wherever appearing therein.

Subsec. (h). Pub. L. 92-603, §§ 207(a)(1), 278(b)(1)(5), added subsec. (h) and substituted "skilled nursing facility" for "skilled nursing home" wherever appearing therein.

Subsec. (i). Pub. L. 92-603, §§ 224(c), 229(c), 233(c), 237(a)(1), 278(b)(7), added subsec. (i) and substituted "skilled nursing facility" for "skilled nursing home" wherever appearing therein.

Subsec. (j). Pub. L. 92-603, § 290, added subsec. (j), relating to orders for suspension of payment.

Pub. L. 92-603, §§ 225, 278(b)(16), added subsec. (j), relating to skilled nursing facilities services, and substituted "skilled nursing facility" for "skilled nursing home" wherever appearing therein.

Subsec. (k). Pub. L. 92-603, § 226(e), added subsec. (k).

1969—Subsec. (e). Pub. L. 91-56 extended from July 1, 1975, to July 1, 1977, the date by which comprehensive care and services for eligible individuals must be made available for a State to be eligible for payments.

1968—Subsec. (a)(1). Pub. L. 90-248, § 222(d), substituted "and, except in the case of individuals sixty-five years of age or older who are not enrolled under part B of subchapter XVIII of this chapter, other insurance premiums" for "and other insurance premiums".

Pub. L. 90-248, § 241(f)(5), deleted "IV," after "I," and inserted "or part A of subchapter IV of this chapter," after "XVI of this chapter,".

Subsec. (a)(2). Pub. L. 90-248, § 225(a), substituted "of the State agency or any other public agency" for "of the State agency (or of the local agency administering the State plan in the political subdivision)".

Subsec. (b). Pub. L. 90-248, § 222(c), designated existing provisions as par. (1) and added par. (2).

Subsec. (b)(2). Pub. L. 90-364 substituted "1969" for "1967".

Subsec. (d)(2). Pub. L. 90-248, § 229(c), provided for treatment of expenditures for which payments were made to the State under subsec. (a) as an overpayment to the extent that the State or local agency administering the plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1396a(a)(25) of this title.

Subsec. (f). Pub. L. 90-248, § 230(a), added subsec. (f).

EFFECTIVE DATE OF 1976 AMENDMENT

Repeal of subsec. (f) of this section by Pub. L. 94-552 effective Jan. 1, 1976, see section 2 of Pub. L. 94-552, set out as an Effective Date of 1976 Amendment note under section 1396a of this title.

Section 202(b) of Pub. L. 94-460 provided that: "The amendment made by subsection (a) (enacting subsec. (m) of this section) shall apply with respect to payments under title XIX of the Social Security Act (this subchapter) to States for services provided—

"(1) after the date of enactment of subsection (a) (Oct. 8, 1976) under contracts under such title entered into or renegotiated after such date, or

"(3) after the expiration of the 1-year period beginning on such date of enactment, whichever occurs first."

EFFECTIVE DATE OF 1975 AMENDMENT

Section 110(b) of Pub. L. 94-182 provided that: "The amendment made by subsection (a) [amending subsec. (g)(1)(C) of this section] shall take effect on the first day of the first calendar month which begins not less than 90 days after the date of enactment of this Act [Dec. 31, 1975]."

Amendment by section 111(b) of Pub. L. 94-182 effective January 1, 1976 (except as otherwise provided therein), see section 111(c) of Pub. L. 94-182, set out as an Effective Date of 1975 Amendment note under section 1396a of this title.

EFFECTIVE DATE OF 1973 AMENDMENT

Amendment by section 13(a)(11), (12) of Pub. L. 93-233 effective with respect to payments under this section for calendar quarters commencing after Dec. 31, 1973, see section 13(d) of Pub. L. 93-233, set out as an Effective Date of 1973 Amendment note under section 1396a of this title.

Amendment of subsec. (b)(2) by section 18(u) of Pub. L. 93-233 effective July 1, 1973, see section 18(z)(4) of Pub. L. 93-233, set out as an Effective Date of 1973 Amendment note under section 1396a of this title.

Section 234(b) of Pub. L. 93-66 provided that: "The amendment made by subsection (a) [repealing subsec. (j) of this section] shall be applicable in the case of expenditures for skilled nursing services and for intermediate care facility services furnished in calendar quarters which begin after December 31, 1972."

EFFECTIVE DATE OF 1972 AMENDMENT

Section 207(b) of Pub. L. 92-603 provided that: "The amendments made by subsection (a) [amending subsecs. (a)(1), (g) and (h) of this section] shall, except as otherwise provided therein, be effective July 1, 1973."

Amendment of subsec. (k) by section 226(e) of Pub. L. 92-603 effective with respect to services provided on or after July 1, 1973, see section 226(f) of Pub. L. 92-603, set out as an Effective Date note under section 1395mm of this title.

Amendment of subsec. (l) by section 233(c) of Pub. L. 92-603 applicable with respect to services furnished by hospitals in accounting periods beginning after Dec. 31, 1972, see section 233(f) of Pub. L. 92-603, set out as a note under section 1395f of this title. See, also, section 16 of Pub. L. 93-233, set out as a note under section 1395f of this title.

Section 235(b) of Pub. L. 92-603 provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to expenditures under State plans approved under title XIX of the Social Security Act [this subchapter], made after June 30, 1971."

Section 237(d)(1) of Pub. L. 92-603 provided that: "The amendments made by subsections (a)(1) and (b) [amending subsec. (l) of this section and section 706(f) of this title] shall apply with respect to services furnished in calendar quarters beginning after June 30, 1973."

Section 349B of Pub. L. 92-603, as amended by Pub. L. 93-368, § 8, Aug. 7, 1974, 88 Stat. 422, provided in part that the enactment of par. (4) of subsec. (a) and the concurrent redesignation of former par. (4) as par. (8) by section 349B of Pub. L. 92-603, and redesignation of such par. (8) as par. (6) by section 299E(a) of Pub. L. 92-603 shall be effective for the period beginning Oct. 1, 1972, and ending June 30, 1977.

EFFECTIVE DATE OF 1968 AMENDMENTS

Section 220(b) of Pub. L. 90-248 provided that:

"(b)(1) In the case of any State whose plan under title XIX of the Social Security Act [this subchapter] is approved by the Secretary of Health, Education, and Welfare under section 1902 [section 1396a of this title] after July 26, 1967, the amendment made by sub-

section (a) [enacting subsec. (f) of this section] shall apply with respect to calendar quarters beginning after the date of enactment of this Act [Jan. 2, 1968].

"(2) In the case of any State whose plan under title XIX of the Social Security Act [this subchapter] was approved by the Secretary of Health, Education, and Welfare under section 1902 of the Social Security Act [section 1396a of this title] prior to July 26, 1967, amendments made by subsection (a) [enacting subsec. (f) of this section] shall apply with respect to calendar quarters beginning after June 30, 1968, except that—

"(A) with respect to the third and fourth calendar quarters of 1968, such subsection shall be applied by substituting in subsection (f) of section 1903 of the Social Security Act [subsec. (f) of this section] 150 percent for 133 1/4 percent each time such latter figure appears in such subsection (f), and

"(B) with respect to all calendar quarters during 1969, such subsection shall be applied by substituting in subsection (f) of section 1903 of such Act [subsec. (f) of this section] 140 percent for 133 1/4 percent each time such latter figure appears in such subsection (f)."

Section 222(d) of Pub. L. 90-248, as amended by section 303(a)(2) of Pub. L. 90-364, provided in part that amendment of subsec. (a)(1) of this section by such section 222(d) shall be effective with respect to calendar quarters beginning after December 31, 1969.

Section 225(b) of Pub. L. 90-248 provided that: "The amendment made by subsection (a) [to subsec. (a)(2) of this section] shall apply with respect to expenditures made after December 31, 1967."

Section 303(b) of Pub. L. 90-364 provided that: "The amendments made by subsection (a) [amending subsec. (b)(2) of this section] shall be effective with respect to calendar quarters beginning after December 31, 1967."

COMPREHENSIVE CARE AND SERVICES FOR ELIGIBLE INDIVIDUALS BY JULY 1, 1977; REQUIREMENT INAPPLICABLE FOR ANY PERIOD PRIOR TO JULY 1, 1971; REGULATIONS; ADVICE TO STATES

Section 2(b) of Pub. L. 91-56, which provided that subsection (e) of this section was inapplicable to the period prior to July 1, 1971, and which authorized the Secretary to issue regulations, was repealed by Pub. L. 92-603, title II, § 230, Oct. 30, 1972, 86 Stat. 1410.

EXEMPTION OF PUERTO RICO, THE VIRGIN ISLANDS, AND GUAM FROM LIMITATIONS ON FEDERAL PAYMENTS FOR MEDICAL ASSISTANCE

Section 248(d) of Pub. L. 90-248 provided that: "The amendment made by section 220(a) of this Act [enacting subsec. (f) of this section] shall not apply in the case of Puerto Rico, the Virgin Islands, or Guam."

NONDUPLICATION OF PAYMENTS TO STATES; LIMITATION ON INSTITUTIONAL CARE

Section 121(b) of Pub. L. 89-97, as amended by section 249D of Pub. L. 92-603, provided that: "No payment may be made to any State under title I, IV, X, XIV, or XVI of the Social Security Act [subchapter I, IV, X, XIV, or XVI of this chapter] with respect to aid or assistance in the form of medical or any other type of remedial care for any period for which such State receives payments under title XIX of such Act [this subchapter], or for any period after December 31, 1969. After the date of enactment of the Social Security Amendments of 1972 [Oct. 30, 1972], Federal matching shall not be available for any portion of any payment by any State under title I, X, XIV, or XVI, or part A of title IV, of the Social Security Act [subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter] for or on account of any medical or any other type of remedial care provided by an institution to any individual as an inpatient thereof, in the case of any State which has a plan approved under title XIX of such Act [this subchapter], if such care is (or could be) provided under a State plan approved under title XIX of such Act [this subchapter] by an

institution certified under such title XIX (this subchapter)."

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 643, 1315, 1396a of this title.

§ 1396c. Operation of State plans

If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

(Aug. 14, 1935, ch. 531, title XIX, § 1904, as added July 30, 1965, Pub. L. 89-97, title I, § 121(a), 79 Stat. 351.)

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in section 1316 of this title.

§ 1396d. Definitions

For purposes of this subchapter—

(a) Medical assistance

The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter IX, XIV, or XVI, or part A of subchapter IV, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, who are—

(i) under the age of 21,

(ii) relatives specified in section 606(b)(1) of this title with whom a child is living if such child, except for section 606(a)(2) of this title, is (or would, if needy, be) a dependent child under part A of subchapter IV of this chapter,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under subchapter I, X, XIV, or XVI of this chapter, or

(vii) blind or disabled as defined in section 1382c of this title, with respect to States not eligible to participate in the State plan program established under subchapter XVI of this chapter,

but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);

(2) outpatient hospital services;

(3) other laboratory and X-ray services;

(4)(A) skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older (B) effective July 1, 1969, such early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary; and (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;

(5) physicians' services furnished by a physician (as defined in section 1395x(r)(1) of this title), whether furnished in the office, the patient's home, a hospital, or a skilled nursing facility, or elsewhere;

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services;

(10) dental services;

(11) physical therapy and related services;

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services;

(14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases;

and the quality of such care when provided on a fee-for-service basis. The Secretary shall submit an interim report to the Congress, within two years after the date of the enactment of this Act (Aug. 13, 1981), and a final report within five years from such date containing, respectively, the interim and final findings and conclusions made as a result of such study."

CONTINUING MEDICAID ELIGIBILITY FOR CERTAIN RECIPIENTS OF VETERANS' ADMINISTRATION PENSIONS

Section 310(b)(1) of Pub. L. 96-272 provided that:

"(A) For purposes of section 1902(a)(10)(A) of the Social Security Act (subsec. (a)(10)(A) of this section), any individual who, prior to the date of enactment of this Act (June 17, 1980) and for the month of December 1978, was eligible for and received aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV of such Act (subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter), or was eligible for and received supplemental security income benefits under title XVI of such Act (subchapter XVI of this chapter) (or a supplementary payment described in section 13(c) of Public Law 93-233) (set out as a note under this section) and was also in receipt of (or was a dependent, for purposes of chapter 15 of title 38, United States Code, as in effect on December 31, 1978, of an individual in receipt of) pension from the Veterans' Administration for the month of December 1978 shall (subject to subparagraph (B)) be deemed to have been receiving such aid, assistance, supplemental security income, or supplementary payment, for each calendar month thereafter (prior to the month in which the provisions of this subparagraph cease to be effective with respect to him as determined under subparagraph (B)), if such individual would have been eligible therefor in December 1978 and in the month in which the provisions of this subparagraph cease to be effective with respect to him as determined under subparagraph (B) had the increase in income of such individual (or of the family of which such individual is a member), attributable to an election (made by such individual or another member of such individual's family) under section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978 (Pub. L. 95-548, set out as a note under section 821 of Title 38, Veterans' Benefits), not occurred.

"(B)(i) The provisions of subparagraph (A) shall take effect on January 1, 1979, and shall cease to be effective, in the case of any individual, for and after the first calendar month beginning more than 10 days after an 'informed election' (as defined in subdivision (ii) of this subparagraph) has been made by such individual (or, if such individual is not eligible to make such an election, by a member of such individual's family who is eligible to make such an election which affects such individual's eligibility for aid, assistance, or benefits under a plan or program referred to in subparagraph (A)).

"(ii) The term 'informed election' means an election made under section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978 (Pub. L. 95-548, set out as a note under section 821 of Title 38) (or a reaffirmation of such an election which previously was made under such section 306) after the date of compliance by the Administrator of Veterans' Affairs (hereinafter in this section referred to as the 'Administrator') with the provisions of paragraph (3)(A) with respect to the individual concerned. An individual who fails, within the time limits prescribed in paragraph (3)(B), to disaffirm an election previously made by such individual under such section 306 shall be deemed, for purposes of this section and such section 306, to have reaffirmed such election."

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 306e-17, 906, 1318, 1320a-7a, 1320c-7, 1332i, 1395v, 1396c, 1396it, 1396b, 1396d, 1396g, 1396i, 1396n, 4736 of this title.

§ 1396b. Payment to States

(a) Computation of amount

From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this subchapter, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1396d(b) of this title, subject to subsections (g), (h), and (j) of this section) of the total amount expended during such quarter as medical assistance under the State plan (including expenditures for premiums under part B of subchapter XVIII of this chapter, for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title, and, except in the case of individuals sixty-five years of age or older and disabled individuals entitled to hospital insurance benefits under subchapter XVIII of this chapter who are not enrolled under part B of subchapter XVIII of this chapter, other insurance premiums for medical or any other type of remedial care or the cost thereof; plus

[See main edition for text of (2)]

(3) an amount equal to—

[See main edition for text of (A)]

(B) 75 per centum of so much of the sums expended during such quarter as are attributable to the operation of systems (whether such systems are operated directly by the State or by another person under a contract with the State) of the type described in subparagraph (A)(i) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by the plan, or to each individual in a sample group of individuals who are furnished such services, of the specific services (other than confidential services) so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services; and

(C) 75 per centum of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient admini-

tration of the State plan) as are attributable to the performance of medical and utilization review by a Professional Standards Review Organization under a contract entered into under section 1396a(d) of this title; plus

(4) Omitted

[See main edition for text of (5)]

(6) subject to subsection (b)(3) of this section, an amount equal to—

(A) 90 per centum of the sums expended during such a quarter within the twelve-quarter period beginning with the first quarter in which a payment is made to the State pursuant to this paragraph, and

(B) 75 per centum of the sums expended during each succeeding calendar quarter,

with respect to costs incurred during such quarter (as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan) which are attributable to the establishment and operation of (including the training of personnel employed by) a State medical fraud control unit (described in subsection (q) of this section); plus

(7) an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b) Quarterly expenditures beginning after December 31, 1969

[See main edition for text of (1) and (2)]

(3) The amount of funds which the Secretary is otherwise obligated to pay a State during a quarter under subsection (a)(6) of this section may not exceed the higher of—

(A) \$125,000, or

(B) one-quarter of 1 per centum of the sums expended by the Federal, State, and local governments during the previous quarter in carrying out the State's plan under this subchapter.

[See main edition for text of (c)]

(d) Estimates of State entitlement; installments; adjustments; overpayment; obligated appropriations; disputed claims

[See main edition for text of (1) to (4)]

(5) In any case in which the Secretary estimates that there has been an overpayment under this section to a State on the basis of a claim by such State that has been disallowed by the Secretary under section 1316(d) of this title, and such State disputes such disallowance, the amount of the Federal payment in controversy shall, at the option of the State, be retained by such State or recovered by the Secretary pending a final determination with respect to such payment amount. If such final determination is to the effect that any amount was properly disallowed, and the State chose to retain payment of the amount in controversy, the Secretary shall offset, from any subsequent

payments made to such State under this subchapter, an amount equal to the proper amount of the disallowance plus interest on such amount disallowed for the period beginning on the date such amount was disallowed and ending on the date of such final determination at a rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day treasury bill auction rates during such period.

(e) Transition costs of closures or conversions permitted

A State plan approved under this subchapter may include, as a cost with respect to hospital services under the plan under this subchapter, periodic expenditures made to reflect transitional allowances established with respect to a hospital closure or conversion under section 1395uu of this title.

[See main edition for text of (f)]

(g) Decrease in Federal medical assistance percentage of amounts paid for services furnished under State plan after June 30, 1973

(1) Subject to paragraph (3), with respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1395mm of this title), the Federal medical assistance percentage shall be decreased as follows: After an individual has received care as an inpatient in a hospital (including an institution for tuberculosis), skilled nursing facility or intermediate care facility on 60 days, or in a hospital for mental diseases on 90 days (whether or not such days are consecutive), during any fiscal year, which for purposes of this section means the four calendar quarters ending with June 30, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual in the same fiscal year shall be decreased by a per centum thereof (determined under paragraph (5)) unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services (including tuberculosis hospitals), skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), there is in operation in the State an effective program of control over utilization of such services; such a showing must include evidence that—

(A) In each case for which payment is made under the State plan, a physician certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and the physician, or a physician assistant or nurse practitioner under the supervision of a physician, recertifies, where such services are furnished over a period of time, in such cases, at least every 60 days (or, in the case of services that are inter-

mediate care facility services described in section 1396d(d) of this title, every year), and accompanied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services; and

[See main edition for text of (B) to (D)]

In determining the number of days on which an individual has received services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under section 1395d of this title.

(2) The Secretary shall, as part of his validation procedures under this subsection, conduct timely sample onsite surveys of private and public institutions in which recipients of medical assistance may receive care and services under a State plan approved under this subchapter, and his findings with respect to such surveys (as well as the showings of the State agency required under this subsection) shall be made available for public inspection.

(3)(A) No reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under this subsection shall take effect—

(i) if such reduction is due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning before January 1, 1977;

(ii) before January 1, 1978;

(iii) unless a notice of such reduction has been provided to the State at least 30 days before the date such reduction takes effect; or

(iv) due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning after September 30, 1977, unless notice of such reduction has been provided to the State no later than the first day of the fourth calendar quarter following the calendar quarter with respect to which such showing was made.

(B) The Secretary shall waive application of any reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under paragraph (1) because a showing by the State, made under such paragraph with respect to a calendar quarter ending after January 1, 1977, and before January 1, 1978, is determined to be either unsatisfactory under such paragraph or invalid under paragraph (2), if the Secretary determines that the State's showing made under paragraph (1) with respect to any calendar quarter ending on or before December 31, 1978, is satisfactory under such paragraph and is valid under paragraph (2).

(4)(A) The Secretary may not find the showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory if the showing is submitted to the Secretary later than the 30th day after the last day of the calendar quarter, unless the State demonstrates to the satisfaction of the Secretary good cause for not meeting such deadline.

(B) The Secretary shall find a showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory under such paragraph with respect to the requirement that the State conduct annual onsite inspections in mental hospitals, skilled nursing facilities, and intermediate care facilities under paragraph (26) and (31) of section 1396a(a) of this title, if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter—

(i) in each of not less than 98 per centum of the number of such hospitals and facilities requiring such inspection, and

(ii) in every such hospital or facility which has 200 or more beds,

and that, with respect to such hospitals and facilities not inspected within such period, the State has exercised good faith and due diligence in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only.

(5) In the case of a State's unsatisfactory or invalid showing made with respect to a type of facility or institutional services in a calendar quarter, the per centum amount of the reduction of the State's Federal medical assistance percentage for that type of services under paragraph (1) is equal to 33½ per centum multiplied by a fraction, the denominator of which is equal to the total number of patients receiving that type of services in that quarter under the State plan in facilities or institutions for which a showing was required to be made under this subsection, and the numerator of which is equal to the number of such patients receiving such type of services in that quarter in those facilities or institutions for which a satisfactory and valid showing was not made for that calendar quarter.

(6) The Secretary shall submit to Congress, not later than sixty days after the end of such calendar quarter, a report on—

(A) his determination as to whether or not each showing, made under paragraph (1) by a State with respect to the calendar quarter, has been found to be satisfactory under such paragraph;

(B) his review (through onsite surveys and otherwise) under paragraph (2) of the validity of showings previously submitted by a State; and

(C) any reduction in the Federal medical assistance percentage he has imposed on a State because of its submittal under paragraph (1) of an unsatisfactory or invalid showing.

[See main edition for text of (A)]

(i) Payment for services performed after December 31, 1972; restrictions

Payment under the preceding provisions of this section shall not be made—

(1) Repealed. Pub. L. 97-35, title XXI, § 2174(b), Aug. 13, 1981, 95 Stat. 809.

(3) with respect to any amount paid for services furnished under the plan after December 31, 1972, by a provider or other person during any period of time, if payment may not be made under subchapter XVIII of this chapter with respect to services furnished by such provider or person during such period of time solely by reason of a determination by the Secretary under section 1395y(d)(1) of this title or under clause (D), (E), or (F) of section 1395cc(b)(2) of this title, or by reason of noncompliance with a request made by the Secretary under clause (C)(ii) of such section 1395cc(b)(2) or under section 1396a(a)(38) of this title; or

[See main edition for text of (3)]

(4) with respect to any amount expended for care or services furnished under the plan by a hospital or skilled nursing facility unless such hospital or skilled nursing facility has in effect a utilization review plan which meets the requirements imposed by section 1395x(k) of this title for purposes of subchapter XVIII of this chapter; and if such hospital or skilled nursing facility has in effect such a utilization review plan for purposes of subchapter XVIII of this chapter, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this subchapter, the Secretary is authorized to waive the requirements of this paragraph if the State agency demonstrates to his satisfaction that it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under section 1395x(k) of this title; or

(5) with respect to any amount expended for any drug product for which payment may not be made under part B of subchapter XVIII of this chapter because of section 1395y(c) of this title; or

(6) with respect to any amount expended for inpatient hospital tests (other than in emergency situations) not specifically ordered by the attending physician or other responsible practitioner.

(j) Adjustment of amount

Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) of this section for any State for any quarter shall be adjusted in accordance with section 1396m of this title.

[See main edition for text of (k) and (l)]

(m) Definition; duties and functions of Secretary; payments to States; provisional determination of status by State

(1)(A) The term "health maintenance organization" means a public or private organization, organized under the laws of any State, which is a qualified health maintenance organization (as defined in section 300e-9(d) of this title) or which—

(i) makes services it provides to individuals eligible for benefits under this subchapter accessible to such individuals, within the area

served by the organization, to the same extent as such services are made accessible to individuals (eligible for medical assistance under the State plan) not enrolled with the organization, and

(ii) has made adequate provision against the risk of insolvency, which provision is satisfactory to the State and which assures that individuals eligible for benefits under this subchapter are in no case held liable for debts of the organization in case of the organization's insolvency.

(B) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a health maintenance organization within the meaning of subparagraph (A), shall be integrated with the administration of section 300e-11(a) and (b) of this title.

(2)(A) Except as provided in subparagraphs (B) and (C), no payment shall be made under this subchapter to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity which is responsible for the provision of inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1396d(a) of this title or for the provision of any three or more of the services described in such paragraphs unless—

(i) the Secretary (or the State as authorized by paragraph (3)) has determined that the entity is a health maintenance organization as defined in paragraph (1);

(ii) less than 75 percent of the membership of the entity which is enrolled on a prepaid basis consists of individuals who (I) are insured for benefits under part B of subchapter XVIII of this chapter or for benefits under both parts A and B of such subchapter, or (II) are eligible to receive benefits under this subchapter;

(iii) such services are provided for the benefit of individuals eligible for benefits under this subchapter in accordance with a contract between the State and the entity under which prepaid payments to the entity are made on an actuarially sound basis;

(iv) such contract provides that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the entity (and of any subcontractor) that pertain (I) to the ability of the entity to bear the risk of potential financial losses, and (II) to services performed or determinations of amounts payable under the contract;

(v) such contract provides that in the entity's enrollment, reenrollment, or disenrollment of individuals who are eligible for benefits under this subchapter and eligible to enroll, reenroll, or disenroll with the entity pursuant to the contract, the entity will not discriminate among such individuals on the basis of their health status or requirements for health care services;

(vi) such contract (I) permits individuals who have elected under the plan to enroll with the entity for provision of such benefits

to terminate such enrollment without cause as of the beginning of the first calendar month following a full calendar month after the request is made for such termination, and (II) provides for notification of each such individual, at the time of the individual's enrollment, of such right to terminate such enrollment; and

(vi) such contract provides that, in the case of medically necessary services which were provided (I) to an individual enrolled with the entity under the contract and entitled to benefits with respect to such services under the State's plan and (II) other than through the organization because the services were immediately required due to an unforeseen illness, injury, or condition, either the entity or the State provides for reimbursement with respect to those services.

(B) Subparagraph (A) does not apply with respect to payments under this subchapter to a State with respect to expenditures incurred by it for payment for services provided by an entity which—

(i) received a grant of at least \$100,000 in the fiscal year ending June 30, 1976, under section 254b(d)(1)(A) or 254c(d)(1) of this title, and (II) for the period beginning July 1, 1976, and ending on the expiration of the period¹ for which payments are to be made under this subchapter has been the recipient of a grant under either such section; and

[See main edition for text of (I); (ii) and (iii)]

(C) Subparagraph (A)(ii) shall not apply with respect to payments under this subchapter to a State with respect to expenditures incurred by it for payment for services by an entity during the three-year period beginning on October 8, 1976, or beginning on the date the entity qualifies as a health maintenance organization (as determined by the Secretary), whichever occurs later, but only if the entity demonstrates to the satisfaction of the Secretary by the submission of plans for each year of such three-year period that it is making continuous efforts and progresses toward achieving compliance with subparagraph (A)(ii).

(D) In the case of a health maintenance organization that is a public entity, the Secretary may modify or waive the requirement described in subparagraph (A)(ii) but only if the Secretary determines that (i) special circumstances warrant such modification or waiver, and (ii) the organization has taken and is taking reasonable efforts to enroll individuals who are not entitled to benefits under the State plan approved under this subchapter or under subchapter XVIII of this chapter.

[See main edition for text of (E)]

(a) State agency action upon disclosure or failure to disclose required information by institution, organization, etc.

The State agency may refuse to enter into any contract or agreement with a hospital, nursing home, or other institution, organiza-

tion, or agency for purposes of participation under the State plan, or otherwise to approve an institution, organization, or agency for such purposes, if any person, who has a direct or indirect ownership or control interest of 5 percent or more in such institution, organization, or agency, or who is an officer, director, agent, or managing employee (as defined in section 1320a-5(b) of this title) of such institution, organization, or agency, is a person described in section 1320a-5(a) of this title (whether or not such institution, organization, or agency has in effect an agreement entered into with the Secretary pursuant to section 1395cc of this title); and, notwithstanding any other provision of this section, the State agency may terminate any such contract, agreement, or approval if it determines that the institution, organization, or agency did not fully and accurately make any disclosure required of it by section 1320a-5(a) of this title at the time such contract or agreement was entered into or such approval was given.

(c) Restrictions on authorized payments to States

Notwithstanding the preceding provisions of this section, no payment shall be made to a State under the preceding provisions of this section for expenditures for medical assistance provided for an individual under its State plan approved under this subchapter to the extent that a private insurer (as defined by the Secretary by regulation) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided medical assistance under the plan.

(p) Assignment of rights of payment; incentive payments for enforcement and collection

(1) When a political subdivision of a State makes, for the State of which it is a political subdivision, or one State makes, for another State, the enforcement and collection of rights of support or payment assigned under section 1396k of this title, pursuant to a cooperative arrangement under such section (either within or outside of such State), there shall be paid to such political subdivision or such other State from amounts which would otherwise represent the Federal share of payments for medical assistance provided to the eligible individuals on whose behalf such enforcement and collection was made, an amount equal to 15 percent of any amount collected which is attributable to such rights of support or payment.

(2) Where more than one jurisdiction is involved in such enforcement or collection, the amount of the incentive payment determined under paragraph (1) shall be allocated among the jurisdictions in a manner to be prescribed by the Secretary.

(q) State medical fraud control unit defined

For the purposes of this section, the term "State medical fraud control unit" means a single identifiable entity of the State government which the Secretary certifies (and annually recertifies) as meeting the following requirements:

¹So in original. Should be "period".

(1) The entity (A) is a unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations, (B) is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, approved by the Secretary, that (i) assure its referral of suspected criminal violations relating to the program under this subchapter to the appropriate authority or authorities in the State for prosecution and (ii) assure its assistance of, and coordination with, such authority or authorities in such prosecutions, or (C) has a formal working relationship with the office of the State Attorney General and has formal procedures (including procedures for its referral of suspected criminal violations to such office) which are approved by the Secretary and which provide effective coordination of activities between the entity and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to the program under this subchapter.

(2) The entity is separate and distinct from the single State agency that administers or supervises the administration of the State plan under this subchapter.

(3) The entity's function is conducting a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of fraud in connection with any aspect of the provision of medical assistance and the activities of providers of such assistance under the State plan under this subchapter.

(4) The entity has procedures for reviewing complaints of the abuse and neglect of patients of health care facilities which receive payments under the State plan under this subchapter, and, where appropriate, for acting upon such complaints under the criminal laws of the State or for referring them to other State agencies for action.

(5) The entity provides for the collection, or referral for collection to a single State agency, of overpayments that are made under the State plan to health care facilities and that are discovered by the entity in carrying out its activities.

(6) The entity employs such auditors, attorneys, investigators, and other necessary personnel and is organized in such a manner as is necessary to promote the effective and efficient conduct of the entity's activities.

(7) The entity submits to the Secretary an application and annual reports containing such information as the Secretary determines, by regulation, to be necessary to determine whether the entity meets the other requirements of this subsection.

(r) Mechanized claims processing and information retrieval systems; operational, etc., requirements

(1XA) In order to receive payments under paragraphs (2) and (7) of subsection (a) of this section without being subject to per centum reductions set forth in subparagraph (C) of this paragraph, a State must provide that mecha-

nized claims processing and information retrieval systems of the type described in subsection (a)(3)(B) of this section and detailed in an advance planning document approved by the Secretary are operational on or before the deadline established under subparagraph (B).

(B) The deadline for operation of such systems for a State is the earlier of (i) September 30, 1982, or (ii) the last day of the sixth month following the date specified for operation of such systems in the State's most recently approved advance planning document submitted before October 7, 1980.

(C) If a State fails to meet the deadline established under subparagraph (B), the per centums specified in paragraphs (2) and (7) of subsection (a) of this section with respect to that State shall each be reduced by 5 percentage points for the first two quarters beginning on or after such deadline, and shall be further reduced by an additional 5 percentage points after each period consisting of two quarters during which the Secretary determines the State fails to meet the requirements of subparagraph (A); except that—

(i) neither such per centum may be reduced by more than 25 percentage points by reason of this paragraph; and

(ii) no reduction shall be made under this paragraph for any quarter following the quarter during which such State meets the requirements of subparagraph (A).

(2XA) In order to receive payments under paragraphs (2) and (7) of subsection (a) of this section without being subject to the per centum reductions set forth in subparagraph (C) of this paragraph, a State must have its mechanized claims processing and information retrieval systems, of the type required to be operational under paragraph (1), initially approved by the Secretary in accordance with paragraph (5XA) on or before the deadline established under subparagraph (B).

(B) The deadline for approval of such systems for a State is the last day of the fourth quarter that begins after the date on which the Secretary determines that such systems became operational as required under paragraph (1).

(C) If a State fails to meet the deadline established under subparagraph (B), the per centums specified in paragraphs (2) and (7) of subsection (a) of this section with respect to that State shall each be reduced by 5 percentage points for the first two quarters beginning after such deadline, and shall be further reduced by an additional 5 percentage points at the end of each period consisting of two quarters during which the State fails to meet the requirements of subparagraph (A); except that—

(i) neither such per centum may be reduced by more than 25 percentage points by reason of this paragraph; and

(ii) no reduction shall be made under this paragraph for any quarter following the quarter during which such State's systems are approved by the Secretary as provided in subparagraph (A).

(D) Any State's systems which are approved by the Secretary for purposes of subsection

(a)(3)(B) of this section on or before October 7, 1980, shall be deemed to be initially approved for purposes of this subsection.

(3)(A) When a State's systems are initially approved, the 75 per centum Federal matching provided in subsection (a)(3)(B) of this section shall become effective with respect to such systems, retroactive to the first quarter beginning after the date on which such systems became operational as required under paragraph (1), except as provided in subparagraph (B).

(B) In the case of any State which was subject to a per centum reduction under paragraph (2), the per centum specified in subsection (a)(3)(B) of this section shall be reduced by 5 percentage points for the first two quarters beginning after the deadline established under paragraph (2)(B), and shall be further reduced by an additional 5 percentage points at the end of each period consisting of two quarters beginning after such deadline and before the date on which such systems are initially approved, except that no reduction shall be made under this paragraph for any quarter following the quarter during which the State's systems are initially approved by the Secretary.

(4)(A) The Secretary shall review all approved systems not less often than once each fiscal year, and shall reapprove or disapprove any such systems. Systems which fail to meet the current performance standards, system requirements, and any other conditions for approval developed by the Secretary under paragraph (6) shall be disapproved. Any State having systems which are so disapproved shall be subject to a per centum reduction under subparagraph (B). The Secretary shall make the determination of reapproval or disapproval and so notify the States not later than the end of the first quarter following the review period.

(B) If the Secretary disapproves a State's systems under subparagraph (A), the Secretary shall, with respect to such State for quarters beginning after the determination of disapproval and before the first quarter beginning after such systems are reapproved, reduce the per centum specified in subsection (a)(3)(B) of this section to a per centum of not less than 50 per centum and not more than 70 per centum as the Secretary determines to be appropriate and commensurate with the nature of noncompliance by such State; except that such per centum may not be reduced by more than 10 percentage points in any 4-quarter period by reason of this subparagraph. No State shall be subject to a per centum reduction under this paragraph (1) before the fifth quarter beginning after such State's systems were initially approved, or (11) on the basis of a review conducted before October 1, 1981.

(C) The Secretary may retroactively waive a per centum reduction imposed under subparagraph (B), if the Secretary determines that the State's systems meet all current performance standards and other requirements for reapproval and that such action would improve the administration of the State's plan under this subchapter, except that no such waiver may extend beyond the four quarters immediately prior to the quarter in which the State's systems are reapproved.

(5)(A) In order to be initially approved by the Secretary, mechanized claims processing and information retrieval systems must be of the type described in subsection (a)(3)(B) of this section and must meet the following requirements:

(i) The systems must be capable of developing provider, physician, and patient profiles which are sufficient to provide specific information as to the use of covered types of services and items, including prescribed drugs.

(ii) The State must provide that information on probable fraud or abuse which is obtained from, or developed by, the systems, is made available to the State's medical fraud control unit (if any) certified under subsection (q) of this section.

(iii) The systems must meet all performance standards and other requirements for initial approval developed by the Secretary under paragraph (6).

(B) In order to be reapproved by the Secretary, mechanized claims processing and information retrieval systems must meet the requirements of subparagraphs (A)(i) and (A)(ii) and performance standards and other requirements for reapproval developed by the Secretary under paragraph (6).

(6) The Secretary, with respect to State systems, shall—

(A) develop performance standards, system requirements, and other conditions for approval for use in initially approving such State systems, and shall further develop written approval procedures for conducting reviews for initial approval, including specific criteria for assessing systems in operation to insure that all such performance standards and other requirements are met;

(B) by not later than October 1, 1980, develop an initial set of performance standards, system requirements, and other conditions for reapproval for use in reapproving or disapproving State systems, and shall further develop written reapproval procedures for conducting reviews for reapproval, including specific criteria for reassessing systems operations over a period of at least six months during each fiscal year to insure that all such performance standards and other requirements are met on a continuous basis;

(C) provide that reviews for reapproval, conducted before October 1, 1981, shall be for the purpose of developing a systems performance data base and assisting States to improve their systems, and that no per centum reduction shall be made under paragraph (4) on the basis of such a review;

(D) insure that review procedures, performance standards, and other requirements developed under subparagraph (B) are sufficiently flexible to allow for differing administrative needs among the States, and that such procedures, standards, and requirements are of a nature which will permit their use by the States for self-evaluation;

(E) notify all States of proposed procedures, standards, and other requirements at least one quarter prior to the fiscal year in which such procedures, standards, and other re-

quirements will be used for conducting reviews for reapproval;

(F) periodically update the systems performance standards, system requirements, review criteria, objectives, regulations, and guides as the Secretary shall from time to time deem appropriate;

(G) provide technical assistance to States in the development and improvement of the systems so as to continually improve the capacity of such systems to effectively detect cases of fraud or abuse;

(H) for the purpose of insuring compatibility between the State systems and the systems utilized in the administration of subchapter XVIII of this chapter—

(i) develop a uniform identification coding system (to the extent feasible) for providers, other persons receiving payments under the State plans (approved under this subchapter) or under subchapter XVIII of this chapter, and beneficiaries of medical services under such plans or subchapter;

(ii) provide liaison between States and carriers and intermediaries having agreements under subchapter XVIII of this chapter to facilitate timely exchange of appropriate data; and

(iii) improve the exchange of data between the States and the Secretary with respect to providers and other persons who have been terminated, suspended, or otherwise sanctioned under a State plan (approved under this subchapter) or under subchapter XVIII of this chapter;

(I) develop and disseminate clear definitions of those types of reasonable costs relating to State systems which are reimbursable under the provisions of subsection (a)(3) of this section; and

(J) report on or before October 1, 1981, to the Congress on the extent to which States have developed and operated effective mechanized claims processing and information retrieval systems.

(7)(A) The Secretary shall waive the provisions of this subsection with respect to initial operation and approval of mechanized claims processing and information retrieval systems with respect to any State which—

(i) had a 1976 population (as reported by the Bureau of the Census) of less than 1,000,000 and which made total expenditures (including Federal reimbursement) for which Federal financial participation is authorized under this subchapter of less than \$100,000,000 in fiscal year 1976 (as reported by such State for such year), or

(ii) is a Commonwealth, or territory or possession, of the United States,

if such State reasonably demonstrates, and the Secretary does not formally disagree, that the application of such provisions would not significantly improve the efficiency of the administration of such State's plan under this subchapter.

(B) If the Secretary determines that the application of the provisions described in subparagraph (A) to a State would significantly improve the efficiency of the administration of the State's plan under this subchapter, the Sec-

retary may withdraw the State's waiver under subparagraph (A) and, in such case, the Secretary shall impose a timetable for such State with respect to compliance with the provisions of this subsection and the imposition of per centum reductions. Such timetable shall be comparable to the timetable established under this subsection as to the amount of time allowed such State to comply and the timing of per centum reductions.

(8)(A) The per centum reductions provided for under this subsection shall not apply to a State for any quarter with respect to which the Secretary determines that such State is unable to comply with the relevant requirements of this subsection—

(i) for good cause (but such a waiver may not be for a period in excess of 2 quarters), or

(ii) due to circumstances beyond the control of such State.

(B) If the Secretary determines under subparagraph (A) that such a reduction will not apply to a State, the Secretary shall report to the Congress on the basis for each such determination and on the modification of all time limitations and deadlines as described in subparagraph (C).

(C) For purposes of determining all time limitations and deadlines imposed under this subsection, any time period during which a State was found under subparagraph (A)(i) to be unable to comply with requirements of this subsection due to circumstances beyond its control shall not be taken into account, and the Secretary shall modify all such time limitations and deadlines with respect to such State accordingly.

(s) Reduction on medical payments to States; limitations on reductions; States included; percentage reduced under certain circumstances

(1)(A) Notwithstanding any other provision of this section (except as otherwise provided in this subsection), the amount of payments which a State is otherwise entitled to receive under this title for any quarter in—

(i) fiscal year 1982, shall be reduced by 3 percent,

(ii) fiscal year 1983, shall be reduced by 4 percent, and

(iii) fiscal year 1984, shall be reduced by 4.5 percent,

of the amount to which the State is otherwise entitled (without regard to payments under subsection (t) of this section and without regard to payments for claims relating to expenditures made before fiscal year 1981).

(B) No reduction may be made under subparagraph (A) for a quarter unless, as of the first day of the quarter, the Secretary has promulgated and has in effect final regulations (on an interim or other basis) implementing paragraphs (10)(C) and (13)(A) of section 1396a(a) of this title (as amended by the Medicare and Medicaid Amendments of 1981).

(C) For purposes of this paragraph, the term "State" only includes the fifty States and the District of Columbia and does not include any State which did not have a plan approved under this subchapter as of July 1, 1981.

(2) The percentage reduction imposed by paragraph (1) for a State for a quarter shall be reduced—

(A) by one percentage point if the State has a qualified hospital cost review program (described in paragraph (3)) for the quarter,

(B) by one percentage point if the State has a high unemployment rate (as determined under paragraph (4)) for the quarter, and

(C) by one percentage point if the total amount of the State's third party and fraud and abuse recoveries (as defined in paragraph (5)(A)) for the previous quarter is equal to or exceeds one percent of the amount of Federal payments that the Secretary estimates are due the State under this subchapter for that previous quarter (without regard to payments under subsection (t) of this section).

(3) For purposes of paragraph (2)(A), a State has a qualified hospital cost review program for a calendar quarter if such program meets the following requirements:

(A) The program must have been established by statute and in effect on July 1, 1981, and at the beginning of the quarter.

(B) The program must be operated directly by the State and must apply (i) to substantially all nonfederal acute care hospitals (as defined by the Secretary) in the State and (ii) to review of either all revenues or expenses for inpatient hospital services (other than revenues under subchapter XVIII of this chapter, unless approved by the Secretary) or at least 75 percent of all revenues or expenses for inpatient hospital services (including revenues under subchapter XVIII of this chapter).

(C) The State must provide the Secretary with satisfactory assurances as to the equitable treatment under the program of all entities (including Federal and State programs) that pay hospitals for inpatient hospital services, of hospital employees, and of hospital patients.

(D) The Secretary determines that the annual rate of increase in aggregate hospital inpatient costs per capita or per admission (as defined by the Secretary) in the State during the most recent calendar year ending at least nine months before such quarter (or, at the State's option, during the 2 or 3 calendar-year period ending with that calendar year) is at least two percentage points less than the annual rate of increase during that calendar year (or that period, as the case may be) in such costs per capita or per admission for hospitals located in the United States (excluding from such computation, with respect to any calendar year in any period, any State which had in existence a qualified hospital cost review program (or, in the case of periods before January 1, 1982, had a hospital cost review program which the Secretary determines met for such periods the provisions of subparagraphs (A), (B), and (C) of this paragraph) during that entire calendar year).

(4)(A) for purposes of paragraph (2)(B), a State has a high unemployment rate with respect to a quarter if the average of the monthly unemployment rates (as determined by the

Bureau of Labor Statistics) for the State for the three months immediately before such quarter is equal to or greater than 150 percent of the average of such rates for the United States for such months.

(B) For purposes of subparagraph (A), the term "United States" only includes the fifty States and the District of Columbia.

(5)(A) For purposes of paragraph (2)(C), the term "third party and fraud and abuse recoveries" means, for a State for a previous quarter—

(i) the total amount that State demonstrates to the Secretary that it has recovered or diverted in the quarter on the basis of (I) third-party payments (described in section 1396a(a)(25) of this title), (II) the operation of its State medicaid fraud control unit (defined in subsection (q) of this section), and (III) other fraud or abuse control activities, plus

(ii) any amount carried forward from the previous quarter under subparagraph (B).

Subclause (i) of clause (i) shall only apply to quarters during fiscal year 1982.

(B) If the total amount of the State's third party and fraud and abuse recoveries (defined in subparagraph (A)) for a quarter (beginning on or after October 1, 1981) exceeds one percent of the amount of Federal payments that the Secretary estimates are due the State under this subchapter for that quarter (without regard to subsection (t) of this section), the amount of such excess shall be carried forward to the following quarter for purposes of clause (ii) of subparagraph (A).

(t) Offset for meeting Federal medicaid expenditure targets; computation for meeting expenditure targets

(1) The Secretary shall determine for each State (as defined in subsection (s)(1)(C) of this section) for each of fiscal years 1982, 1983, and 1984, a target amount of Federal medicaid expenditures. Such target amount for a State for fiscal year—

(A) 1982, is equal to 109 percent of the estimate (based upon the last such estimate for such State received by the Secretary before April 1, 1981) of the Federal share of expenditures under this subchapter (other than interest paid under subsection (d)(5) of this section, without taking into account reductions in payment under subsection (s) of this section or additional payments under this subsection, and without regard to payments for claims relating to expenditures made prior to October 1, 1980) in fiscal year 1981 for such State;

(B) 1983, is equal to the target amount determined under subparagraph (A) for the State increased or decreased by a percentage equal to the percentage increase or decrease (as the case may be) in the index of the medical care expenditure category of the consumer price index for all urban consumers (published by the Bureau of Labor Statistics) between September 1982 and September 1983; and

(C) 1984, is equal to the target amount determined under subparagraph (A) for the

State increased or decreased by a percentage equal to the percentage increase or decrease (as the case may be) in the index of the medical care expenditure category of the consumer price index for all urban consumers (published by the Bureau of Labor Statistics) between September 1982 and September 1984.

(3) Notwithstanding any other provision of this section (except as otherwise provided in this subsection), the amount of payments which a State (with a State plan approved under this subchapter) is otherwise entitled to receive for the first quarter of any fiscal year (beginning with fiscal year 1983 and ending with fiscal year 1985) shall be supplemented by an amount equal to the lesser of—

(A) the amount by which the Secretary determines or estimates (subject to appropriate subsequent adjustments) the Federal share of expenditures under this subchapter (other than interest paid under subsection (d)(5) of this section, without taking into account reductions in payment under subsection (s) of this section, or payments under this subsection, without regard to payments for claims relating to expenditures made prior to October 1, 1980, and subject to paragraph (3) of this subsection) under the State's plan for the previous fiscal year was less than the target amount of Federal medical expenditures for that State for that fiscal year determined under paragraph (1), or

(B) the amount of the reductions imposed with respect to the State under subsection (s) of this section for the quarters in the previous fiscal year.

(3) Only for the purpose of computing under this subsection the Federal share of expenditures for a State for fiscal year 1984 (in the case of the payment which may be made for the first quarter of fiscal year 1985), the Federal medical assistance percentage for fiscal year 1984 shall be the Federal medical assistance percentage for States in effect for fiscal year 1983, disregarding any change in such percentage between fiscal year 1983 and fiscal year 1984.

(As amended Aug. 1, 1977, Pub. L. 95-83, title I, § 105(a)(1), (2), 91 Stat. 384; Oct. 25, 1977, Pub. L. 95-142, §§ 3(c)(2), 8(c), 10(a), 11(a), 17(a)-(c), 20(a), 91 Stat. 1179, 1195, 1196, 1201, 1205; Nov. 1, 1978, Pub. L. 95-559, § 14(c), 92 Stat. 2141; Nov. 10, 1978, Pub. L. 95-626, title I, § 102(b)(3), 92 Stat. 3551; Oct. 4, 1979, Pub. L. 96-79, title I, § 128, 93 Stat. 629; Oct. 7, 1980, Pub. L. 96-398, title IX, § 901, 94 Stat. 1609; Dec. 8, 1980, Pub. L. 96-499, title IX, §§ 905(b), (c), 961(a), 963, 964, 94 Stat. 2618, 2650, 2651; Aug. 13, 1981, Pub. L. 97-35, title XXI, §§ 2101(a)(2), 2103(b)(1), 2106(b)(3), 2113(n), 2161(a), (b), 2163, 2164(a), 2174(b), 2178(a), 2183(a), 95 Stat. 786, 788, 792, 795, 803, 804, 806, 809, 813, 816.)

REPEAL OF SUBSECS. (s) AND (t)

Pub. L. 97-35, title XXI, § 2161(c), Aug. 13, 1981, 95 Stat. 805, provided that, effective for calendar quarters beginning on or after Oct. 1, 1984, subsec. (s) of this section is repealed and, effective after payments for the first quarter of the fiscal year 1985, subsec. (t) of this section is repealed.

REFERENCES IN TEXT

The Medicare and Medicaid Amendments of 1981, referred to in subsec. (a)(1)(B), is Pub. L. 97-35, title XXI, subtitles A (§§ 2101 to 2114), B (§§ 2121 to 2156), and C (§§ 2161 to 2184), Aug. 13, 1981, 95 Stat. 785 to 816. For complete classification of this Act to the Code, see Short Title of 1981 Amendment note set out under section 1305 of this title and Tables.

CODIFICATION

Subsec. (a)(4), providing for payments to states of 100 per centum of the sums expended for costs incurred during a quarter attributable to compensation or training of personnel responsible for inspecting public or private institutions providing long-term care to recipients of medical assistance to determine compliance with health or safety standards, was omitted from the Code pursuant to section 249B of Pub. L. 92-603, as amended, which provided that the enactment of subsec. (a)(4) and the redesignation of former subsec. (a)(4) as (a)(5) (which paragraph has been subsequently redesignated (a)(7)) was effective for the period beginning Oct. 1, 1972, and ending Sept. 30, 1980. See Effective Date of 1972 Amendment note below.

AMENDMENTS

1981—Subsec. (a)(3)(B), Pub. L. 97-35, § 2113(n), substituted "and" for "plus" at the end of subpar. (B) and added subpar. (C).

Subsec. (d)(5), Pub. L. 97-35, § 2163, substituted "determination at a rate" for "determination (but not to exceed a period of twelve months with respect to disallowances made prior to October 1, 1981, or six months with respect to disallowances made thereafter) at a rate".

Subsec. (e), Pub. L. 97-35, § 2101(a)(2), added subsec. (e).

Subsec. (g)(1)(A), Pub. L. 97-35, § 2183(a), inserted "and the physician, or a physician assistant or nurse practitioner under the supervision of a physician" and "or, in the case of services that are intermediate care facility services described in section 1396d(d) of this title, every year" in the parenthetical material.

Subsec. (i)(1), Pub. L. 97-35, § 2174(b), struck out par. (1), which provided that payments shall not be made with respect to any amount paid for items or services furnished under the plan after Dec. 31, 1972, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under the fourth and fifth sentences of section 1395u(b)(3) of this title.

Subsec. (i)(5), Pub. L. 97-35, § 2103(b)(1), added par. (5).

Subsec. (i)(6), Pub. L. 97-35, § 2164(a), added par. (6).

Subsec. (m)(1)(A), Pub. L. 97-35, § 2178(a)(1), redefined the term "Health Maintenance Organization" substantially, and substituted reference to public and private organizations making services to individuals eligible for benefits under this subchapter and which makes adequate provision against the risk of insolvency for reference to a legal entity which provides health services to individuals enrolled in such organization and providing services and benefits to individuals eligible for benefits under specified provisions of this subchapter.

Subsec. (m)(2)(A), Pub. L. 97-35, § 2178(a)(2), in cl. (ii), substituted "75 percent of the membership of the entity which is enrolled on a prepaid basis" for "one-half of the membership of the entity", and added cl. (iii) to (vii).

Subsec. (m)(2)(D), Pub. L. 97-35, § 2178(a)(3), added subpar. (D).

Subsec. (n), Pub. L. 97-35, § 2106(b)(3), struck out "of this section" following "section 1396c of this title" thereby perfecting the amendment made by Pub. L. 96-499, § 906(c)(3).

Subsec. (s). Pub. L. 97-35, § 2161(a), added subsec. (s).

Subsec. (t). Pub. L. 97-35, § 2161(b), added subsec. (t).

1980—Subsec. (a)(1). Pub. L. 96-499, § 905(b), inserted reference to subsection (j) of this section.

Subsec. (a)(6). Pub. L. 96-499, § 963, substituted "such a quarter within the twelve-quarter period beginning with the first quarter in which a payment is made to the State pursuant to this paragraph, and (B) 75 per centum of the sums expended during each succeeding calendar quarter" for "each quarter beginning on or after October 1, 1977, and ending before October 1, 1980".

Subsec. (d)(5). Pub. L. 96-499, § 961(a), added par. (5).

Subsec. (g)(3)(B). Pub. L. 96-499, § 964, substituted "January 1, 1978" for "October 1, 1977" and "any calendar quarter ending on or before December 31, 1978" for "the calendar quarter ending on December 31, 1977".

Subsec. (j). Pub. L. 96-499, § 905(c)(1), substituted provisions relating to the adjustment of amounts determined under subsec. (a)(1) of this section in accordance with section 1396m of this title for provisions relating to orders for suspension of payment.

Subsec. (n). Pub. L. 96-499, § 905(c)(2), struck out "or is subject to a suspension of payment order issued under subsection (j)" following "section 1395cc of this title".

Subsec. (r). Pub. L. 96-398 added subsec. (r).

1979—Subsec. (m)(2)(C). Pub. L. 96-79 substituted "the date the entity qualifies as a health maintenance organization (as determined by the Secretary)" for "the date the entity enters into a contract with the State under this subchapter for the provision of health services on a prepaid risk basis".

1978—Subsec. (m)(1)(B). Pub. L. 95-559 struck out "shall be administered through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and the administration of such duties and functions" following "subparagraph (A)".

Subsec. (m)(2)(B)(i)(I). Pub. L. 95-626 substituted "section 254b(d)(1)(A)" for "section 247d(d)(1)(A)".

1977—Subsec. (a)(3)(B). Pub. L. 95-142, § 10(a), added provisions relating to notice to individuals in a sample group and provisions exempting notice respecting confidential services from notice requirements.

Subsec. (a)(6). Pub. L. 95-142, § 17(a), added par. (6). Former par. (6) was redesignated as (7).

Subsec. (a)(7). Pub. L. 95-142, § 17(a), redesignated former par. (6) as (7).

Subsec. (b)(3). Pub. L. 95-142, § 17(b), added par. (3).

Subsec. (g). Pub. L. 95-142, § 30(a), in par. (1) substituted "Subject to paragraph (3), with respect to" for "With respect to" and "by a per centum thereof (determined under paragraph (5))" for "by 33 per centum thereof", in par. (2) added "timely" preceding "sample onsite surveys", and added para. (3) to (6).

Subsec. (i)(2). Pub. L. 95-142, § 3(c)(2), added provisions relating to noncompliance under sections 1395cc(b)(2) and 1396a(a)(38) of this title.

Subsec. (m)(2)(A). Pub. L. 95-83, § 105(a)(1), in revising the text, incorporated former cl. (i) (I) and (II) provisions in the introductory text relating to responsibility for providing inpatient hospital services and other described services, substituting "capitation basis" for "capitation risk basis" and inserting the word "unless"; redesignated as cl. (i) former cl. (ii), substituting "has determined that the entity is a health maintenance organization" for "has not determined to be a health maintenance organization"; and redesignated as cl. (ii) former cl. (iii), substituting "less than one-half of the membership of the entity consists of individuals who (I) are insured for benefits under part B of subchapter XVIII of this chapter or for benefits under both parts A and B of such subchapter, or (II) are eligible to receive benefits under this subchapter" for "more than one-half of the membership of which consists of individuals who are insured under

parts A and B of subchapter XVIII of this chapter or recipients of benefits under this subchapter."

Subsec. (m)(2)(C). Pub. L. 95-83, § 105(a)(2), substituted reference to subpar. "(A)(ii)" for "(A)(iii)" wherever appearing.

Subsec. (n). Pub. L. 95-142, § 8(c), added subsec. (n).

Subsecs. (o), (p). Pub. L. 95-142, § 11(a), added subsecs. (o) and (p).

Subsec. (q). Pub. L. 95-142, § 17(c), added subsec. (q).

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by section 2113(n) of Pub. L. 97-35, to subsec. (a)(3)(B) of this section, applicable to agreements with Professional Standards Review Organizations entered into on or after Oct. 1, 1981, see section 2113(o) of Pub. L. 97-35, set out as an Effective Date of 1981 Amendment note under section 1320c of this title.

Amendment by section 2101(a)(2) of Pub. L. 97-35, enacting subsec. (e), applicable only to services furnished by a hospital during any accounting year beginning on or after Oct. 1, 1981, see section 2101(c) of Pub. L. 97-35, set out as an Effective Date note under section 1395uu of this title.

Section 2183(b) of Pub. L. 97-35 provided that: "The amendments made by subsection (a) [amending subsec. (g)(1)(A) of this section] shall apply to payments made to States for calendar quarters beginning on or after October 1, 1981."

Amendment by section 2174(b) of Pub. L. 97-35 applicable to services furnished on or after Oct. 1, 1981, see section 2174(c) of Pub. L. 97-35, set out as an Effective Date of 1981 Amendment note under section 1396a of this title.

Section 2103(b)(2) of Pub. L. 97-35 provided that: "The amendment made by paragraph (1) [adding subsec. (i)(5) of this section] shall apply to amounts expended on or after October 1, 1981."

Section 2184(b) of Pub. L. 97-35 provided that: "The amendments made by subsection (a) [adding subsec. (i)(6) of this section] shall apply to tests occurring on or after October 1, 1981."

Amendment by section 2178(a) of Pub. L. 97-35 to subsec. (m)(1)(A), (2)(A), (D), applicable with respect to services furnished, under a State plan approved under this subchapter, on or before Oct. 1, 1981, except that such amendments not applicable with respect to services furnished by a health maintenance organization under a contract with a State entered into under this subchapter before Oct. 1, 1981, unless the organization requests that such amendments apply and the Secretary and the State agency agree to such request, see section 2178(c) of Pub. L. 97-35, set out as an Effective Date of 1981 Amendment note under section 1396a of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Section 961(b) of Pub. L. 96-499 provided that: "The amendment made by subsection (a) [amending subsec. (d) of this section] shall be effective with respect to expenditures for services furnished on or after October 1, 1980."

EFFECTIVE DATE OF 1977 AMENDMENTS

Amendment of subsec. (i)(3) by section 3(c)(2) of Pub. L. 95-142 effective Jan. 1, 1978, see section 3(e) of Pub. L. 95-142, set out as an Effective Date note under section 1320a-3 of this title.

Subsec. (n) effective with respect to contracts, agreements, etc., made on and after the first day of the fourth month beginning after Oct. 25, 1977, see section 8(e) of Pub. L. 95-142, set out as an Effective Date note under section 1320a-8 of this title.

Section 10(b) of Pub. L. 95-142 provided that: "The amendment made by subsection (a) [amending subsec. (a)(3)(B) of this section] shall apply with respect to calendar quarters beginning after the date of the enactment of this Act [Oct. 25, 1977]."

Section 11(c) of Pub. L. 95-142 provided that: "The amendment made by subsection (a) (adding subsections (o) and (p) of this section) shall apply with respect to medical assistance provided, under a State plan approved under title XIX of the Social Security Act (this subchapter), on and after January 1, 1978."

Section 17(e)(1) of Pub. L. 95-142 provided that: "The amendment made by subsection (a) (adding subsec. (a)(6) of this section and redesignating former subsec. (a)(6) of this section as (a)(7)) shall apply with respect to calendar quarters beginning after September 30, 1977."

Section 20(c) of Pub. L. 95-142, as amended by Pub. L. 96-292, § 8(e), June 13, 1978, 92 Stat. 318, provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section (amending subsec. (g) of this section and section 1396a(a)(26) of this title) shall be effective on October 1, 1977, and the Secretary of Health, Education, and Welfare shall promptly adjust payments made to States under section 1903 of the Social Security Act (this section) to reflect the changes made by such amendments.

"(2) The amount of any reduction in the Federal medical assistance percentage of a State, otherwise required to be imposed under section 1903(g)(1) of the Social Security Act (subsec. (g)(1) of this section) because of an unsatisfactory or invalid showing made by the State with respect to a calendar quarter beginning on or after January 1, 1977, shall be determined under such section as amended by this section. Subparagraph (B) of paragraph (4) of section 1903(g) of such Act, as added by this section (subsec. (g)(4)(B) of this section), shall apply to any showing made by a State under such section with respect to a calendar quarter beginning on or after January 1, 1977."

Section 105(a)(3) of Pub. L. 95-83 provided that:

"The amendments made by paragraphs (1) and (2) (amending this section) shall apply with respect to payments under title XIX of the Social Security Act (this subchapter) to States for services provided—

"(A) after October 8, 1976, under contracts under such title (this subchapter) entered into or renegotiated after such date, or

"(B) after the expiration of the one-year period beginning on such date, whichever occurs first."

EFFECTIVE DATE OF 1972 AMENDMENT

Section 249B of Pub. L. 92-603, as amended by Pub. L. 93-368, § 8, Aug. 7, 1974, 88 Stat. 422; Pub. L. 95-83, title VII, § 309(b), Aug. 1, 1977, 91 Stat. 396, provided in part that the enactment of par. (4) of subsec. (a) and the concurrent redesignation of former par. (4) as par. (5) by section 249B of Pub. L. 92-603 shall be effective for the period beginning Oct. 1, 1972, and ending Sept. 30, 1980.

MEDICAID PAYMENTS FOR INDIAN HEALTH SERVICE FACILITIES TO BE PAID ENTIRELY BY FEDERAL FUNDS; EXCLUSION OF PAYMENTS TO STATES IN COMPUTATION OF TARGET AMOUNT OF FEDERAL MEDICAID EXPENDITURES

Pub. L. 97-62, §§ 102, 118, Dec. 15, 1981, 96 Stat. 1193, 1197, as amended by Pub. L. 97-161, Mar. 31, 1982, 96 Stat. 22, provided, for the period Dec. 15, 1981, to not later than Sept. 30, 1982, that: "Notwithstanding section 1903(s) of the Social Security Act (subsec. (s) of this section), all medicaid payments to the States for Indian health service facilities as defined by section 1911 of the Social Security Act (section 1396j of this title) shall be paid entirely by Federal funds, and notwithstanding section 1903(t) of the Social Security Act (subsec. (t) of this section), all medicaid payments to the States for Indian health service facilities shall not be included in the computation of the target amount of Federal medicaid expenditures."

PROMULGATION OF REGULATIONS FOR IMPLEMENTATION OF AMENDMENTS BY SECTION 17 OF PUB. L. 95-142.

Section 17(e)(2) of Pub. L. 95-142 required the Secretary of Health, Education, and Welfare to establish regulations, not later than 90 days after Oct. 25, 1977, to carry out the amendments made by section 17 (amending sections 1395b-1 and 1396b of this title). See section 1302 of this title.

DEFERRAL OF IMPLEMENTATION OF DECREASES IN MATCHING FUNDS

Section 6 of Pub. L. 95-59, June 30, 1977, 91 Stat. 285, provided that: "Notwithstanding the provisions of subsection (g) of section 1903 of the Social Security Act (subsec. (g) of this section), the amount payable to any State for the calendar quarters during the period commencing April 1, 1977, and ending September 30, 1977, on account of expenditures made under a State plan approved under title XIX of such Act (this subchapter), shall not be decreased by reason of the application of the provisions of such subsection with respect to any period for which such State plan was in operation prior to April 1, 1977."

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 632a, 643, 1315, 1396a, 1396n of this title.

§ 1396d. Definitions

For purposes of this subchapter—

(a) Medical assistance

The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, who are—

(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose, or any reasonable category of such individuals,

(ii) relatives specified in section 606(b)(1) of this title with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of subchapter IV of this chapter,

[See main edition for text of (iii) to (vii)]

but whose income and resources are insufficient to meet all of such cost—

[See main edition for text of (1)]

(2)(A) outpatient hospital services, and (B) consistent with State law permitting such services, rural health clinic services (as de-

quarters beginning on or after October 1, 1984, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(3) In the case of a State plan for medical assistance under title XIX of the Social Security Act (this subchapter) which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act (July 18, 1984)."

Section 2362(b) of Pub. L. 98-369 provided that: "The amendment made by subsection (a) (adding subsec. (x)(4) of this section) shall apply to children born on or after October 1, 1984."

Amendment by section 2363(a)(1) of Pub. L. 98-369 applicable to calendar quarters beginning on or after July 18, 1984, except that, in the case of individuals admitted to skilled nursing facilities before that date, the amendment shall not require recertifications sooner or more frequently than were required under the law in effect before that date, see section 2363(c) of Pub. L. 98-369, set out as a note under section 1396b of this title.

Section 2367(c) of Pub. L. 98-369 provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section (amending sections 1393a and 1396k of this title) shall become effective on October 1, 1984.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act (this subchapter) which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirement imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act (July 18, 1984)."

Section 2368(c) of Pub. L. 98-369 provided that: "The amendments made by this section (amending subsec. (a)(26) and (31) of this section) shall become effective on the date of the enactment of this Act (July 18, 1984)."

PAYMENT FOR PSYCHIATRIC HOSPITAL SERVICES

Section 2346 of Pub. L. 98-369 provided that: "The provisions of section 1902(a)(13) of the Social Security Act (42 U.S.C. 1396a(a)(13)), in so far as they require a reduction of the amount of payment otherwise to be made to a public psychiatric hospital due to the level of care received in such hospital, shall not apply to payments to hospitals before July 1, 1985, and such a reduction made for payments during the 12-month period ending June 30, 1986, and during the 12-month period ending June 30, 1987, shall be one-third and two-thirds, respectively, of the amount of the reduction which would have been made without regard to this section."

MORATORIUM ON REGULATORY ACTIONS BY SECRETARY

Section 2373(c) of Pub. L. 98-369 provided that:

"(1) The Secretary of Health and Human Services shall not take any compliance, disallowance, penalty, or other regulatory action against a State during the moratorium period described in paragraph (2) by reason of such State's plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) being determined to be in violation of section 1902(a)(10)(C)(iii) of such Act (42 U.S.C.

1396a(a)(10)(C)(iii)) on account of such plan's having a standard or methodology which the Secretary interprets as being less restrictive than the standard or methodology required under such section.

"(2) The moratorium period is the period beginning on the date of the enactment of this Act (July 18, 1984) and ending 18 months after the date on which the Secretary submits the report required under paragraph (3).

"(3) The Secretary shall report to the Congress within 12 months after the date of the enactment of this Act (July 18, 1984) with respect to the appropriateness, and impact on States and recipients of medical assistance, of applying standards and methodologies utilized in cash assistance programs to those recipients of medical assistance who do not receive cash assistance, and any recommendations for changes in such requirements.

"(4) No provision of law shall repeal or suspend the moratorium imposed by this subsection unless such provision specifically amends or repeals this subsection."

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 300e-17, 705, 1315, 1320a-7a, 1382i, 1395v, 1395cc, 1395tt, 1396b, 1396c, 1396d, 1396g, 1396i, 1396j, 1396n, 1396o, 4728, 6022, 6042 of this title.

§ 1396b. Payment to States

[See main edition for text of (a) to (f)]

(g) Decrease in Federal medical assistance percentage of amounts paid for services furnished under State plan after June 30, 1973

(1) Subject to paragraph (3), with respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1395mm of this title or which is a qualified health maintenance organization (as defined in section 300e-9(d) of this title)), the Federal medical assistance percentage shall be decreased as follows: After an individual has received inpatient hospital services or intermediate care facility services for 60 days, skilled nursing facility services for 30 days, or inpatient mental hospital services for 90 days (whether or not such days are consecutive), during any fiscal year, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual shall be decreased by a per centum thereof (determined under paragraph (5)) unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services, skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), such State has an effective program of medical review of the care of patients in mental hospitals, skilled nursing facilities, and intermediate care facilities pursuant to paragraphs (26) and (31) of section 1396a(a) of this title whereby the professional management of each case is reviewed and evaluated at least annually by independent professional

review teams. In determining the number of days on which an individual has received services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under section 1395d of this title.

[See main edition for text of (2) and (3)]

(4) *[See main edition for text of (A)]*

(B) The Secretary shall find a showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory under such paragraph with respect to the requirement that the State conduct annual onsite inspections in mental hospitals, skilled nursing facilities, and intermediate care facilities under paragraphs (26) and (31) of section 1396a(a) of this title, if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter—

(i) in each of not less than 98 per centum of the number of such hospitals and facilities requiring such inspection, and

(ii) in every such hospital or facility which has 200 or more beds,

and that, with respect to such hospitals and facilities not inspected within such period, the State has exercised good faith and due diligence in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only.

[See main edition for text of (5)]

(6)(A) Recertifications required under section 1396a(a)(44) of this title shall be conducted at least every 60 days in the case of inpatient hospital services.

(B) Such recertifications in the case of skilled nursing facility services shall be conducted at least—

(i) 30 days after the date of the initial certification,

(ii) 60 days after the date of the initial certification,

(iii) 90 days after the date of the initial certification, and

(iv) every 60 days thereafter.

(C) Such recertifications in the case of intermediate care facility services shall be conducted at least—

(i) 60 days after the date of the initial certification,

(ii) 180 days after the date of the initial certification,

(iii) 12 months after the date of the initial certification,

(iv) 18 months after the date of the initial certification,

(v) 24 months after the date of the initial certification, and

(vi) every 12 months thereafter.

(D) For purposes of determining compliance with the schedule established by this paragraph, a recertification shall be considered to have been done on a timely basis if it was per-

formed not later than 10 days after the date the recertification was otherwise required and the State establishes good cause why the physician or other person making such recertification did not meet such schedule.

(7) It is the duty and responsibility of the Secretary to assure that standards which govern the provision of care in skilled nursing facilities and intermediate care facilities under plans approved under this subchapter, and the enforcement of such standards, are adequate to protect the health and safety of residents and to promote the effective and efficient use of public moneys.

[See main edition for text of (h)]

(i) Payment for services performed after December 31, 1972; restrictions

Payment under the preceding provisions of this section shall not be made—

[See main edition for text of (1) to (5)]

(6) with respect to any amount expended for inpatient hospital tests (other than in emergency situations) not specifically ordered by the attending physician or other responsible practitioner; or

(7) with respect to any amount expended for clinical diagnostic laboratory tests performed by a physician, independent laboratory, or hospital, to the extent such amount exceeds the amount that would be recognized under section 1395(h) of this title for such tests performed for an individual enrolled under part B of subchapter XVIII of this chapter.

[See main edition for text of (f) to (i)]

(m) "Health maintenance organization" defined; duties and functions of Secretary; payments to States; provisional determination of status by State

[See main edition for text of (1)]

(2)(A) Except as provided in subparagraphs (B) and (C), no payment shall be made under this subchapter to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity which is responsible for the provision of inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1396d(a) of this title or for the provision of any three or more of the services described in such paragraphs unless—

[See main edition for text of (4) to (v)]

(vi) such contract (I) except as provided under subparagraph (F), permits individuals who have elected under the plan to enroll with the entity for provision of such benefits to terminate such enrollment without cause as of the beginning of the first calendar month following a full calendar month after the request is made for such termination, and (II) provides for notification of each such individual, at the time of the individual's enroll-

ment, of such right to terminate such enrollment; and

[See main edition for text of (vi)]

(B) Subparagraph (A) does not apply with respect to payments under this subchapter to a State with respect to expenditures incurred by it for payment for services provided by an entity which—

(i) received a grant of at least \$100,000 in the fiscal year ending June 30, 1976, under section 254b(d)(1)(A) or 254c(d)(1) of this title, and for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this subchapter has been the recipient of a grant under either such section; and

(ii) provides to its enrollees, on a prepaid capitation risk basis or on any other risk basis, all of the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1396d(a) of this title and, to the extent required by section 1396a(a)(13)(A)(ii) of this title to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1396d(a) of this title; or

[See main edition for text of (ii) and (iii)]

(C) Subparagraph (A)(ii) shall not apply with respect to payments under this subchapter to a State with respect to expenditures incurred by it for payment for services by an entity during the three-year period beginning on October 8, 1976, or beginning on the date the entity qualifies as a health maintenance organization (as determined by the Secretary), whichever occurs later, but only if the entity demonstrates to the satisfaction of the Secretary by the submission of plans for each year of such three-year period that it is making continuous efforts and progress toward achieving compliance with subparagraph (A)(ii).

[See main edition for text of (D)]

(E) In the case of a health maintenance organization that—

(i) is a nonprofit organization with at least 25,000 members,

(ii) is and has been a qualified health maintenance organization (as defined in section 300e-9(d) of this title) for a period of at least four years,

(iii) provides basic health services through members of the staff of the organization,

(iv) is located in an area designated as medically underserved under section 300e-1(7) of this title, and

(v) previously received a waiver of the requirement described in subparagraph (A)(ii) under section 1315 of this title,

the Secretary may modify or waive the requirement described in subparagraph (A)(ii) but only if the Secretary determines that special circumstances warrant such modification or waiver and that the organization has taken and is taking reasonable efforts to enroll individuals who are not entitled to benefits under the State plan approved under this subchapter or under subchapter XVIII of this chapter.

(F)(i) In the case of a contract with a health maintenance organization described in clause (ii), a State plan may restrict the period in which requests for termination of enrollment without cause under subparagraph (A)(vi)(i) are permitted to the first month of each period of enrollment, each such period of enrollment not to exceed six months in duration, but only if the State provides notification, at least twice per year, to individuals enrolled with such organization of the right to terminate such enrollment and the restriction on the exercise of this right. Such restriction shall not apply to requests for termination of enrollment for cause.

(ii) A health maintenance organization referred to in clause (i) is an organization which—

(I) is a qualified health maintenance organization (as defined in section 300e-9(d) of this title) or a health maintenance organization which is receiving (and has received during the previous two years) a grant of at least \$100,000 under section 254b(d)(1)(A) or 254c(d)(1) of this title or is receiving (and has received during the previous two years) at least \$100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965, and

(II) meets the requirement of subparagraph (A)(ii).

[See main edition for text of (3): (a) to (r)]

(a) Repealed. Pub. L. 97-35, title XXI, § 2161(c)(1), Aug. 13, 1981, 95 Stat. 805, as amended by Pub. L. 97-248, title I, § 137(a)(2), Sept. 3, 1982, 96 Stat. 876

(t) Repealed. Pub. L. 97-35, title XXI, § 2161(c)(2), Aug. 13, 1981, 95 Stat. 805, as amended by Pub. L. 97-248, title I, § 137(a)(2), Sept. 3, 1982, 96 Stat. 876

[See main edition for text of (u)]

(Aug. 14, 1935, ch. 531, title XIX, § 1903, as added July 30, 1965, Pub. L. 89-97, title I, § 121(a), 79 Stat. 349, and amended Jan. 2, 1968, Pub. L. 90-248, title II, §§ 220(a), 222(c), (d), 225(a), 229(c), 241(f)(5), 81 Stat. 898, 901, 902, 904, 917; June 28, 1968, Pub. L. 90-364, title III, § 303(a)(1), 82 Stat. 274; Aug. 9, 1969, Pub. L. 91-56, § 2(a), 83 Stat. 99; Oct. 30, 1972, Pub. L. 92-603, title II, §§ 207(a), 221(c)(6), 224(c), 225, 226(e), 229(c), 230, 233(c), 235(a), 237(a)(1), 249B, 278(b)(1), (5), (16), 290, 295, 299E(a), 86 Stat. 1379, 1380, 1389, 1395, 1396, 1404, 1410, 1411, 1414, 1415, 1453, 1454, 1457, 1459, 1462; July 9, 1973, Pub. L. 93-66, title II, § 234(a), 87 Stat. 160; Dec. 31, 1973, Pub. L. 93-233, §§ 13(a)(11), (12), 18(r)-(v), (x)(5), (6), (y)(1), 87 Stat. 963, 971-973; Dec. 31, 1975, Pub. L. 94-182, title I, §§ 110(a), 111(b), 89 Stat. 1054; Oct. 8, 1976, Pub. L. 94-460, title II, § 202(a), 90 Stat. 1957; Oct. 18, 1976, Pub. L. 94-552, § 1, 90 Stat. 2540; Aug. 1, 1977, Pub. L. 95-83, title I, § 105(a)(1), (2), 91 Stat. 384; Oct. 25, 1977, Pub. L. 95-142, §§ 3(c)(2), 8(c), 10(a), 11(a), 17(a)-(c), 20(a), 91 Stat. 1179, 1195, 1196, 1201, 1205; Nov. 1, 1978, Pub. L. 95-559, § 14(c), 92 Stat. 2141; Nov. 10, 1978, Pub. L. 95-626, title I, § 102(b)(3), 92 Stat. 3551; Oct. 4, 1979, Pub. L. 96-79, title I, § 128, 93 Stat. 629; Oct. 7, 1980, Pub. L. 96-398,

title IX, § 901, 94 Stat. 1609; Dec. 8, 1980, Pub. L. 96-499, title IX, §§ 905(b), (c), 961(a), 963, 964, 94 Stat. 2618, 2650, 2651; Aug. 13, 1981, Pub. L. 97-35, title XXI, §§ 2101(a)(2), 2103(b)(1), 2106(b)(3), 2113(n), 2161, 2163, 2164(a), 2174(b), 2178(a), 2183(a), 95 Stat. 786, 788, 792, 795, 803-806, 809, 813, 816; Sept. 3, 1982, Pub. L. 97-248, title I, §§ 133(a), 137(a)(1), (2), (b)(11)-(16), (27), (g), 146(b), 96 Stat. 373, 376, 378, 379, 381, 394; Jan. 12, 1983, Pub. L. 97-448, title III, § 309(b)(16), 96 Stat. 2409; July 18, 1984, Pub. L. 98-369, div. B, title III, §§ 2303(g)(2), 2363(a)(2), (4), (b), 2364, 2373(b)(11)-(14), 98 Stat. 1066, 1106, 1107, 1111, 1112; Nov. 8, 1984, Pub. L. 98-617, § 3(a)(6), 98 Stat. 3295.)

REFERENCES IN TEXT

Part A of subchapter IV of this chapter, referred to in subsecs. (a) and (f), is classified to section 601 et seq. of this title.

Part B of subchapter XVIII of this chapter, referred to in subsecs. (a), (b), (i), and (m), is classified to section 1395j et seq. of this title.

The Appalachian Regional Development Act of 1965, referred to in subsec. (m)(2)(B)(ii), (F)(ii), is Pub. L. 89-4, Mar. 9, 1965, 79 Stat. 8, as amended, which is set out in the Appendix to Title 40, Public Buildings, Property, and Works. For complete classification of this act to the Code, see Tables.

AMENDMENTS

1984—Subsec. (g)(1). Pub. L. 98-369, § 2363(a)(2)(A), (B), in provision preceding subpar. (A), substituted "inpatient hospital services or intermediate care facility services for 60 days, skilled nursing facility services for 30 days, or inpatient mental hospital services for" for "care as an inpatient in a hospital (including an institution for tuberculosis), skilled nursing facility or intermediate care facility on 60 days, or in a hospital for mental diseases on", and struck out "which for purposes of this section means the four calendar quarters ending with June 30" before "the Federal medical assistance percentage", and struck out "in the same fiscal year" before "shall be decreased by a percentage thereof".

Pub. L. 98-369, § 2363(a)(2)(C), substituted ", skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), such State has an effective program of medical review of the care of patients in mental hospitals, skilled nursing facilities, and intermediate care facilities pursuant to paragraphs (26) and (31) of section 1396a(a) of this title whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams" for "(including tuberculosis hospitals), skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), there is in operation in the State an effective program of control over utilization of such services, such a showing must include evidence that—" and former subpars. (A) through (D) requirement for evidence concerning an effective program of utilization of certain medical services.

Subsec. (g)(4)(B). Pub. L. 98-369, § 2373(b)(11), substituted "paragraphs (26)" for "paragraph (26)" and "diligence" for "deligence".

Subsec. (g)(6). Pub. L. 98-369, § 2363(a)(4), in amending par. (6) generally, substituted provisions relating to recertifications for provisions relating to reports to Congress concerning Secretary's determination and review of showing respecting any decrease of Federal medical assistance percentage of amounts paid for services.

Subsec. (g)(7). Pub. L. 98-369, § 2363(b), as amended by Pub. L. 98-617, § 3(a)(6), added par. (7).

Subsec. (ix)(7). Pub. L. 98-369, § 2303(g)(2), added par. (7).

Subsec. (m)(2)(A)(vi). Pub. L. 98-369, § 2364(1), added "except as provided under subparagraph (F)," after "(I)".

Subsec. (m)(2)(B)(ix)(1). Pub. L. 98-369, § 2373(b)(12)(A), (C), struck out "(II)" before "for the period" and substituted "period" for "peroid".

Subsec. (m)(2)(B)(ix)(11). Pub. L. 98-369, § 2373(b)(12)(B), substituted "of section 1396d(a) of this title" for "of such section".

Subsec. (m)(2)(C). Pub. L. 98-369, § 2373(b)(13), realigned margin of subpar. (C).

Subsec. (m)(2)(E), (F). Pub. L. 98-369, § 2364(2), added subpars. (E) and (F).

Subsec. (a)(3)(B). Pub. L. 98-369, § 2373(b)(14), substituted "non-Federal" for "nonfederal".

EFFECTIVE DATE OF 1984 AMENDMENTS

Amendment by Pub. L. 98-617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98-369, see section 3(c) of Pub. L. 98-617, set out as a note under section 1395f of this title.

Amendment by section 2303(g)(2) of Pub. L. 98-369 applicable to payments for calendar quarters beginning on or after Oct. 1, 1984, but not applicable to clinical diagnostic laboratory tests furnished to inpatients of a provider operating under a waiver granted pursuant to section 602(k) of Pub. L. 98-21, set out as a note under section 1395y of this title, see section 2303(j)(2) and (3) of Pub. L. 98-369, set out as a note under section 1395i of this title.

Section 2363(c) of Pub. L. 98-369 provided that: "The amendments made by subsection (a) [amending sections 1396a and 1396b of this title] apply to calendar quarters beginning on or after the date of the enactment of this Act [July 18, 1984], except that, in the case of individuals admitted to skilled nursing facilities before such date, the amendments made by such subsection shall not require recertifications sooner or more frequently than were required under the law in effect before such date."

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by section 137(a)(1), (2) of Pub. L. 97-248 effective as if originally included in the provision of the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97-35, to which such amendment relates, see section 137(d)(1) of Pub. L. 97-248, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Section 2161(c)(1) of Pub. L. 97-35, as amended by section 137(a)(2) of Pub. L. 97-248, provided in part that repeal of subsec. (a) is effective for calendar quarters beginning on or after Oct. 1, 1984.

Section 2161(c)(2) of Pub. L. 97-35, as amended by section 137(a)(2) of Pub. L. 97-248, provided in part that repeal of subsection (i) is effective after payments for the first quarter of fiscal year 1985.

§ 1394d. Definitions

For purposes of this subchapter—

(a) Medical assistance

The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 300e-17, 705, 1315, 1320a-7a, 1382i, 1395v, 1395cc, 1395tt, 1396b, 1396c, 1396d, 1396g, 1396i, 1396l, 1396n, 1396o, 4728, 6022, 6042 of this title.

§ 1306b. Payment to States

[See main edition for text of (a) to (f)]

(g) Decrease in Federal medical assistance percentage of amounts paid for services furnished under State plan after June 30, 1973

(1) Subject to paragraph (3), with respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1395mm of this title or which is a qualified health maintenance organization (as defined in section 300e-9(d) of this title)), the Federal medical assistance percentage shall be decreased as follows: After an individual has received inpatient hospital services or intermediate care facility services for 60 days, skilled nursing facility services for 30 days, or inpatient mental hospital services for 90 days (whether or not such days are consecutive), during any fiscal year, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual shall be decreased by a per centum thereof (determined under paragraph (5)) unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services, skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), such State has an effective program of medical review of the care of patients in mental hospitals, skilled nursing facilities, and intermediate care facilities pursuant to paragraphs (26) and (31) of section 1396a(a) of this title whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams. In determining the number of days on which an individual has received services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under section 1395d of this title.

[See main edition for text of (2) and (3)]

(4) *[See main edition for text of (4)]*

(B) The Secretary shall find a showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory under such paragraph with respect to the requirement that the State conduct annual onsite inspections in mental hospitals, skilled nursing facilities, and intermediate care facilities under paragraphs (26) and (31) of section 1396a(a) of this title, if the showing demonstrates that the State has conducted such an onsite inspection during the

12-month period ending on the last date of the calendar quarter—

(i) in each of not less than 98 per centum of the number of such hospitals and facilities requiring such inspection, and

(ii) in every such hospital or facility which has 200 or more beds,

and that, with respect to such hospitals and facilities not inspected within such period, the State has exercised good faith and due diligence in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only.

[See main edition for text of (5)]

(6)(A) Recertifications required under section 1396a(a)(44) of this title shall be conducted at least every 60 days in the case of inpatient hospital services.

(B) Such recertifications in the case of skilled nursing facility services shall be conducted at least—

(i) 30 days after the date of the initial certification,

(ii) 60 days after the date of the initial certification,

(iii) 90 days after the date of the initial certification, and

(iv) every 60 days thereafter.

(C) Such recertifications in the case of intermediate care facility services shall be conducted at least—

(i) 60 days after the date of the initial certification,

(ii) 180 days after the date of the initial certification,

(iii) 12 months after the date of the initial certification,

(iv) 18 months after the date of the initial certification,

(v) 24 months after the date of the initial certification, and

(vi) every 12 months thereafter.

(D) For purposes of determining compliance with the schedule established by this paragraph, a recertification shall be considered to have been done on a timely basis if it was performed not later than 10 days after the date the recertification was otherwise required and the State establishes good cause why the physician or other person making such recertification did not meet such schedule.

(7) It is the duty and responsibility of the Secretary to assure that standards which govern the provision of care in skilled nursing facilities and intermediate care facilities under plans approved under this subchapter, and the enforcement of such standards, are adequate to protect the health and safety of residents and to promote the effective and efficient use of public moneys.

[See main edition for text of (h)]

(i) Payment for services performed after December 31, 1972; restrictions

Payment under the preceding provisions of this section shall not be made—

[See main edition for text of (i) to (5)]

(6) with respect to any amount expended for inpatient hospital tests (other than in emergency situations) not specifically ordered by the attending physician or other responsible practitioner; or

(7) with respect to any amount expended for clinical diagnostic laboratory tests performed by a physician, independent laboratory, or hospital, to the extent such amount exceeds the amount that would be recognized under section 1395(h) of this title for such tests performed for an individual enrolled under part B of subchapter XVIII of this chapter.

[See main edition for text of (j) to (l)]

(m) "Health maintenance organization" defined; duties and functions of Secretary; payments to States; provisional determination of status by State

[See main edition for text of (1)]

(2)(A) Except as provided in subparagraphs (B) and (C), no payment shall be made under this subchapter to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity which is responsible for the provision of inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1396d(a) of this title or for the provision of any three or more of the services described in such paragraphs unless—

[See main edition for text of (i) to (v)]

(vi) such contract (I) except as provided under subparagraph (F), permits individuals who have elected under the plan to enroll with the entity for provision of such benefits to terminate such enrollment without cause as of the beginning of the first calendar month following a full calendar month after the request is made for such termination, and (II) provides for notification of each such individual, at the time of the individual's enrollment, of such right to terminate such enrollment; and

[See main edition for text of (vi)]

(B) Subparagraph (A) does not apply with respect to payments under this subchapter to a State with respect to expenditures incurred by it for payment for services provided by an entity which—

(i)(I) received a grant of at least \$100,000 in the fiscal year ending June 30, 1976, under section 254b(d)(1)(A) or 254c(d)(1) of this title, and for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this subchapter has been the recipient of a grant under either such section; and

(II) provides to its enrollees, on a prepaid capitation risk basis or on any other risk basis, all of the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1396d(a) of this title and, to the extent required by section 1396a(a)(13)(A)(ii) of this title to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1396d(a) of this title; or

[See main edition for text of (ii) and (iii)]

(C) Subparagraph (A)(ii) shall not apply with respect to payments under this subchapter to a State with respect to expenditures incurred by it for payment for services by an entity during the three-year period beginning on October 8, 1976, or beginning on the date the entity qualifies as a health maintenance organization (as determined by the Secretary), whichever occurs later, but only if the entity demonstrates to the satisfaction of the Secretary by the submission of plans for each year of such three-year period that it is making continuous efforts and progress toward achieving compliance with subparagraph (A)(ii).

[See main edition for text of (D)]

(E) In the case of a health maintenance organization that—

(i) is a nonprofit organization with at least 25,000 members,

(ii) is and has been a qualified health maintenance organization (as defined in section 300e-9(d) of this title) for a period of at least four years,

(iii) provides basic health services through members of the staff of the organization,

(iv) is located in an area designated as medically underserved under section 300e-1(7) of this title, and

(v) previously received a waiver of the requirement described in subparagraph (A)(ii) under section 1315 of this title,

the Secretary may modify or waive the requirement described in subparagraph (A)(ii) but only if the Secretary determines that special circumstances warrant such modification or waiver and that the organization has taken and is taking reasonable efforts to enroll individuals who are not entitled to benefits under the State plan approved under this subchapter or under subchapter XVIII of this chapter.

(F)(i) In the case of a contract with a health maintenance organization described in clause (ii), a State plan may restrict the period in which requests for termination of enrollment without cause under subparagraph (A)(vi)(I) are permitted to the first month of each period of enrollment, each such period of enrollment not to exceed six months in duration, but only if the State provides notification, at least twice per year, to individuals enrolled with such organization of the right to terminate such enrollment and the restriction on the exercise of this right. Such restriction shall not apply to requests for termination of enrollment for cause.

(ii) A health maintenance organization referred to in clause (i) is an organization which—

(I) is a qualified health maintenance organization (as defined in section 300e-9(d) of this title) or a health maintenance organization which is receiving (and has received during the previous two years) a grant of at least \$100,000 under section 254b(d)(1)(A) or 254c(d)(1) of this title or is receiving (and has received during the previous two years) at least \$100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965, and

(II) meets the requirement of subparagraph (A)(II).

[See main edition for text of (3); (n) to (r)]

(a) Repealed. Pub. L. 97-35, title XXI, § 2161(c)(1), Aug. 13, 1981, 95 Stat. 805, as amended by Pub. L. 97-248, title I, § 137(a)(2), Sept. 3, 1982, 96 Stat. 876

(i) Repealed. Pub. L. 97-35, title XXI, § 2161(c)(2), Aug. 13, 1981, 95 Stat. 805, as amended by Pub. L. 97-248, title I, § 137(a)(2), Sept. 3, 1982, 96 Stat. 876

[See main edition for text of (u)]

(Aug. 14, 1935, ch. 531, title XIX, § 1903, as added July 30, 1965, Pub. L. 89-97, title I, § 121(a), 79 Stat. 349, and amended Jan. 2, 1968, Pub. L. 90-248, title II, §§ 220(a), 222(c), (d), 225(a), 229(c), 241(f)(5), 81 Stat. 898, 901, 902, 904, 917; June 28, 1968, Pub. L. 90-364, title III, § 303(a)(1), 82 Stat. 274; Aug. 9, 1969, Pub. L. 91-56, § 2(a), 83 Stat. 99; Oct. 30, 1972, Pub. L. 92-603, title II, §§ 207(a), 221(c)(6), 224(c), 225, 226(e), 229(c), 230, 233(c), 235(a), 237(a)(1), 249B, 278(b)(1), (5), (16), 290, 295, 299E(a), 86 Stat. 1379, 1380, 1389, 1395, 1396, 1404, 1410, 1411, 1414, 1415, 1453, 1454, 1457, 1459, 1462; July 9, 1973, Pub. L. 93-66, title II, § 234(a), 87 Stat. 160; Dec. 31, 1973, Pub. L. 93-233, §§ 13(a)(1), (12), 18(r)-(v), (x)(5), (6), (y)(1), 87 Stat. 963, 971-973; Dec. 31, 1975, Pub. L. 94-182, title I, §§ 110(a), 111(b), 89 Stat. 1054; Oct. 8, 1976, Pub. L. 94-460, title II, § 202(a), 90 Stat. 1957; Oct. 18, 1976, Pub. L. 94-552, § 1, 90 Stat. 2540; Aug. 1, 1977, Pub. L. 95-83, title I, § 105(a)(1), (2), 91 Stat. 384; Oct. 25, 1977, Pub. L. 95-142, §§ 3(c)(2), 8(c), 10(a), 11(a), 17(a)-(c), 20(a), 91 Stat. 1179, 1195, 1196, 1201, 1205; Nov. 1, 1978, Pub. L. 95-559, § 14(c), 92 Stat. 2141; Nov. 10, 1978, Pub. L. 95-626, title I, § 102(b)(3), 92 Stat. 3551; Oct. 4, 1979, Pub. L. 96-79, title I, § 128, 93 Stat. 629; Oct. 7, 1980, Pub. L. 96-398, title IX, § 901, 94 Stat. 1609; Dec. 5, 1980, Pub. L. 96-499, title IX, §§ 905(b), (c), 961(a), 963, 964, 94 Stat. 2618, 2650, 2651; Aug. 13, 1981, Pub. L. 97-35, title XXI, §§ 2101(a)(2), 2103(b)(1), 2106(b)(3), 2113(n), 2161, 2163, 2164(a), 2174(b), 2178(a), 2183(a), 95 Stat. 786, 788, 792, 795, 803-806, 809, 813, 816; Sept. 3, 1982, Pub. L. 97-248, title I, §§ 133(a), 137(a)(1), (2), (b)(11)-(16), (27), (g), 146(b), 96 Stat. 373, 376, 378, 379, 381, 394; Jan. 12, 1983, Pub. L. 97-448, title III, § 309(b)(16), 96 Stat. 2409; July 18, 1984, Pub. L. 98-369, div. B, title III, §§ 2303(g)(2), 2363(a)(2), (4), (b), 2364, 2373(b)(11)-(14), 98 Stat. 1066, 1106, 1107, 1111, 1112; Nov. 8, 1984, Pub. L. 98-617, § 3(a)(6), 98 Stat. 3295.)

REFERENCES IN TEXT

Part A of subchapter IV of this chapter, referred to in subsecs. (a) and (f), is classified to section 601 et seq. of this title.

Part B of subchapter XVIII of this chapter, referred to in subsecs. (a), (b), (l), and (m), is classified to section 1395j et seq. of this title.

The Appalachian Regional Development Act of 1965, referred to in subsec. (m)(2)(B)(ii), (F)(ii), is Pub. L. 89-4, Mar. 9, 1965, 79 Stat. 8, as amended, which is set out in the Appendix to Title 40, Public Buildings, Property, and Works. For complete classification of this act to the Code, see Tables.

AMENDMENTS

1984—Subsec. (g)(1). Pub. L. 98-369, § 2363(a)(2)(A), (B), in provision preceding subpar. (A), substituted "inpatient hospital services or intermediate care facility services for 60 days, skilled nursing facility services for 30 days, or inpatient mental hospital services for" for "care as an inpatient in a hospital (including an institution for tuberculosis), skilled nursing facility or intermediate care facility on 60 days, or in a hospital for mental diseases on", and struck out "which for purposes of this section means the four calendar quarters ending with June 30," before "the Federal medical assistance percentage", and struck out "in the same fiscal year" before "shall be decreased by a per centum thereof".

Pub. L. 98-369, § 2363(a)(2)(C), substituted ", skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), such State has an effective program of medical review of the care of patients in mental hospitals, skilled nursing facilities, and intermediate care facilities pursuant to paragraphs (26) and (31) of section 1396a(a) of this title whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams" for "(including tuberculosis hospitals), skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), there is in operation in the State an effective program of control over utilization of such services; such a showing must include evidence that—" and former subpars. (A) through (D) requirement for evidence concerning an effective program of utilization of certain medical services.

Subsec. (g)(4)(B). Pub. L. 98-369, § 2373(b)(11), substituted "paragraphs (26)" for "paragraph (26)" and "diligence" for "deligence".

Subsec. (g)(6). Pub. L. 98-369, § 2363(a)(4), in amending par. (6) generally, substituted provisions relating to recertifications for provisions relating to reports to Congress concerning Secretary's determination and review of showing respecting any decrease of Federal medical assistance percentage of amounts paid for services.

Subsec. (g)(7). Pub. L. 98-369, § 2363(b), as amended by Pub. L. 98-617, § 3(a)(6), added par. (7).

Subsec. (l)(7). Pub. L. 98-369, § 2303(g)(3), added par. (7).

Subsec. (m)(2)(A)(vi). Pub. L. 98-369, § 2364(1), added "except as provided under subparagraph (F)," after "(I)".

Subsec. (m)(2)(B)(ix)(i). Pub. L. 98-369, § 2373(b)(12)(A), (C), struck out "(II)" before "for the period" and substituted "period" for "peroid".

Subsec. (m)(2)(B)(ix)(ii). Pub. L. 98-369, § 2373(b)(12)(B), substituted "of section 1396d(a) of this title" for "of such section".

Subsec. (m)(2)(C). Pub. L. 98-369, § 2373(b)(13), realigned margin of subpar. (C).

Subsec. (m)(2)(E), (F). Pub. L. 98-369, § 2364(2), added subpars. (E) and (F).

Subsec. (s)(3)(B). Pub. L. 98-369, § 2373(b)(14), substituted "non-Federal" for "nonfederal".

EFFECTIVE DATE OF 1984 AMENDMENTS

Amendment by Pub. L. 98-617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98-369, see section 3(c) of Pub. L. 98-617, set out as a note under section 1395f of this title.

Amendment by section 2303(g)(2) of Pub. L. 98-369 applicable to payments for calendar quarters beginning on or after Oct. 1, 1984, but not applicable to clinical diagnostic laboratory tests furnished to inpatients of a provider operating under a waiver granted pursuant to section 602(k) of Pub. L. 98-21, set out as a note under section 1395y of this title, see section 2303(j)(2) and (3) of Pub. L. 98-369, set out as a note under section 1395f of this title.

Section 2363(c) of Pub. L. 98-369 provided that: "The amendments made by subsection (a) (amending sections 1396a and 1396b of this title) apply to calendar quarters beginning on or after the date of the enactment of this Act (July 18, 1984), except that, in the case of individuals admitted to skilled nursing facilities before such date, the amendments made by such subsection shall not require recertifications sooner or more frequently than were required under the law in effect before such date."

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 137(a)(1), (2) of Pub. L. 97-248 effective as if originally included in the provision of the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97-35, to which such amendment relates, see section 137(d)(1) of Pub. L. 97-248, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Section 2161(c)(1) of Pub. L. 97-35, as amended by Pub. L. 97-248, title 1, § 137(a)(2), Sept. 3, 1982, 96 Stat. 376, provided in part that repeal of subsec. (a) is effective for calendar quarters beginning on or after Oct. 1, 1984.

Section 2161(c)(2) of Pub. L. 97-35, as amended by Pub. L. 97-248, title 1, § 137(a)(2), Sept. 3, 1982, 96 Stat. 376, provided in part that repeal of subsection (t) is effective after payments for the first quarter of fiscal year 1985.

§ 1396d. Definitions

For purposes of this subchapter—

(a) Medical assistance

The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, who are—

[See main edition for text of (i) to (viii)]

but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for mental diseases);

[See main edition for text of (2) and (3)]

(4)(A) skilled nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older; (B) effective July 1, 1969, such early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary; and (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;

[See main edition for text of (5) to (8)]

(9) clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician;

[See main edition for text of (10) to (13)]

(14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases;

(15) intermediate care facility services (other than such services in an institution for mental diseases) for individuals who are determined, in accordance with section 1396a(a)(31)(A) of this title, to be in need of such care;

[See main edition for text of (16)]

(17) services furnished by a nurse-midwife (as defined in subsection (m) of this section) which the nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider; and

[See main edition for text of (18)]

except as otherwise provided in paragraph (16), such term does not include—

[See main edition for text of (A)]

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under subchapter I, X, XIV, or XVI

Addendum 3

Part 447

42 CFR Ch. IV (10-1-86 Edition)

PART 447—PAYMENTS FOR SERVICES

Subpart A—Payments: General Provisions

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- 447.1 Purpose.
- 447.10 Prohibition against reassignment of provider claims.
- 447.15 Acceptance of State payment as payment in full.
- 447.25 Direct payments to certain recipients for physicians' or dentists' services.
- 447.30 Withholding the Federal share of payments to Medicaid providers to recover Medicare overpayments.
- 447.31 Withholding Medicare payments to recover Medicaid overpayments.
- 447.35 Limits on FFP for capital expenditures.
- 447.40 Payments for reserving beds in institutions.
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COST SHARING

- 447.50 Cost sharing: Basis and purpose.

ENROLLMENT FEE, PREMIUM OR SIMILAR COST SHARING CHARGE

- 447.51 Requirements and options.
- 447.52 Minimum and maximum income-related charges.

DEDUCTIBLE, COINSURANCE, CO-PAYMENT OR SIMILAR COST-SHARING CHARGE

- 447.53 Applicability, specifications; multiple charges.
- 447.54 Maximum allowable charges.
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- 447.56 Income-related charges.
- 447.57 Restrictions on payments to providers.
- 447.58 Payments to prepaid capitation organizations.

FEDERAL FINANCIAL PARTICIPATION

- 447.59 FFP: Conditions relating to cost-sharing.

Subpart B—Payment Methods: General Provisions

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AUTHORITY: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

SOURCE: 43 FR 45253, Sept. 29, 1978, unless otherwise noted.

Subpart A—Payments: General Provisions

§ 447.1 Purpose.

This subpart prescribes State plan requirements, FFP limitations and procedures concerning payments made by State Medicaid agencies for Medicaid services.

§ 447.10 Prohibition against reassignment of provider claims.

(a) *Basis and purpose.* This section implements section 1902(a)(32) of the Act which prohibits State payments for Medicaid services to anyone other than a provider or recipient, except in specified circumstances; and implements, in part, section 1902(a)(43) concerning payments to physicians for laboratory services (see also § 447.342).

(b) *Definitions.* For purposes of this section:

"Facility" means an institution that furnishes health care services to inpatients.

"Factor" means an individual or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold or transferred to the individual organization for an added fee or a deduction of a portion of the accounts receivable. Factor does not include a business representative as described in paragraph (f) of this section.

"Organized health care delivery system" means a public or private organization for delivering health services. It includes, but is not limited to, a clinic, a group practice prepaid capitation plan, and a health maintenance organization.

(c) *State plan requirements.* A State plan must provide that the requirements of paragraphs (d) through (h) of this section are met.

(d) *Who may receive payment.* Payment may be made only—

- (1) To the provider; or
- (2) To the recipient if he is a non-cash recipient eligible to receive the payment under § 447.25; or
- (3) In accordance with paragraphs (e), (f), and (g) of this section.

(e) *Reassignments.* Payment may be made in accordance with a reassign-

ment from the provider to a government agency or reassignment by a court order.

(f) *Business agents.* Payment may be made to a business agent, such as a billing service or an accounting firm, that furnishes statements and receives payments in the name of the provider, if the agent's compensation for this service is—

(1) Related to the cost of processing the billing;

(2) Not related on a percentage or other basis to the amount that is billed or collected; and

(3) Not dependent upon the collection of the payment.

(g) *Individual practitioners.* Payment may be made to—

(1) A physician who bills for outside laboratory services that the physician orders and pays for, but that he or she did not personally perform or supervise, or which were not performed or supervised by another physician with whom he or she shares a practice.

(2) The employer of the practitioner, if the practitioner is required as a condition of employment to turn over his fees to the employer;

(3) The facility in which the service is provided, if the practitioner has a contract under which the facility submits the claim; or

(4) A foundation, plan, or similar organization operating an organized health care delivery system, if the practitioner has a contract under which the organization submits the claim.

(h) *Prohibition of payment to factors.* Payment for any service furnished to a recipient by a provider may not be made to or through a factor, either directly or by power of attorney.

[43 FR 45253, Sept. 29, 1978, as amended at 46 FR 42672, Aug. 24, 1981]

§ 447.15 Acceptance of State payment as payment in full.

A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid

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by the individual. However, the provider may not deny services to any eligible individual on account of the individual's inability to pay the cost sharing amount imposed by the plan in accordance with § 431.55(g) or § 447.53. The previous sentence does not apply to an individual who is able to pay. An individual's inability to pay does not eliminate his or her liability for the cost sharing charge.

[50 FR 23012, May 30, 1985]

§ 447.25 Direct payments to certain recipients for physicians' or dentists' services.

(a) *Basis and purpose.* This section implements section 1905(a) of the Act by prescribing requirements applicable to States making direct payments to certain recipients for physicians' or dentists' services.

(b) *State plan requirements.* Except for groups specified in paragraph (c) of this section, a State may make direct payments to recipients for physicians' or dentists' services. If it does so, the State plan must—

- (1) Provide for direct payments; and
- (2) Specify the conditions under which payments are made.

(c) *Federal financial participation.* No FFP is available in expenditures for direct payment for physicians' or dentists' services to any recipient—

(1) Who is receiving assistance under the State's approved plan under title I, IV-A, X, XIV or XVI (AABD) of the Act; or

(2) To whom supplemental security benefits are being paid under title XVI of the Act; or

(3) Who is receiving or eligible for a State supplementary payment or would be eligible if he were not in a medical institution, and who is eligible for Medicaid as a categorically needy recipient.

(d) *Federal requirements.* (1) Direct payments to recipients under this section are an alternative to payments directly to providers and are subject to the same conditions; for example, the State's reasonable charge schedules are applicable.

(2) Direct payments must be supported by providers' bills for services.

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§ 447.30 Withholding the Federal share of payments to Medicaid providers to recover Medicare overpayments.

(a) *Basis and purpose.* This section implements section 1914 of the Act, which provides for withholding the Federal share of Medicaid payments to a provider if the provider has not arranged to repay Medicare overpayments or has failed to provide information to determine the amount of the overpayments. The intent of the statute and regulations is to facilitate the recovery of Medicare overpayments. The provision enables recovery of overpayments when institutions have reduced participation in Medicare or when physicians and suppliers have submitted few or no claims under Medicare, thus not receiving enough in Medicare reimbursement to permit offset of the overpayment.

(b) *When withholding occurs.* The Federal share of Medicaid payments may be withheld from any provider specified in paragraph (c) of this section to recover Medicare overpayments that HCFA has been unable to collect if the provider participates in Medicaid and—

(1) The provider has not made arrangements satisfactory to HCFA to repay the Medicare overpayment; or

(2) HCFA has been unable to collect information from the provider to determine the existence or amount of Medicare overpayment.

(c) The Federal share of Medicaid payments may be withheld with respect to the following providers:

(1) An institutional provider that has or previously had in effect a Medicare provider agreement under section 1866 of the Act; and

(2) A Medicaid provider who has previously accepted Medicare payment on the basis of an assignment under section 1842(b)(3)(B)(ii) of the Act; and during the 12 month period preceding the quarter in which the Federal share is to be withheld for a Medicare overpayment, submitted no claims under Medicare or submitted claims which total less than the amount of overpayment.

(d) *Order to reduce State payment.*

(1) HCFA may, at its discretion, issue an order to the Medicaid agency

of any State that is using the provider's services, to reduce its payment to the provider by the amount specified in paragraph (f) of this section.

(2) The order to reduce payment to the provider will remain in effect until—

(i) The Medicaid agency determines that the overpayment has been completely recovered; or

(ii) HCFA terminates the order.

(3) HCFA may withhold FFP from any State that does not comply with the order specified in paragraph (d)(1) of this section to reduce payment to the provider and claims FFP for the expenditure on its quarterly expenditure report.

(e) *Notice of withholding.* (1) Before the Federal share of payments may be withheld under this section, HCFA will notify the provider and the Medicaid agency of each State that HCFA believes may use the overpaid provider's services under Medicaid.

(2) The notice will include the instruction to reduce State payments, as provided under paragraph (d) of this section.

(3) HCFA will send the notice referred to in paragraph (e)(1) by certified mail, return receipt requested.

(4) Each Medicaid agency must identify the amount of payment due the provider under Medicaid and give that information to HCFA in the next quarterly expenditure report.

(5) The Medicaid agency may appeal any disallowance of FFP resulting from the withholding decision to the Grant Appeals Board, in accordance with 45 CFR Part 16.

(f) *Amount to be withheld.* HCFA may require the Medicaid agency to reduce the Federal share of its payment to the provider by the lesser of the following amounts.

(1) The Federal matching share of payments to the provider, or

(2) The total Medicare overpayment to the provider.

(g) *Effective date of withholding.* Withholding of payment will become effective no less than 60 days after the day on which the agency receives notice of withholding.

(h) *Duration of withholding.* No Federal funds are available in expenditures for services that are furnished

by a provider specified in paragraph (c) of this section from the date on which the withholding becomes effective until the termination of withholding under paragraph (i) of this section.

(i) *Termination of withholding.*

(1) HCFA will terminate the order to reduce State payment if it determines that any of the following has occurred:

(i) The Medicare overpayment is completely recovered;

(ii) The institution or person makes an agreement satisfactory to HCFA to repay the overpayment; or

(iii) HCFA determines that there is no overpayment based on newly acquired evidence or a subsequent audit.

(2) HCFA will notify each State that previously received a notice ordering the withholding that the withholding has been terminated.

(j) *Procedures for restoring excess withholding.* If an amount ultimately determined to be in excess of the Medicare overpayment is withheld, HCFA will restore any excess funds withheld.

(k) *Recovery of funds from Medicaid agency.* A provider is not entitled to recover from the Medicaid agency the amount of payment withheld by the agency in accordance with a HCFA order issued under paragraph (d) of this section.

[50 FR 19688, May 10, 1985; 50 FR 22307, June 3, 1985]

§ 447.31 Withholding Medicare payments to recover Medicaid overpayments.

(a) *Basis and purpose.* Section 1885 of the Act provides authority for HCFA to withhold Medicare payments to a Medicaid provider in order to recover Medicaid overpayments to the provider. Section 405.375 of this chapter sets forth the Medicare rules implementing section 1885, and specifies under what circumstances withholding will occur and the providers that are subject to withholding. This section establishes the procedures that the Medicaid agency must follow when requesting that HCFA withhold Medicare payments.

(b) *Agency notice to provider.* (1) Before the agency requests recovery of a Medicaid overpayment through Medicare, the agency must send either

or both of the following notices, in addition to that required under paragraph (b)(2) of this section, to the provider.

(i) Notice that—

- (A) There has been an overpayment;
- (B) Repayment is required; and
- (C) The overpayment determination is subject to agency appeal procedures, but we may withhold Medicare payments while an appeal is in progress.

(ii) Notice that—

- (A) Information is needed to determine the amount of overpayment if any; and
- (B) The provider has at least 30 days in which to supply the information to the agency.

(2) Notice that, 30 days or later from the date of the notice, the agency intends to refer the case to HCFA for withholding of Medicare payments.

(3) The agency must send all notices to providers by certified mail, return receipt requested.

(c) *Documentation to be submitted to HCFA.* The agency must submit the following information or documentation to HCFA (unless otherwise specified) with the request for withholding of Medicare payments.

(1) A statement of the reason that withholding is requested.

(2) The amount of overpayment, type of overpayment, date the overpayment was determined, and the closing date of the pertinent cost reporting period (if applicable).

(3) The quarter in which the overpayment was reported on the quarterly expenditure report (Form HCFA 64).

(4) As needed, and upon request from HCFA, the names and addresses of the provider's officers and owners for each period that there is an outstanding overpayment.

(5) A statement of assurance that the State agency has met the notice requirements under paragraph (b) of this section.

(6) As needed, and upon request for HCFA, copies of notices (under paragraph (b) of this section), and reports of contact or attempted contact with the provider concerning the overpayment, including any reduction or suspension of Medicaid payments made with respect to that overpayment.

(7) A copy of the provider's agreement with the agency under § 431.107 of this chapter.

(d) *Notification to terminate withholding.* (1) If an agency has requested withholding under this section, it must notify HCFA if any of the following occurs:

(i) The Medicaid provider makes an agreement satisfactory to the agency to repay the overpayment;

(ii) The Medicaid overpayment is completely recovered; or

(iii) The agency determines that there is no overpayment, based on newly acquired evidence or subsequent audit.

(2) Upon receipt of notification from the State agency, HCFA will terminate withholding.

(e) *Accounting for returned overpayment.* The agency must treat as a recovered overpayment the amounts received from HCFA to offset Medicaid overpayments.

(f) *Procedures for restoring excess withholding.* The agency must establish procedures satisfactory to HCFA to assure the return to the provider of amounts withheld under this section that are ultimately determined to be in excess of overpayments. Those procedures are subject to HCFA review.

[50 FR 19689, May 10, 1985]

§ 447.35 Limits on FFP for capital expenditures.

(a) *Basis and purpose.* (1) Section 1122 of the Act provides for exclusion from FFP of expenses related to certain capital expenditures. The cost containment and quality control regulations of the Public Health Service (Part 100 of this title) concern agreements between the Secretary and the States under section 1122, procedures for reviewing proposed capital expenditures, and determinations by the Secretary as to allowability of expenses related to capital expenditures.

(2) This section identifies categories of expenses for which FFP is not available under Medicaid if a State has an agreement under section 1122 and the Secretary has determined under section 1122 and Part 100 that the expenses are not allowable.

(b) *FFP limits.* Except as provided in § 100.108(b) of this title, no FFP is available in expenses related to a capital expenditure if the Secretary determines that—

(1) The State designated planning agency had not been given timely written notice of a capital expenditure in accordance with § 100.106 of this title; or

(2) The planning agency has, under section 1122 and Part 100 of this title, submitted to the Secretary its finding that the proposed expenditure is not consistent with the standards, criteria or plans described in § 100.104(a)(2) of this title.

(c) *Expenses related to a capital expenditure.* Expenses related to a capital expenditure include the following, regardless of the manner in which the expenses are recorded in the provider's records and cost report:

- (1) Depreciation.
- (2) Interest on borrowed funds.
- (3) A return on equity capital (in the case of proprietary facilities).
- (4) Other costs of activities that are essential to the acquisition, improvement, modernization, expansion, or replacement of the plant, buildings, and equipment with respect to which the expenditure is made, including, but not limited to—
 - (i) Studies, surveys, designs, plans, working drawings, and specifications;
 - (ii) Transportation;
 - (iii) Installation and start-up expenses;
 - (iv) In-transit insurance;
 - (v) Costs of grading and paving;
 - (vi) Taxes assessed during the construction period;
 - (vii) Costs of demolishing or razing structures on land;
 - (viii) Title fees;
 - (ix) Permit and license fees;
 - (x) Broker commissions;
 - (xi) Architectural, legal, accounting, and appraisal fees; and
 - (xii) Interest, finance, or carrying charges on bonds, notes, and other costs incurred for borrowing funds.

(d) *FFP for costs of conformity determination.* FFP is available in expenditures for reasonable costs incurred by a provider to determine whether a proposed capital expenditure is in conformity with applicable standards, cri-

teria, or plans for adequate health care resources in the area. However, no FFP is available if the provider makes the capital expenditure without the approval required by Part 100 of this title.

(e) *Exclusion of expenses related to capital expenditures: Payment on a reasonable cost or cost-related basis.* If payment is made on a reasonable cost or cost-related basis, expenses related to capital expenditures that are not available for FFP must be specifically excluded from allowable cost computations.

(f) *Exclusion of expenses related to capital expenditures: Payment on other than a reasonable cost or cost-related basis.* If payment is made on a per capita, fixed fee, negotiated rate, or any other basis (other than reasonable cost or cost-related), expenses related to capital expenditures that are not available for FFP must be excluded from the payment rate as follows:

(1) For a facility that participates in the Medicare program, the State shall—

(i) Compute the percentage difference between the Medicare allowable costs before and after the deduction of unallowed expenses; and

(ii) Reduce the Medicaid payment rate to the facility by that percentage.

(2) For a facility that does not participate in the Medicare program, the State must reduce the payment rate by an estimated amount. The estimate is based upon a comparative analysis of the facility's expenses related to capital expenditures as reflected in the facility's periodic financial statements. For example, the State may compute the percentage difference between the facility's expenses related to capital expenditures as recorded in its financial statements and those expenses less the amounts for which FFP is not available, and reduce the payment rate by that percentage.

(g) *Equivalent deduction if a facility is obtained by a lease.* If a person obtained by lease or comparable arrangement any facility, part of a facility, or equipment for a facility that would have been considered a capital expenditure if the person had purchased it—

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(1) In determining payments for services furnished in that facility, an amount must be deducted from rental expense which is a reasonable equivalent of the amount that would have been excluded if the person had purchased the facility or equipment; and

(2) In computing the person's return on equity capital, any amount deposited under the terms of the lease or comparable arrangement must be deducted from that return.

(h) *Capital assets acquired by donation or exchange.* If a person acquired by donation or exchange any facility, part of a facility, or equipment for a facility that would have been considered a capital expenditure if the person had purchased it, the acquisition is treated as a capital expenditure for purposes of excluding expenses related to capital expenditures.

(i) *Reconsideration of FFP determination.* (1) Any person or State adversely affected by a determination by the Secretary under section 1122 of the Act, this subpart or Part 100 of this title may, within 6 months of the date of the determination, request the Secretary to reconsider the determination. A determination by the Secretary under section 1122 of the Act is not subject to administrative or judicial review.

(2) A State is also entitled upon request to receive a reconsideration of a disallowance under this subpart, in accordance with section 1116(d) of the Act and 45 CFR Part 16.

§ 447.40 Payments for reserving beds in institutions.

(a) The Medicaid agency may make payments to reserve a bed during a recipient's temporary absence from an inpatient facility, if—

(1) The State plan provides for such payments and specifies any limitations on the policy; and

(2) Absences for purposes other than required hospitalization (which cannot be anticipated and planned) are included in the patient's plan of care.

(b) An agency that pays for reserved beds in an inpatient facility may pay less for a reserved bed than an occupied bed if there is a cost differential between the two beds. (Section 1102 of the Act.)

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(43 FR 48253, Sept. 29, 1978, as amended at 51 FR 24491, July 3, 1986)

§ 447.45 Timely claims payment.

(a) *Basis and purpose.* This section implements section 1902(a)(37) of the Act by specifying—

(1) State plan requirements for—

(i) Timely processing of claims for payment;

(ii) Prepayment and postpayment claims reviews; and

(2) Conditions under which the Administrator may grant waivers of the time requirements.

(b) *Definitions.* "Claim" means (1) a bill for services, (2) a line item of service, or (3) all services for one recipient within a bill.

"Clean claim" means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

A "shared health facility" means any arrangement in which—

(1) Two or more health care practitioners practice their professions at a common physical location;

(2) The practitioners share common waiting areas, examining rooms, treatment rooms, or other space, the services of supporting staff, or equipment;

(3) The practitioners have a person (who may himself be a practitioner)—

(i) Who is in charge of, controls, manages, or supervises substantial aspects of the arrangement or operation for the delivery of health or medical services at the common physical location other than the direct furnishing of professional health care services by the practitioners to their patients; or

(ii) Who makes available to the practitioners the services of supporting staff who are not employees of the practitioners; and

(iii) Who is compensated in whole or in part, for the use of the common physical location or related support services, on a basis related to amounts charged or collected for the services rendered or ordered at the location or on any basis clearly unrelated to the

value of the services provided by the person; and

(4) At least one of the practitioners received payments on a fee-for-service basis under titles V, XVIII, and XIX in an amount exceeding \$5,000 for any one month during the preceding 12 months or in an aggregate amount exceeding \$40,000 during the preceding 12 months.

The term does not include a provider of services (as specified in §489.2(b) of this chapter), a health maintenance organization (as defined in section 1301(a) of the Public Health Service Act), a hospital cooperative shared services organization meeting the requirements of section 501(c) of the Internal Revenue Code of 1954, or any public entity.

"Third party" is defined in § 433.135 of this chapter.

(c) *State plan requirements.* A State plan must (1) provide that the requirements of paragraphs (d), (e)(2), (f) and (g) of this section are met; and

(2) Specify the definition of a claim, as provided in paragraph (b) of this section, to be used in meeting the requirements for timely claims payment. The definition may vary by type of service (e.g., physician service, hospital service).

(d) *Timely processing of claims.* (1) The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service.

(2) The agency must pay 90 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt.

(3) The agency must pay 90 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 90 days of the date of receipt.

(4) The agency must pay all other claims within 12 months of the date of receipt, except in the following circumstances:

(i) This time limitation does not apply to retroactive adjustments paid to providers who are reimbursed under a retrospective payment system, as defined in § 447.272 of this part.

(ii) If a claim for payment under Medicare has been filed in a timely manner, the agency may pay a Medicaid claim relating to the same services within 6 months after the agency or the provider receives notice of the disposition of the Medicare claim.

(iii) The time limitation does not apply to claims from providers under investigation for fraud or abuse.

(iv) The agency may make payments at any time in accordance with a court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.

(5) The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim.

(6) The date of payment is the date of the check or other form of payment.

(e) *Waivers.* (1) The Administrator may waive the requirements of paragraphs (d) (2) and (3) of this section upon request by an agency if he finds that the agency has shown good faith in trying to meet them. In deciding whether the agency has shown good faith, the Administrator will consider whether the agency has received an unusually high volume of claims which are not clean claims, and whether the agency is making diligent efforts to implement an automated claims processing and information retrieval system.

(2) The agency's request for a waiver must contain a written plan of correction specifying all steps it will take to meet the requirements of this section.

(3) The Administrator will review each case and if he approves a waiver, will specify its expiration date, based on the State's capability and efforts to meet the requirements of this section.

(f) *Prepayment and postpayment claims review.* (1) For all claims, the agency must conduct prepayment claims review consisting of—

(i) Verification that the recipient was included in the eligibility file and that the provider was authorized to furnish the service at the time the service was furnished;

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(ii) Checks that the number of visits and services delivered are logically consistent with the recipient's characteristics and circumstances, such as type of illness, age, sex, service location.

(iii) Verification that the claim does not duplicate or conflict with one reviewed previously or currently being reviewed;

(iv) Verification that a payment does not exceed any reimbursement rates or limits in the State plan; and

(v) Checks for third party liability within the requirements of § 433.135 of this chapter.

(2) The agency must conduct post-payment claims review that meets the requirements of Parts 455 and 456 of this chapter, dealing with fraud and utilization control.

(g) *Reports.* The agency must provide any reports and documentation on compliance with this section that the Administrator may require.

(Secs. 1102 and 1902(a)(37) of the Social Security Act (42 U.S.C. 1302, 1396a(a)(37)))

[44 FR 30344, May 25, 1979]

COST SHARING

§ 447.50 Cost sharing: Basis and purpose.

(a) Section 1902(a)(14) of the Act permits States to require certain recipients to share some of the costs of Medicaid by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges. For States that impose cost sharing payments, §§ 447.51–447.59 prescribe State plan requirements and options for cost sharing, specify the standards and conditions under which States may impose cost sharing, set forth minimum amounts and the methods for determining maximum amounts, and prescribe conditions for FFP that relate to cost sharing requirements.

ENROLLMENT FEE, PREMIUM OR SIMILAR COST SHARING CHARGE

§ 447.51 Requirements and options.

(a) The plan must provide that the Medicaid agency does not impose any enrollment fee, premium, or similar charge upon categorically needy individuals, as defined in §§ 435.4 and

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436.3 of this subchapter, for any services available under the plan.

(b) The plan may impose an enrollment fee, premium, or similar charge on medically needy individuals, as defined in §§ 435.4 and 436.3 of this subchapter, for any services available under the plan.

(c) For each charge imposed under paragraph (b) of this section, the plan must specify—

(1) The amount of the charge;

(2) The period of liability for the charge; and

(3) The consequences for an individual who does not pay.

(d) The plan must provide that any charge imposed under paragraph (b) of this section is related to total gross family income as set forth under § 447.52.

§ 447.52 Minimum and maximum income-related charges.

For the purpose of relating the amount of an enrollment fee, premium, or similar charge to total gross family income, as required under § 447.51(d), the following rules apply:

(a) *Minimum charge.* A charge of at least \$1.00 per month is imposed on each—

(1) One- or two-person family with monthly gross income of \$150 or less;

(2) Three- or four-person family with monthly gross income of \$300 or less; and

(3) Five- or more-person family with monthly gross income of \$350 or less.

(b) *Maximum charge.* Any charge related to gross family income that is above the minimum listed in paragraph (a) of this section may not exceed the standards shown in the following table:

MAXIMUM MONTHLY CHARGE

| Gross family income (per month) | Family size | | |
|---------------------------------|-------------|--------|-----------|
| | 1 or 2 | 3 or 4 | 5 or more |
| \$150 or less | \$1 | \$1 | \$1 |
| \$151 to \$200 | 2 | 1 | 1 |
| \$201 to \$250 | 3 | 1 | 1 |
| \$251 to \$300 | 4 | 1 | 1 |
| \$301 to \$350 | 5 | 2 | 1 |
| \$351 to \$400 | 6 | 3 | 2 |
| \$401 to \$450 | 7 | 4 | 3 |
| \$451 to \$500 | 8 | 5 | 4 |
| \$501 to \$550 | 9 | 6 | 5 |

MAXIMUM MONTHLY CHARGE—Continued

| Gross family income (per month) | Family size | | |
|---------------------------------|-------------|--------|-----------|
| | 1 or 2 | 3 or 4 | 5 or more |
| \$651 to \$800 | 10 | 7 | 8 |
| \$801 to \$850 | 11 | 8 | 7 |
| \$851 to \$700 | 12 | 9 | 8 |
| \$701 to \$750 | 13 | 10 | 9 |
| \$751 to \$800 | 14 | 11 | 10 |
| \$801 to \$850 | 15 | 12 | 11 |
| \$851 to \$900 | 16 | 13 | 12 |
| \$901 to \$950 | 17 | 14 | 13 |
| \$951 to \$1,000 | 18 | 15 | 14 |
| More than \$1,000 | 19 | 16 | 15 |

(c) *Income-related charges.* The agency must impose an appropriately higher charge for each higher level of family income, within the maximum amounts specified in paragraph (b) of this section.

(43 FR 45253, Sept. 29, 1978, as amended at 45 FR 24889, Apr. 11, 1980)

DEDUCTIBLE, COINSURANCE, CO-PAYMENT OR SIMILAR COST-SHARING CHARGE

§ 447.53 Applicability; specification; multiple charges.

(a) *Basic requirements.* Except as specified in paragraph (b) of this section, the plan may impose a nominal deductible, coinsurance, copayment, or similar charge upon categorically and medically needy individuals for any service under the plan.

(b) *Exclusions from cost sharing.* Effective October 1, 1982, the plan may not provide for imposition of a deductible, coinsurance, copayment, or similar charge upon categorically or medically needy individuals (except as specified in paragraph (b)(6) of this section) for the following:

(1) *Children.* Services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over but under 21) are excluded from cost sharing.

(2) *Pregnant women.* Services furnished to pregnant women if such services relate to the pregnancy, or to any other medical condition which may complicate the pregnancy are excluded from cost sharing obligations. These services include routine prenatal care, labor and delivery, routine

post-partum care, and complications of pregnancy or delivery likely to affect the pregnancy, such as hypertension, diabetes, urinary tract infection, and services furnished during the postpartum period for conditions or complications related to the pregnancy. The postpartum period is the immediate postpartum period not to exceed six weeks. States may further exclude from cost sharing all services furnished to pregnant women if they desire.

(3) *Institutionalized individuals.* Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution if the individual is required (pursuant to § 435.725, § 435.733, § 435.832, or § 436.832), as a condition of receiving services in the institution, to spend all but a minimal amount of his income required for personal needs, for medical care costs are excluded from cost sharing.

(4) *Emergency services.* Services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in—

(i) Placing the patient's health in serious jeopardy;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part.

(5) *Family planning.* Family planning services and supplies furnished to individuals of child-bearing age are excluded from cost sharing.

(6) *HMO Enrollees.* Services furnished by a health maintenance organization (HMO) to categorically needy individuals enrolled in the HMO are excluded from cost sharing. States may further exclude copayment charges for HMO services furnished to medically needy individuals.

(c) *Prohibition against multiple charges.* For any service, the plan may not impose more than one type of charge referred to in paragraph (a) of this section.

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(d) *State plan specifications.* For each charge imposed under this section, the plan must specify—

- (1) The service for which the charge is made;
- (2) The amount of the charge;
- (3) The basis for determining the charge;
- (4) The basis for determining whether an individual is unable to pay the charge and the means by which such an individual will be identified to providers; and
- (5) The procedures for implementing and enforcing the exclusions from cost sharing found in paragraph (b) of this section.

[43 FR 45253, Sept. 29, 1978, as amended at 47 FR 21051, May 17, 1982, 48 FR 5736, Jan. 8, 1983, 50 FR 23013, May 30, 1985]

§ 447.54 Maximum allowable charges.

(a) *Non-institutional services.* Except as specified in paragraph (b), for non-institutional services, the plan must provide that—

- (1) Any deductible it imposes does not exceed \$2.00 per month per family for each period of Medicaid eligibility. For example, if Medicaid eligibility is certified for a 3-month period, the maximum deductible which may be imposed on a family for that period of eligibility is \$6.00;
- (2) Any coinsurance rate it imposes does not exceed 5 percent of the payment the agency makes for the services; and
- (3) Any co-payments it imposes do not exceed the amounts shown in the following table:

| State payment for the service | Maximum copayment chargeable to recipient |
|-------------------------------|---|
| \$10 or less | \$0.50 |
| \$10.01 to \$25 | 1.00 |
| \$25.01 to \$50 | 2.00 |
| \$50.01 or more | 3.00 |

(b) *Waiver of the requirement that cost sharing amounts be nominal.* Upon approval from HCFA, the requirement that cost sharing charges

must be nominal may be waived, in accordance with section 431.55(g) for nonemergency services furnished in a hospital emergency room.

(c) *Institutional services.* For institutional services, the plan must provide that the maximum deductible, coinsurance or co-payment charge for each admission does not exceed 50 percent of the payment the agency makes for the first day of care in the institution.

(d) *Cumulative maximum.* The plan may provide for a cumulative maximum amount for all deductible, coinsurance or co-payment charges that it imposes on any family during a specified period of time.

[48 FR 5736, Jan. 8, 1983]

§ 447.55 Standard co-payment.

(a) The plan may provide for a standard, or fixed, co-payment amount for any service.

(b) This standard copayment amount for any service may be determined by applying the maximum copayment amounts specified in § 447.54 (a) and (b) to the agency's average or typical payment for that service. For example, if the agency's typical payment for prescribed drugs is \$4 to \$5 per prescription, the agency might set a standard copayment of \$0.50 per prescription.

§ 447.56 Income-related charges.

Subject to the maximum allowable charges specified in § 447.54 (a) and (b), the plan may provide for income-related deductible, coinsurance or co-payment charges. For example, an agency may impose a higher charge on medically needy recipients than it imposes upon categorically needy recipients.

§ 447.57 Restrictions on payments to providers.

(a) The plan must provide that the agency does not increase the payment it makes to any provider to offset uncollected amounts for deductibles, coinsurance, copayments or similar charges that the provider has waived or are uncollectable, except as permitted under paragraph (b) of this section.

(b) For those providers that the agency reimburses under Medicare reasonable cost reimbursement principles, in accordance with Subpart B of this part, an agency may increase its payment to offset uncollected deductible, coinsurance, copayment, or similar charges that are bad debts of providers.

§ 447.58 Payments to prepaid capitation organizations.

Except for HMO services subject to the co-payment exclusion in § 447.53(b)(6), if the agency contracts with a prepaid capitation organization that does not impose the agency's deductibles, coinsurance, co-payments or similar charges on its recipient members, the plan must provide that the agency calculates its payments to the organization as if those cost sharing charges were collected.

(48 FR 8736, Jan. 8, 1983)

FEDERAL FINANCIAL PARTICIPATION

§ 447.59 FFP: Conditions relating to cost sharing.

No FFP in the State's expenditures for services is available for—

(a) Any cost sharing amounts that recipients should have paid as enrollment fees, premiums, deductibles, coinsurance, copayments, or similar charges under §§ 447.50 through 447.58 (except for amounts that the agency pays as bad debts of providers under § 447.57); and

(b) Any amounts paid by the agency on behalf of ineligible individuals, whether or not the individual had paid any required premium or enrollment fee.

**Subpart B—Payment Methods:
General Provisions**

§ 447.200 Basis and purpose.

This subpart prescribes State plan requirements for setting payment rates to implement, in part, section 1902(a)(30) of the Act, which requires that payments for services be consistent with efficiency, economy, and quality of care.

(46 FR 48840, Oct. 1, 1981)

§ 447.201 State plan requirements.

(a) A State plan must provide that the requirements in this subpart are met.

(b) The plan must describe the policy and the methods to be used in setting payment rates for each type of service included in the State's Medicaid program.

§ 447.202 Audits.

The Medicaid agency must assure appropriate audit of records if payment is based on costs of services or on a fee plus cost of materials.

§ 447.203 Documentation of payment rates.

(a) The agency must maintain documentation of payment rates and make it available to HHS upon request.

(b) The agency must record, in State manuals or other official files, the following information for increases in payment rates for individual practitioner services:

(1) An estimate of the percentile of the range of customary charges to which the revised payment structure equates and a description of the methods used to make the estimate.

(2) An estimate of the composite average percentage increase of the revised payment rates over the preceding rates.

§ 447.204 Encouragement of provider participation.

The agency's payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

§ 447.205 Public notice of changes in Statewide methods and standards for setting payment rates.

(a) When notice is required. Except as specified in paragraph (b) of this section, the agency must provide public notice of any significant proposed change in its methods and standards for setting payment rates for services.

(b) When notice is not required. Notice is not required if—

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(1) The change is being made to conform to Medicare methods or levels of reimbursement;

(2) The change is required by court order; or

(3) The change is based on changes in wholesalers' or manufacturers' prices of drugs or materials, if the agency's reimbursement system is based on material cost plus a professional fee.

(c) *Content of notice.* The notice must—

(1) Describe the proposed change in methods and standards;

(2) Give an estimate of any expected increase or decrease in annual aggregate expenditures;

(3) Explain why the agency is changing its methods and standards;

(4) Identify a local agency in each county (such as the social services agency or health department) where copies of the proposed changes are available for public review;

(5) Give an address where written comments may be sent and reviewed by the public; and

(6) If there are public hearings, give the location, date and time for hearings or tell how this information may be obtained.

(d) *Publication of notice.* The notice must—

(1) Be published before the proposed effective date of the change; and

(2) Appear as a public announcement in one of the following publications:

(i) A State register similar to the *FEDERAL REGISTER*.

(ii) The newspaper of widest circulation in each city with a population of 50,000 or more.

(iii) The newspaper of widest circulation in the State, if there is no city with a population of 50,000 or more.

[46 FR 54680, Dec. 3, 1981; 47 FR 8567, Mar. 1, 1982, as amended at 48 FR 56057, Dec. 19, 1983]

Subpart C—Payment for Inpatient Hospital and Long-Term Care Facility Services

SOURCE: 46 FR 47971, Sept. 30, 1981, unless otherwise noted.

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§ 447.250 Basis and purpose.

(a) This subpart implements section 1902(a)(13)(A) of the Act, which requires that the State plan provide for payment for hospital and long-term care facility services through the use of rates that the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with State and Federal laws, regulations, and quality and safety standards.

(b) Section 447.253(a)(2) implements section 1902(a)(30) of the Act, which requires that payments be consistent with efficiency, economy, and quality of care;

(c) Section 447.271 implements section 1903(l)(3) of the Act, which requires that payments for inpatient hospital services not exceed the hospital's customary charges.

(d) Section 447.280 implements section 1913(b) of the Act, which concerns reimbursement for long-term care services furnished by swing-bed hospitals.

[48 FR 56057, Dec. 19, 1983]

PAYMENT RATES

§ 447.251 Definitions.

For the purposes of this subpart—

"Long-term care facility services" means skilled nursing facility (SNF) services and intermediate care facility (ICF) services, including intermediate care facility services for the mentally retarded (ICF/MR).

"Provider" means an institution that furnishes inpatient hospital services or an institution that furnishes long-term care facility services.

[46 FR 47971, Sept. 30, 1981; 46 FR 54743, Nov. 4, 1981]

§ 447.252 State plan requirements.

(a) The plan must provide that the requirements of this subpart are met.

(b) The plan must specify comprehensively the methods and standards used by the agency to set payment rates in a manner consistent with 45 CFR 201.2.

(c) If the agency chooses to apply the cost limits established under Medicare (see § 413.30 of this chapter) on an individual provider basis, the plan must specify this requirement.

(Approved by the Office of Management and Budget under control number 0938-0193)

[48 FR 56058, Dec. 19, 1983, as amended at 51 FR 34833, Sept. 30, 1986]

§ 447.253 Other requirements.

(a) *State assurances.* In order to receive HCFA approval of a significant State plan change in payment methods and standards, the Medicaid agency must make assurances satisfactory to HCFA that the requirements set forth in paragraphs (b) through (g) of this section are being met, must submit the related information required by § 447.255 of this subpart, and must comply with all other requirements of this subpart.

(b) *Findings.* Whenever the Medicaid agency makes a significant change in its methods and standards, but not less often than annually, the agency must make the following findings:

(1) *Payment rates.* (i) The Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

(ii) With respect to inpatient hospital services—

(A) The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs;

(B) The methods and standards used to determine payment rates provide that reimbursement for hospital patients receiving services at an inappropriate level of care under conditions similar to those described in section 1861(v)(1)(G) of the Act will be made at lower rates, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G); and

(C) The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

(2) *Upper limits.* The Medicaid agency's estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for inpatient hospital services or long-term care facility services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement.

(c) *Provider appeals.* The Medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates.

(d) *Uniform cost reporting.* The Medicaid agency must provide for the filing of uniform cost reports by each participating provider.

(e) *Audit requirements.* The Medicaid agency must provide for periodic audits of the financial and statistical records of participating providers.

(f) *Public notice.* The Medicaid agency must provide that it has complied with the public notice requirements in § 447.205 of this part when it is proposing significant changes to its methods or standards for setting payment rates for inpatient hospital or LTC facility services.

(g) *Rates paid.* The Medicaid agency must pay for inpatient hospital and long term care services using rates determined in accordance with methods and standards specified in an approved State plan.

[48 FR 56057, Dec. 19, 1983]

§ 447.255 Related information.

The Medicaid agency must submit, with the assurances described in § 447.253(a), the following information:

(a) The amount of the estimated average proposed payment rate for each type of provider (hospital, SNF, ICF, or ICF/MR), and the amount by

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which that estimated average rate increased or decreased relative to the average payment rate in effect for each type of provider for the immediately preceding rate period;

(b) An estimate of the short-term and, to the extent feasible, long-term effect the change in the estimated average rate will have on—

(1) The availability of services on a Statewide and geographic area basis;

(2) The type of care furnished;

(3) The extent of provider participation; and

(4) The degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

[48 FR 84058, Dec. 19, 1983]

§ 447.256 Procedures for HCFA action on assurances and State plan amendments.

(a) *Criteria for approval.* (1) HCFA approval action on State plans and significant or other State plan amendments, is taken in accordance with 45 CFR 201.2 and 201.3 and sections 1116, 1902(b) and 1915(f) of the Act.

(2) In the case of State plan and plan amendment changes in payment methods and standards, HCFA bases its approval on the acceptability of the Medicaid agency's assurances that the requirements of § 447.253 have been met, and the State's compliance with the other requirements of this subpart.

(b) *Time limit.* HCFA will send a notice to the agency of its determination as to whether the assurances regarding a State plan amendment are acceptable within 90 days of the date HCFA receives the assurances described in § 447.253, and the related information described in § 447.255 of this subpart. If HCFA does not send a notice to the agency of its determination within this time limit and the provisions in paragraph (a) of this section are met, the assurances and/or the State plan amendment will be deemed accepted and approved.

(c) *Effective date.* A State plan amendment that is approved will become effective not earlier than the first day of the calendar quarter in which an approvable amendment is

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submitted in accordance with 45 CFR 201.3(g) and 447.253.

[48 FR 84058, Dec. 19, 1983]

UPPER LIMITS

§ 447.271 Upper limits based on customary charges.

(a) Except as provided in paragraph (b) of this section, the agency may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services.

(b) The agency may pay a public provider that provides services free or at a nominal charge at the same rate that would be used if the provider's charges were equal to or greater than its costs.

SWING-BED HOSPITALS

§ 447.280 Hospital providers of SNF and ICF services (swing-bed hospitals).

(a) If the State plan provides for SNF services furnished by a swing-bed hospital, as specified in § 440.40(a) of this chapter, the methods and standards used to determine payments rates must provide for payment for the routine SNF services at the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

(b) If the State plan provides for ICF services furnished by a swing-bed hospital, as specified in § 440.150(f) of this chapter, the methods and standards used to determine payment rates must provide for payment for the routine ICF services at the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

[47 FR 31833, July 30, 1982]

Subpart D—Payment Methods for Other Institutional and Noninstitutional Services

Source: 43 FR 45253, Sept. 29, 1978, unless otherwise noted. Redesignated at 46 FR 47973, Sept. 30, 1981.

§ 447.300 Basis and purpose.

In this subpart, §§ 447.302 through 447.334 and 447.361 implement section 1902(a)(30) of the Act, which requires that payments be consistent with efficiency, economy and quality of care. Section 447.342 of this subpart implements section 1902(a)(43) of the Act, which permits the State plan to provide for payment to a physician for laboratory services which the physician did not personally perform or supervise. Section 447.371 implements section 1902(a)(13)(F) of the Act, which requires that the State plan provide for payment for rural health clinic services in accordance with regulations prescribed by the Secretary.

[46 FR 48560, Oct. 1, 1981]

§ 447.302 State plan requirements.

A State plan must provide that the requirements of this subpart are met.

[46 FR 48560, Oct. 1, 1981]

§ 447.304 Adherence to upper limits; FFP.

(a) The Medicaid agency must not pay more than the upper limits described in this subpart.

(b) In the case of payments made under the plan for deductibles and co-insurance payable on an assigned Medicare claim for noninstitutional services, those payments may be made only up to the reasonable charge under Medicare.

(c) FFP is available in expenditures for payments for services that do not exceed the upper limits.

NOTE: The Secretary may waive any limitation on reimbursement imposed by Subpart D of this part for experiments conducted under section 402 of Pub. L. 90-428, Incentives for Economy Experimentation, as amended by section 222(b) of Pub. L. 92-603, and under section 222(a) of Pub. L. 92-603.

[46 FR 48560, Oct. 1, 1981; 46 FR 84744, Nov. 4, 1981]

OUTPATIENT HOSPITAL AND CLINIC SERVICES

§ 447.321 Outpatient hospital services and clinic services: Upper limits of payment.

The agency may not pay more than the combined payments the provider gets from the beneficiaries and carri-

ers or intermediaries for providing comparable services under comparable circumstances under Medicare.

OTHER INPATIENT AND OUTPATIENT FACILITIES

§ 447.325 Other inpatient and outpatient facility services: Upper limits of payment.

The agency may pay the customary charges of the provider but must not pay more than the prevailing charges in the locality for comparable services under comparable circumstances.

Drugs

§ 447.331 Drugs: Upper limits of payment.

(a) The agency may not pay more for prescribed drugs than the lower of ingredient cost plus a reasonable dispensing fee or the provider's usual and customary charge to the general public.

(b) Cost must be determined in accordance with § 447.332.

(c) The dispensing fee must be set by the agency under § 447.333.

[43 FR 45253, Sept. 29, 1978, as amended at 45 FR 24889, Apr. 11, 1980]

§ 447.332 Cost of drugs.

(a) Multiple-source drugs. A "multiple-source drug" means a drug marketed or sold by two or more manufacturers or labelers or a drug marketed or sold by the same manufacturer or labeler under two or more different proprietary names or both under a proprietary name and without such a name. Except as specified in paragraph (b), the cost of each multiple source drug designated by the Pharmaceutical Reimbursement Board (45 CFR Part 19) and published in the FEDERAL REGISTER must be the lower of—

(1) The maximum allowable cost (MAC) established by the Board and published in the FEDERAL REGISTER; or

(2) The estimated acquisition cost as described in paragraph (c) of this section.

(b) Exception: Certification of brand name drugs. (1) The cost of a multiple-source drug is not limited to the MAC if a physician certifies in his own handwriting that, in his medical judg-

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ment, a specific brand is medically necessary for a particular recipient.

(2) The agency must decide what certification form and procedure are used.

(3) A checkoff box on a form is not acceptable but a notation like "brand necessary" is allowable.

(4) The agency may allow providers to keep the certification forms if the forms will be available for inspection by the agency or HHS.

(c) *All other drugs.* (1) The agency must set the cost of all other prescribed drugs at the estimated acquisition cost.

(2) "Estimated acquisition cost" means the agency's best estimate of what price providers generally are paying for a drug.

(3) The basis for the estimate must be the package size providers buy most frequently.

NOTE: To help Medicaid agencies with these estimates, HHS makes available information, on a current basis, on the acquisition cost of the most frequently prescribed drugs.

§ 447.333 Dispensing fee.

(a) The agency may set the dispensing fee by taking into account the results of surveys of the costs of pharmacy operation. The agency must periodically survey pharmacy operations including—

- (1) Operational data;
- (2) Professional services data;
- (3) Overhead data; and
- (4) Profit data.

(b) The dispensing fee may vary according to—

- (1) Size and location of pharmacy;
- (2) Whether the drug is a legend item (for which Federal law requires a prescription) or nonlegend item; and
- (3) Whether the drug is dispensed by a physician or an outpatient department of an institution.

(c) The dispensing fee may also vary for drugs furnished recipients in institutions by a pharmacy using a unit dose system. In those cases—

- (1) The dispensing fee is added to the ingredient cost of the drug actually used; and
- (2) The fee is either—
 - (i) An amount added to the cost of each unit dose; or

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(ii) A daily or monthly capitation rate per recipient being furnished drugs.

§ 447.334 Upper limits for drugs furnished as part of services.

The upper limits for payment for prescribed drugs in this subpart also apply to payment for drugs provided as part of skilled nursing facility services and intermediate care facility services and under prepaid capitation arrangements.

CLINICAL LABORATORY SERVICES

§ 447.342 Physician billing for clinical laboratory services.

(a) This section applies when a State plan provides for payments to physicians for clinical laboratory services.

(b) [Reserved]

(c) A state plan may provide for payment to a physician who bills for clinical laboratory services performed by an outside laboratory. Under these circumstances, the plan must provide that the agency will not pay the physician more than the amount that would be authorized under Medicare in accordance with § 405.515 (b), (c), and (d) of this chapter.

[46 FR 48560, Oct. 1, 1981]

PREPAID CAPITATION PLANS

§ 447.361 Upper limits of payment: Risk contract.

Under a risk contract, Medicaid payments to the contractor, for a defined scope of services to be furnished to a defined number of recipients, may not exceed the cost to the agency of providing those same services on a fee-for-service basis, to an actuarially equivalent nonenrolled population group.

[48 FR 84025, Nov. 30, 1983]

§ 447.362 Upper limits of payment: Non-risk contract.

Under a nonrisk contract, Medicaid payments to the contractor may not exceed—

(a) What Medicaid would have paid, on a fee-for-service basis, for the services actually furnished to recipients; plus

(b) The net savings of administrative costs the Medicaid agency achieves by contracting with the plan instead of purchasing the services on a fee-for-service basis.

[48 FR 54025, Nov. 30, 1983]

- RURAL HEALTH CLINIC SERVICES

§ 447.571 Services furnished by rural health clinics.

The agency must pay for rural health clinic services, as defined in § 440.20(b) of this subchapter, and for other ambulatory services furnished by a rural health clinic, as defined in § 440.20(c) of this subchapter, as follows:

(a) For provider clinics, the agency must pay the reasonable cost of rural health clinic services and other ambulatory services on the basis of the cost reimbursement principles in Part 413 of this chapter. For purposes of this section, a provider clinic is an integral part of a hospital, skilled nursing facility, or home health agency that is participating in Medicare and is licensed, governed, and supervised with other departments of the facility.

(b) For clinics other than provider clinics that do not offer any ambulatory services other than rural health clinic services, the agency must pay for rural health clinic services at the reasonable cost rate per visit determined by a Medicare carrier under §§ 405.2426 through 405.2429 of this chapter.

(c) For clinics other than provider clinics that do offer ambulatory services other than rural health clinic services, the agency must pay for the other ambulatory services by one of the following methods:

(1) The agency may pay for other ambulatory services and rural health clinic services at a single rate per visit that is based on the cost of all services furnished by the clinic. The rate must be determined by a Medicare carrier under §§ 405.2426 through 405.2429 of this chapter.

(2) The agency may pay for other ambulatory services at a rate set for each service by the agency. The rate must not exceed the upper limits in this subpart. The agency must pay for

rural health clinic services at the Medicare reimbursement rate per visit, as specified in § 405.2426 of this chapter.

(3) The agency may pay for dental services at a rate per visit that is based on the cost of dental services furnished by the clinic. The rate must be determined by a Medicare carrier under §§ 405.2426 through 405.2429 of this chapter. The agency must pay for ambulatory services other than dental services under paragraph (c) (1) or (2) of this section.

(d) For purposes of paragraph (c) (1) and (3) of this section, "visit" means a face-to-face encounter between a clinic patient and any health professional whose services are reimbursed under the State plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

[43 FR 45253, Sept. 29, 1978, as amended at 51 FR 34833, Sept. 30, 1986]

PART 455—PROGRAM INTEGRITY: MEDICAID

Sec.

455.1 Basis and scope.

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Subpart A—Medicaid Agency Fraud Detection and Investigation Program

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455.21 Cooperation with State Medicaid fraud control unit.

Addendum 4

recipient makes application for aid)" preceding "medical care".

EFFECTIVE DATE OF 1965 AMENDMENT

Amendment by section 221 of Pub. L. 89-97 applicable in the case of expenditures made after Dec. 31, 1965, under a State plan approved under this subchapter, see section 221(e) of Pub. L. 89-97, set out as an Effective Date of 1965 Amendment note under section 303 of this title.

Amendment by section 402(d) of Pub. L. 89-97 applicable in the case of expenditures made after Dec. 31, 1965, under a state plan approved under subchapter I, X, XIV, or XVI of this chapter, see section 402(e) of Pub. L. 89-97, set out as an Effective Date of 1965 Amendment note under section 306 of this title.

EFFECTIVE DATE OF 1962 AMENDMENT

Amendment by section 156(d) of Pub. L. 87-543 applicable in the case of applications made after Sept. 30, 1962, under a State plan approved under subchapter I, IV, X, or XIV of this chapter, see section 156(e) of Pub. L. 87-543, set out as an Effective Date of 1962 Amendment note under section 306 of this title.

SUBCHAPTER XV—UNEMPLOYMENT COMPENSATION FOR FEDERAL EMPLOYEES

§§ 1361 to 1364. Repealed. Pub. L. 89-554, § 8(a), Sept. 6, 1966, 80 Stat. 658, 660, 661

Section 1361, act Aug. 14, 1935, ch. 531, title XV, § 1501, as added Sept. 1, 1954, ch. 1212, § 4(a), 68 Stat. 1130, and amended Aug. 28, 1958, Pub. L. 85-848, § 2, 72 Stat. 1087, July 12, 1960, Pub. L. 86-624 § 30(g), 74 Stat. 420, Sept. 13, 1960, Pub. L. 86-778, title V, § 531(e), 542(d), 74 Stat. 984, 986, defined terms used in this subchapter.

Pub. L. 90-248, title IV, § 403(f), Jan. 2, 1968, 81 Stat. 932, amended section 1361(a)(6), (9), without reference to repeal of such section by Pub. L. 89-554, § 8(a).

Section 1362, act Aug. 14, 1935, ch. 531, title XV, § 1502, as added Sept. 1, 1954, ch. 1212, § 4(a), 68 Stat. 1131, and amended Sept. 13, 1960, Pub. L. 86-778, title V, § 543(b)(1)(A), 74 Stat. 985, provided for compensation of Federal employees under state agreements.

Section 1363, act Aug. 14, 1935, ch. 531, title XV, § 1503, as added Sept. 1, 1954, ch. 1212, § 4(a), 68 Stat. 1132, and amended Sept. 13, 1960, Pub. L. 86-778, title V, § 543(b)(1)(B), (C), (c)(1), 74 Stat. 986, provided for compensation of Federal employees in absence of state agreement.

Section 1364, act Aug. 14, 1935, ch. 531, title XV, § 1504, as added Sept. 1, 1954, ch. 1212, § 4(a), 68 Stat. 1133, and amended Sept. 13, 1960, Pub. L. 86-778, title V, § 542(b)(2), 74 Stat. 986, related to assignment to State of Federal service and wages.

§ 1365. Repealed. Pub. L. 86-442, § 1, Apr. 22, 1960, 74 Stat. 61

Section, act Aug. 14, 1935, ch. 531, title XV, § 1505, as added Sept. 1, 1954, ch. 1212, § 4(a), 68 Stat. 1133, related to the status of a Federal employee who was performing Federal service at the time of his separation from employment by the United States.

EFFECTIVE DATE OF REPEAL

Repeal of section effective only with respect to benefit years which began more than thirty days after the date of enactment of Pub. L. 86-442 (Apr. 22, 1960).

§§ 1366 to 1371. Repealed. Pub. L. 89-554, § 8(a), Sept. 6, 1966, 80 Stat. 658, 660, 661

Section 1366, act Aug. 14, 1935, ch. 531, title XV, § 1506, as added Sept. 1, 1954, ch. 1212, § 4(a), 68 Stat. 1133, provided for payments to States.

Section 1367, act Aug. 14, 1935, ch. 531, title XV, § 1507, as added Sept. 1, 1954, ch. 1212, § 4(a), 68 Stat.

1134, and amended Aug. 28, 1958, Pub. L. 85-848, § 4, 72 Stat. 1089, Sept. 13, 1960, Pub. L. 86-778, title V, § 531(f), 74 Stat. 984, provided for dissemination of information by both Federal and State agencies.

Section 1368, act Aug. 14, 1935, ch. 531, title XV, § 1508, as added Sept. 1, 1954, ch. 1212, § 4(a), 68 Stat. 1135, related to penalties.

Section 1369, act Aug. 14, 1935, ch. 531, title XV, § 1509, as added Sept. 1, 1954, ch. 1212, § 4(a), 68 Stat. 1135, related to rules and regulations.

Section 1370, act Aug. 14, 1935, ch. 531, title XV, § 1510, as added Sept. 1, 1954, ch. 1212, § 4(a), 68 Stat. 1135, related to authorization of appropriations.

Section 1371, act Aug. 14, 1935, ch. 531, title XV, § 1511, as added Aug. 28, 1958, Pub. L. 85-848, § 3, 72 Stat. 1087, and amended Sept. 2, 1958, Pub. L. 85-857, § 13(1)(3), 72 Stat. 1265, Apr. 22, 1960, Pub. L. 86-442, § 2, 74 Stat. 62, Sept. 13, 1960, Pub. L. 86-778, title V, § 542(c), 74 Stat. 986, provided an ex-servicemen's unemployment compensation program.

SUBCHAPTER XVI—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

SUBCHAPTER REFERRED TO IN OTHER SECTIONS

This subchapter is referred to in sections 401, 428, 602, 1301, 1306a, 1308, 1309, 1311, 1315, 1316, 1318, 1319, 1382, 1382c, 1395v, 1395z, 1396a, 1396b, 1396d, 1397a, 1397b, 1397c, 1397f, 6862 of this title, title 7 sections 1431, 2012, title 29 section 981; title 48 section 1421q.

§ 1381. Statement of purpose; authorization of appropriations

For the purpose of establishing a national program to provide supplemental security income to individuals who have attained age 65 or are blind or disabled, there are authorized to be appropriated sums sufficient to carry out this subchapter.

(Aug. 14, 1935, ch. 531, title XVI, § 1601, as added Oct. 30, 1972, Pub. L. 92-603, title III, § 301, 86 Stat. 1465.)

PRIOR PROVISIONS

A prior section 1381, act Aug. 14, 1935, ch. 531, title XVI, § 1601, as added July 25, 1962, Pub. L. 87-543, title I, § 141(a), 76 Stat. 197, authorized appropriations for grants to States for aid to the aged, blind, or disabled, and for medical assistance for the aged, prior to the general amendment of title XVI of the Social Security Act by Pub. L. 92-603, § 301.

EFFECTIVE DATE

Section 301 of Pub. L. 92-603 provided in part that this section is to take effect Jan. 1, 1974.

CONTINUATION OF FEDERAL FINANCIAL PARTICIPATION IN EXPERIMENTAL, PILOT, OR DEMONSTRATION PROJECTS APPROVED BEFORE OCTOBER 1973, FOR PERIOD ON-AND-AFTER DECEMBER 31, 1973, WITHOUT DENIAL OR REDUCTION ON ACCOUNT OF SUBCHAPTER XVI PROVISIONS, WAIVER OF SUBCHAPTER XVI RESTRICTIONS FOR INDIVIDUALS, FEDERAL PAYMENTS OF NON-FEDERAL SHARE AS SUPPLEMENTARY PAYMENTS

Subchapter provisions without effect on Federal Financial Participation in Experimental, Pilot or Demonstration Projects approved before Oct. 1, 1973, for period on-and-after Dec. 31, 1973, see section 11 of Pub. L. 93-233, Dec. 31, 1973, 87 Stat. 968, set out as a note under section 1315 of this title.

PUERTO RICO, GUAM, AND VIRGIN ISLANDS

Enactment of section 1601 of the Social Security Act (this section) by Pub. L. 92-603, eff. Jan. 1, 1974, was not applicable to Puerto Rico, Guam, and the Virgin Islands. See section 303(b) of Pub. L. 92-603, set out as

a note under section 301 of this title. Therefore, as to Puerto Rico, Guam, and the Virgin Islands, section 1601 of the Social Security Act (this section) as it existed prior to reenactment by Pub. L. 92-603 continues to apply as follows:

§ 1381 Authorization of appropriations

For the purpose (a) of enabling each State, as far as practicable under the conditions in such State, to furnish financial assistance to needy individuals who are 65 years of age or over, are blind, or are 18 years of age or over and permanently and totally disabled, (b) of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance on behalf of individuals who are 65 years of age or over and who are not recipients of aid to the aged, blind, or disabled but whose income and resources are insufficient to meet the costs of necessary medical services, and (c) of encouraging each State, as far as practicable under the conditions in such State, to furnish rehabilitation and other services to help individuals referred to in clause (a) or (b) to attain or retain capability for self-support or self-care, there is authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for aid to the aged, blind, or disabled, or for aid to the aged, blind, or disabled and medical assistance for the aged.

(Aug. 14, 1935, ch. 531, title XVI, § 1601, as added July 25, 1962, Pub. L. 87-543, title I, § 141(a), 76 Stat. 197.)

PAYMENTS UNDER CHAPTER PROVISIONS IN EFFECT BEFORE JANUARY 1, 1974, FOR ACTIVITIES CARRIED OUT THROUGH DECEMBER 31, 1973, UNDER STATE PLANS APPROVED UNDER SUBCHAPTER I, X, XIV, OR XVI PROVISIONS, AND FOR ADMINISTRATIVE ACTIVITIES AFTER JANUARY 1, 1974, CLOSING OUT SUCH ACTIVITIES

Pub. L. 93-233, § 19(b), Dec. 31, 1973, 87 Stat. 974, provided that "Notwithstanding the provisions of section 301 of the Social Security Amendments of 1972 [enacting this subchapter], the Secretary of Health, Education, and Welfare shall make payments to the 50 States and the District of Columbia after December 31, 1973, in accordance with the provisions of the Social Security Act [this chapter] as in effect prior to January 1, 1974, for (1) activities carried out through the close of December 31, 1973, under State plans approved under title [subchapter] I, X, XIV, or XVI, of such Act [this chapter], and (2) administrative activities carried out after December 31, 1973, which such Secretary determines are necessary to bring to a close activities carried out under such State plans."

§ 1381a. Basic entitlement to benefits

Every aged, blind, or disabled individual who is determined under part A to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this subchapter, be paid benefits by the Secretary of Health, Education, and Welfare.

(Aug. 14, 1935, ch. 531, title XVI, § 1602, as added Oct. 30, 1972, Pub. L. 92-603, title III, § 301, 86 Stat. 1465.)

Prior Provisions

A prior section 1602 of act Aug. 14, 1935, ch. 531, title XVI, as added July 25, 1962, Pub. L. 87-543, title I, § 141(a), 76 Stat. 198, and amended Oct. 13, 1964, Pub. L. 88-450, § 5(b), 78 Stat. 1078, July 30, 1965, Pub. L. 89-97, title II, § 221(dx3), title IV, § 403(e), 79 Stat. 388, 418; Jan. 2, 1968, Pub. L. 90-248, title II, §§ 210(a)(5), 213(a)(4), 341(d), 81 Stat. 896, 898, 917, formerly classified to section 1382 of this title, set forth the required contents of state plans for aid to the aged, blind, or disabled, and for medical assistance for the aged, prior to the general amendment of title

XVI of the Social Security Act by Pub. L. 92-603, § 301.

EFFECTIVE DATE

Section 301 of Pub. L. 92-603 provided in part that this section is to take effect Jan. 1, 1974.

PUERTO RICO, GUAM, AND THE VIRGIN ISLANDS

Enactment of provisions of Pub. L. 92-603, eff. Jan. 1, 1974, not applicable to Puerto Rico, Guam, and the Virgin Islands, see section 303(b) of Pub. L. 92-603, set out as a note under section 301 of this title.

PART A—DETERMINATION OF BENEFITS

PART REFERRED TO IN OTHER SECTIONS

This part is referred to in section 1381a of this title.

§ 1382. Eligibility for benefits

(a) Definition of eligible individual

(1) Each aged, blind, or disabled individual who does not have an eligible spouse and—

(A) whose income, other than income excluded pursuant to section 1382a(b) of this title, is at a rate of not more than \$1,752 (or, if greater, the amount determined under section 1382f of this title) for the calendar year 1974 or any calendar year thereafter, and

(B) whose resources, other than resources excluded pursuant to section 1382b(a) of this title, are not more than (i) in case such individual has a spouse with whom he is living, \$2,250, or (ii) in case such individual has no spouse with whom he is living, \$1,500,

shall be an eligible individual for purposes of this subchapter.

(2) Each aged, blind, or disabled individual who has an eligible spouse and—

(A) whose income (together with the income of such spouse), other than income excluded pursuant to section 1382a(b) of this title, is at a rate of not more than \$2,628 (or, if greater, the amount determined under section 1382f of this title) for the calendar year 1974, or any calendar year thereafter, and

(B) whose resources (together with the resources of such spouse), other than resources excluded pursuant to section 1382b(a) of this title, are not more than \$2,250,

shall be an eligible individual for purposes of this subchapter.

(b) Amount of benefits

(1) The benefit under this subchapter for an individual who does not have an eligible spouse shall be payable at the rate of \$1,752 (or, if greater, the amount determined under section 1382f of this title) for the calendar year 1974 and any calendar year thereafter, reduced by the amount of income, not excluded pursuant to section 1382a(b) of this title, of such individual.

(2) The benefit under this subchapter for an individual who has an eligible spouse shall be payable at the rate of \$2,628 (or, if greater, the amount determined under section 1382f of this title) for the calendar year 1974 and any calendar year thereafter, reduced by the amount of income, not excluded pursuant to section 1382a(b) of this title, of such individual and spouse.

Subsec. (a)(3). Pub. L. 97-35, § 2184(c)(2)(B), struck out "(including expenditures for premiums under part B of subchapter XVIII of this chapter for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care or the cost thereof)".

Subsec. (a)(3). Pub. L. 97-35, § 2353(i)(1)(A), redesignated subpar. (A)(iv) as subpar. (A), struck out former subpars. (A)(i), which included services prescribed pursuant to subsec. (c)(1) of this section and provided to applicants for or recipients of aid to the permanently and totally disabled to help them attain self-support, (A)(ii), which included other services, specified by the Secretary as likely to prevent or reduce dependency, and (A)(iii), which included any of the services in subpars. (A)(i) and (ii) deemed appropriate for individuals likely to become applicants for or recipients of aid to the permanently and totally disabled, redesignated former subpar. (C) as (B), and struck out former subpar. (B), which included one-half of so much of the expenditures, not included in subpar. (A), as are for services for applicants for or recipients of aid to the permanently and totally disabled or individuals likely to become applicants or recipients, and subpars. (D) and (E) and provision following subpar. (E), which specified what services were includible.

Subsec. (a)(4). Pub. L. 97-35, § 2353(i)(1)(B), struck out par. (4), which provided payment, in the case of any State whose plan approved under section 1352 of this title did not meet the requirements of subsec. (c)(1) of this section, of an amount equal to one-half of the total of the sums expended during the quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

Subsec. (c). Pub. L. 97-35, § 2353(i)(2), struck out subsec. (c), which prescribed eligibility requirements for payments.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by section 2353(i) of Pub. L. 97-35 effective, except as otherwise explicitly provided, Oct. 1, 1981, see section 2354 of Pub. L. 97-35, set out as an Effective Date note under section 1397 of this title.

EFFECTIVE DATE OF 1975 AMENDMENT

Amendment by section 3 of Pub. L. 93-647 effective with respect to payments under sections 603 and 803 of this title for quarters commencing after Sept. 30, 1975, see section 7(b) of Pub. L. 93-647, set out as an Effective Date of 1975 Amendment note under section 303 of this title.

Amendment by section 5 of Pub. L. 93-647 effective with respect to payments for quarters commencing after Sept. 30, 1975, see section 7(a) of Pub. L. 93-647, set out as an Effective Date of 1975 Amendment note under section 303 of this title.

TRANSFER OF FUNCTIONS

The Secretary of Health, Education, and Welfare was redesignated the Secretary of Health and Human Services by section 509(b) of Pub. L. 96-88, which is classified to section 3508(b) of Title 20, Education.

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 643, 1318, 1318, 1319 of this title.

§ 1354. Operation of State plans

In the case of any State plan for aid to the permanently and totally disabled which has been approved by the Secretary of Health and Human Services, if the Secretary after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds—

[See main edition for text of (1) and (2) and concluding provisions]

(As amended Oct. 17, 1979, Pub. L. 96-88, title V, § 509(b), 93 Stat. 695.)

TRANSFER OF FUNCTIONS

The Secretary of Health, Education, and Welfare was redesignated the Secretary of Health and Human Services by section 509(b) of Pub. L. 96-88, which is classified to section 3508(b) of Title 20, Education.

§ 1355. Definitions

For the purposes of this subchapter, the term "aid to the permanently and totally disabled" means money payments to needy individuals eighteen years of age or older who are permanently and totally disabled, but does not include any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases. Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 1352 of this title includes provision for—

[See main edition for text of (1) to (5) and concluding provisions]

(As amended Aug. 13, 1981, Pub. L. 97-35, title XXI, § 2184(c)(3), 95 Stat. 817.)

AMENDMENTS

1981—Pub. L. 97-35 struck out in provision preceding par. (1) ", or (if provided on or after the third month before the month in which the recipient makes application for aid) medical care in behalf of, or any type of remedial care recognized under State law in behalf of," following "money payments to".

SUBCHAPTER XVI—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

SUBCHAPTER REFERRED TO IN OTHER SECTIONS

This subchapter is referred to in sections 401, 604, 428, 602, 670, 671, 673, 701, 909, 1301, 1306a, 1308, 1309, 1310, 1311, 1315, 1316, 1318, 1319, 1320a-6, 1320b-2, 1320b-3, 1382, 1382c, 1395v, 1395z, 1396a, 1396b, 1396d, 1997, 6862, 8624 of this title; title 7 sections 2012, 2014, 2015, 2026; title 8 section 1522; title 26 section 51; title 29 sections 762a, 802, 858, 967; title 48 section 1421q.

§ 1381. Statement of purpose; authorization of appropriations

APPLICATION TO NORTHERN MARIANA ISLANDS

For applicability of this section to the Northern Mariana Islands, see section 502(a)(1) of the Covenant to Establish a Commonwealth of the Northern Mariana Islands in Political Union with the United States of America, as set forth in Pub. L. 94-241, Mar. 24, 1976, 90 Stat. 263, eff. Jan. 9, 1978, pursuant to Proc. No. 4534, Oct. 24, 1977, 42 F.R. 6593, set out as notes under section 1681 of Title 48, Territories and Insular Possessions.

PUERTO RICO, GUAM, AND VIRGIN ISLANDS

Enactment of section 1601 of the Social Security Act (this section) by Pub. L. 92-603, eff. Jan. 1, 1974, was not applicable to Puerto Rico, Guam, and the Virgin Islands. See section 303(b) of Pub. L. 92-603, set out as a note under section 301 of this title. Therefore, as to Puerto Rico, Guam, and the Virgin Islands, section 1601 of the Social Security Act (this section) as it existed prior to reenactment by Pub. L. 92-603, and as amended, continues to apply and reads as follows:

§ 1381. Authorization of appropriations

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish financial assistance to needy individuals who are 65 years of age or over, are blind, or are 18 years of age or over and permanently and totally disabled, there is authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health and Human Services, State plans for aid to the aged, blind, or disabled.

(Aug. 14, 1935, ch. 531, title XVI, § 1601, as added July 25, 1962, Pub. L. 87-543, title I, § 141(a), 76 Stat. 197, and amended Oct. 17, 1979, Pub. L. 96-88, title V, § 509(b), 93 Stat. 695; Aug. 13, 1981, Pub. L. 97-35, title XXI, § 2184(d)(3), title XXIII, § 2353(m)(1), 95 Stat. 817, 873.)

§ 1381a. Basic entitlement to benefits**CHANGE OF NAME**

The Secretary of Health, Education, and Welfare was redesignated the Secretary of Health and Human Services by section 3508(b) of Title 20, Education.

APPLICATION TO NORTHERN MARIANA ISLANDS

For applicability of this section to the Northern Mariana Islands, see section 502(a)(1) of the Covenant to Establish a Commonwealth of the Northern Mariana Islands in Political Union with the United States of America, as set forth in Pub. L. 94-241, Mar. 24, 1976, 90 Stat. 263, eff. Jan. 9, 1978, pursuant to Proc. No. 4534, Oct. 24, 1977, 42 F.R. 6593, set out as notes under section 1681 of Title 48, Territories and Insular Possessions.

PART A—DETERMINATION OF BENEFITS**§ 1382. Eligibility for benefits**

[See main edition for text of (a) and (b)]

(c) Retrospective accounting; relevant considerations; effective date of application; waiver of limitations

(1) An individual's eligibility for a benefit under this subchapter for a month shall be determined on the basis of the individual's (and eligible spouse's, if any) income, resources, and other relevant characteristics in such month, and, except as provided in paragraph (2), the amount of such benefit shall be determined for such month on the basis of income and other characteristics in the first or, if the Secretary so determines, second month preceding such month. Eligibility for and the amount of such benefits shall be redetermined at such time or times as may be provided by the Secretary.

(2) The amount of such benefit for the month in which application for such benefits is filed or, if the Secretary so determines, for such month and the following month, and for any month following a month of ineligibility for such benefits (or, if the Secretary so deter-

mines, such month and the following month) shall be determined on the basis of the individual's (and eligible spouse's, if any) income and other relevant circumstances in such month.

(3) For purposes of this subsection, an application shall be effective as of the first day of the month in which it is filed.

(4) The Secretary may waive the limitations specified in subparagraphs (A) and (B) of subsection (e)(1) of this section on an individual's eligibility and benefit amount for a month (to the extent either such limitation is applicable by reason of such individual's presence throughout such month in a hospital, extended care facility, nursing home, or intermediate care facility) if such waiver would promote the individual's removal from such institution or facility. Upon waiver of such limitations, the Secretary shall apply, to the month preceding the month of removal, or, if the Secretary so determines, the two months preceding the month of removal, the benefit rate that is appropriate to such individual's living arrangement subsequent to his removal from such institution or facility.

[See main edition for text of (d)]

(e) Limitation on eligibility of certain individuals

[See main edition for text of (1) to (3)]

(4) No benefit shall be payable under this subchapter, except as provided in section 1382h of this title (or section 1382e(c)(3) of this title), with respect to an eligible individual or his eligible spouse who is an aged, blind, or disabled individual solely by application of section 1382c(a)(3)(F) of this title for any month, after the third month, in which he engages in substantial gainful activity during the fifteen-month period following the end of his trial work period determined by application of section 1382c(a)(4)(D)(i) of this title.

[See main edition for text of (f) to (h)]

(As amended June 9, 1980, Pub. L. 96-265, title III, § 303(c)(2), 94 Stat. 453; Aug. 13, 1981, Pub. L. 97-35, title XXIII, § 2341(a), 95 Stat. 865.)

AMENDMENTS

1981—Subsec. (c). Pub. L. 97-35 substituted provision that eligibility and benefit generally be determined on a one-month retrospective basis, with the first month of eligibility, the month in which the application is filed, eligibility and benefit amount both determined on a prospective basis for provision that eligibility and benefit amount be determined on a quarterly prospective basis and inserted provision authorizing the Secretary to grant waivers.

1980—Subsec. (e)(4). Pub. L. 96-265 added par. (4).

EFFECTIVE DATE OF 1981 AMENDMENT AND TRANSITIONAL PROVISIONS

Section 2341(c) of Pub. L. 97-35 provided that:

"(1) The amendments made by this section (amending subsec. (c) of this section and section 1382a(b)(3) of this title) shall be effective with respect to months after the first calendar quarter which ends more than five months after the month in which this Act is enacted [August, 1981].

"(2) The Secretary of Health and Human Services may, under conditions determined by him to be neces-

SUBCHAPTER XIV—GRANTS TO STATES FOR AID TO THE PERMANENTLY AND TOTALLY DISABLED

SUBCHAPTER REFERRED TO IN OTHER SECTIONS

This subchapter is referred to in sections 428, 602, 671, 1301, 1306a, 1308, 1309, 1311, 1315, 1316, 1318, 1319, 1320b-2, 1320b-3, 1320b-7, 1382, 1382c, 1395v, 1396a, 1396b, 1396d of this title; title 7 section 2012; title 26 section 6103.

§ 1352. State plans for aid to the permanently and totally disabled

ENACTMENT OF SUBSECTION (a)(13)

Pub. L. 98-369, div. B, title VI, § 2651(g), (1)(2), July 18, 1984, 98 Stat. 1150, 1151, provided that, effective Apr. 1, 1985, unless a waiver has been granted to a State to delay the effective date but in no event beyond Sept. 30, 1986, subsection (a) is amended by striking out "and" at the end of clause (11); and by inserting before the period at the end thereof the following: "; and (13) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1320b-7 of this title".

SUBCHAPTER XVI—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

SUBCHAPTER REFERRED TO IN OTHER SECTIONS

This subchapter is referred to in sections 401, 404, 428, 602, 612, 670, 671, 673, 701, 909, 1301, 1306a, 1308, 1309, 1310, 1311, 1315, 1316, 1318, 1319, 1320a-6, 1320b-2, 1320b-3, 1320b-6, 1320b-7, 1382, 1382c, 1395v, 1395z, 1396a, 1396b, 1396d, 1396p, 1997, 2013, 6862, 8624 of this title; title 7 sections 2012, 2014, 2015, 2026; title 8 section 1822; title 26 sections 51, 6103, title 29 section 762a; title 48 section 1421q.

§ 1381a. Basic entitlement to benefits

Every aged, blind, or disabled individual who is determined under part A of this subchapter to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this subchapter, be paid benefits by the Secretary of Health and Human Services.

(Aug. 14, 1935, ch. 531, title XVI, § 1602, as added Oct. 30, 1972, Pub. L. 92-603, title III, § 301, 86 Stat. 1465, and amended July 18, 1984, Pub. L. 98-369, div. B, title VI, § 2663(J)(2)(E), 98 Stat. 1170.)

AMENDMENTS

1984—Pub. L. 98-369 substituted "Health and Human Services" for "Health, Education, and Welfare".

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98-369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98-369, set out as a note under section 401 of this title.

PART A—DETERMINATION OF BENEFITS

§ 1382. Eligibility for benefits

(a) "Eligible individual" defined

(1) Each aged, blind, or disabled individual who does not have an eligible spouse and—

[See main edition for text of (A)]

(B) whose resources, other than resources excluded pursuant to section 1382b(a) of this title, are not more than (i) in case such individual has a spouse with whom he is living, the applicable amount determined under paragraph (3)(A), or (ii) in case such individual has no spouse with whom he is living, the applicable amount determined under paragraph (3)(B),

shall be an eligible individual for purposes of this subchapter.

(2) Each aged, blind, or disabled individual who has an eligible spouse and—

[See main edition for text of (A)]

(B) whose resources (together with the resources of such spouse), other than resources excluded pursuant to section 1382b(a) of this title, are not more than the applicable amount determined under paragraph (3)(A),

shall be an eligible individual for purposes of this subchapter.

(3)(A) The dollar amount referred to in clause (i) of paragraph (1)(B), and in paragraph (2)(B), shall be \$2,250 prior to January 1, 1985, and shall be increased to \$2,400 on January 1, 1985, to \$2,550 on January 1, 1986, to \$2,700 on January 1, 1987, to \$2,850 on January 1, 1988, and to \$3,000 on January 1, 1989.

(B) The dollar amount referred to in clause (ii) of paragraph (1)(B), shall be \$1,500 prior to January 1, 1985, and shall be increased to \$1,600 on January 1, 1985, to \$1,700 on January 1, 1986, to \$1,800 on January 1, 1987, to \$1,900 on January 1, 1988, and to \$2,000 on January 1, 1989.

[See main edition for text of (b)]

(c) Period for determination of benefits

(1) An individual's eligibility for a benefit under this subchapter for a month shall be determined on the basis of the individual's (and eligible spouse's, if any) income, resources, and other relevant characteristics in such month, and, except as provided in paragraphs (2), (3), and (4), the amount of such benefit shall be determined for such month on the basis of income and other characteristics in the first or, if the Secretary so determines, second month preceding such month. Eligibility for and the amount of such benefits shall be redetermined at such time or times as may be provided by the Secretary.

[See main edition for text of (2) to (6); (d)]

(e) Limitation on eligibility of certain individuals

(1)(A) Except as provided in subparagraphs (B), (C), and (D), no person shall be an eligible individual or eligible spouse for purposes of this

the requirements of section 1320b-7 of this title.

[See main edition for text of (b)]

(As amended July 18, 1984, Pub. L. 98-369, div. B, title VI, § 2651(g), 98 Stat. 1150.)

AMENDMENTS

1984—Subsec. (a)(13). Pub. L. 98-369 added cl. (13).

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98-369 effective Apr. 1, 1985, except as otherwise provided, see section 2651(i)(2) of Pub. L. 98-369, set out as an Effective Date note under section 1320b-7 of this title.

SUBCHAPTER XVI—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

SUBCHAPTER REFERRED TO IN OTHER SECTIONS

This subchapter is referred to in sections 401, 404, 428, 602, 612, 670, 671, 673, 701, 909, 1301, 1306a, 1308, 1309, 1310, 1311, 1315, 1316, 1318, 1319, 1320a-6, 1320b-2, 1320b-3, 1320b-6, 1320b-7, 1382, 1382c, 1395v, 1395z, 1396a, 1396b, 1396d, 1396p, 1997, 3013, 6862, 8624 of this title; title 7 sections 2012, 2014, 2015, 2017, 2026, title 8 section 1822; title 26 sections 81, 8103; title 29 section 782a; title 48 section 1421q.

§ 1381a. Basic entitlement to benefits

Every aged, blind, or disabled individual who is determined under part A of this subchapter to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this subchapter, be paid benefits by the Secretary of Health and Human Services.

(Aug. 14, 1935, ch. 531, title XVI, § 1602, as added Oct. 30, 1972, Pub. L. 92-603, title III, § 301, 86 Stat. 1465, and amended July 18, 1984, Pub. L. 98-369, div. B, title VI, § 2663(j)(2)(E), 98 Stat. 1170.)

AMENDMENTS

1984—Pub. L. 98-369 substituted "Health and Human Services" for "Health, Education, and Welfare".

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98-369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98-369, set out as a note under section 401 of this title.

PART A—DETERMINATION OF BENEFITS

§ 1382. Eligibility for benefits

(a) "Eligible individual" defined

(1) Each aged, blind, or disabled individual who does not have an eligible spouse and—

[See main edition for text of (A)]

(B) whose resources, other than resources excluded pursuant to section 1382b(a) of this title, are not more than (i) in case such individual has a spouse with whom he is living, the applicable amount determined under paragraph (3)(A), or (ii) in case such individual has no spouse with whom he is living, the

applicable amount determined under paragraph (3)(B),

shall be an eligible individual for purposes of this subchapter.

(2) Each aged, blind, or disabled individual who has an eligible spouse and—

[See main edition for text of (A)]

(B) whose resources (together with the resources of such spouse), other than resources excluded pursuant to section 1382b(a) of this title, are not more than the applicable amount determined under paragraph (3)(A),

shall be an eligible individual for purposes of this subchapter.

(3)(A) The dollar amount referred to in clause (i) of paragraph (1)(B), and in paragraph (2)(B), shall be \$2,250 prior to January 1, 1985, and shall be increased to \$2,400 on January 1, 1985, to \$2,550 on January 1, 1986, to \$2,700 on January 1, 1987, to \$2,850 on January 1, 1988, and to \$3,000 on January 1, 1989.

(B) The dollar amount referred to in clause (ii) of paragraph (1)(B), shall be \$1,500 prior to January 1, 1985, and shall be increased to \$1,600 on January 1, 1985, to \$1,700 on January 1, 1986, to \$1,800 on January 1, 1987, to \$1,900 on January 1, 1988, and to \$2,000 on January 1, 1989.

[See main edition for text of (b)]

(c) Period for determination of benefits

(1) An individual's eligibility for a benefit under this subchapter for a month shall be determined on the basis of the individual's (and eligible spouse's, if any) income, resources, and other relevant characteristics in such month, and, except as provided in paragraphs (2), (3), and (4), the amount of such benefit shall be determined for such month on the basis of income and other characteristics in the first or, if the Secretary so determines, second month preceding such month. Eligibility for and the amount of such benefits shall be redetermined at such time or times as may be provided by the Secretary.

[See main edition for text of (2) to (6); (d)]

(e) Limitation on eligibility of certain individuals

(1)(A) Except as provided in subparagraphs (B), (C), and (D), no person shall be an eligible individual or eligible spouse for purposes of this subchapter with respect to any month if throughout such month he is an inmate of a public institution.

[See main edition for text of (B) and (C)]

(D) A person may be an eligible individual or eligible spouse for purposes of this subchapter with respect to any month throughout which he is a resident of a public emergency shelter for the homeless (as defined in regulations which shall be prescribed by the Secretary); except that no person shall be an eligible individual or eligible spouse by reason of this subparagraph more than three months in any 12-month period.

Addendum 5

(Aug. 14, 1935, ch. 831, title XVIII, § 1880, as added Sept. 30, 1976, Pub. L. 94-437, title IV, § 401(b), 90 Stat. 1408.)

REFERENCES IN TEXT

Section 403 of such Act, referred to in subsec. (d), is section 403 of the Indian Health Care Improvement Act, Pub. L. 94-437, which is set out as a note under section 1871 of Title 25, Indiana.

MEDICARE PAYMENTS NOT CONSIDERED IN DETERMINING APPROPRIATIONS FOR INDIAN HEALTH CARE

Section 401(c) of Pub. L. 94-437 provided that: "Any payments received for services provided to beneficiaries hereunder (under this section) shall not be considered in determining appropriations for health care and services to Indians."

PREFERENCE IN SERVICES FOR INDIANS WITH MEDICARE COVERAGE NOT AUTHORIZED

Section 401(d) of Pub. L. 94-437 provided that: "Nothing herein authorizes the Secretary to provide services to an Indian beneficiary with coverage under title XVIII of the Social Security Act, as amended [this subchapter], in preference to an Indian beneficiary without such coverage."

SUBCHAPTER XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

SUBCHAPTER REFERRED TO IN OTHER SECTIONS

This subchapter is referred to in sections 247d, 254c, 254h, 294v, 300e-6, 602, 603, 713, 1301, 1306, 1308, 1309, 1315, 1316, 1318, 1319, 1320a-1, 1320a-2, 1382, 1382e, 1382g, 1383c, 1395b-1, 1395v, 1395x, 1395z, 1395cc, 1397a, 1397b, 1397c, 3689e, 3024, 3028 of this title; title 32 section 1715w; title 38 section 4108.

SUBCHAPTER REFERRED TO IN D.C. CODE

This subchapter is referred to in sections 1-266, 1-267 of the District of Columbia Code.

§ 1394. Appropriations

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for medical assistance.

(Aug. 14, 1935, ch. 831, title XIX, § 1901, as added July 30, 1965, Pub. L. 89-97, title I, § 121(a), 79 Stat. 243, and amended Dec. 31, 1973, Pub. L. 93-233, § 13(a)(1), 87 Stat. 960.)

AMENDMENTS

1973—Pub. L. 93-233 substituted in item (1) "disabled individuals" for "permanently and totally disabled individuals".

EFFECTIVE DATE OF 1973 AMENDMENT

Amendment by Pub. L. 93-233 effective with respect to payments under section 1394b of this title for calendar quarters commencing after Dec. 31, 1973, see sec-

tion 13(d) of Pub. L. 93-233, set out as an Effective Date of 1973 Amendment note under section 1394a of this title.

§ 1394a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1394b of this title are authorized by this subchapter; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, and (B) for the training and effective use of paid sub-professional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency;

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI of this chapter (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI of this chapter, or by the agency or agencies admin-

entering the supplemental security income program established under subchapter XVI or the State plan approved under part A of subchapter IV of this chapter if the State is not eligible to participate in the State plan program established under subchapter XVI of this chapter.

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals.

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services, and

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions;

(10) provide—

(A) for making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter;

(B) that the medical assistance made available to any individual described in clause (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in clause (A); and

(C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be, as determined in accordance with standards prescribed by the Secretary—

(i) for making medical assistance available to all individuals who would, except

for income and resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them supplemental security income benefits under subchapter XVI of this chapter, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and

(ii) that the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration, and scope;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1396d(a) of this title to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of subchapter XVIII of this chapter to individuals eligible therefor (either pursuant to an agreement entered into under section 1395v of this title or by reason of the payment of premiums under such subchapter by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of subchapter XVIII of this chapter for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, and (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A);

(11)(A) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan, and (B) effective July 1, 1969, provide, to the extent prescribed by the Secretary, for entering into agreements, with any agency, institution, or organization receiving payments for part or all of the cost of plans or projects under subchapter V of the chapter, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such plan or project under subchapter V of this

chapter and which are included in the State plan approved under this section and (ii) making such provision as may be appropriate for reimbursing such agency, institution, or organization for the cost of any such care and services furnished any individual for which payment would otherwise be made to the State with respect to him under section 1396b of this title;

(12) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

(13) provide—

(A)(i) for the inclusion of some institutional and some noninstitutional care and services, and

(ii) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services, and

(B) in the case of individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, for the inclusion of at least the care and services listed in clauses (1) through (5) of section 1396d(a) of this title, and

(C) in the case of individuals not included under subparagraph (B) for the inclusion of at least—

(i) the care and services listed in clauses (1) through (5) of section 1396d(a) of this title or

(ii)(I) the care and services listed in any 7 of the clauses numbered (1) through (16) of such section and (II) in the event the care and services provided under the State plan include hospital or skilled nursing facility services, physicians' services to an individual in a hospital or skilled nursing facility during any period he is receiving hospital services from such hospital or skilled nursing facility services from such facility, and

(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1320a-1 of this title, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1395x(v) of this title as the reasonable cost of such services for purposes of subchapter XVIII of this chapter; and

(E) effective July 1, 1976, for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary;

(14) effective January 1, 1973, provide that—

(A) in the case of individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or who meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be, and individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10)(A)—

(i) no enrollment fee, premium, or similar charge, and no deduction, cost sharing, or similar charge with respect to the care and services listed in clauses (1) through (5) and (7) of section 1396d(a) of this title, will be imposed under the plan, and

(ii) any deduction, cost sharing, or similar charge imposed under the plan with respect to other care and services will be nominal in amount (as determined in accordance with standards approved by the Secretary and included in the plan), and

(B) with respect to individuals (other than individuals with respect to whom there is being paid, or who are eligible or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10)(A)) who are not receiving aid or assistance under any such State plan and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be—

(i) there may be imposed an enrollment fee, premium, or similar charge which (as determined in accordance with standards prescribed by the Secretary) is related to the individual's income, and

(ii) any deductible, cost-sharing, or similar charge imposed under the plan will be nominal;

(15) in the case of eligible individuals 65 years of age or older who are covered by either or both of the insurance programs established by subchapter XVIII of this chapter, provide where, under the plan, all of any deductible, cost sharing, or similar charge imposed with respect to such individual under the insurance program established by such subchapter is not met, the portion thereof which is met shall be determined on a basis

reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to such individual's income or his income and resources;

(16) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulation) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom;

(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;

(18) provide that no lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the plan (except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual), and that there

shall be no adjustment or recovery (except, in the case of an individual who was 65 years of age or older when he received such assistance, from his estate, and then only after the death of his surviving spouse, if any, and only at a time when he has no surviving child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title with respect to States which are not eligible to participate in such program) of any medical assistance correctly paid on behalf of such individual under the plan;

(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients;

(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases—

(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodical determination of his need for continued treatment in the institution;

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance, for services referred to in section 303(a)(4)(A)(i) and (ii), section 303(a)(1)(A)(i) and (ii), or section 1383(a)(4)(A)(i) and (ii) of this title which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out; and

(D) provide methods of determining the reasonable cost of institutional care for such patients;

(21) If the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental diseases;

(22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B) the standards, for private or public institutions in which recipients of medical assistance under the plan may receive care or services, that will be utilized by the State authority or authorities responsible for establishing and maintaining such standards, (C) the cooperative arrangements with State health agencies and State vocational rehabilitation agencies entered into with a view to maximum utilization of and coordination of the provision of medical assistance with the services administered or supervised by such agencies, and (D) other standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality;

(23) except in the case of Puerto Rico, the Virgin Islands, and Guam, provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services; and a State plan shall not be deemed to be out of compliance with the requirements of this paragraph or paragraph (1) or (10) solely by reason of the fact that the State (or any political subdivision thereof) has entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization;

(24) effective July 1, 1969, provide for consultative services by health agencies and other appropriate agencies of the State to hospitals, nursing facilities, home health agencies, clinics, laboratories, and such other institutions as the Secretary may specify in order to assist them (A) to qualify for payments under this chapter, (B) to establish and maintain such fiscal records as may be necessary for the proper and efficient administration of this chapter, and (C) to provide information needed to determine payments due under this chapter on account of care and services furnished to individuals;

(25) provide (A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal li-

ability of third parties to pay for care and services (available under the plan) arising out of injury, disease, or disability, (B) that where the State or local agency knows that a third party has such a legal liability such agency will treat such legal liability as a resource of the individual on whose behalf the care and services are made available for purposes of paragraph (17)(B), and (C) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

(26) effective July 1, 1969, provide (A) for a regular program of medical review (including medical evaluation) of each patient's need for skilled nursing facility care or (in the case of individuals who are eligible therefor under the State plan) need for care in a mental hospital, a written plan of care, and, where applicable, a plan of rehabilitation prior to admission to a skilled nursing facility; (B) for periodic inspections to be made in all skilled nursing facilities and mental institutions (if the State plan includes care in such institutions) within the State by one or more medical review teams (composed of physicians and other appropriate health and social service personnel) of (i) the care being provided in such nursing facilities (and mental institutions, if care therein is provided under the State plan) to persons receiving assistance under the State plan, (ii) with respect to each of the patients receiving such care, the adequacy of the services available in particular nursing facilities (or institutions) to meet the current health needs and promote the maximum physical well-being of patients receiving care in such facilities (or institutions), (iii) the necessity and desirability of the continued placement of such patients in such nursing facilities (or institutions), and (iv) the feasibility of meeting their health care needs through alternative institutional or noninstitutional services; and (C) for the making by such team or teams of full and complete reports of the findings resulting from such inspections together with any recommendations to the State agency administering or supervising the administration of the State plan;

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency may from time to time request;

(28) provide that any skilled nursing facility receiving payments under such plan must satisfy all of the requirements contained in section 1395x(j) of this title, except that the exclusion contained therein with respect to institutions which are primarily for the care and treatment of mental diseases and tuberculosis shall not apply for purposes of this subchapter;

(29) include a State program which meets the requirements set forth in section 1396g of this title, for the licensing of administrators of nursing homes;

(30) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(1)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care;

(31) provide (A) for a regular program of independent professional review (including medical evaluation of each patient's need for intermediate care) and a written plan of service prior to admission or authorization of benefits in an intermediate care facility as determined under regulations of the Secretary; (B) for periodic on-site inspections to be made in all such intermediate care facilities (if the State plan includes care in such institutions) within the State by one or more independent professional review teams (composed of physicians or registered nurses and other appropriate health and social service personnel) of (i) the care being provided in such intermediate care facilities to persons receiving assistance under the State plan (ii) with respect to each of the patients receiving such care, the adequacy of the services available in particular intermediate care facilities to meet the current health needs and promote the maximum physical well-being of patients receiving care in such facilities, (iii) the necessity and desirability of the continued placement of such patients in such facilities, and (iv) the feasibility of meeting their health care needs through alternative institutional or non-institutional services; and (C) for the making by such team or teams of full and complete reports of the findings resulting from such inspections, together with any recommendations to the State agency administering or supervising the administration of the State plan;

(32) provide that no payment under the plan for any care or service to an individual by a physician, dentist, or other individual practitioner shall be made to anyone other than such individual or such physician, dentist, or practitioner, except that payment may be made (A) to the employer of such physician, dentist, or practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (B) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service;

(33) provide—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consist-

ent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto to the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the penultimate sentence of this subsection; and

(B) that the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title, or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this subchapter the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan;

(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;

(35) effective January 1, 1973, provide that any intermediate care facility receiving payments under such plan must supply to the licensing agency of the State full and complete information as to the identity (A) of each person having (directly or indirectly) an ownership interest of 10 per centum or more in such intermediate care facility or who is the owner (in whole or in part) of any mortgage, deed or trust, note, or other obligation secured (in whole or in part) by such intermediate care facility or any of the property or assets of such intermediate care facility, (B) in case an intermediate care facility is organized as a corporation, of each officer and director of the corporation, and (C) in case an intermediate care facility is organized as a partnership, of each partner; and promptly report any changes which would affect the current accuracy of the information so required to be supplied; and

(36) provide that within 90 days following the completion of each survey of any health care facility, laboratory, agency, clinic, or organization, by the appropriate State agency described in paragraph (9), such agency shall (in accordance with regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (A) the statutory conditions of participation imposed under this subchapter, and (B) the major additional

conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization.

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this subchapter, the State agency which administered or supervised the administration of the plan of such State approved under subchapter X of this chapter (or subchapter XVI of this chapter, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under subchapter I of this chapter (or subchapter XVI of this chapter, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under subchapter X of this chapter (or subchapter XVI of this chapter, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this subchapter (except for purposes of paragraph (10)). For purposes of paragraphs (9)(A), (29), (31), and (33), and of section 1396b(i)(4) of this title, the terms "skilled nursing facility" and "nursing home" do not include a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

For purposes of paragraph (10) any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under subchapter I, X, XIV, or XVI, of this chapter, or part A of subchapter IV of this chapter and who for such month was entitled to monthly insurance benefits under subchapter II of this chapter shall for purposes of this subchapter only be deemed to be eligible for financial aid or assistance for any month thereafter if such individual would have been eligible for financial aid or assistance for such month had the increase in monthly insurance benefits under subchapter II of this chapter resulting from enactment of Public Law 92-336 not been applicable to such individual.

(b) Approval by Secretary

The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that he shall not approve any plan which imposes, as a condition of eligibility for medical assistance under the plan—

- (1) an age requirement of more than 65 years; or
- (2) effective July 1, 1967, any age requirement which excludes any individual who has not attained the age of 21 and is or would, except for the provisions of section 606(a)(2) of this title, be a dependent child under part A of subchapter IV of this chapter; or

(3) any residence requirement which excludes any individual who resides in the State; or

(4) any citizenship requirement which excludes any citizen of the United States.

(c) Same; reduction of aid or assistance under State plans under other subchapters

Notwithstanding subsection (b) of this section, the Secretary shall not approve any State plan for medical assistance if he determines that the approval and operation of the plan will result in a reduction in aid or assistance in the form of money payments (other than so much, if any, of the aid or assistance in such form as was, immediately prior to the effective date of the State plan under this subchapter, attributable to medical needs) provided for eligible individuals under a plan of such State approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter.

(d) Repealed. Pub. L. 92-603, title II, § 231, Oct. 30, 1972, 86 Stat. 1410

(e) Continued eligibility of families determined ineligible because of income and resources or hours of work limitations of plan

Notwithstanding any other provision of this subchapter, effective January 1, 1974, each State plan approved under this subchapter must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of subchapter IV of this chapter in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such aid because of increased hours of, or increased income from, employment, shall, while a member of such family is employed, remain eligible for assistance under the plan approved under this subchapter (as though the family was receiving aid under the plan approved under part A of subchapter IV of this chapter) for 4 calendar months beginning with the month in which such family became ineligible for aid under the plan approved under part A of subchapter IV of this chapter because of income and resources or hours of work limitations contained in such plan.

(f) Effective date of State plan as determinative of duty of State to provide medical assistance to aged, blind, or disabled individuals

Notwithstanding any other provision of this subchapter, except as provided in subsection (e) of this section, no State not eligible to participate in the State plan program established under subchapter XVI of this chapter shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of subchapter XVI of this chapter) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this subchapter and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such

individual as determined in accordance with section 1396b(f) of this title (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to clause (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under clause (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under clause (10)(A), or (2) an eligible individual or eligible spouse, as defined in subchapter XVI of this chapter, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under clause (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to clause (10)(C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under clause (10)(A) of that subsection.

(Aug. 14, 1935, ch. 531, title XIX, § 1902, as added July 30, 1965, Pub. L. 89-97, title I, § 121(a), 79 Stat. 344, and amended Jan. 2, 1968, Pub. L. 90-248, title II, §§ 210(a)(6), 223(a), 224(a), (c)(1), 227(a), 228(a), 229(a), 231, 234(a), 235(a), 236(a), 237, 238, 241(f)(1)-(4), title III, § 302(b), 81 Stat. 896, 901-906, 908, 911, 917, 929; Aug. 9, 1969, Pub. L. 91-56, § 2(c), (d), 83 Stat. 99; Dec. 28, 1971, Pub. L. 92-223, § 4(b), 85 Stat. 809; Oct. 30, 1972, Pub. L. 92-603, title II, §§ 208(a), 209(a), (b)(1), 221(c)(5), 231, 232(a), 238(b), 237(a)(2), 239(a), (b), 240, 246(a), 249(a), 255(a), 268(a), 274(a), 278(a)(18), (19), (b)(14), 298, 299A, 299D(b), 86 Stat. 1381, 1389, 1410, 1415-1418, 1424, 1426, 1446, 1450, 1452-1454, 1460, 1462; Dec. 31, 1973, Pub. L. 93-233, §§ 13(a)(2)-(10), 18(o), (p), (q), (x)(1)-(4), 87 Stat. 960-962, 971, 972; Aug. 7, 1974, Pub. L. 93-368, § 9(a), 88 Stat. 422; July 1, 1975, Pub. L. 94-48, §§ 1, 2, 89 Stat. 247; Dec. 31, 1975, Pub. L. 94-182, title I, § 111(a), 89 Stat. 1054; Oct. 18, 1976, Pub. L. 94-552, § 1, 90 Stat. 2540.)

REFERENCES IN TEXT

Section 803 of this title, referred to in subsec. (a)(20)(C), was repealed by Pub. L. 93-647, § 3(b), Jan. 4, 1975, 88 Stat. 2349.

Section 1383(a)(4)(A) (i) and (ii) of this title, referred to in subsec. (a)(20)(C), was omitted in the general amendment of title XVI of the Social Security Act by Pub. L. 92-603, § 301.

Pub. L. 92-336, referred to in provisions following subsec. (a)(36), is Pub. L. 92-336, July 1, 1972, 86 Stat. 606, which amended sections 401, 403, 409, 411, 418,

427, 428, and 430 of this title and sections 165, 1401, 1402, 3101, 3111, 3121, 3122, 3125, 6413, and 6654 of Title 26, Internal Revenue Code, and enacted provisions set out as notes under sections 403, 409, 415, and 428 of this title and sections 165 and 1401 of Title 26.

AMENDMENTS

1976—Subsec. (g). Pub. L. 94-552 repealed subsec. (g) provisions for consent to suit and waiver of immunity by State.

1975—Subsec. (a)(23). Pub. L. 94-48, § 2, added "except in the case of Puerto Rico, the Virgin Islands, and Guam."

Subsec. (a), foll. par. (36). Pub. L. 94-48, § 1, added provision relating to eligibility under this subchapter of any individual who was eligible for the month of August 1972, under a State plan approved under subchapters I, X, XIV, XVI, or part A of subchapter IV of this chapter if such individual would have been eligible for such month had the increase in monthly insurance benefits under subchapter II of this chapter resulting from enactment of Pub. L. 92-336 not been applicable to such individual.

Subsec. (g). Pub. L. 94-182 added subsec. (g).

1974—Subsec. (a)(14)(B)(i). Pub. L. 93-368 substituted "may" for "shall".

1973—Subsec. (a)(5). Pub. L. 93-233, § 13(a)(2)(A), (B), substituted "to administer or to supervise the administration of the plan" for "to administer the plan" and "to supervise the administration of the plan" in that order and added after the parenthetical phrase the conditional provision "if the State is eligible to participate in the State plan program established under subchapter XVI of this chapter, or by the agency or agencies administering the supplemental security income program established under subchapter XVI of this chapter or the State plan approved under part A of subchapter IV of this chapter if the State is not eligible to participate in the State plan program established under subchapter XVI of this chapter".

Subsec. (a)(10). Pub. L. 93-233, § 13(a)(3), incorporated existing text in provisions designated as cl. (A), providing therein for medical assistance to individuals with respect to whom supplemental security income benefits are paid, incorporated existing par. (A) in provisions designated as cl. (B); incorporated existing par. (B) in provisions designated as cl. (C), providing therein for individuals not meeting income and resources requirements of the supplemental security income program; substituted in cls. (B)(ii), (C), (CX)(ii) and "medical assistance" for "medical or remedial care and services" appearing in predecessor provisions and in cl. (CXi) "except for income and resources" for "if needy" appearing in predecessor provision; and in the exception provisions included reference to par. (16) of section 1396(a) of this title in item (I), substituted "deductibles" for "the deductibles" in item (II), and added item (III).

Subsec. (a)(13)(B). Pub. L. 93-233, § 13(a)(4), substituted "any plan of the State approved" for "the State's plan approved" and inserted after "part A of subchapter IV of this chapter" text reading ", or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter".

Subsec. (a)(13)(CX)(ii)(I). Pub. L. 93-233, § 18(x)(1), substituted reference to clause "16" for "14".

Subsec. (a)(14)(A). Pub. L. 93-233, § 13(a)(5), substituted "any plan of the State approved" for "a State plan approved" and "with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or who meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be, and individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance

made available to individuals described in paragraph (10XA)" for "who meet the income and resources requirements of the one of such State plans which is appropriate".

Subsec. (a)(14)(B). Pub. L. 93-233, § 13(a)(6)(A)-(D), inserted after "with respect to individuals" the parenthetical provision "(other than individuals with respect to whom there is being paid, or who are eligible or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10XA))"; inserted after "any such State plan" the clause "and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter"; substituted "the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be," for "the one of such State plans which is appropriate"; and struck out "or who, after December 31, 1973, are included under the State plan for medical assistance pursuant to subsection (a)(10)(B) of this section approved under this subchapter" preceding the hyphen and cl. (I), respectively.

Subsec. (a)(17). Pub. L. 93-233, § 13(a)(7)(A)-(D), (8), substituted "any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter" for "the State's plan approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter"; "except for income and resources" for "if he met the requirements as to need"; "any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter" for "a State plan approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter"; "such aid, assistance, or benefits" for "and amount of such aid or assistance under such plan"; and "(with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program)" for "is blind or permanently and totally disabled".

Subsec. (a)(18). Pub. L. 93-233, § 13(a)(8), substituted "(with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program)" for "is blind or permanently and totally disabled".

Subsec. (a)(20)(C). Pub. L. 93-233, § 13(a)(9), inserted reference to section 803(a)(1)(A)(i) and (ii) of this title.

Subsec. (a)(21). Pub. L. 93-233, § 18(x)(4) provided for substitution of "nursing facilities" for "nursing homes".

Subsec. (a)(24). Pub. L. 93-233, § 18(x)(4) provided for substitution of "nursing facilities" for "nursing homes".

Subsec. (a)(26)(B). Pub. L. 93-233, § 18(x)(4), provided for substitution of "nursing facility" and "nursing facilities" for "nursing home" and "nursing homes", changes already executed under 1972 Amendment by Pub. L. 92-603, § 278(a)(19).

Subsec. (a)(33)(A). Pub. L. 93-233, § 18(x)(2), substituted "penultimate sentence" for "last sentence".

Subsec. (a)(34). Pub. L. 93-233, § 18(o), inserted "(or application was made on his behalf in the case of a deceased individual)" following "he made application".

Subsec. (a)(35)(A). Pub. L. 93-233, § 18(p), required the intermediate care facility to supply full and complete information respecting the person who is the

owner (in whole or in part) of any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the intermediate care facility or any of the property or assets of the intermediate care facility.

Subsec. (a)(35) to (37). Pub. L. 93-233, § 18(x)(3)(A), (B), substituted "; and" for "." at end of par. (35); and corrected numerical sequence of paragraphs, redesignating par. (37) as (36), the original subsec. (a) having been enacted without a par. (36).

Subsec. (e). Pub. L. 93-233, § 18(q), substituted "each family which was receiving aid pursuant to a plan of the State approved under part A" for "each family which was eligible for assistance pursuant to part A", "for such aid because of increased hours of, or increased income from, employment" for "for such assistance because of increased income from employment", and "remain eligible for assistance under the plan approved under this subchapter (as though the family was receiving aid under the plan approved under part A of subchapter IV of this chapter) for 4 calendar months beginning with the month in which such family became ineligible for aid under the plan approved under part A of subchapter IV of this chapter because of income and resources or hours of work limitations" for "remain eligible for such assistance for 4 calendar months following the month in which such family would otherwise be determined to be ineligible for such assistance because of the income and resources limitations".

Subsec. (f). Pub. L. 93-233, § 13(a)(10)(A)-(D) substituted: "no State not eligible to participate in the State plan program established under subchapter XVI of this chapter" for "no State" and "any supplemental security income payment and State supplementary payment made with respect to such individual" for "such individual's payment under subchapter XVI of this chapter" and "as recognized under State law" for "as defined in section 213 of Title 26" in parenthetical text; and added two end sentences for consideration of certain individuals as eligible for medical assistance under cl. (10)(A) or (C) of subsec. (a) of this section or as eligible for such assistance under cl. (10)(A) in States not providing such assistance under cl. (10)(C), respectively.

1972—Subsec. (a). Pub. L. 92-603, §§ 268(a), 278(b)(14), added provisions exempting Christian Science sanatoriums from certain nursing facility and nursing home requirements.

Subsec. (a)(9). Pub. L. 92-603, § 239(a), added provisions to utilize state health agency for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services.

Subsec. (a)(13)(A)(ii). Pub. L. 92-603, § 278(a)(18), (b)(14), substituted "skilled nursing facility" for "skilled nursing home".

Subsec. (a)(13)(C). Pub. L. 92-603, § 278(a)(18), (b)(14), substituted "skilled nursing facility" for "skilled nursing home".

Subsec. (a)(13)(D). Pub. L. 92-603, §§ 221(c)(5), 232(a), added provisions that the reasonable cost of inpatient hospital services shall not exceed the amount determined under section 1395x(v) of this title and inserted reference to the consistency of methods and standards with section 1320a-1 of this title for determining the reasonable cost of inpatient hospital services.

Subsec. (a)(13)(E). Pub. L. 92-603, § 249(a), added subpar. (E).

Subsec. (a)(14). Pub. L. 92-603, § 208(a), substituted a nominal amount for an amount reasonably related to the recipient's income as the amount of the deduction, cost sharing, or similar charge imposed under the plan and added provisions covering individuals who are not receiving aid or assistance under any state plan and who do not meet the income and resources requirements and covering individuals who are included under the state plan for medical assistance pursuant to subsec. (a)(10)(B) of this section approved under this subchapter.

Subsec. (a)(23). Pub. L. 92-603, § 240, added provisions allowing States to adopt comprehensive health

care programs while still complying with medical requirements.

Subsec. (a)(26). Pub. L. 92-603, § 274(a), 278(a)(19), (b)(14), substituted "evaluation" for "evaluation" and "care" for "care" and substituted "skilled nursing facility" and "skilled nursing facilities" for "skilled nursing home" and "skilled nursing homes".

Subsec. (a)(28). Pub. L. 92-603, § 246(a), substituted "skilled nursing facility" for "skilled nursing home" and substituted a simple reference to the requirements contained in section 1395x(j) of this title with a specified exception for provisions spelling out in detail the requirements for skilled nursing homes receiving payments.

Subsec. (a)(30). Pub. L. 92-603, § 237(a)(2), substituted "under the plan (including but not limited to utilization review plans as provided for in section 1396b(1)(4) of this title)" for "under the plan".

Subsec. (a)(31)(A). Pub. L. 92-603, § 298, struck out "which provides more than a minimum level of health care services" following "intermediate care facility".

Subsec. (a)(32). Pub. L. 92-603, § 236(b)(3), added par. (32).

Subsec. (a)(33). Pub. L. 92-603, § 239(b)(3), added par. (33).

Subsec. (a)(34). Pub. L. 92-603, § 255(a)(3), added par. (34).

Subsec. (a)(35). Pub. L. 92-603, § 299A(3), added par. (35).

Subsec. (a)(37). Pub. L. 92-603, § 299D(b)(3), added par. (37).

Subsec. (d). Pub. L. 92-603, § 231, repealed subsec. (d), which related to modification of state plans for medical assistance under certain circumstances.

Subsec. (e). Pub. L. 92-603, § 209(a), added subsec. (e).

Subsec. (f). Pub. L. 92-603, § 209(b)(1), added subsec. (f).

1971—Subsec. (a)(31). Pub. L. 92-233 added par. (31).
1969—Subsec. (c). Pub. L. 91-56, § 2(c), substituted "aid or assistance in the form of money payments (other than so much, if any, of the aid or assistance in such form as was, immediately prior to the effective date of the State plan under this subchapter, attributable to medical needs)" for "aid or assistance (other than so much of the aid or assistance as is provided for under the plan of the State approved under this subchapter)".

Subsec. (d). Pub. L. 91-56, § 2(d), added subsec. (d).

1968—Subsec. (a)(2). Pub. L. 90-248, § 231, changed the date on which State plans must meet certain financial participation requirements by substituting "July 1, 1969" for "July 1, 1970".

Subsec. (a)(4). Pub. L. 90-248, § 210(a)(6), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (a)(10). Pub. L. 90-248, §§ 223(a), 241(f)(1), deleted "IV," after "I," and inserted ", and part A of subchapter IV of this chapter" after "XVI of this chapter", and designated existing provisions as item I and added item II.

Subsec. (a)(11). Pub. L. 90-248, § 302(b), designated existing provisions as cl. (A) and added cl. (B).

Subsec. (a)(13). Pub. L. 90-248, § 224(a), designated existing provisions as subpar. (A), incorporated existing cl. (A) in provisions designated as subpars. (B) and (C)-(I), making subpar. (B) and (C) applicable to individuals receiving aid or assistance under an approved State plan and to individuals not covered under subpar. (B), respectively, added cl. (II) of subpar. (C), redesignated former cl. (B) as subpar. (D), and deleted effective date of July 1, 1967, for former cls. (A) and (B).

Subsec. (a)(13)(A). Pub. L. 90-248, § 224(c)(1), designated existing provisions as cl. (I) and added cl. (II).

Subsec. (a)(14)(A). Pub. L. 90-248, § 235(a)(1), inserted "in the case of individuals receiving aid or assistance under State plans approved under subchapters I, X, XIV, XVI, and part A of subchapter IV of this chapter,".

Subsec. (a)(14)(B). Pub. L. 90-248, § 235(a)(2), inserted "inpatient hospital services or" after "respect to" and substituted "to an individual" for "him".

Subsec. (a)(15). Pub. L. 90-248, § 235(a)(3), deleted subpar. (B) provision for meeting the full cost of any deductible imposed with respect to any such individual under the insurance program established by part A of such subchapter, deleted subpar. (B) designation preceding "where, under the plan", and substituted therein "established by such subchapter" for "established by part B of such subchapter".

Subsec. (a)(17). Pub. L. 90-248, § 238, inserted in the parenthetical expression "and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under the State's plan approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter, based on the variations between shelter costs in urban areas and in rural areas" following "all groups".

Pub. L. 90-248, § 241(f)(2), in clause (B) deleted "IV," after "I," and inserted ", or part A of subchapter IV of this chapter" after "XVI of this chapter".

Subsecs. (a)(23) to (30). Pub. L. 90-248, §§ 227(a), 228(a), 229(a), 234(a), 236(a), 237, added pars. (23), (24), (25), (26)-(28), (29), (30), respectively.

Subsec. (b)(2). Pub. L. 90-248, § 241(f)(3), inserted "part A of" before "subchapter IV".

Subsec. (c). Pub. L. 90-248, § 241(f)(4), deleted "IV," after "I," and inserted ", or part A of subchapter IV of this chapter" after "XVI of this chapter".

EFFECTIVE DATE OF 1976 AMENDMENT

Section 2 of Pub. L. 94-552 provided that: "The amendments made by the first section [repealing subsec. (g) of this section and section 1396b(i) of this title] shall take effect as of January 1, 1976."

EFFECTIVE DATE OF 1975 AMENDMENT

Section 111(c) of Pub. L. 94-182 provided that: "The amendments made by this section [amending subsec. (g) of this section and section 1396b(i) of this title] shall (except as otherwise provided for therein) become effective January 1, 1976."

EFFECTIVE DATE OF 1974 AMENDMENT

Section 9(b) of Pub. L. 93-368 provided that: "The amendment made by subsection (a) [to subsec. (a)(14)(B)(i) of this section] shall be effective January 1, 1973."

EFFECTIVE DATE OF 1973 AMENDMENT

Section 13(d) of Pub. L. 93-233 provided that: "The amendments made by subsection (a) [to subsecs. (a)(5), (10), (13)(B), (14)(A), (B), (17), (18), (20)(C), and (f) of this section and sections 1396, 1396b(a)(1), (f)(4), and 1396(a), (a)(iv)-(vii), (j), and (k) of this title] shall be effective with respect to payments under section 1903 of the Social Security Act [section 1396b of this title] for calendar quarters commencing after December 31, 1973."

Section 18(a-3)(4) of Pub. L. 93-233 provided that: "The amendments made by subsections (o) and (u) [of subsec. (a)(3) of this section and section 1396b(b)(3) of this title] shall be effective July 1, 1973."

EFFECTIVE DATE OF 1972 AMENDMENT

Section 268(c) of Pub. L. 92-603 provided that: "The amendments made by this section [amending subsec. (a) of this section and section 1396g(g)(1) of this title] shall be effective on the date of the enactment of this Act (Oct. 30, 1972)."

Amendment of subsec. (a)(9) and (a)(33) by section 239(a), (b) of Pub. L. 92-603 to be effective Jan. 1, 1973 (or earlier if the state plan so provides), see section 239(d) of Pub. L. 92-603, set out as an Effective Date of 1972 Amendment note under section 705 of this title.

Amendment of subsec. (a)(13) by section 232(a) of Pub. L. 92-603 effective July 1, 1973 or earlier if the

State plan so provides, see section 232(c) of Pub. L. 92-603, set out as an Effective Date of 1972 Amendment note under section 705 of this title.

Section 308(b) of Pub. L. 92-603 provided that: "The amendment made by subsection (a) [amending subsec. (a)(14) of this section] shall be effective January 1, 1973 (or earlier if the State plan so provided)."

Amendment of subsec. (a)(28) by section 346(a) of Pub. L. 92-603 to be effective July 1, 1973, see section 346(c) of Pub. L. 92-603, set out as an Effective Date of 1972 Amendment note under section 1395x of this title.

Section 237(d)(2) of Pub. L. 92-603 provided that: "The amendment made by subsection (a)(2) [amending subsec. (a)(30) of this section] shall be effective July 1, 1973."

Amendment of subsec. (a)(32) by section 236(b) of Pub. L. 92-603 effective Jan. 1, 1973 or earlier if the state plan so provides, see section 236(c) of Pub. L. 92-603, set out as an Effective Date of 1972 Amendment note under section 1395u of this title.

Section 255(b) of Pub. L. 92-603 provided that: "The amendments made by subsection (a) [adding subsec. (a)(34) of this section] shall be effective July 1, 1973."

Amendment of subsec. (a)(37) by section 299D(b) of Pub. L. 92-603 effective beginning Jan. 1, 1973, or within 6 months following Oct. 30, 1972, whichever is later, see section 299D(c) of Pub. L. 92-603, set out as an Effective Date of 1972 Amendment note under section 1395aa of this title.

Section 209(b)(2) of Pub. L. 92-603 provided that: "The amendment made by this subsection [adding subsec. (f) of this section] shall become effective on January 1, 1974."

EFFECTIVE DATE OF 1971 AMENDMENT

Section 4(d) of Pub. L. 92-223, as amended by section 292 of Pub. L. 92-603, provided that: "The amendments made by this section [enacting subsec. (a)(31) of this section and section 1396d(a)(16), (c), (d) of this title and repealing section 1320a of this title] shall become effective January 1, 1972; except that the repeal made by subsection (c) [repealing section 1320a of this title], shall not become effective in the case of any State, which on January 1, 1972 did not have in effect a State plan approved under title XIX of the Social Security Act [this subchapter], until the first day of the first month (occurring after such date) that such State does have in effect a State plan approved under such title [this subchapter]."

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment of subsec. (a)(4) by section 210(a)(6) of Pub. L. 90-248 effective July 1, 1969, or, if earlier (with respect to a State's plan approved under this subchapter) on the date as of which the modification of the State plan to comply with such amendment is approved, see section 210(b) of Pub. L. 90-248, set out as an Effective Date of 1968 Amendment note under section 302 of this title.

Section 223(b) of Pub. L. 90-248 provided that: "The amendments made by subsection (a) [to subsec. (a)(10) of this section] shall apply with respect to calendar quarters beginning after June 30, 1967."

Section 224(b) of Pub. L. 90-248 provided that: "The amendment made by subsection (a) [to subsec. (a)(13) (other than (A)(II)) of this section] shall apply with respect to calendar quarters beginning after December 31, 1967."

Section 224(c)(2) of Pub. L. 90-248 provided that: "The amendment made by paragraph (1) of this subsection [amending subsec. (a)(13)(A) of this section] shall apply with respect to calendar quarters beginning after June 30, 1970."

Section 227(b) of Pub. L. 90-248, as amended by section 271A of Pub. L. 92-603, effective from and after July 1, 1972, provided that: "The amendments made by this section [enacting subsec. (a)(23) of this section] shall apply with respect to calendar quarters beginning after June 30, 1969, except that such amendments shall apply in the case of Puerto Rico, the

Virgin Islands, and Guam only with respect to calendar quarters beginning after June 30, 1975."

Section 229(b) of Pub. L. 90-248 provided that: "The amendment made by subsection (a) [enacting subsec. (a)(25) of this section] shall apply with respect to legal liabilities of third parties arising after March 31, 1968."

Section 234(b) of Pub. L. 90-248 provided that: "The amendments made by subsection (a) of this section [enacting subsecs. (a)(26) to (28) of this section] (unless otherwise specified in the body of such amendments) shall take effect on January 1, 1969."

Section 235(b) of Pub. L. 90-248 provided that: "The amendments made by subsection (a) [to subsecs. (a)(14), (15) of this section] shall be effective in the case of calendar quarters beginning after December 31, 1967."

Enactment of subsec. (a)(29) by section 236(a) of Pub. L. 90-248 effective July 1, 1970, except as otherwise specified in the text thereof, see section 236(c) of Pub. L. 90-248, set out as an Effective Date note under section 1396g of this title.

Section 237 of Pub. L. 90-248 provided in part that enactment of subsec. (a)(30) by section 237 shall be effective Apr. 1, 1968.

Section 238 of Pub. L. 90-248 provided in part that amendment of subsec. (a)(17) by section 238 shall be effective July 1, 1969.

TRANSFER OF FUNCTIONS

Functions, powers, and duties of Secretary of Health, Education, and Welfare under subsec. (a)(4)(A) of this section insofar as relates to the prescription of personnel standards on a merit basis, transferred to United States Civil Service Commission, see section 4728(a)(3)(D) of this title.

PRESERVATION OF MEDICAID ELIGIBILITY FOR INDIVIDUALS WHO CEASE TO BE ELIGIBLE FOR SUPPLEMENTAL SECURITY INCOME BENEFITS ON ACCOUNT OF COST-OF-LIVING INCREASES IN SOCIAL SECURITY BENEFITS

Pub. L. 94-566, title V, § 503, Oct. 20, 1976, 90 Stat. 2685, provided that: "In addition to other requirements imposed by law as a condition for the approval of any State plan under title XIX of the Social Security Act [this subchapter], there is hereby imposed the requirement (and each such State plan shall be deemed to require) that medical assistance under such plan shall be provided to any individual, for any month after June 1977 for which such individual is entitled to a monthly insurance benefit under title II of such Act [subchapter II of this chapter] but is not eligible for benefits under title XVI of such Act [subchapter XVI of this chapter], in like manner and subject to the same terms and conditions as are applicable under such State plan in the case of individuals who are eligible for and receiving benefits under such title XVI [subchapter XVI of this chapter] for such month, if for such month such individual would be (or could become) eligible for benefits under such title XVI [subchapter XVI of this chapter] except for amounts of income received by such individual and his spouse (if any) which are attributable to increase in the level of monthly insurance benefits payable under title II of such Act [subchapter II of this chapter] which have occurred pursuant to section 215(l) of such Act [section 415(l) of this title], in the case of such individual, since the last month after April 1977 for which such individual was both eligible for (and received) benefits under such title XVI [subchapter XVI of this chapter] and was entitled to a monthly insurance benefit under such title II [subchapter II of this chapter], and, in the case of such individual's spouse (if any), since the last such month for which such spouse was both eligible for (and received) benefits under such title XVI [subchapter XVI of this chapter] and was entitled to a monthly insurance benefit under such title II [subchapter II of this chapter]. Solely for purposes of this section, payments of the type described in section 1616(a) of the Social Security Act [section 1382(a) of this title] or of the type described

in section 212(a) of Pub. L. 93-66 (set out as note under section 1382 of this title) shall be deemed to be benefits under title XVI of the Social Security Act (subchapter XVI of this chapter)."

MEDICAID ELIGIBILITY FOR INDIVIDUALS RECEIVING MANDATORY STATE SUPPLEMENTARY PAYMENTS; EFFECTIVE DATE

Section 13(c) of Pub. L. 93-233 provided that:

"In addition to other requirements imposed by law as conditions for the approval of any State plan under title XIX of the Social Security Act (this subchapter), there is hereby imposed (effective January 1, 1974) the requirement (and each such State plan shall be deemed to require) that medical assistance under such plan shall be provided to any individual—

"(1) for any month for which there (A) is payable with respect to such individual a supplementary payment pursuant to an agreement entered into between the State and the Secretary of Health, Education, and Welfare under section 212(a) of Public Law 93-66 (set out as note under section 1382 of this title), and (B) would be payable with respect to such individual such a supplementary payment, if the amount of the supplementary payments payable pursuant to such agreement were established without regard to paragraph (3)(A)(ii) of such section 212(a) (set out as note under section 1382 of this title), and

"(2) in like manner, and subject to the same terms and conditions, as medical assistance is provided under such plan to individuals with respect to whom benefits are payable for such month under the supplementary security income program established by title (subchapter) XVI of the Social Security Act (this chapter).

Federal matching under title XIX of the Social Security Act (this subchapter) shall be available for the medical assistance furnished to individuals who are eligible for such assistance under this subsection."

COVERAGE OF ESSENTIAL PERSONS UNDER MEDICAID

Section 230 of Pub. L. 93-66, title II, July 9, 1973, 87 Stat. 169, provided that:

"In the case of any State plan (approved under title XIX of the Social Security Act (this subchapter)) which for December 1973 provided medical assistance to persons described in section 1905(a)(vi) of such Act (section 1396d(a)(vi) of this title), there is hereby imposed the requirement (and such State plan shall be deemed to require) that medical assistance under such plan be provided to each such person (who for December 1973 was eligible for medical assistance under such plan) for each month (after December 1973) that—

"(1) the individual (referred to in the last sentence of section 1905(a) of such Act (section 1396d(a) of this title)) with whom such person is living continues to meet the criteria (as in effect for December 1973) for aid or assistance under a State plan (referred to in such sentence), and

"(2) such person continues to have the relationship with such individual described in such sentence and meets the other criteria (referred to in such sentence) with respect to a State plan (so referred to) as such plan was in effect for December 1973.

Federal matching under title XIX of the Social Security Act (this subchapter) shall be available for the medical assistance furnished to individuals eligible for such assistance under this section."

PERSONS IN MEDICAL INSTITUTIONS

Section 231 of Pub. L. 93-66, title II, July 9, 1973, 87 Stat. 169, as amended by Pub. L. 93-233, § 13(b)(1), Dec. 31, 1973, 87 Stat. 964, provided that:

"For purposes of section 1902(a)(10) of the Social Security Act (subsec. (a)(10) of this section), any individual who, for all (or any part of) the month of December 1973—

"(1) was an inpatient in an institution qualified for reimbursement under title XIX of the Social Security Act (this subchapter), and

"(2)(A) received or would (except for his being an inpatient in such institution) have been eligible to receive aid or assistance under a State plan approved under title I, X, XIV, or XVI of such Act (subchapter I, X, XIV, or XVI of this chapter), and

"(B) on the basis of his status as described in subparagraph (A), was included as an individual eligible for medical assistance under a State plan approved under title XIX of such Act (this subchapter) (whether or not such individual actually received aid or assistance under a State plan referred to in subparagraph (A)),

shall be deemed to be receiving such aid or assistance for such month and for each succeeding month in a continuous period of months if, for each month in such period—

"(3) such individual continues to be (for all of such month) an inpatient in such an institution and would (except for his being an inpatient in such institution) continue to meet the conditions of eligibility to receive aid or assistance under such plan (as such plan was in effect for December 1973), and

"(4) such individual is determined (under the utilization review and other professional audit procedures applicable to State plans approved under title XIX of the Social Security Act (this subchapter)) to be in need of care in such an institution.

Federal matching under title XIX of the Social Security Act (this subchapter) shall be available for the medical assistance furnished to individuals eligible for such assistance under this section."

BLIND AND DISABLED MEDICALLY INDIGENT PERSONS

Section 232 of Pub. L. 93-66, title II, July 9, 1973, 87 Stat. 169, as amended by Pub. L. 93-233, § 13(b)(2), Dec. 31, 1973, 87 Stat. 964, provided that: "For purposes of section 1902(a)(10) of the Social Security Act (subsec. (a)(10) of this section), any individual who, for the month of December 1973 was eligible (subsec. (a)(10) of this section) for medical assistance by reason of his having been determined to meet the criteria for blindness or disability (established by a State plan approved under title I, X, XIV, or XVI of such Act (subchapter I, X, XIV, or XVI of this chapter)), shall be deemed for purposes of title XIX (this subchapter) to be an individual who is blind or disabled within the meaning of section 1614(a) of the Social Security Act (section 1382c(a) of this title) for each month in a continuous period of months (beginning with the month of January 1974), if, for each month in such period, such individual continues to meet the criteria for blindness or disability so established by such a State plan (as it was in effect for December 1973). Federal matching under title XIX of the Social Security Act (this subchapter) shall be available for the medical assistance furnished to individuals eligible for such assistance under this section, and the other conditions of eligibility contained in the plan of the State approved under title XIX (this subchapter) (as it was in effect in December 1973)."

IMPACT OF 1972 SOCIAL SECURITY BENEFITS INCREASE UNDER PUB. L. 92-336 UPON ELIGIBILITY FOR ASSISTANCE UNDER THIS SUBCHAPTER

Section 249E of Pub. L. 92-603, as amended by section 233 of Pub. L. 93-66, title II, July 9, 1973, 87 Stat. 160, provided that: "For purposes of section 1902(a)(10) of the Social Security Act (subsec. (a)(10) of this section) any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV of such Act (subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter) and who for such month was entitled to monthly insurance benefits under title II of such Act (subchapter II of this chapter) shall be deemed to be eligible for such aid or assistance for any month thereafter prior to July 1975 if such individual would have been eligible for such aid or assistance for such month had the increase in monthly insurance benefits under title II of such Act (subchapter II of this chap-

ter) resulting from enactment of Pub. L. 92-336 (see Tables volume) not been applicable to such individual."

NURSING HOMES ELIGIBLE FOR MATCHING FUNDS FOR HOME SERVICES WHEN MEETING STATE LICENSURE REQUIREMENTS AFTER JUNE 30, 1968

Section 234(c) of Pub. L. 90-248 provided that: "Notwithstanding any other provision of law, after June 30, 1968, no Federal funds shall be paid to any State as Federal matching under title I, X, XIV, XVI, or XIX of the Social Security Act (subchapter I, X, XIV, XVI, or XIX of this chapter) for payments made to any nursing home or on account of any nursing home services provided by such nursing home for any period during which such nursing home is determined not to meet fully all requirements of the State for licensure as a nursing home, except that the Secretary may prescribe a reasonable period or periods of time during which a nursing home which has formerly met such requirements will be eligible for payments which include Federal participation if during such period or periods such home promptly takes all necessary steps to again meet such requirements."

DISTRICT OF COLUMBIA: PLAN FOR MEDICAL ASSISTANCE

Pub. L. 90-237, § 1, Dec. 27, 1967, 81 Stat. 744, provided:

"That (a) the Commissioner of the District of Columbia (now Mayor) (hereafter in this Act (enacting this note and material set out as a note under section 1395v of this title) referred to as the 'Commissioner') may submit under title XIX of the Social Security Act (this subchapter) to the Secretary of Health, Education, and Welfare (hereafter in this Act referred to as the 'Secretary') a plan for medical assistance (and any modifications of such plan) to enable the District of Columbia to receive Federal financial assistance under such title for a medical assistance program established by the Commissioner under such plan.

"(b)(1) Notwithstanding any other provision of law, the Commissioner may take such action as may be necessary to submit such plan to the Secretary and to establish and carry out such medical assistance program, except that in prescribing the standards for determining eligibility for and the extent of medical assistance under the District of Columbia's plan for medical assistance, the Commissioner may not (except to the extent required by title XIX of the Social Security Act) (this subchapter)—

"(A) prescribe maximum income levels for recipients of medical assistance under such plan which exceed (i) the title XIX maximum income levels if such levels are in effect, or (ii) the Commissioner's maximum income levels for the local medical assistance program if there are no title XIX maximum income levels in effect; or

"(B) prescribe criteria which would permit an individual or family to be eligible for such assistance if such individual or family would be ineligible, solely by reason of his or its resources, for medical assistance both under the plan of the State of Maryland approved under title XIX of the Social Security Act (this subchapter) and under the plan of the State of Virginia approved under such title.

"(2) For purposes of subparagraph (A) of paragraph (1) of this subsection—

"(A) the term 'title XIX maximum income levels' means any maximum income levels which may be specified by title XIX of the Social Security Act (this subchapter) for recipients of medical assistance under State plans approved under that title;

"(B) the term 'the Commissioner's maximum income levels for the local medical assistance program' means the maximum income levels prescribed for recipients of medical assistance under the District of Columbia's medical assistance program in effect in the fiscal year ending June 30, 1967; and

"(C) during any of the first four calendar quarters in which medical assistance is provided under such plan there shall be deemed to be no title XIX maxi-

imum income levels in effect if the title XIX maximum income levels in effect during such quarter are higher than the Commissioner's maximum income levels for the local medical assistance program."

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 1315, 1395v, 1396b, 1396d, 1396g, 1396i, 4728 of this title; title 21 section 1172.

SECTION REFERRED TO IN D.C. CODE

This section is referred to in section 23-901 of the District of Columbia Code.

§ 1396b. Payment to States

(a) Computation of amount

From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this subchapter, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1396d(b) of this title, subject to subsections (g) and (h) of this section) of the total amount expended during such quarter as medical assistance under the State plan (including expenditures for premiums under part B of subchapter XVIII of this chapter, for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title, and, except in the case of individuals sixty-five years of age or older and disabled individuals entitled to hospital insurance benefits under subchapter XVIII of this chapter who are not enrolled under part B of subchapter XVIII of this chapter, other insurance premiums for medical or any other type of remedial care or the cost thereof; plus

(2) an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel, of the State agency or any other public agency; plus

(3) an amount equal to—

(A) 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such mechanized claims processing and information retrieval systems as the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of subchapter XVIII of this chapter, including the State's share of the

overpayments under subchapter XIX of this chapter, and

(3) assure the restoration to the institution or person of amounts withheld under this section which are ultimately determined to be in excess of overpayments under subchapter XIX of this chapter and to which the institution or person would otherwise be entitled under this subchapter.

(c) **Payment to States of amounts recovered**

Notwithstanding any other provision of this chapter, from the trust funds established under sections 1395i and 1395t of this title, as appropriate, the Secretary shall pay to the appropriate State agency amounts recovered under this section to offset the State agency's overpayment under subchapter XIX of this chapter. Such payments shall be accounted for by the State agency as recoveries of overpayments under the State plan.

(Aug. 14, 1935, ch. 531, title XVIII, § 1885, as added Aug. 13, 1981, Pub. L. 97-35, title XXI, § 2104, 95 Stat. 788.)

SUBCHAPTER XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

SUBCHAPTER REFERRED TO IN OTHER SECTIONS

This subchapter is referred to in sections 242b, 254a-1, 254b, 254c, 254e, 254h, 254n, 300e, 300e-6, 300m-6, 300z-5, 602, 603, 606, 614, 632a, 671, 672, 673, 705, 709, 1301, 1306, 1308, 1309, 1310, 1315, 1316, 1318, 1320a-1, 1320a-2, 1320a-3, 1320a-5, 1320a-7, 1320a-7a, 1320a-8, 1320b-2, 1320b-3, 1320b-4, 1320b-5, 1320c-4, 1320c-9, 1382, 1382g, 1382h, 1382i, 1383c, 1395b-1, 1395v, 1395x, 1395y, 1395z, 1395cc, 1395tt, 1395vv, 1997, 3013, 3026, 3035b, 3524, 3624 of this title; title 7 sections 2026, 3178, title 8 section 1522, title 12 sections 1715w, 1718a-7; title 26 section 1622; title 38 sections 622, 4108.

61396. Appropriations

CHANGES OF NAME

The Secretary of Health, Education, and Welfare was redesignated the Secretary of Health and Human Services by section 3508(b) of Title 20, Education.

61396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

[See main edition for text of (1) to (3)]

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as com-

munity service aides, in the administration of the plan and for the use, of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency, and (C) that each State or local officer or employee who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer or employee, and each partner of such an officer or employee shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of title 18.

[See main edition for text of (5) to (8)]

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (which ever is utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions, and

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1395x(e)(9) of this title or paragraphs (11) and (12) of section 1395x(s) of this title, or, in the case of a laboratory which is in a rural health clinic, of section 1395x(aa)(2)(G) of this title;

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title, to all individuals receiving aid or assistance under any plan of the State approved under subchapter 1, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including pregnant women deemed by the State to be receiving such aid as authorized in section 606(g) of this title and individuals considered by the State to be receiving such aid as authorized under section 614(g) of this title), or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter;

(B) that the medical assistance made available to any individual described in subparagraph (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);

(C) that if medical assistance is included for any group of individuals described in section 1396d(a) of this title who are not described in subparagraph (A), then—

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance and (II) the amount, duration, and scope of medical assistance made available to individuals in the group;

(ii) the plan must make available medical assistance—

(I) to individuals described in section 1396d(a)(i) of this title, and

(II) to pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);

(iii) such medical assistance must include (I) with respect to children under 18 and individuals entitled to institutional services, ambulatory services, and (II) with respect to pregnant women, prenatal care and delivery services; and

(iv) if such medical assistance includes services in institutions for mental diseases or intermediate care facility services for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title or the care and services listed in any 7 of the paragraphs numbered (1) through (17) of such section; and

(D) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services;

[See main edition for text of concluding par.]

(11)(A) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan, and (B) effective July 1, 1969, provide, to the extent prescribed by the Secretary, for entering into agreements, with any agency, institution, or organization receiving payments under (or through an allotment under) subchapter V of this chapter, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such subchapter or allotment and which are included in the State plan approved under this section

and (ii) making such provision as may be appropriate for reimbursing such agency, institution, or organization for the cost of any such care and services furnished any individual for which payment would otherwise be made to the State with respect to him under section 1396b of this title;

[See main edition for text of (12)]

(13) provide—

(A) for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1395x(v)(1)(G) of this title), for lower reimbursement rates reflecting the level of care actually received (in a manner consistent with section 1395x(v)(1)(G) of this title)) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, skilled nursing facility, and intermediate care facility and periodic audits by the State of such reports; and

(B) for payment for services described in section 1396d(a)(2)(B) of this title provided by a rural health clinic under the plan of 100 percent of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary may prescribe in regulations under section 1395i(a)(3) of this title, or, in the case of services to which those regulations do not apply, on such tests of reasonableness as the Secretary may prescribe in regulations under this subparagraph;

(C) Repealed. Pub. L. 97-35, title XXI, § 2171(b), Aug. 13, 1981, 95 Stat. 808.

(D) Repealed. Pub. L. 97-35, title XXI, § 2173(a)(1)(A), Aug. 13, 1981, 95 Stat. 809.

(E) Redesignated (A)

(F) Redesignated (B)

(14) effective January 1, 1973, provide that—

(A) in the case of individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or who meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be, and individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10)(A)—

(i) no enrollment fee, premium, or similar charge, and no deduction, cost sharing, or similar charge with respect to the care and services listed in paragraphs (1) through (5), (7), and (17) of section 1396d(a) of this title, will be imposed under the plan, and

[See main edition for text of (ii), (B), (15) to (19)]

(20) If the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases—

[See main edition for text of (A)]

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodical determination of his need for continued treatment in the institution; and

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 303(a)(4)(A)(i) and (ii), section 303(a)(1)(A)(i) and (ii), or section 1383(a)(4)(A)(i) and (ii) of this title which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out;

(D) Repealed. Pub. L. 97-35, title XXI, § 2173(a)(2)(C), Aug. 13, 1981, 95 Stat. 809.

[See main edition for text of (21) and (22)]

(23) except as provided in section 1396n and except in the case of Puerto Rico, the Virgin

Islands, and Guam, provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services;

[See main edition for text of (24)]

(25) provide (A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties to pay for care and services (available under the plan) arising out of injury, disease, or disability, (B) that where the State or local agency knows that a third party has such a legal liability such agency will treat such legal liability as a resource of the individual on whose behalf the care and services are made available for purposes of paragraph (17)(B), and (C) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

(26) effective July 1, 1969, provide (A) for a regular program of medical review (including medical evaluation) of each patient's need for skilled nursing facility care or (in the case of individuals who are eligible therefor under the State plan) need for care in a mental hospital, a written plan of care, and, where applicable, a plan of rehabilitation prior to admission to a skilled nursing facility; (B) for periodic inspections to be made in all skilled nursing facilities and mental institutions (if the State plan includes care in such institutions) within the State by one or more medical review teams (composed of physicians and other appropriate health and social service personnel, or, in the case of skilled nursing facilities, composed of physicians or registered nurses and other appropriate health and social service personnel) of (i) the care being provided in such nursing facilities (and mental institutions, if care therein is provided under the State plan) to persons receiving assistance under the State plan, (ii) with respect to each of the patients receiving such care, the adequacy of the services available in particular nursing facilities (or institutions) to meet the current health needs and promote the maximum physical well-being of patients receiving care in such facilities (or institutions), (iii) the necessity and desirability of the continued placement of such patients in such nursing facilities (or institutions), and (iv) the feasibility of meeting their health care needs through alternative institutional or noninstitutional services; and (C) for the making by such team or teams of full and complete reports of the findings resulting from such inspections together with any recommendations to the State agency adminis-

tering or supervising the administration of the State plan;

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request;

[See main edition for text of (28) and (29)]

(30) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(1)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care;

[See main edition for text of (31)]

(32) provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise; except that—

(A) in the case of any care or service provided by a physician, dentist, or other individual practitioner, such payment may be made (i) to the employer of such physician, dentist, or other practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (ii) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service; and

(B) nothing in this paragraph shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the person or institution providing the care or service involved if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of such person or institution from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such person or institution under the plan is unrelated (directly or indirectly) to the amount of such payments or the bill-

ings therefor, and is not dependent upon the actual collection of any such payment;

(33) provide—

[See main edition for text of (A)]

(B) that the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title, or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this subchapter the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan, except that, if the Secretary has cause to question the adequacy of such determinations, the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation;

[See main edition for text of (34)]

(35) provide that any disclosing entity (as defined in section 1320a-3(a)(2) of this title) receiving payments under such plan complies with the requirements of section 1320a-3 of this title;

(36) provide that within 90 days following the completion of each survey of any health care facility, laboratory, agency, clinic, or organization, by the appropriate State agency described in paragraph (9), such agency shall (in accordance with regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (A) the statutory conditions of participation imposed under this subchapter, and (B) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization;

(37) provide for claims payment procedures which (A) ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of receipt of such claims, and (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed,

to ensure the proper and efficient payment of claims and management of the program;

(38) require that an entity (other than an individual practitioner or a group of practitioners) that furnishes, or arranges for the furnishing of, items or services under the plan, shall supply (within such period as may be specified in regulations by the Secretary or by the single State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, respectively, (A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such entity has had, during the previous twelve months, business transactions in an aggregate amount in excess of \$25,000, and (B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such entity and any wholly owned supplier or between such entity and any subcontractor;

(39) provide that the State agency shall bar any specified person from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1320a-7 of this title, and provide that no payment may be made under the plan with respect to any item or service furnished by such person during such period;

(40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1320a(a) of this title to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization;

(41) provide that whenever a provider of services or any other person is terminated, suspended, or otherwise sanctioned or prohibited from participating under the State plan, the State agency shall promptly notify the Secretary of such action;

(42) provide (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for such entities also providing services under subchapter XVIII of this chapter, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of such proportion of costs of each such common audit as is determined under methods specified by the Secretary under section 1320a-8(a) of this title;

(43) if the State plan makes provision for payment to a physician for laboratory services the performance of which such physician (or any other physician with whom he shares his practice) did not personally perform or supervise, include provision to insure that pay-

ment under the State plan for such laboratory services not exceed the payment authorized for such services by section 1395u(h) of this title; and

(44) provide for—

(A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1396d(a)(4)(B) of this title, of the availability of early and periodic screening, diagnostic, and treatment services as described in section 1396d(a)(4)(B) of this title,

(B) providing or arranging for the provision of such screening services in all cases where they are requested, and

(C) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services.

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this subchapter, the State agency which administered or supervised the administration of the plan of such State approved under subchapter X of this chapter (or subchapter XVI of this chapter, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under subchapter I of this chapter (or subchapter XVI of this chapter, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under subchapter X of this chapter (or subchapter XVI of this chapter, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this subchapter (except for purposes of paragraph (10)). For purposes of paragraphs (9)(A), (29), (31), and (33), and of section 1396b(1)(4) of this title, the terms "skilled nursing facility" and "nursing home" do not include a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

For purposes of paragraph (10) any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter and who for such month was entitled to monthly insurance benefits under subchapter II of this chapter shall for purposes of this subchapter only be deemed to be eligible for financial aid or assistance for any month thereafter if such individual would have been eligible for financial aid or assistance for such month had the increase in monthly insurance

benefits under subchapter II of this chapter resulting from enactment of Public Law 92-336 not been applicable to such individual.

The requirement of clause (A) of paragraph (37) with respect to a State plan may be waived by the Secretary if he finds that the State has exercised good faith in trying to meet such requirement.

(b) Approval by Secretary

The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that he shall not approve any plan which imposes, as a condition of eligibility for medical assistance under the plan—

(1) an age requirement of more than 65 years; or

(2) any age requirement which excludes any individual who has not attained the age of 19 and is a dependent child under part A of subchapter IV of this chapter;

[See main edition for text of (3) and (4); (c)]

(d) Performance of medical or utilization review functions

If a State contracts with a Professional Standards Review Organization designated, conditionally or otherwise, under part B of subchapter XI of this chapter for the performance of medical or utilization review functions required under this subchapter of a State plan with respect to specific services or providers (or services or providers in a geographic area of the State), such requirements shall be deemed to be met for those services or providers (or services or providers in that area) by delegation to such Organization (or Organizations) under the contract of the State's authority to conduct such review activities if the contract provides for the performance of activities not inconsistent with part B of subchapter XI of this chapter and provides for such assurances of satisfactory performance by such Organization (or Organizations) as the Secretary may prescribe.

(e) Continued eligibility of families determined ineligible because of income and resources or hours of work limitations of plan

(1) Notwithstanding any other provision of this subchapter, effective January 1, 1974, each State plan approved under this subchapter must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of subchapter IV of this chapter in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such aid because of increased hours of, or increased income from, employment, shall, while a member of such family is employed, remain eligible for assistance under the plan approved under this subchapter (as though the family was receiving aid under the plan approved under part A of subchapter IV of this chapter) for 4 calendar months beginning with the month in which such family became ineligible for aid under the plan approved under part A of subchapter IV of this chapter because of income and resources or hours of work limitations contained in such plan.

(3XA) In the case of an individual who is enrolled with a qualified health maintenance or-

ganization (as defined in title XIII of the Public Health Service Act [42 U.S.C. 300e et seq.]) under a contract described in section 1396b(m)(2)(A) of this title and who would (but for this paragraph) lose eligibility for benefits under this subchapter before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this subchapter, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but only with respect to such benefits provided to the individual as an enrollee of such organization.

(B) For purposes of subparagraph (A), the term "minimum enrollment period" means, with respect to an individual's enrollment with a health maintenance organization under a State plan, a period, established by the State, of not more than six months beginning on the date the individual's enrollment with the organization becomes effective.

[See main edition for text of (f)]

(g) Repealed. Pub. L. 96-499, title IX, § 913(d), Dec. 5, 1980, 94 Stat. 2620

(h) Repealed. Pub. L. 97-35, title XXI, § 2173(b)(1), Aug. 13, 1981, 95 Stat. 809

(i) Termination of certification for participation of and suspension of State payments to skilled nursing facilities and intermediate care facilities

(1) In addition to any other authority under State law, where a State determines that a skilled nursing facility or intermediate care facility which is certified for participation under its plan no longer substantially meets the provisions of section 1395x(j) of this title or section 1396d(c) of this title, respectively, and further determines that the facility's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the State shall provide for the termination of the facility's certification for participation under the plan and may provide, or

(B) do not immediately jeopardize the health and safety of its patients, the State may, in lieu of providing for terminating the facility's certification for participation under the plan, provide

that no payment will be made under the State plan with respect to any individual admitted to such facility after a date specified by the State.

(2) The State shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the provisions of section 1395x(j) of this title or section 1396d(c) of this title (as the case may be), to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

(3) The State's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the State, and its effectiveness shall terminate (A) when the State finds that the facility is in substantial compliance (or is making

good faith efforts to achieve substantial compliance) with the provisions of section 1395x(j) of this title or section 1396d(c) of this title (as the case may be), or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the State shall terminate such facility's certification for participation under the plan effective with the first day of the first month following the month specified in such clause.

(j) Disposal of resources for less than fair market value

(1) Notwithstanding any other provision of this subchapter, an individual who would otherwise be eligible for medical assistance under the State plan approved under this subchapter may be denied such assistance if such individual would not be eligible for such medical assistance but for the fact that he disposed of resources for less than fair market value. If the State plan provides for the denial of such assistance by reason of such disposal of resources, the State plan shall specify a procedure for implementing such denial which, except as provided in paragraph (2), is not more restrictive than the procedure specified in section 1382b(c) of this title.

(2) In any case where the uncompensated value of disposed of resources exceeds \$12,000, the State plan may provide for a period of ineligibility which exceeds 24 months. If a State plan provides for a period of ineligibility exceeding 24 months, such plan shall provide for the period of ineligibility to bear a reasonable relationship to such uncompensated value.

(3) In any case where an individual is ineligible for medical assistance under the State plan solely because of the applicability to such individual of the provisions of section 1382b(c) of this title, the State plan may provide for the eligibility of such individual for medical assistance under the plan if such individual would be so eligible if the State plan requirements with respect to disposal of resources applicable under paragraphs (1) and (2) of this subsection were applied in lieu of the provisions of section 1382b(c) of this title.

(As amended Oct. 25, 1977, Pub. L. 95-142, §§ 2(a)(3), (b)(1), 3(c)(1), 7(b), (c), 9, 19(b)(2), 30(b), 91 Stat. 1176, 1178, 1193, 1195, 1204, 1207; Dec. 13, 1977, Pub. L. 95-210, § 2(c), 91 Stat. 1488; Nov. 1, 1978, Pub. L. 95-559, § 14(a)(1), 92 Stat. 2140; June 17, 1980, Pub. L. 96-272, title III, § 308(c), 94 Stat. 531; Dec. 5, 1980, Pub. L. 96-499, title IX, §§ 902(b), 903(b), 905(a), 912(b), 913(c), (d), 914(b)(1), 916(b)(1), 918(b)(1), 962(a), 965(b), 94 Stat. 2613, 2615, 2618-2621, 2624, 2626, 2650, 2652; Dec. 28, 1980, Pub. L. 96-611, § 5(b), 94 Stat. 3568; Aug. 13, 1981, Pub. L. 97-35, title XXI, §§ 2105(c), 2113(m), 2171(a), (b), 2172(a), 2173(a), (b)(1), 2174(a), 2175(a), (d)(1), 2178(b), 2181(a)(2), 2182, 2193(c)(9), 95 Stat. 792, 795, 807-809, 811, 814-816, 828.)

REFERENCES IN TEXT

Section 303(a)(4)(A) of this title, referred to in subsec. (a)(20)(C), was amended generally by Pub. L. 97-35, title XXIII, § 2353(a)(1)(A), Aug. 13, 1981, 95 Stat. 871, and as so amended does not contain cl. (1) and (11).

The Public Health Service Act, referred to in subsec. (e)(2)(A), is act July 1, 1944, ch. 373, 58 Stat. 682, as amended. Title XIII of the Public Health Service Act is classified generally to subchapter XI (§ 300e et seq.) of chapter 6A of this title. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

AMENDMENTS

1981—Subsec. (a)(9)(C). Pub. L. 97-35, § 2175(d)(1)(C), added subpar. (C).

Subsec. (a)(10)(A). Pub. L. 97-35, § 2171(a)(1), substituted "including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title, to all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including pregnant women deemed by the State to be receiving such aid as authorized by section 606(g) of this title and individuals considered by the State to be receiving such aid as authorized under section 614(g) of this title)" for "to all individuals receiving aid or assistance under any plan of the State approved under subchapters I, X, XIV, or XVI, or part A of subchapter IV of this chapter".

Subsec. (a)(10)(B). Pub. L. 97-35, § 2171(a)(2), substituted reference to subparagraph for reference to clause in two places.

Subsec. (a)(10)(C). Pub. L. 97-35, § 2171(a)(3), substituted provisions relating to plans for medical assistance included for any group of individuals described in section 1396d(a) of this title who are not described in subpar. (A) for provisions relating to medical assistance for any group of individuals not described in subpar. (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplementary security income program under subchapter XVI of this chapter, as the case may be, as determined in accordance with standards prescribed by the Secretary with specified exceptions.

Subsec. (a)(10)(D). Pub. L. 97-35, § 2171(a)(3), added subpar. (D).

Subsec. (a)(11). Pub. L. 97-35, § 2193(c)(9), substituted "under or through an allotment under) subchapter V of this chapter, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such subchapter or allotment" for "for part or all of the cost of plans or projects under subchapter V of this chapter, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such plan or project under subchapter V of this chapter".

Subsec. (a)(13)(A). Pub. L. 97-35, § 2171(b), struck out former subpar. (A), which provided that a State plan must provide for the inclusion of some institutional and some noninstitutional care and services and for the inclusion of home health services for any individual who is entitled to skilled nursing facility services.

Pub. L. 97-35, § 2173(a)(1)(B), (C), redesignated former subpar. (E) as (A), and in subpar. (A), as so redesignated, made the subsection applicable to hospital facilities, added reference to rates which take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care under conditions similar to those described in section 1395x(v)(1)(G) of this title, for lower reimbursement rates reflecting the level of care actually received in a

manner consistent with such section, and substituted "safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality" for "safety standards".

Subsec. (a)(13)(B) Pub L. 97-35, § 2171(b), struck out former subpar (B), which provided that a State plan must provide in the case of individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, for the inclusion of at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title.

Pub L. 97-35, § 2173(a)(1)(C), redesignated former subpar (F) as (B).

Subsec. (a)(13)(C) Pub L. 97-35, § 2171(b), struck out subpar (C), which provided for care and services of individuals not included in former subpar (B).

Subsec. (a)(13)(D) Pub L. 97-35, § 2173(a)(1)(A), struck out subpar (D), which provided for payment of the reasonable cost of inpatient hospital services provided under the plan with provisions for determination of such costs with certain maximum limitations and for payment of reasonable cost of inappropriate inpatient services described in subsec. (b)(1) of this section.

Subsec. (a)(13)(E) Pub L. 97-35, § 2173(a)(1)(C), redesignated former subpar (E) as (A).

Subsec. (a)(13)(F) Pub L. 97-35, § 2173(a)(1)(C), redesignated former subpar (F) as (B).

Subsec. (a)(20)(D) Pub L. 97-35, § 2173(a)(2), struck out subpar (D) which required provision for methods of determining the reasonable cost of institutional care of such patients.

Subsec. (a)(23) Pub L. 97-35, § 2175(a), substituted "except as provided in section 1396n and except in the case of" for "except in the case of", and struck out provision that a State plan shall not be deemed to be out of compliance with the requirements of this paragraph or pars (1) and (10) of this subsection solely by reason of the fact that the State or any political subdivision thereof has entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic.

Subsec. (a)(25)(C) Pub L. 97-35, § 2182, substituted "of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State" for "of the individual, the State".

Subsec. (a)(30) Pub L. 97-35, § 2174(a), substituted "that payments are consistent" for "that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent".

Subsec. (a)(39) Pub L. 97-35, § 2105(c), substituted "person" for "individual" in two places.

Subsec. (a)(44) Pub L. 97-35, § 2181(a)(2)(C), added par. (44).

Subsec. (b)(2) Pub L. 97-35, § 2172(a), substituted "any age requirement which excludes any individual who has not attained the age of 19 and is a dependent child under part A of subchapter IV of this chapter;" for "effective July 1, 1967, any age requirement which excludes any individual who has not attained the age of 21 and is or would, except for the provisions of section 604(a)(2) of this title, be a dependent child under part A of subchapter IV of this chapter, or".

Subsec. (d) Pub L. 97-35, § 2113(m), added subsec. (d).

Subsec. (e) Pub L. 97-35, § 2178(b), designated existing provisions as par. (1), and added par. (2).

Subsec. (h) Pub L. 97-35, § 2173(b)(1), repealed subsec. (h), which related to skilled nursing and intermediate care facility services.

1980—Subsec. (a)(13)(B) Pub L. 96-499, § 965(b)(1), substituted "paragraphs (1) through (5) and (17)" for "clauses (1) through (5)".

Subsec. (a)(13)(C)(i) Pub L. 96-499, § 965(b)(2), substituted "paragraphs (1) through (5) and (17)" for "clauses (1) through (5)".

Subsec. (a)(13)(C)(ii) Pub L. 96-499, § 965(b)(3), substituted "paragraphs numbered (1) through (17)" for "clauses numbered (1) through (16)".

Subsec. (a)(13)(D) Pub L. 96-499, § 902(b)(1), designated existing provisions as cl (i) and added cl (ii).

Subsec. (a)(13)(D)(i) Pub L. 96-499, §§ 903(b), 905(a), inserted "(except where the State agency is subject to an order under section 1396m of this title)" following "payment" and ", except that in the case of hospitals reimbursed for services under part A of subchapter XVIII of this chapter in accordance with section 1395f(b)(3) of this title, the plan must provide for payment of inpatient hospital services provided in such hospitals under the plan in accordance with the reimbursement system used under such section" following "subchapter XVIII of this chapter".

Subsec. (a)(13)(E) Pub L. 96-499, § 905(a), inserted "(except where the State agency is subject to an order under section 1396m of this title)".

Pub L. 96-499, § 962(a), substituted provisions which required a State plan for medical assistance to provide for payment of skilled nursing facility and intermediate care facility services provided under such plan through the use of rates determined in accordance with methods and standards developed by the State rather than on a reasonable cost related basis, required the filing of uniform cost reports by each facility, and required periodic audits of such reports by the State.

Subsec. (a)(14)(A)(i) Pub L. 96-499, § 965(b)(4), substituted "paragraphs (1) through (5), (7), and (17)" for "clauses (1) through (5) and (7)".

Subsec. (a)(33)(B) Pub L. 96-499, § 916(b)(1)(B), inserted exception authorizing the Secretary where there was cause to question the adequacy of participation determinations to make independent determinations concerning the extent to which individual institutions and agencies met the requirements for participation.

Subsec. (a)(35) Pub L. 96-499, § 912(b), substituted "disclosing entity (as defined in section 1320a-3(a)(2) of this title)" for "intermediate care facility".

Subsec. (a)(39) Pub L. 96-499, § 913(c), substituted provisions requiring that State plans for medical assistance authorize the State agency to bar specified individuals from participation in the program under the State plan when required by the Secretary to do so pursuant to section 1320a-7 of this title for provisions requiring that State plans for medical assistance provide for the suspension of physicians or other individuals from participation in the State plan upon notification by the Secretary that such physician or other individual had been suspended from participation in the plan under subchapter XVIII of this chapter.

Subsec. (a)(41) Pub L. 96-272 added par. (41).

Subsec. (a)(42) Pub L. 96-499, § 916(b)(1), added par. (42).

Subsec. (a)(43) Pub L. 96-499, § 918(b)(1)(C), added par. (43).

Subsec. (g) Pub L. 96-499, § 912(d), struck out subsec. (g), which related to the waiver of suspension of payments to physicians or practitioners suspended from participation in approved State plans.

Subsec. (h) Pub L. 96-499, § 902(b)(2), added subsec. (h).

Subsec. (i) Pub L. 96-499, § 918(b)(1)(A), added subsec. (i).

Subsec. (j) Pub L. 96-611 added subsec. (j).

1978—Subsec. (a)(4)(C). Pub. L. 95-559 added cl. (C).
1977—Subsec. (a)(13)(F). Pub. L. 95-210, § 2(c)(1), added subpar. (F).

Subsec. (a)(23). Pub. L. 95-210, § 2(c)(2), added “, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic” following “who elect to obtain such care and services from such organization”.

Subsec. (a)(26). Pub. L. 95-142, § 20(b), added provision relating to staff of skilled nursing facilities.

Subsec. (a)(27)(B). Pub. L. 95-142, § 9, added “or the Secretary” following “State agency” wherever appearing therein.

Subsec. (a)(32). Pub. L. 95-142, § 2(a)(3), substituted provisions relating to terms, conditions, etc., for payments under an assignment or power of attorney, for provisions relating to terms, conditions, etc., for payments to anyone other than the individual receiving any care or service provided by a physician, dentist, or other individual practitioner, or such physician, dentist, or practitioner.

Subsec. (a)(35). Pub. L. 95-142, § 2(c)(1)(A), substituted provisions relating to requirements for intermediate care facilities to comply with section 1320a-3 of this title for provisions relating to disclosure requirements, effective Jan. 1, 1973, applicable to intermediate care facilities with respect to ownership, corporate, status, etc.

Subsec. (a)(37). Pub. L. 95-142, §§ 2(b)(1)(C), 2(c)(1)(C), 7(b)(1), added subsec. (a)(37) and made and struck out minor changes in phraseology, necessitating no changes in text.

Subsec. (a)(38). Pub. L. 95-142, §§ 2(c)(1)(D), 7(b)(2), 19(b)(2)(A), added par. (38) and made and struck out minor changes in phraseology necessitating no changes in text.

Subsec. (a)(39). Pub. L. 95-142, §§ 7(b)(3), 19(b)(2)(B), added par. (39).

Subsec. (a)(40). Pub. L. 95-142, § 19(b)(2)(C), added par. (40).

Subsec. (a), foll. par. (40). Pub. L. 95-142, § 2(b)(1)(D) added paragraph relating to waiver of requirement of clause (A) of par. (37).

Subsec. (g). Pub. L. 95-142, § 7(c), added subsec. (g).

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by section 2113(m) of Pub. L. 97-35 applicable to agreements with Professional Standards Review Organizations entered into on or after Oct. 1, 1981, see section 2113(o) of Pub. L. 97-35, set out as an Effective Date of 1981 Amendment note under section 1320c of this title.

Section 2171(c) of Pub. L. 97-35 provided that: “The amendments made by this section [amending subsec. (a)(10) and repealing subsec. (a)(13)(A), (B), and (C) of this section] shall become effective on the date of the enactment of this Act [Aug. 13, 1981].”

Section 2172(c) of Pub. L. 97-35 provided that: “The amendments made by this section [amending subsec. (b)(2) of this section and section 1396d(a)(1), (1) of this title] shall become effective on the date of the enactment of this Act [Aug. 13, 1981].”

Section 2173(b)(2) of Pub. L. 97-35 provided that: “The amendment made by paragraph (1) [repealing subsec. (h) of this section] shall not apply with respect to services furnished before the date the Secretary of Health and Human Services first promulgates and has in effect final regulations (on an interim or other basis) to carry out section 1902(a)(13)(A) of the Social Security Act (as amended by this subtitle) [subsec. (a)(13)(A) of this section].”

Section 2174(c) of Pub. L. 97-35 provided that: “The amendments made by this section [amending subsec. (a)(30) of this section and section 1396b(1) of this title] shall apply to services furnished on or after October 1, 1981.”

Section 2175(d)(2) of Pub. L. 97-35 provided that:

“(A) The amendments made by paragraph (1) [adding subsec. (a)(9)(C) of this section] shall (except

as provided under subparagraph (B)) be effective with respect to payments under title XIX of the Social Security Act [this subchapter] for calendar quarters beginning on or after October 1, 1981.

“(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act [this subchapter] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirement imposed by the amendment made by paragraph (1)(C) [subsec. (a)(9)(C) of this section], the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar year beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Aug. 13, 1981].”

Section 2178(c) of Pub. L. 97-35 provided that: “The amendments made by this section [amending subsec. (e) of this section and section 1396b(m)(1)(A), (2)(A), (D) of this title] shall apply with respect to services furnished, under a State plan approved under title XIX of the Social Security Act [this subchapter], on or after October 1, 1981; except that such amendments shall not apply with respect to services furnished by a health maintenance organization under a contract with a State entered into under such title before October 1, 1981 unless the organization requests that such amendments apply and the Secretary of Health and Human Services and the single State agency (administering or supervising the administration of the State plan under such title) agree to such request.”

Amendment by section 2181(a)(2) of Pub. L. 97-35 effective Oct. 1, 1981, see section 2181(b) of Pub. L. 97-35, set out as an Effective Date of 1981 Amendment note under section 603 of this title.

For effective date, savings, and transitional provisions relating to amendment by section 2193(c)(9) of Pub. L. 97-35, see section 2194 of Pub. L. 97-35, set out as a note under section 701 of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by section 902(b) of Pub. L. 96-499, effective on the date on which final regulations to implement the amendment are first issued, see section 902(c) of Pub. L. 96-499, set out as an Effective Date of 1980 Amendment note under section 1320c-7 of this title.

Section 914(b)(3) of Pub. L. 96-499 provided that:

“(A) The amendments made by paragraph (1) [enacting subsec. (a)(42) of this section] shall (except as provided under subparagraph (B)) apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act [this subchapter], on and after the first day of the first calendar quarter beginning more than 30 days after the date of the enactment of this Act [Dec. 5, 1980].

“(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by paragraph (1), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.”

Section 918(b)(2) of Pub. L. 96-499 provided that:

“(A) The amendments made by paragraph (1) [enacting subsec. (a)(43) of this section] shall (except as otherwise provided in subparagraph (B)) apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act [this subchapter], on and after the first day of the first calendar quarter that begins more than six

months after the date of the enactment of this Act (Dec. 5, 1980).

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by paragraph (1), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act."

Section 962(b) of Pub. L. 96-499 provided that: "The amendment made by subsection (a) [amending subsec. (a)(13)(E) of this section] shall become effective on October 1, 1980."

Section 965(c) of Pub. L. 96-499 provided that:

"(1) The amendments made by this section [amending sections 1396a and 1396d of this title] shall (except as provided under paragraph (2)) be effective with respect to payments under title XIX of the Social Security Act [this subchapter] for calendar quarters beginning more than one hundred and twenty days after the date of the enactment of this Act (Dec. 5, 1980).

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act."

EFFECTIVE DATE OF 1978 AMENDMENT

Section 14(a)(2) of Pub. L. 95-559 provided that:

"(A) Except as provided in subparagraph (B), the amendments made by paragraph (1) [enacting subsec. (a)(4)(C) of this section] shall take effect one hundred and eighty days after the date of the enactment of this Act (Nov. 1, 1978).

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act [this subchapter] which the Secretary determines requires State legislation in order for the plan to meet the requirement added by the amendments made by paragraph (1), such amendments shall not apply with respect to such State plan before ninety days after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act (Nov. 1, 1978)."

EFFECTIVE DATE OF 1977 AMENDMENTS

Amendment of subsec. (a)(13)(F) and (23) by Pub. L. 95-210 applicable to medical assistance provided under a State plan approved under subchapter XIX of this chapter, on and after the first day of the first calendar quarter that begins more than six months after Dec. 13, 1977, with exception for plans requiring State legislation, see section 2(f) of Pub. L. 95-210, set out as an Effective Date of 1977 Amendment note under section 1395cc of this title.

Amendment of subsec. (a)(32) by section 2a(x3) of Pub. L. 95-142 applicable with respect to care and services furnished on or after Oct. 25, 1977, see section 2a(x4) of Pub. L. 95-142, set out as an Effective Date of 1977 Amendment note under section 1395g of this title.

Amendment of subsec. (a)(35) and (38) by section 2(c)(1) of Pub. L. 95-142 effective Jan. 1, 1978, see section 2(c) of Pub. L. 95-142, set out as an Effective Date note under section 1390a-3 of this title.

Section 2(b)(2) of Pub. L. 95-142 provided that: "The amendments made by paragraph (1) [adding par. (37) and a new unnumbered paragraph at the end of subsec. (a)] shall apply to calendar quarters beginning on and after July 1, 1978, with respect to State plans approved under title XIX of the Social Security Act [subchapter XIX of this chapter]."

Section 7(e)(2) of Pub. L. 95-142 provided that: "The amendment made by subsection (b) [adding subsec. (a)(39) of this section] shall become effective on January 1, 1978."

Section 10(c)(2) of Pub. L. 95-142 provided that:

"(A) The amendments made by subsection (b) [adding subsec. (a)(40) of this section and amending section 1395x(v)(1)(F) of this title] shall apply with respect to operations of a hospital, skilled nursing facility, or intermediate care facility, on and after the first day of its first fiscal year which begins after the end of the six-month period beginning on the date a uniform reporting system is established (under section 1121(a) of the Social Security Act) [section 1320a(a) of this title] for that type of health services facility.

"(B) The amendments made by subsection (b) [adding subsec. (a)(40) of this section and amending section 1395x(v)(1)(F) of this title] shall apply, with respect to the operation of a health services facility or organization which is neither a hospital, a skilled nursing facility, nor an intermediate care facility, on and after the first day of its first fiscal year which begins after such date as the Secretary of Health, Education, and Welfare determines to be appropriate for the implementation of the reporting requirement for that type of facility or organization.

"(C) Except as provided in subparagraphs (A) and (B), the amendments made by subsection (b)(2) [adding subsec. (a)(40) of this section] shall apply, with respect to State plans approved under title XIX of the Social Security Act [this subchapter], on and after October 1, 1977."

Amendment of subsec. (a)(26) by section 20(b) of Pub. L. 95-142 effective on Oct. 1, 1977, and the Secretary to adjust payments made to States under section 1396b of this title to reflect such amendment, see section 20(c) of Pub. L. 95-142, set out as an Effective Date of 1977 Amendment note under section 1396b of this title.

EFFECTIVE DATE OF 1973 AMENDMENT

Section 232(c) of Pub. L. 93-603 provided that: "The amendments made by this section [amending former section 705 of this title and section 1396a(a)(13)(D) of this title] shall be effective July 1, 1973 (or earlier if the State plan so provides)."

Section 239(d) of Pub. L. 93-603 provided that: "The amendments made by this section [amending former section 705 of this title and amending section 1396a(a) of this title] shall be effective January 1, 1973 (or earlier if the State plan so provides)."

TRANSFER OF FUNCTIONS

Functions, powers, and duties of Secretary of Health and Human Services under subsec. (a)(4)(A) of this section, insofar as relates to the prescription of personnel standards on a merit basis, transferred to Office of Personnel Management, see section 4728(a)(3)(D) of this title.

EVALUATION AND STUDY OF REASONS FOR TERMINATION BY MEDICAID BENEFICIARIES OF MEMBERSHIP IN HEALTH MAINTENANCE ORGANIZATIONS

Section 2178(d) of Pub. L. 97-35 provided that: "The Secretary of Health and Human Services shall conduct a study evaluating the extent of, and reasons for, the termination by medicaid beneficiaries of their memberships in health maintenance organizations. In conducting such study, the Secretary shall place special emphasis on the quantity and quality of medical care provided in health maintenance organizations

and the quality of such care when provided on a fee-for-service basis. The Secretary shall submit an interim report to the Congress, within two years after the date of the enactment of this Act [Aug. 13, 1981], and a final report within five years from such date containing, respectively, the interim and final findings and conclusions made as a result of such study."

CONTINUING MEDICAID ELIGIBILITY FOR CERTAIN RECIPIENTS OF VETERANS' ADMINISTRATION PENSIONS

Section 310(b)(1) of Pub. L. 96-272 provided that:

"(A) For purposes of section 1902(a)(10)(A) of the Social Security Act [subsec. (a)(10)(A) of this section], any individual who, prior to the date of enactment of this Act [June 17, 1980] and for the month of December 1978, was eligible for and received aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV of such Act [subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter], or was eligible for and received supplemental security income benefits under title XVI of such Act [subchapter XVI of this chapter] (or a supplementary payment described in section 13(c) of Public Law 93-233) [set out as a note under this section] and was also in receipt of (or was a dependent, for purposes of chapter 15 of title 38, United States Code, as in effect on December 31, 1978, of an individual in receipt of) pension from the Veterans' Administration for the month of December 1978 shall (subject to subparagraph (B)) be deemed to have been receiving such aid, assistance, supplemental security income, or supplementary payment, for each calendar month thereafter (prior to the month in which the provisions of this subparagraph cease to be effective with respect to him as determined under subparagraph (B)), if such individual would have been eligible therefor in December 1978 and in the month in which the provisions of this subparagraph cease to be effective with respect to him as determined under subparagraph (B) had the increase in income of such individual (or of the family of which such individual is a member), attributable to an election (made by such individual or another member of such individual's family) under section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978 [Pub. L. 95-588, set out as a note under section 521 of Title 38, Veterans' Benefits], not occurred.

"(B)(i) The provisions of subparagraph (A) shall take effect on January 1, 1979, and shall cease to be effective, in the case of any individual, for and after the first calendar month beginning more than 10 days after an 'informed election' (as defined in subdivision (ii) of this subparagraph) has been made by such individual (or, if such individual is not eligible to make such an election, by a member of such individual's family who is eligible to make such an election which affects such individual's eligibility for aid, assistance, or benefits under a plan or program referred to in subparagraph (A)).

"(ii) The term 'informed election' means an election made under section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978 [Pub. L. 95-588, set out as a note under section 521 of Title 38] (or a reaffirmation of such an election which previously was made under such section 306) after the date of compliance by the Administrator of Veterans' Affairs (hereinafter in this section referred to as the 'Administrator') with the provisions of paragraph (3)(A) with respect to the individual concerned. An individual who fails, within the time limits prescribed in paragraph (3)(B), to disaffirm an election previously made by such individual under such section 306 shall be deemed, for purposes of this section and such section 306, to have reaffirmed such election."

Section Referred to in Other Sections

This section is referred to in sections 300e-17, 705, 1315, 1320a-7a, 1320c-7, 1382i, 1395v, 1395oc, 1395ti, 1396b, 1396d, 1396g, 1396i, 1396n, 4728 of this title.

9 1396b. Payment to States

(a) Computation of amount

From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this subchapter, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1396d(b) of this title, subject to subsections (g), (h), and (j) of this section) of the total amount expended during such quarter as medical assistance under the State plan (including expenditures for premiums under part B of subchapter XVIII of this chapter, for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title, and, except in the case of individuals sixty-five years of age or older and disabled individuals entitled to hospital insurance benefits under subchapter XVIII of this chapter who are not enrolled under part B of subchapter XVIII of this chapter, other insurance premiums for medical or any other type of remedial care or the cost thereof; plus

[See main edition for text of (2)]

(3) an amount equal to—

[See main edition for text of (A)]

(B) 75 per centum of so much of the sums expended during such quarter as are attributable to the operation of systems (whether such systems are operated directly by the State or by another person under a contract with the State) of the type described in subparagraph (A)(i) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by the plan, or to each individual in a sample group of individuals who are furnished such services, of the specific services (other than confidential services) so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services; and

(C) 75 per centum of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient adminis-

EFFECTIVE DATE OF 1964 AMENDMENT

Amendment by Pub. L. 86-369 applicable to items and services furnished on or after July 18, 1964, see section 2321(g) of Pub. L. 86-369, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by Pub. L. 95-142 applicable with respect to durable medical equipment purchased or rented on or after Oct. 1, 1977, see section 16(b) of Pub. L. 95-142, set out as a note under section 1395f of this title.

EFFECTIVE DATE

Section applicable only with respect to items purchased after Dec. 31, 1967, see section 132(c) of Pub. L. 90-248, set out as an Effective Date of 1968 Amendment note under section 1395f of this title.

SUBCHAPTER XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS**SUBCHAPTER REFERRED TO IN OTHER SECTIONS**

This subchapter is referred to in sections 242b, 254a-1, 254b, 254c, 254e, 254h, 254n, 300e, 300e-6, 300m-6, 300x-4, 300z-5, 602, 603, 606, 614, 632a, 652, 671, 672, 673, 705, 709, 1301, 1306, 1308, 1309, 1310, 1315, 1316, 1318, 1320a-1, 1320a-2, 1320a-3, 1320a-5, 1320a-7, 1320a-7a, 1320a-8, 1320b-2, 1320b-3, 1320b-4, 1320b-5, 1320b-7, 1320c-2, 1320c-10, 1382, 1382g, 1382h, 1382i, 1383c, 1395b-1, 1395v, 1395x, 1395y, 1395z, 1395cc, 1395mm, 1395tt, 1395vv, 1395ww, 1997, 3013, 3026, 3035b, 6024, 6624 of this title; title 7 sections 2026, 3178; title 8 section 1522; title 10 section 1079, title 12 sections 1715w, 1715z-7; title 25 section 1622; title 26 section 6103; title 38 sections 622, 4108.

§ 1396. Appropriations

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

(Aug. 14, 1935, ch. 531, title XIX, § 1901, as added July 30, 1965, Pub. L. 89-97, title I, § 121(a), 79 Stat. 343, and amended Dec. 31, 1973, Pub. L. 93-233, § 13(a)(1), 87 Stat. 960; July 18, 1984, Pub. L. 98-369, div. B, title VI, § 2663(j)(3)(C), 98 Stat. 1171.)

AMENDMENTS

1984—Pub. L. 98-369 struck out "Health, Education, and Welfare" after "Secretary".

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98-369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 3064(b) of Pub. L. 98-369, set out as a note under section 601 of this title.

§ 1396a. State plans for medical assistance**(a) Contents**

A State plan for medical assistance must—

[See main edition for text of (1) to (8)]

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions, and

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1395x(e)(9) of this title or paragraphs (11) and (12) of section 1395x(s) of this title, or, in the case of a laboratory which is in a rural health clinic, of section 1395x(aa)(2)(G) of this title;

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title, to—

(i) all individuals—

(I) who are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including individuals eligible under this subchapter by reason of section 602(a)(37) or 606(h) of this title, or considered by the State to be receiving such aid as authorized under section 614(g) of this title),

(II) with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or

(III) who are qualified pregnant women or children as defined in section 1396d(n) of this title;

[See main edition for text of (ii), (B) to (D) and closing provisions; (11) and (12)]

(13) provide—

(A) for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital

patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1395x(v)(1)(G) of this title), for lower reimbursement rates reflecting the level of care actually received (in a manner consistent with section 1395x(v)(1)(G) of this title)) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, skilled nursing facility, and intermediate care facility and periodic audits by the State of such reports;

(B) that the State shall provide assurances satisfactory to the Secretary that the payment methodology utilized by the State for payments to hospitals, skilled nursing facilities, and intermediate care facilities can reasonably be expected not to increase such payments, solely as a result of a change of ownership, in excess of the increase which would result from the application of section 1395x(v)(1)(O) of this title; and

(C) for payment for services described in section 1396d(a)(2)(B) of this title provided by a rural health clinic under the plan of 100 percent of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary may prescribe in regulations under section 1395i(a)(3) of this title, or, in the case of services to which those regulations do not apply, on such tests of reasonableness as the Secretary may prescribe in regulations under this subparagraph;

[See main edition for text of (14) to (19)]

(20) If the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases—

[See main edition for text of (A)]

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodic determination of his need for continued treatment in the institution; and

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients

65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 303(a)(4)(A)(i) and (ii) or section 1383(a)(4)(A)(i) and (ii) of this title which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out;

[See main edition for text of (21) to (25)]

(26) If the State plan includes medical assistance for inpatient mental hospital services, provide—

(A) with respect to each patient receiving such services, for a regular program of medical review (including medical evaluation) of his need for such services, and for a written plan of care;

(B) for periodic inspections to be made in all mental institutions within the State by one or more medical review teams (composed of physicians and other appropriate health and social service personnel) of the care being provided to each person receiving medical assistance, including (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the institution, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and

(C) for full reports to the State agency by each medical review team of the findings of each inspection under subparagraph (B), together with any recommendations;

[See main edition for text of (27)]

(28) provide that any skilled nursing facility receiving payments under such plan must satisfy all of the requirements contained in section 1395x(j) of this title, except that the exclusion contained therein with respect to institutions which are primarily for the care and treatment of mental diseases shall not apply for purposes of this subchapter;

[See main edition for text of (29)]

(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(1)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care;

(B) provide, under the program described in subparagraph (A), that—

(i) each admission to a hospital, skilled nursing facility, intermediate care facility, or hospital for mental diseases is reviewed

or screened in accordance with criteria established by medical and other professional personnel who are not themselves directly responsible for the care of the patient involved, and who do not have a significant financial interest in any such institution and are not, except in the case of a hospital, employed by the institution providing the care involved, and

(II) the information developed from such review or screening, along with the data obtained from prior reviews of the necessity for admission and continued stay of patients by such professional personnel, shall be used as the basis for establishing the size and composition of the sample of admissions to be subject to review and evaluation by such personnel, and any such sample may be of any size up to 100 percent of all admissions and must be of sufficient size to serve the purpose of (I) identifying the patterns of care being provided and the changes occurring over time in such patterns so that the need for modification may be ascertained, and (II) subjecting admissions to early or more extensive review where information indicates that such consideration is warranted to a hospital, skilled nursing facility, intermediate care facility, or hospital for mental diseases;

(31) with respect to skilled nursing facility services (and with respect to intermediate care facility services, where the State plan includes medical assistance for such services) provide—

(A) with respect to each patient receiving such services, for a written plan of care, prior to admission to or authorization of benefits in such facility, in accordance with regulations of the Secretary, and for a regular program of independent professional review (including medical evaluation) which shall periodically review his need for such services;

(B) with respect to each skilled nursing or intermediate care facility within the State, for periodic onsite inspections of the care being provided to each person receiving medical assistance, by one or more independent professional review teams (composed of a physician or registered nurse and other appropriate health and social service personnel), including with respect to each such person (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the facility, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and

(C) for full reports to the State agency by each independent professional review team of the findings of each inspection under subparagraph (B), together with any recommendations;

[See main edition for text of (32)]

(33) provide—

(A) that the State health agency, or other appropriate State medical agency, shall be

responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the second sentence of this subsection; and

[See main edition for text of (B), (34) to (41)]

(42) provide (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for such entities also providing services under subchapter XVIII of this chapter, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such subchapter, and (C) for payment of such proportion of costs of each such common audit as is determined under methods specified by the Secretary under section 1320a-8(a) of this title;

(43) provide for—

(A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1396d(a)(4)(B) of this title, of the availability of early and periodic screening, diagnostic, and treatment services as described in section 1396d(a)(4)(B) of this title,

(B) providing or arranging for the provision of such screening services in all cases where they are requested, and

(C) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services;

(44) in each case for which payment for inpatient hospital services, skilled nursing facility services, intermediate care facility services, or inpatient mental hospital services is made under the State plan—

(A) a physician certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and the physician, or a physician assistant or nurse practitioner under the supervision of a physician, recertifies, where such services are furnished over a period of time, in such cases, at least as often as required under section 1396b(g)(6) of this title (or, in the case of services that are intermediate care facility services provided in an institution for the mentally retarded, every year), and accompanied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary), that such

services are or were required to be given on an inpatient basis because the individual needs or needed such services, and

(B) such services were furnished under a plan established and periodically reviewed and evaluated by a physician; and

(45) provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1396k of this title.

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this subchapter, the State agency which administered or supervised the administration of the plan of such State approved under subchapter X of this chapter (or subchapter XVI of this chapter, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under subchapter I of this chapter (or subchapter XVI of this chapter, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under subchapter X of this chapter (or subchapter XVI of this chapter, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this subchapter (except for purposes of paragraph (10)). The provisions of paragraphs (9)(A), (31), and (33) and of section 1396b(1)(4) of this title shall not apply to a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

[See main edition for text of closing para.; (b) to (d)]

(e) Continued eligibility of families determined ineligible because of income and resources or hours of work limitations of plan

[See main edition for text of (1) to (3)]

(4) A child born to a woman eligible for and receiving medical assistance under a State plan on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of one year so long as the child is a member of the woman's household and the woman remains eligible for such assistance.

(f) Effective date of State plan as determinative of duty of State to provide medical assistance to aged, blind, or disabled individuals

Notwithstanding any other provision of this subchapter, except as provided in subsection (e) of this section, no State not eligible to participate in the State plan program established

under subchapter XVI of this chapter shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of subchapter XVI of this chapter) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this subchapter and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1396b(f) of this title (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to paragraph (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under paragraph (10)(A), or (2) an eligible individual or eligible spouse, as defined in subchapter XVI of this chapter, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under paragraph (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to paragraph (10)(C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection.

[See main edition for text of (g) to (j)]

(As amended July 18, 1984, Pub. L. 98-369, div. B, title III, §§ 2303(g)(1), 2314(b), 2335(e), 2361(a), 2362(a), 2363(a)(1), 2367(a), 2368(a), (b), 2373(b)(1)-(10), 98 Stat. 1066, 1079, 1091, 1104, 1105, 1108, 1109, 1111; Aug. 16, 1984, Pub. L. 98-378, § 20(c), 98 Stat. 1322; Nov. 8, 1984, Pub. L. 98-617, § 3(a)(7), (b)(10), 98 Stat. 3295, 3296.)

AMENDMENT OF SUBSECTION (a)

Pub. L. 98-369, div. B, title VI, § 2651(c), (1)(2), 98 Stat. 1149, 1151, provided that, effective Apr. 1, 1985, subsection (a) of this section is amended:

- (1) by striking out "and" at the end of par. (44),
 (2) by substituting "; and" for the period at the end of par. (45), and
 (3) by inserting after par. (45) the following new paragraph:
- (46) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1320b-7 of this title.

REFERENCES IN TEXT

Pub. L. 92-336, referred to in provisions following subsec. (a)(45), is Pub. L. 92-336, July 1, 1972, 86 Stat. 406, which amended sections 401, 403, 409, 411, 415, 427, 428, and 430 of this title and sections 165, 1401, 1402, 3101, 3111, 3121, 3122, 3125, 6413, and 6454 of Title 26, Internal Revenue Code, and enacted provisions set out as notes under sections 403, 409, 415, and 428 of this title and sections 165 and 1401 of Title 26.

AMENDMENTS

1984—Subsec. (a)(9)(C). Pub. L. 98-369, § 2373(b)(1), realigned margin of subpar. (C).

Subsec. (a)(10)(A). Pub. L. 98-369, § 2373(b)(2), realigned margins of subpar. (A).

Subsec. (a)(10)(A)(i). Pub. L. 98-369, § 2361(a), amended cl. (i) generally. Prior to the amendment cl. (i) read as follows: "(i) all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including pregnant women deemed by the State to be receiving such aid as authorized in section 606(g) of this title and individuals considered by the State to be receiving such aid as authorized under section 614(g) of this title), or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, and".

Subsec. (a)(10)(A)(i)(I). Pub. L. 98-378, § 20(c), substituted "section 602(a)(37) or 606(h) of this title" for "section 602(a)(37) of this title."

Subsec. (a)(13)(A). Pub. L. 98-369, § 2373(b)(3), made clarifying amendment by striking out "(A)" and all that follows through "hospital" the first place it appears and inserting in lieu thereof "(A) for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital", resulting in no change in text.

Subsec. (a)(13)(B), (C). Pub. L. 98-369, § 2314(b), added subpar. (B) and redesignated former subpar. (B) as (C).

Subsec. (a)(20)(B). Pub. L. 98-369, § 2373(b)(4), substituted "periodic" for "periodical".

Subsec. (a)(20)(C). Pub. L. 98-369, § 2373(b)(5), struck out reference to section 803(a)(1)(A)(i) and (ii) of this title.

Subsec. (a)(26). Pub. L. 98-369, § 2368(b), in amending par. (26) generally, revised existing provisions to continue their application to review of inpatient mental hospital service programs, and to sever provisions relating to review of skilled nursing programs. See par. (31) of this section.

Subsec. (a)(26)(B)(ii). Pub. L. 98-617, § 3(a)(7), repealed the amendment made by Pub. L. 98-369, § 2373(b)(6). See below.

Pub. L. 98-369, § 2373(b)(6), provided that cl. (ii) is amended by substituting "facilities" for "homes".

Subsec. (a)(26)(C). Pub. L. 98-617, § 3(b)(10), realigned margin of subpar. (C).

Subsec. (a)(28). Pub. L. 98-369, § 2335(e), struck out "and tuberculosis" after "mental diseases".

Subsec. (a)(30). Pub. L. 98-369, § 2363(a)(1)(A), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (a)(31). Pub. L. 98-369, § 2368(a), in amending par. (31) generally, revised existing provisions to cover review of skilled nursing facilities.

Subsec. (a)(33)(A). Pub. L. 98-369, § 2373(b)(7), substituted "second sentence" for "penultimate sentence".

Subsec. (a)(42). Pub. L. 98-369, § 2373(b)(8), substituted "subchapter" for "part" after "audits conducted for purposes of such".

Subsec. (a)(43). Pub. L. 98-369, § 2303(g)(1), redesignated par. (44) as (43), and struck out former par. (43) which provided that if the State plan makes provision for payment to a physician for laboratory services the performance of which such physician, or other physician with whom he shares his practice, did not personally perform or supervise, the plan include provision to insure that payment for such services not exceed the payment authorized by section 1395u(h) of this title.

Subsec. (a)(44). Pub. L. 98-369, § 2363(a)(1)(B), added par. (44).

Pub. L. 98-369, § 2303(g)(1)(C), redesignated former par. (44) as (43).

Subsec. (a)(45). Pub. L. 98-369, § 2367(a), added par. (45).

Subsec. (a), foll. par. (45). Pub. L. 98-369, § 2373(b)(9), substituted "The provisions of paragraph (9)(A), (31), and (33) and of section 1396b(i)(4) of this title shall not apply to" for "For purposes of paragraph (9)(A), (26), (31), and (33), and of section 1396b(i)(4) of this title, the term 'skilled nursing facility' and 'nursing home' do not include".

Subsec. (e)(4). Pub. L. 98-369, § 2362(a), added par. (4).

Subsec. (f). Pub. L. 98-369, § 2373(b)(10), substituted "paragraph (10)(A)" and "paragraph (10)(C)" for "clause (10)(A)" and "clause (10)(C)", wherever appearing.

EFFECTIVE DATE OF 1984 AMENDMENTS

Amendment by Pub. L. 98-617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98-369, see section 3(c) of Pub. L. 98-617, set out as a note under section 1395f of this title.

Amendment by section 2303(g)(1) of Pub. L. 98-369 applicable to clinical diagnostic laboratory tests furnished on or after July 1, 1984, but not applicable to clinical diagnostic laboratory tests furnished to inpatients of a provider operating under a waiver granted pursuant to section 602(k) of Pub. L. 98-21, set out as a note under section 1395f of this title, see section 2303(j)(1) and (3) of Pub. L. 98-369, set out as a note under section 1395f of this title.

Section 2314(c)(3) of Pub. L. 98-369 provided that:

"(A) Except as provided in subparagraph (B), the amendments made by subsection (b) [amending subsec. (a)(13) of this section] shall apply to medical assistance furnished on or after October 1, 1984.

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act [this subchapter] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirement imposed by the amendments made by this section [amending sections 1395x and 1396a of this title and enacting provisions set out as a note under section 1395x of this title], the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2335(e) of Pub. L. 98-369 effective July 18, 1984, see section 2335(g) of Pub. L. 98-369, set out as a note under section 1395f of this title.

Section 2361(d) of Pub. L. 98-369 provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [amending sections 606, 1396a, and 1396d of this title] shall apply to calendar

quarters beginning on or after October 1, 1984, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [this subchapter] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [July 18, 1984]."

Section 2362(b) of Pub. L. 98-369 provided that: "The amendment made by subsection (a) [adding subsec. (e)(4) of this section] shall apply to children born on or after October 1, 1984."

Amendment by section 2363(a)(1) of Pub. L. 98-369 applicable to calendar quarters beginning on or after July 18, 1984, except that, in the case of individuals admitted to skilled nursing facilities before that date, the amendment shall not require recertifications sooner or more frequently than were required under the law in effect before that date, see section 2363(c) of Pub. L. 98-369, set out as a note under section 1396b of this title.

Section 2367(c) of Pub. L. 98-369 provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [amending sections 1393a and 1396k of this title] shall become effective on October 1, 1984.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [this subchapter] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirement imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [July 18, 1984]."

Section 2368(c) of Pub. L. 98-369 provided that: "The amendments made by this section [amending subsec. (a)(26) and (31) of this section] shall become effective on the date of the enactment of this Act [July 18, 1984]."

PAYMENT FOR PSYCHIATRIC HOSPITAL SERVICES

Section 2386 of Pub. L. 98-369 provided that: "The provisions of section 1902(a)(13) of the Social Security Act [42 U.S.C. 1396a(a)(13)], in so far as they require a reduction of the amount of payment otherwise to be made to a public psychiatric hospital due to the level of care received in such hospital, shall not apply to payments to hospitals before July 1, 1985, and such a reduction made for payments during the 12-month period ending June 30, 1986, and during the 12-month period ending June 30, 1987, shall be one-third and two-thirds, respectively, of the amount of the reduction which would have been made without regard to this section."

MORATORIUM ON REGULATORY ACTIONS BY SECRETARY

Section 2373(c) of Pub. L. 98-369 provided that:

"(1) The Secretary of Health and Human Services shall not take any compliance, disallowance, penalty, or other regulatory action against a State during the moratorium period described in paragraph (2) by reason of such State's plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] being determined to be in violation of section 1902(a)(10)(C)(i)(III) of such Act [42 U.S.C.

1396a(a)(10)(C)(i)(III)] on account of such plan's having a standard or methodology which the Secretary interprets as being less restrictive than the standard or methodology required under such section.

"(2) The moratorium period is the period beginning on the date of the enactment of this Act [July 18, 1984] and ending 18 months after the date on which the Secretary submits the report required under paragraph (3).

"(3) The Secretary shall report to the Congress within 12 months after the date of the enactment of this Act [July 18, 1984] with respect to the appropriateness, and impact on States and recipients of medical assistance, of applying standards and methodologies utilized in cash assistance programs to those recipients of medical assistance who do not receive cash assistance, and any recommendations for changes in such requirements.

"(4) No provision of law shall repeal or suspend the moratorium imposed by this subsection unless such provision specifically amends or repeals this subsection."

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 300e-17, 705, 1315, 1320a-7a, 1382i, 1395v, 1395cc, 1395tt, 1396b, 1396c, 1396d, 1396g, 1396i, 1396l, 1396n, 1396o, 4728, 6022, 6042 of this title.

§ 1396b. Payment to States

[See main edition for text of (a) to (f)]

(g) Decrease in Federal medical assistance percentage of amounts paid for services furnished under State plan after June 30, 1973

(1) Subject to paragraph (3), with respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1395mm of this title or which is a qualified health maintenance organization (as defined in section 300e-9(d) of this title)), the Federal medical assistance percentage shall be decreased as follows: After an individual has received inpatient hospital services or intermediate care facility services for 60 days, skilled nursing facility services for 30 days, or inpatient mental hospital services for 90 days (whether or not such days are consecutive), during any fiscal year, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual shall be decreased by a per centum thereof (determined under paragraph (5)) unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services, skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), such State has an effective program of medical review of the care of patients in mental hospitals, skilled nursing facilities, and intermediate care facilities pursuant to paragraphs (26) and (31) of section 1396a(a) of this title whereby the professional management of each case is reviewed and evaluated at least annually by independent professional

equipment available to individuals entitled to benefits under this subchapter on a lease-purchase basis whenever possible.

(Aug. 14, 1935, ch. 531, title XVIII, § 1889, formerly § 1833(f), as added Jan. 2, 1968, Pub. L. 90-248, title I, § 132(b), 81 Stat. 850, and amended Oct. 30, 1972, Pub. L. 92-603, title II, § 245(d), 86 Stat. 1424; Oct. 25, 1977, Pub. L. 95-142, § 16(a), 91 Stat. 1200; renumbered and amended July 18, 1984, Pub. L. 98-369, div. B, title III, § 2321(d), 98 Stat. 1084.)

CODIFICATION

Section was formerly set out as subsec. (f) of section 1395f of this title prior to its renumbering and transfer by Pub. L. 98-369.

AMENDMENTS

1984—Subsec. (a). Pub. L. 98-369, § 2321(d)(4)(B), redesignated par. (1) of section 1395(f) of this title as subsec. (a).

Pub. L. 98-369, § 2321(d)(1), struck out “as described in section 1395x(x)(6) of this title” after “furnished an individual”.

Subsec. (b). Pub. L. 98-369, § 2321(d)(4)(B), redesignated par. (2) of section 1395(f) of this title as subsec. (b).

Pub. L. 98-369, § 2321(d)(2), substituted “any” for “the 20 percent” and struck out “under subsection (a) of this section” after “amount applicable”.

Subsec. (c). Pub. L. 98-369, § 2321(d)(4)(B), redesignated par. (3) of section 1395(f) of this title as subsec. (c).

Pub. L. 98-369, § 2321(d)(3), substituted “subsection (a) of this section” for “paragraph (1)”.

Subsec. (d). Pub. L. 98-369, § 2321(d)(4)(B), redesignated par. (4) of section 1395(f) of this title as subsec. (d).

1977—Par. (1). Pub. L. 95-142 substituted provisions relating to determinations by the Secretary with respect to presumptions regarding the purchase price or practicality of buying or renting durable medical equipment, for provisions relating to the purchase price of durable medical equipment authorized to be paid by the Secretary.

Par. (2). Pub. L. 95-142 substituted provisions relating to waiver of the coinsurance amount in the purchase of used durable medical equipment, for provisions relating to reimbursement procedures established by the Secretary in cases of rental of durable medical equipment.

Para. (3), (4). Pub. L. 95-142 added para. (3) and (4).

1972—Pub. L. 92-603 designated existing provisions as par. (1)(A) and added para. (1)(B) and (2).

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98-369 applicable to items and services furnished on or after July 18, 1984, see section 2321(g) of Pub. L. 98-369, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by Pub. L. 95-142 applicable with respect to durable medical equipment purchased or rented on or after Oct. 1, 1977, see section 16(b) of Pub. L. 95-142, set out as a note under section 1395f of this title.

EFFECTIVE DATE

Section applicable only with respect to items purchased after Dec. 31, 1967, see section 132(c) of Pub. L. 90-248, set out as an Effective Date of 1968 Amendment note under section 1395f of this title.

SUBCHAPTER XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

SUBCHAPTER REFERRED TO IN OTHER SECTIONS

This subchapter is referred to in sections 242b, 254b, 254c, 254e, 254h, 254n, 300c, 300e-6, 300m-6, 300x-4, 300z-5, 602, 603, 606, 614, 632a, 652, 671, 672, 673, 705, 709, 1301, 1306, 1308, 1309, 1310, 1315, 1316, 1318, 1320a-1, 1320a-2, 1320a-3, 1320a-5, 1320a-7, 1320a-7a, 1320a-8, 1320b-2, 1320b-3, 1320b-4, 1320b-5, 1320b-7, 1320c-2, 1320c-10, 1382, 1382g, 1382h, 1382i, 1383c, 1395b-1, 1395v, 1395x, 1395y, 1395z, 1395cc, 1395mm, 1395tt, 1395vv, 1395ww, 1997, 3013, 3026, 3035b, 6024, 6624 of this title; title 7 sections 2017, 3178, title 8 section 1622; title 10 section 1079, title 12 sections 1715w, 1715z-7; title 24 section 170a; title 25 section 1622; title 26 section 6103; title 28 sections 622, 4108.

§ 1396. Appropriations

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

(Aug. 14, 1935, ch. 531, title XIX, § 1901, as added July 30, 1965, Pub. L. 89-97, title I, § 121(a), 79 Stat. 343, and amended Dec. 31, 1973, Pub. L. 93-233, § 13(a)(1), 87 Stat. 960; July 18, 1984, Pub. L. 98-369, div. B, title VI, § 2663(j)(3)(C), 98 Stat. 1171.)

AMENDMENTS

1984—Pub. L. 98-369 struck out “Health, Education, and Welfare” after “Secretary”.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98-369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98-369, set out as a note under section 401 of this title.

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

[See main edition for text of (1) to (8)]

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions, and

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1395x(e)(9) of this title or paragraphs (11) and (12) of section 1395x(s) of this title, or, in the case of a laboratory which is in a rural health clinic, of section 1395x(aa)(2)(G) of this title;

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title, to—

(i) all individuals—

(I) who are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including individuals eligible under this subchapter by reason of section 602(a)(37) or 606(h) of this title, or considered by the State to be receiving such aid as authorized under section 614(g) of this title),

(II) with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or

(III) who are qualified pregnant women or children as defined in section 1396d(n) of this title;¹

[See main edition for text of (ii), (B) to (D), closing provisions, (11) and (12)]

(13) provide—

(A) for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1395x(v)(1)(G) of this title), for lower reimbursement rates reflecting the level of care actually received (in a manner consistent with section 1395x(v)(1)(G) of this title)) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance

have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, skilled nursing facility, and intermediate care facility and periodic audits by the State of such reports;

(B) that the State shall provide assurances satisfactory to the Secretary that the payment methodology utilized by the State for payments to hospitals, skilled nursing facilities, and intermediate care facilities can reasonably be expected not to increase such payments, solely as a result of a change of ownership, in excess of the increase which would result from the application of section 1395x(v)(1)(O) of this title; and

(C) for payment for services described in section 1396d(a)(2)(B) of this title provided by a rural health clinic under the plan of 100 percent of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary may prescribe in regulations under section 1395l(a)(3) of this title, or, in the case of services to which those regulations do not apply, on such tests of reasonableness as the Secretary may prescribe in regulations under this subparagraph;

[See main edition for text of (14) to (19)]

(20) If the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases—

[See main edition for text of (A)]

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodic determination of his need for continued treatment in the institution; and

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 303(a)(4)(A)(i) and (ii) or section 1383(a)(4)(A)(i) and (ii) of this title which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out;

[See main edition for text of (21) to (25)]

¹So in original. Probably should be followed by "and".

(36) If the State plan includes medical assistance for inpatient mental hospital services, provide—

(A) with respect to each patient receiving such services, for a regular program of medical review (including medical evaluation) of his need for such services, and for a written plan of care;

(B) for periodic inspections to be made in all mental institutions within the State by one or more medical review teams (composed of physicians and other appropriate health and social service personnel) of the care being provided to each person receiving medical assistance, including (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the institution, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and

(C) for full reports to the State agency by each medical review team of the findings of each inspection under subparagraph (B), together with any recommendations;

[See main edition for text of (27)]

(28) provide that any skilled nursing facility receiving payments under such plan must satisfy all of the requirements contained in section 1395x(j) of this title, except that the exclusion contained therein with respect to institutions which are primarily for the care and treatment of mental diseases shall not apply for purposes of this subchapter;

[See main edition for text of (29)]

(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(x)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care;

(B) provide, under the program described in subparagraph (A), that—

(i) each admission to a hospital, skilled nursing facility, intermediate care facility, or hospital for mental diseases is reviewed or screened in accordance with criteria established by medical and other professional personnel who are not themselves directly responsible for the care of the patient involved, and who do not have a significant financial interest in any such institution and are not, except in the case of a hospital, employed by the institution providing the care involved, and

(ii) the information developed from such review or screening, along with the data obtained from prior reviews of the necessity for admission and continued stay of patients by such professional personnel, shall be used as the basis for establishing the size and composition of the sample of admis-

sions to be subject to review and evaluation by such personnel, and any such sample may be of any size up to 100 percent of all admissions and must be of sufficient size to serve the purpose of (i) identifying the patterns of care being provided and the changes occurring over time in such patterns so that the need for modification may be ascertained, and (ii) subjecting admissions to early or more extensive review where information indicates that such consideration is warranted to a hospital, skilled nursing facility, intermediate care facility, or hospital for mental diseases;

(31) with respect to skilled nursing facility services (and with respect to intermediate care facility services, where the State plan includes medical assistance for such services) provide—

(A) with respect to each patient receiving such services, for a written plan of care, prior to admission to or authorization of benefits in such facility, in accordance with regulations of the Secretary, and for a regular program of independent professional review (including medical evaluation) which shall periodically review his need for such services;

(B) with respect to each skilled nursing or intermediate care facility within the State, for periodic onsite inspections of the care being provided to each person receiving medical assistance, by one or more independent professional review teams (composed of a physician or registered nurse and other appropriate health and social service personnel), including with respect to each such person (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the facility, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and

(C) for full reports to the State agency by each independent professional review team of the findings of each inspection under subparagraph (B), together with any recommendations;

[See main edition for text of (32)]

(33) provide—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and where applicable, to the State agency described in the second sentence of this subsection; and

[See main edition for text of (B), (34) to (41)]

(42) provide (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for such entities also providing services under subchapter XVIII of this chapter, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such subchapter, and (C) for payment of such proportion of costs of each such common audit as is determined under methods specified by the Secretary under section 1320a-8(a) of this title;

(43) provide for—

(A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1396d(a)(4)(B) of this title, of the availability of early and periodic screening, diagnostic, and treatment services as described in section 1396d(a)(4)(B) of this title,

(B) providing or arranging for the provision of such screening services in all cases where they are requested, and

(C) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services;

(44) in each case for which payment for inpatient hospital services, skilled nursing facility services, intermediate care facility services, or inpatient mental hospital services is made under the State plan—

(A) a physician certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and the physician, or a physician assistant or nurse practitioner under the supervision of a physician, recertifies, where such services are furnished over a period of time, in such cases, at least as often as required under section 1396b(g)(6) of this title (or, in the case of services that are intermediate care facility services provided in an institution for the mentally retarded, every year), and accompanied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services, and

(B) such services were furnished under a plan established and periodically reviewed and evaluated by a physician;

(45) provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1396k of this title; and

(46) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1320b-7 of this title.

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State sub-

mits its plan for approval under this subchapter, the State agency which administered or supervised the administration of the plan of such State approved under subchapter X of this chapter (or subchapter XVI of this chapter, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under subchapter I of this chapter (or subchapter XVI of this chapter, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under subchapter X of this chapter (or subchapter XVI of this chapter, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this subchapter (except for purposes of paragraph (10)). The provisions of paragraphs (9)(A), (31), and (33) and of section 1396b(i)(4) of this title shall not apply to a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

[See main edition for text of closing para.; (b) to (d)]

(e) Continued eligibility of families determined ineligible because of income and resources or hours of work limitations of plan

[See main edition for text of (1) to (3)]

(4) A child born to a woman eligible for and receiving medical assistance under a State plan on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of one year so long as the child is a member of the woman's household and the woman remains eligible for such assistance.

(f) Effective date of State plan as determinative of duty of State to provide medical assistance to aged, blind, or disabled individuals

Notwithstanding any other provision of this subchapter, except as provided in subsection (e) of this section, no State not eligible to participate in the State plan program established under subchapter XVI of this chapter shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of subchapter XVI of this chapter) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this subchapter and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under

such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1396b(f) of this title (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to paragraph (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under paragraph (10)(A), or (2) an eligible individual or eligible spouse, as defined in subchapter XVI of this chapter, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under paragraph (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to paragraph (10)(C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection.

[See main edition for text of (g) to (j)]

(As amended July 18, 1984, Pub. L. 98-369, div. B, title III, §§ 2303(g)(1), 2314(b), 2335(e), 2361(a), 2362(a), 2363(a)(1), 2367(a), 2368(a), (b), 2373(b)(1)-(10), title VI, § 2651(c), 98 Stat. 1066, 1079, 1091, 1104, 1105, 1108, 1109, 1111, 1149; Aug. 16, 1984, Pub. L. 98-378, § 20(c), 98 Stat. 1322; Nov. 8, 1984, Pub. L. 98-617, § 3(a)(7), (b)(10), 98 Stat. 3295, 3296.)

REFERENCES IN TEXT

Pub. L. 92-336, referred to in provisions following subsec. (a)(46), is Pub. L. 92-336, July 1, 1972, 86 Stat. 406, which amended sections 401, 403, 409, 411, 415, 427, 428, and 430 of this title and sections 165, 1401, 1402, 3101, 3111, 3121, 3122, 3125, 6413, and 6654 of Title 26, Internal Revenue Code, and enacted provisions set out as notes under sections 403, 409, 415, and 428 of this title and sections 165 and 1401 of Title 26.

AMENDMENTS

1964—Subsec. (a)(9)(C). Pub. L. 88-369, § 2373(b)(1), realigned margin of subpar. (C).

Subsec. (a)(10)(A). Pub. L. 98-369, § 2373(b)(2), realigned margins of subpar. (A).

Subsec. (a)(10)(A)(i). Pub. L. 98-369, § 2361(a), amended cl. (i) generally. Prior to the amendment cl. (i) read as follows: "(i) all individuals receiving aid or assistance under any plan of the State approved under

subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including pregnant women deemed by the State to be receiving such aid as authorized in section 606(g) of this title and individuals considered by the State to be receiving such aid as authorized under section 614(g) of this title), or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter; and".

Subsec. (a)(10)(A)(i)(1). Pub. L. 98-378, § 20(c), substituted "section 602(a)(37) or 606(b) of this title" for "section 602(a)(37) of this title".

Subsec. (a)(13)(A). Pub. L. 98-369, § 2373(b)(3), made clarifying amendment by striking out "(A)" and all that follows through "hospital" the first place it appears and inserting in lieu thereof "(A) for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital", resulting in no change in text.

Subsec. (a)(13)(B), (C). Pub. L. 98-369, § 2314(b), added subpar. (B) and redesignated former subpar. (B) as (C).

Subsec. (a)(20)(B). Pub. L. 98-369, § 2373(b)(4), substituted "periodic" for "periodical".

Subsec. (a)(20)(C). Pub. L. 98-369, § 2373(b)(5), struck out reference to section 803(a)(1)(A)(i) and (ii) of this title.

Subsec. (a)(26). Pub. L. 98-369, § 2368(b), in amending par. (26) generally, revised existing provisions to continue their application to review of inpatient mental hospital service programs, and to sever provisions relating to review of skilled nursing programs. See par. (31) of this section.

Subsec. (a)(26)(B)(ii). Pub. L. 98-617, § 3(a)(7), repealed the amendment made by Pub. L. 98-369, § 2373(b)(6). See below.

Pub. L. 98-369, § 2373(b)(6), provided that cl. (ii) is amended by substituting "facilities" for "homes".

Subsec. (a)(26)(C). Pub. L. 98-617, § 3(b)(10), realigned margin of subpar. (C).

Subsec. (a)(28). Pub. L. 98-369, § 2335(e), struck out "and tuberculosis" after "mental diseases".

Subsec. (a)(30). Pub. L. 98-369, § 2363(a)(1)(A), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (a)(31). Pub. L. 98-369, § 2368(a), in amending par. (31) generally, revised existing provisions to cover review of skilled nursing facilities.

Subsec. (a)(33)(A). Pub. L. 98-369, § 2373(b)(7), substituted "second sentence" for "penultimate sentence".

Subsec. (a)(42). Pub. L. 98-369, § 2373(b)(8), substituted "subchapter" for "part" after "audits conducted for purposes of such".

Subsec. (a)(43). Pub. L. 98-369, § 2303(g)(1), redesignated par. (44) as (43), and struck out former par. (43) which provided that if the State plan makes provision for payment to a physician for laboratory services the performance of which such physician, or other physician with whom he shares his practice, did not personally perform or supervise, the plan include provision to insure that payment for such services not exceed the payment authorized by section 1395u(h) of this title.

Subsec. (a)(44). Pub. L. 98-369, § 2363(a)(1)(B), added par. (44).

Pub. L. 98-369, § 2303(g)(1)(C), redesignated former par. (44) as (43).

Subsec. (a)(45). Pub. L. 98-369, § 2367(a), added par. (45).

Subsec. (a)(46). Pub. L. 98-369, § 2651(c), added par. (46).

Subsec. (a), foll. par. (46). Pub. L. 98-369, § 2373(b)(9), substituted "The provisions of paragraph (9)(A), (31), and (33) and of section 1396b(1)(4) of this title shall not apply to" for "For purposes of paragraph (9)(A), (36), (31), and (33), and of section 1396b(1)(4) of this title, the term 'skilled nursing facility' and 'nursing home' do not include".

Subsec. (e)(4). Pub. L. 98-369, § 2362(a), added par. (4).

Subsec. (f). Pub. L. 98-369, § 2373(b)(10), substituted "paragraph (10)(A)" and "paragraph (10)(C)" for "clause (10)(A)" and "clause (10)(C)", respectively, wherever appearing.

EFFECTIVE DATE OF 1984 AMENDMENTS

Amendment by Pub. L. 98-617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98-369, see section 3(c) of Pub. L. 98-617, set out as a note under section 1395f of this title.

Amendment by section 2303(g)(1) of Pub. L. 98-369 applicable to clinical diagnostic laboratory tests furnished on or after July 1, 1984, but not applicable to clinical diagnostic laboratory tests furnished to inpatients of a provider operating under a waiver granted pursuant to section 602(k) of Pub. L. 98-21, set out as a note under section 1395y of this title, see section 2303(j)(1) and (3) of Pub. L. 98-369, set out as a note under section 1395f of this title.

Section 2314(c)(3) of Pub. L. 98-369 provided that:

"(A) Except as provided in subparagraph (B), the amendments made by subsection (b) [amending subsec. (a)(13) of this section] shall apply to medical assistance furnished on or after October 1, 1984.

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act [this subchapter] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirement imposed by the amendments made by this section [amending sections 1395x and 1396a of this title and enacting provisions set out as a note under section 1395x of this title], the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2335(e) of Pub. L. 98-369 effective July 18, 1984, see section 2335(g) of Pub. L. 98-369, set out as a note under section 1395f of this title.

Section 2361(d) of Pub. L. 98-369 provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [amending sections 606, 1396a, and 1396d of this title] shall apply to calendar quarters beginning on or after October 1, 1984, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [this subchapter] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [July 18, 1984]."

Section 2362(b) of Pub. L. 98-369 provided that: "The amendment made by subsection (a) [adding subsec. (e)(4) of this section] shall apply to children born on or after October 1, 1984."

Amendment by section 2363(a)(1) of Pub. L. 98-369 applicable to calendar quarters beginning on or after July 18, 1984, except that, in the case of individuals admitted to skilled nursing facilities before that date, the amendment shall not require recertifications sooner or more frequently than were required under the law in effect before that date, see section 2363(c) of Pub. L. 98-369, set out as a note under section 1396b of this title.

Section 2367(c) of Pub. L. 98-369 provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [amending sections 1396a and 1396k of this title] shall become effective on October 1, 1984.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [this subchapter] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirement imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [July 18, 1984]."

Section 2368(c) of Pub. L. 98-369 provided that: "The amendments made by this section [amending subsec. (a)(26) and (31) of this section] shall become effective on the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2651(c) of Pub. L. 98-369 effective Apr. 1, 1985, except as otherwise provided, see section 2651(f)(2) of Pub. L. 98-369, set out as an Effective Date note under section 1320b-7 of this title.

PAYMENT FOR PSYCHIATRIC HOSPITAL SERVICES

Section 2366 of Pub. L. 98-369 provided that: "The provisions of section 1902(a)(13) of the Social Security Act [42 U.S.C. 1396a(a)(13)], in so far as they require a reduction of the amount of payment otherwise to be made to a public psychiatric hospital due to the level of care received in such hospital, shall not apply to payments to hospitals before July 1, 1985, and such a reduction made for payments during the 12-month period ending June 30, 1986, and during the 12-month period ending June 30, 1987, shall be one-third and two-thirds, respectively, of the amount of the reduction which would have been made without regard to this section."

MORATORIUM ON REGULATORY ACTIONS BY SECRETARY

Section 2373(c) of Pub. L. 98-369 provided that:

"(1) The Secretary of Health and Human Services shall not take any compliance, disallowance, penalty, or other regulatory action against a State during the moratorium period described in paragraph (2) by reason of such State's plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] being determined to be in violation of section 1902(a)(10)(C)(i)(III) of such Act [42 U.S.C. 1396a(a)(10)(C)(i)(III)] on account of such plan's having a standard or methodology which the Secretary interprets as being less restrictive than the standard or methodology required under such section.

"(2) The moratorium period is the period beginning on the date of the enactment of this Act [July 18, 1984] and ending 18 months after the date on which the Secretary submits the report required under paragraph (3).

"(3) The Secretary shall report to the Congress within 12 months after the date of the enactment of this Act [July 18, 1984] with respect to the appropriateness, and impact on States and recipients of medical assistance, of applying standards and methodologies utilized in cash assistance programs to those recipients of medical assistance who do not receive cash assistance, and any recommendations for changes in such requirements.

"(4) No provision of law shall repeal or suspend the moratorium imposed by this subsection unless such provision specifically amends or repeals this subsection."

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 300e-17, 705, 1315, 1320a-7a, 1382i, 1395v, 1395cc, 1395tt, 1396b, 1396c, 1396d, 1396g, 1396i, 1396l, 1396n, 1396o, 4728, 6022, 6042 of this title.

§ 1396b. Payment to States

[See main edition for text of (a) to (f)]

(g) Decrease in Federal medical assistance percentage of amounts paid for services furnished under State plan after June 30, 1973

(1) Subject to paragraph (3), with respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1395mm of this title or which is a qualified health maintenance organization (as defined in section 300e-9(d) of this title)), the Federal medical assistance percentage shall be decreased as follows: After an individual has received inpatient hospital services or intermediate care facility services for 60 days, skilled nursing facility services for 30 days, or inpatient mental hospital services for 90 days (whether or not such days are consecutive), during any fiscal year, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual shall be decreased by a per centum thereof (determined under paragraph (5)) unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services, skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), such State has an effective program of medical review of the care of patients in mental hospitals, skilled nursing facilities, and intermediate care facilities pursuant to paragraphs (26) and (31) of section 1396a(a) of this title whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams. In determining the number of days on which an individual has received services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under section 1395d of this title.

[See main edition for text of (2) and (3)]

(4) *[See main edition for text of (A)]*

(B) The Secretary shall find a showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory under such paragraph with respect to the requirement that the State conduct annual onsite inspections in mental hospitals, skilled nursing facilities, and intermediate care facilities under paragraphs (26) and (31) of section 1396a(a) of this title, if the showing demonstrates that the State has conducted such an onsite inspection during the

12-month period ending on the last date of the calendar quarter—

(i) in each of not less than 98 per centum of the number of such hospitals and facilities requiring such inspection, and

(ii) in every such hospital or facility which has 200 or more beds,

and that, with respect to such hospitals and facilities not inspected within such period, the State has exercised good faith and due diligence in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only.

[See main edition for text of (5)]

(6)(A) Recertifications required under section 1396a(a)(44) of this title shall be conducted at least every 60 days in the case of inpatient hospital services.

(B) Such recertifications in the case of skilled nursing facility services shall be conducted at least—

(i) 30 days after the date of the initial certification,

(ii) 60 days after the date of the initial certification,

(iii) 90 days after the date of the initial certification, and

(iv) every 60 days thereafter.

(C) Such recertifications in the case of intermediate care facility services shall be conducted at least—

(i) 60 days after the date of the initial certification,

(ii) 180 days after the date of the initial certification,

(iii) 12 months after the date of the initial certification,

(iv) 18 months after the date of the initial certification,

(v) 24 months after the date of the initial certification, and

(vi) every 12 months thereafter.

(D) For purposes of determining compliance with the schedule established by this paragraph, a recertification shall be considered to have been done on a timely basis if it was performed not later than 10 days after the date the recertification was otherwise required and the State establishes good cause why the physician or other person making such recertification did not meet such schedule.

(7) It is the duty and responsibility of the Secretary to assure that standards which govern the provision of care in skilled nursing facilities and intermediate care facilities under plans approved under this subchapter, and the enforcement of such standards, are adequate to protect the health and safety of residents and to promote the effective and efficient use of public moneys.

[See main edition for text of (h)]

Addendum 6

§ 435.603

needy in Subpart H and the medically needy in Subpart I of this part.

[45 FR 82258, Dec. 18, 1980]

§ 435.603 Applications for other benefits.

(a) As a condition of eligibility, the agency must require applicants and recipients to take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which they are entitled, unless they can show good cause for not doing so.

(b) Annuities, pensions, retirement and disability benefits include, but are not limited to, veterans' compensation and pensions, OASDI benefits, railroad retirement benefits, and unemployment compensation.

§ 435.604 Assignment of rights to benefits.

For medical assistance furnished on or after October 1, 1984—

(a) As a condition of eligibility, the agency must require legally able applicants and recipients to assign rights to medical support or other third party payments to the Medicaid agency and to cooperate with the agency in obtaining medical support or payments. (Part 433, Subpart D, contains specific requirements for these assignments.)

(b) The requirements for assignment of rights must be applied uniformly for all groups covered under the plan.

[50 FR 46666, Nov. 12, 1985]

Subpart H—Financial Requirements for the Categorically Needy

§ 435.700 Scope.

This subpart prescribes financial requirements for determining the eligibility of categorically needy individuals under Subparts B and C of this part. The requirements apply only to individuals who are not receiving AFDC, SSI, or an optional State supplement. The financial eligibility requirements of AFDC, SSI, or the State supplement apply to individuals receiving those payments. This subpart also prescribes requirements for applying an institutionalized recipient's income to cost of care.

42 CFR Ch. IV (10-1-86 Edition)

FINANCIAL REQUIREMENTS APPLICABLE TO OPTIONAL GROUPS: FAMILIES AND CHILDREN

§ 435.711 General requirements.

In determining eligibility for families and children, a Medicaid agency must apply the financial eligibility requirements of the State's AFDC plan.

§ 435.712 Financial responsibility of spouses and parents.

(a) For families and children, the agency must consider income and resources of spouses or parents as available to the individual whether or not they are actually contributed, if they live in the same household. For this purpose, "parent" includes a stepparent if he is equally liable with the natural parent for the support of children under State law of general applicability.

(b) If the spouse or parent does not live with the individual, the agency must consider only income and resources that are actually contributed to the individual from a parent or spouse as available to him.

(c) Even if State law confers adult status below age 21, the agency must consider parental income and resources as available to a child, if he is living with the parent, until he becomes 21.

FINANCIAL ELIGIBILITY REQUIREMENTS APPLICABLE TO OPTIONAL GROUPS: THE AGED, BLIND, AND DISABLED IN STATES COVERING INDIVIDUALS RECEIVING SSI

§ 435.721 General requirements.

(a) This section applies when an agency provides Medicaid to—

(1) All SSI recipients or to all SSI recipients and to State supplement recipients; and

(2) One or more of the optional coverage groups specified in §§ 435.210 (eligible for but not receiving cash), 435.211 and 435.231 (institutionalized individuals).

(b) If the agency, under § 435.120, provides Medicaid to SSI recipients but not to optional State supplement recipients, it must use the SSI financial eligibility requirements to deter-

Addendum 7

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ble under conditions in each state; therefore, regulations are valid. *Jacquet v Westerfield* (1978, CA5 La) 569 F2d 1339.

HEW (now HHS) regulation providing that state may recoup overpayments from current assistance payments as long as reductions in assistance are within "reasonable limits" and do not cause "undue hardship" to recipients is to be construed as not authorizing recoupment if it would deprive parent or child of shelter or subsistence necessary for maintenance of minimum standard of health and well-being, and therefore does not conflict with Social Security Act (42 USCS §§ 601, 602(a)(10)). *Harrell v Harder* (1974, DC Conn) 369 F Supp 810, 18 FR Serv 2d 1281.

Federal regulations are violated by State Department of Public Aid policy and practice of recoupment from current assistance payments without consideration on case-by-case basis of whether proposed reduction would cause assistance unit undue hardship. *Howell v Trainor* (1977, ND Ill) 432 F Supp 1235.

11. Procedural requirements for reducing benefits

Form of notice proposed by state Department of Public Aid with respect to reasons for cancellation or reduction of AFDC grants is insufficient where, although notice states ultimate reason for reduction or cancellation of benefits, it fails to provide recipient with breakdown of income and allowable deductions, and therefore recipient has little protection against errors committed by Department in determining amount of his grant. *Dilda v Quern* (1980, CA7 Ill) 612 F2d 1055, cert den 447 US 935, 65 L Ed 2d

1130, 100 S Ct 3039 and (disagreed with *Garrett v Puett* (CA6 Tenn) 707 F2d 930).

Goldberg does not require prior notice and hearing when termination of assistance is produced by state-wide policy changes in welfare programs implemented pursuant to agency's legislative rule-making function. *Whitfield v King* (1973, MD Ala) 364 F Supp 1296, supp op (MD Ala) 399 F Supp 348, affd 431 US 910, 53 L Ed 2d 221, 97 S Ct 2166.

Annotations:

Sufficiency of notice or hearing required prior to termination of welfare benefits. 47 ALR3d 277.

12. Judicial review

Review of state welfare regulations under "least restrictive alternative" doctrine to insure that public assistance to poor persons is provided in manner not unnecessarily destructive of family unity is not mandated by: (1) goal of AFDC program to encourage care of dependent children in their own homes or homes of relatives set forth at 42 USCS § 601; or (2) by requirement of 42 USCS § 602(a)(15) that each state submit plan "for preventing or reducing incidence of births out of wedlock and otherwise strengthening family life." *Black v Beame* (1977, CA2 NY) 550 F2d 815.

Claimants asserting state policy violates rights under Equal Protection clause of Fourteenth Amendment and conflicts with various provisions of Social Security Act of 1935 [42 USCS §§ 601 et seq] can recover attorneys fees pursuant to 42 USCS §§ 1983, 1988 even if recovery is based on claims other than constitutionally-based ones. *Lund v Affleck* (1977, DC RI) 442 F Supp 1109, affd (CA1 RI) 587 F2d 75.

§ 602. State plans for aid and services to needy families with children; contents; approval by Secretary; records and reports; treatment of earned income advances

(a) Contents. A State plan for aid and services to needy families with children must—

- (1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;
- (2) provide for financial participation by the State;
- (3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan;
- (4) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for aid to families with

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42 USCS § 602

dependent children is denied or is not acted upon with reasonable promptness;

(5) provide such methods of administration (including after January 1, 1940, methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) except as may be otherwise provided in paragraph (8) or (31) and section 415 [42 USCS § 615], provide that the State agency—

(A) shall, in determining need, take into consideration any other income and resources of any child or relative claiming aid to families with dependent children, or of any other individual (living in the same home as such child and relative) whose needs the State determines should be considered in determining the need of the child or relative claiming such aid;

(B) shall determine ineligible for aid any family the combined value of whose resources (reduced by any obligations or debts with respect to such resources) exceeds \$1,000 or such lower amount as the State may determine, but not including as a resource for purposes of this subparagraph (i) a home owned and occupied by such child, relative, or other individual and so much of the family member's ownership interest in one automobile as does not exceed such amount as the Secretary may prescribe, (ii) under regulations prescribed by the Secretary, burial plots (one for each such child, relative, and other individual), and funeral agreements or (iii) for such period or periods of time as the Secretary may prescribe, real property which the family is making a good-faith effort to dispose of, but any aid payable to the family for any such period shall be conditioned upon such disposal, and any payments of such aid for that period shall (at the time of the disposal) be considered overpayments to the extent that they would not have been made had the disposal occurred at the beginning of the period for which the payments of such aid were made; and

(C) may, in the case of a family claiming or receiving aid under this part [42 USCS §§ 601 et seq.] for any month, take into consideration as income (to the extent the State determines appropriate, as specified in such plan, and notwithstanding any other provision of law)—

(i) an amount not to exceed the value of the family's monthly allotment of food stamp coupons, to the extent such value duplicates the amount for food included in the maximum amount that

would be payable under the State plan to a family of the same composition with no other income; and

(ii) an amount not to exceed the value of any rent or housing subsidy provided to such family, to the extent such value duplicates the amount for housing included in the maximum amount that would be payable under the State plan to a family of the same composition with no other income;

(8)(A) provide that, with respect to any month, in making the determination under paragraph (7), the State agency—

(i) shall disregard all of the earned income of each dependent child receiving aid to families with dependent children who is (as determined by the State in accordance with standards prescribed by the Secretary) a full-time student or a part-time student who is not a full-time employee attending a school, college, or university, or a course of vocational or technical training designed to fit him for gainful employment;

(ii) shall disregard from the earned income of any child or relative applying for or receiving aid to families with dependent children, or of any other individual (living in the same home as such relative and child) whose needs are taken into account in making such determination, the first \$75 of the total of such earned income for such month;

(iii) shall disregard from the earned income of any child, relative, or other individual specified in clause (ii), an amount equal to expenditures for care in such month for a dependent child, or an incapacitated individual living in the same home as the dependent child, receiving aid to families with dependent children and requiring such care for such month, to the extent that such amount (for each such dependent child or incapacitated individual) does not exceed \$160 (or such lesser amount as the Secretary may prescribe in the case of an individual not engaged in full-time employment or not employed throughout the month);

(iv) shall disregard from the earned income of any child or relative receiving aid to families with dependent children, or of any other individual (living in the same home as such relative and child) whose needs are taken into account in making such determination, an amount equal to (I) the first \$30 of the total of such earned income not disregarded under any other clause of this subparagraph plus (II) one-third of the remainder thereof (but excluding, for purposes of this subparagraph, earned income derived from participation on a project maintained under the programs established by section 432(b)(2) and (3) [42 USCS § 632(b)(2), (3)]);

(v) may disregard the income of any dependent child applying for or receiving aid to families with dependent children which is derived from a program carried out under the Job Training Partnership Act (as originally enacted), but only in such amounts,

and for such period of time (not to exceed six months with respect to earned income) as the Secretary may provide in regulations;

(vi) shall disregard the first \$50 of any child support payments received in such month with respect to the dependent child or children in any family applying for or receiving aid to families with dependent children (including support payments collected and paid to the family under section 457(b) [42 USCS § 657(b)]); and

(vii) may disregard all or any part of the earned income of a dependent child who is a full-time student and who is applying for aid to families with dependent children, but only if the earned income of such child is excluded for such month in determining the family's total income under paragraph (18);

(B) provide that (with respect to any month) the State agency—

(i) shall not disregard, under clause (ii), (iii), or (iv) of subparagraph (A), any earned income of any one of the persons specified in subparagraph (A)(ii) if such person—

(I) terminated his employment or reduced his earned income without good cause within such period (of not less than thirty days) preceding such month as may be prescribed by the Secretary;

(II) refused without good cause, within such period preceding such month as may be prescribed by the Secretary, to accept employment in which he is able to engage which is offered through the public employment offices of the State, or is otherwise offered by an employer if the offer of such employer is determined by the State or local agency administering the State plan, after notification by the employer, to be a bona fide offer of employment; or

(III) failed without good cause to make a timely report (as prescribed by the State plan pursuant to paragraph (14)) to the State agency of earned income received in such month; and

(ii)(I) shall not disregard—

(a) under subclause (II) of subparagraph (A)(iv), in a case where such subclause has already been applied to the income of the persons involved for four consecutive months while they were receiving aid under the plan, or

(b) under subclause (I) of subparagraph (A)(iv), in a case where such subclause has already been applied to the income of the persons involved for twelve consecutive months while they were receiving aid under the plan,

any earned income of any of the persons specified in subparagraph (A)(ii), if, with respect to such month, the income of the persons so specified was in excess of their need, as determined by the State agency pursuant to paragraph (7) (without regard to subparagraph (A)(iv) of this paragraph), unless the persons

received aid under the plan in one or more of the four months preceding such month; and

(II) in the case of the earned income of a person with respect to whom subparagraph (A)(iv) has been applied for four consecutive months, shall not apply the provisions of subclause (II) of such subparagraph to any month after such month, or apply the provisions of subclause (I) of such subparagraph to any month after the eighth month following such month, for so long as he continues to receive aid under the plan, and shall not apply the provisions of either such subclause to any month thereafter until the expiration of an additional period of twelve consecutive months during which he is not a recipient of such aid; and

(C) provide that in implementing this paragraph the term "earned income" shall mean gross earned income, prior to any deductions for taxes or for any other purposes;

(9) provide safeguards which restrict the use or disclosure of information concerning applicants or recipients to purposes directly connected with (A) the administration of the plan of the State approved under this part [42 USCS §§ 601 et seq.], the plan or program of the State under part B, C, or D of this title [42 USCS §§ 620 et seq., 630 et seq., 651 et seq.] or under title I, X, XIV, XVI, XIX, or XX [42 USCS §§ 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq., 1396 et seq., 1397 et seq.], or the supplemental security income program established by title XVI [42 USCS §§ 1381 et seq.], (B) any investigation, prosecution, or criminal or civil proceeding, conducted in connection with the administration of any such plan or program, (C) the administration of any other Federal or federally assisted program which provides assistance, in cash or in kind, or services, directly to individuals on the basis of need, and (D) any audit or similar activity conducted in connection with the administration of any such plan or program by any governmental entity which is authorized by law to conduct such audit or activity; and the safeguards so provided shall prohibit disclosure, to any committee or legislative body (other than an entity referred to in clause (D) with respect to an activity referred to in such clause), of any information which identifies by name or address any such applicant or recipient; but such safeguards shall not prevent the State agency or the local agency responsible for the administration of the State plan in the locality (whether or not the State has enacted legislation allowing public access to Federal welfare records) from furnishing a State or local law enforcement officer, upon his request, with the current address of any recipient if the officer furnishes the agency with such recipient's name and social security account number and satisfactorily demonstrates that such recipient is a fugitive felon, that the location or apprehension of such felon is within the officer's official duties, and that the request is made in the proper exercise of those duties;

(10)(A) provide that all individuals wishing to make application for aid to families with dependent children shall have opportunity to do so,

and that aid to families with dependent children shall, subject to paragraphs (25) and (26), be furnished with reasonable promptness to all eligible individuals; and

(B) provide that an application for aid under the plan will be effective no earlier than the date such application is filed with the State agency or local agency responsible for the administration of the State plan, and the amount payable for the month in which the application becomes effective, if such application becomes effective after the first day of such month, shall bear the same ratio to the amount which would be payable if the application had been effective on the first day of such month as the number of days in the month including and following the effective date of the application bears to the total number of days in such month;

(11) provide for prompt notice (including the transmittal of all relevant information) to the State child support collection agency (established pursuant to part D of this title [42 USCS §§ 651 et seq.]) of the furnishing of aid to families with dependent children with respect to a child who has been deserted or abandoned by a parent (including a child born out of wedlock without regard to whether the paternity of such child has been established); (12) provide, effective October 1, 1950, that no aid will be furnished any individual under the plan with respect to any period with respect to which he is receiving old-age assistance under the State plan approved under section 2 of this Act [42 USCS § 302];

(13) with respect to families who are required to report monthly to the State agency pursuant to paragraph (14) (and at the option of the State with respect to other families), provide that—

(A) except as provided in subparagraph (B), the state agency (i) will determine a family's eligibility for aid for a month on the basis of the family's income, composition, resources, and other similar relevant circumstances during such month, and (ii) will determine the amount of such aid on the basis of the income and other relevant circumstances in the first or, at the option of the State (but only where the Secretary determines it to be appropriate, in the case of families who are required to report monthly to the State agency pursuant to paragraph (14)), second month preceding such month; and

(B) in the case of the first month, or at the option of the State (but only where the Secretary determines it to be appropriate, in the case of families who are required to report monthly to the State agency pursuant to paragraph (14)), the first and second months, in a period of consecutive months for which aid is payable, the State agency will determine the amount of aid on the basis of the family's income and other relevant circumstances in such first or second month;

(14) with respect to families in the category of recent work history or earned income cases (and at the option of the State with respect to families in other categories), provide (A) that the State agency will require each family to which it furnishes aid to families with dependent

children (or to which it would provide such aid but for paragraph (22) or (32)) to report, as a condition to the continued receipt of such aid (or to continuing to be deemed to be a recipient of such aid), each month to the State agency on—

(i) the income received, family composition, and other relevant circumstances during the prior month; and

(ii) the income and resources it expects to receive, or any changes in circumstances affecting continued eligibility or benefit amount, that it expects to occur, in that month (or in future months);

except that (with the prior approval of the Secretary in recent work history and earned income cases) the State may select categories of recipients who may report at specified less frequent intervals upon a determination that to require individuals in such categories to report monthly would result in unwarranted expenditures for administration of this paragraph; and

(B) that, in addition to whatever action may be appropriate based on other reports or information received by the State agency, the State agency will take prompt action to adjust the amount of assistance payable, as may be appropriate, on the basis of the information contained in the report (or upon the failure of the family to furnish a timely report), and will give an appropriate explanatory notice, concurrent with its action, to the family;

(15) provide (A) for the development of a program, for each appropriate relative and dependent child receiving aid under the plan and for each appropriate individual (living in the same home as a relative and child receiving such aid) whose needs are taken into account in making the determination under paragraph (7), for preventing or reducing the incidence of births out of wedlock and otherwise strengthening family life, and for implementing such program by assuring that in all appropriate cases (including minors who can be considered to be sexually active) family planning services are offered to them and are provided promptly (directly or under arrangements with others) to all individuals voluntarily requesting such services, but acceptance of family planning services provided under the plan shall be voluntary on the part of such members and individuals and shall not be a prerequisite to eligibility for or the receipt of any other service under the plan; and (B) to the extent that services provided under this paragraph are furnished by the staff of the State agency or the local agency administering the State plan in each of the political subdivisions of the State, for the establishment of a single organizational unit in such State or local agency, as the case may be, responsible for the furnishing of such services;

(16) provide that where the State agency has reason to believe that the home in which a relative and child receiving aid reside is unsuitable for the child because of the neglect, abuse, or exploitation of such child it shall bring such condition to the attention of the appropriate court or law enforcement agencies in the State, providing such data with respect to the situation it may have;

(17) provide that if a child or relative applying for or receiving aid to families with dependent children, or any other person whose need the State considers when determining the income of a family, receives in any month an amount of earned or unearned income which, together with all other income for that month not excluded under paragraph (8), exceeds the State's standard of need applicable to the family of which he is a member—

(A) such amount of income shall be considered income to such individual in the month received, and the family of which such person is a member shall be ineligible for aid under the plan for the whole number of months that equals (i) the sum of such amount and all other income received in such month, not excluded under paragraph (8), divided by (ii) the standard of need applicable to such family, and (B) any income remaining (which amount is less than the applicable monthly standard) shall be treated as income received in the first month following the period of ineligibility specified in subparagraph (A);

except that the State may at its option recalculate the period of ineligibility otherwise determined under subparagraph (A) (but only with respect to the remaining months in such period) in any one or more of the following cases: (i) an event occurs which, had the family been receiving aid under the State plan for the month of the occurrence, would result in a change in the amount of aid payable for such month under the plan, or (ii) the income received has become unavailable to the members of the family for reasons that were beyond the control of such members, or (iii) the family incurs, becomes responsible for, and pays medical expenses (as allowed by the State) in a month of ineligibility determined under subparagraph (A) (which expenses may be considered as an offset against the amount of income received in the first month of such ineligibility);

(18) provide that no family shall be eligible for aid under the plan for any month if, for that month, the total income of the family (other than payments under the plan), without application of paragraph (8), other than paragraph (8)(A)(v), exceeds 185 percent of the State's standard of need for a family of the same composition, except that in determining the total income of the family the State may exclude any earned income of a dependent child who is a full-time student, in such amounts and for such period of time (not to exceed 6 months) as the State may determine;

(19) provide—

(A) that every individual, as a condition of eligibility for aid under this part [42 USCS §§ 601 et seq.], shall register for manpower services, training, employment, and other employment-related activities (including employment search, not to exceed eight weeks in total in each year) with the Secretary of Labor as provided by regulations issued by him, unless such individual is—

- (i) a child who is under age 16 or attending, full-time, an elementary, secondary, or vocational (or technical) school;
 - (ii) a person who is ill, incapacitated, or of advanced age;
 - (iii) a person so remote from a work incentive project that his effective participation is precluded;
 - (iv) a person whose presence in the home is required because of illness or incapacity of another member of the household;
 - (v) the parent or other relative of a child under the age of six who is personally providing care for the child with only very brief and infrequent absences from the child;
 - (vi) the parent or other caretaker of a child who is deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent, if another adult relative is in the home and not excluded by clause (i), (ii), (iii), or (iv) of this subparagraph (unless he has failed to register as required by this subparagraph, or has been found by the Secretary of Labor to have refused without good cause to participate under a work incentive program or accept employment as described in subparagraph (F) of this paragraph);
 - (vii) a person who is working not less than 30 hours per week;
 - (viii) the parent of a child who is deprived of parental support or care by reason of the unemployment of a parent, if the other parent (who is the principal earner, as defined in section 407(d) [42 USCS § 607(d)]) is not excluded by the preceding clauses of this subparagraph; or
 - (ix) a woman who is pregnant if it has been medically verified that the child is expected to be born in the month in which such registration would otherwise be required or within the 3-month period immediately following such month;
- and that any individual referred to in clause (v) shall be advised of his or her option to register, if he or she so desires, pursuant to this paragraph, and shall be informed of the child care services (if any) which will be available to him or her in the event he or she should decide so to register;
- (B) that aid to families with dependent children under the plan will not be denied by reason of such registration or the individual's certification to the Secretary of Labor under subparagraph (G) of this paragraph, or by reason of an individual's participation on a project under the program established by section 432(b)(2) or (3) [42 USCS § 632(b)(2), (3)];
- (C) for arrangements to assure that there will be made a non-Federal contribution to the work incentive programs established by part C [42 USCS §§ 630 et seq.] by appropriate agencies of the State or private organizations of 10 per centum of the cost of such programs, as specified in section 435(b) [42 USCS § 635(b)];

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(D) that (i) training incentives authorized under section 434 [42 USCS § 634] shall be disregarded in determining the needs of an individual under paragraph (7), and (ii) in determining such individual's needs the additional expenses attributable to his participation in a program established by into account;

(E) [Repealed]

(F) that if (and for such period as is prescribed under joint regulations of the Secretary and the Secretary of Labor) any child, relative or individual has been found by the Secretary of Labor under section 433(g) [42 USCS § 633(g)] to have refused without good cause to participate under a work incentive program established by part C [42 USCS §§ 630 et seq.] with respect to which the Secretary of Labor has determined his participation is consistent with the purposes of such part C [42 USCS §§ 630 et seq.], or to have refused without good cause to accept employment in which he is able to engage which is offered through the public employment offices of the State, or is otherwise offered by an employer if the offer of such employer is determined, after notification by him, to be a bona fide offer of employment—

(i) if the relative makes such refusal, such relative's needs shall not be taken into account in making the determination under paragraph (7), and aid for any dependent child in the family in the form of payments of the type described in section 406(b)(2) [42 USCS § 606(b)(2)] (which in such a case shall be without regard to clauses (A) through (D) thereof [42 USCS § 606(b)(2)(A)–(D)]) or section 472 [42 USCS § 672] will be made unless the State agency, after making reasonable efforts, is unable to locate an appropriate individual to whom such payments can be made;

(ii) if the parent who has been designated as the principal earner, for purposes of section 407 [42 USCS § 607], makes such refusal, aid will be denied to all members of the family;

(iii) aid with respect to a dependent child will be denied if a child who is the only child receiving aid in the family makes such refusal;

(iv) if there is more than one child receiving aid in the family, aid for any such child will be denied (and his needs will not be taken into account in making the determination under paragraph (7)) if that child makes such refusal; and

(v) if such individual makes such refusal, such individual's needs shall not be taken into account in making the determination under paragraph (7);

(G) that the State agency will have in effect a special program which (i) will be administered by a separate administrative unit (which will, to the maximum extent feasible, be located in the same facility as that utilized for the administration of programs established pursuant to section 432(b)(1), (2), or (3) [42 USCS § 632(b)(1), (2), (3)]) and the

employees of which will, to the maximum extent feasible, perform services only in connection with the administration of such program, (ii) will provide (through arrangements with others or otherwise) for individuals who have been registered pursuant to subparagraph (A) of this paragraph (I) in accordance with the order of priority listed in section 433(a) [42 USCS § 633(a)], such health, vocational rehabilitation, counseling, child care, and other social and supportive services as are necessary to enable such individuals to accept employment or receive manpower training provided under section 432(b)(1), (2), or (3) [42 USCS § 632(b)(1), (2), (3)], and will, when arrangements have been made to provide necessary supportive services, including child care, certify to the Secretary of Labor those individuals who are ready for employment or training under section 432(b)(1), (2), or (3) [42 USCS § 632(b)(1), (2), (3)], (II) such social and supportive services as are necessary to enable such individuals as determined appropriate by the Secretary of Labor actively to engage in other employment-related (including but not limited to employment search) activities, as well as timely payment for necessary employment search expenses, and (III) for a period deemed appropriate by the Secretary of Labor after such an individual accepts employment, such social and supportive services as are reasonable and necessary to enable him to retain such employment, (iii) will participate in the development of operational and employability plans under section 433(b) [42 USCS § 633(b)]; and (iv) provides for purposes of clause (ii) that, when more than one kind of child care is available, the mother may choose the type, but she may not refuse to accept child care services if they are available; and (H) that an individual participating in employment search activities shall not be referred to employment opportunities which do not meet the criteria for appropriate work and training to which an individual may otherwise be assigned under section 432(b)(1), (2), or (3) [42 USCS § 632(b)(1), (2), (3)];

(20) provide that the State has in effect a State plan for foster care and adoption assistance approved under part E of this title [42 USCS §§ 670 et seq.];

(21) provide—

(A) that, for purposes of this part [42 USCS §§ 601 et seq.], participation in a strike shall not constitute good cause to leave, or to refuse to seek or accept employment; and

(B)(i) that aid to families with dependent children is not payable to a family for any month in which any caretaker relative with whom the child is living is, on the last day of such month, participating in a strike, and (ii) that no individual's needs shall be included in determining the amount of aid payable for any month to a family under the plan if, on the last day of such month, such individual is participating in a strike;

(22) provide that the State agency will promptly take all necessary steps to correct any overpayment or underpayment of aid under the State plan, and, in the case of—

(A) an overpayment to an individual who is a current recipient of such aid (including a current recipient whose overpayment occurred during a prior period of eligibility), recovery will be made by repayment by the individual or by reducing the amount of any future aid payable to the family of which he is a member, except that such recovery shall not result in the reduction of aid payable for any month, such that the aid, when added to such family's liquid resources and to its income (without application of paragraph (8)), is less than 90 percent of the amount payable under the State plan to a family of the same composition with no other income (and, in the case of an individual to whom no payment is made for a month solely by reason of recovery of an overpayment, such individual shall be deemed to be a recipient of aid for such month);

(B) an overpayment to any individual who is no longer receiving aid under the plan, recovery shall be made by appropriate action under State law against the income or resources of the individual or the family; and

(C) an underpayment, the corrective payment shall be disregarded in determining the income of the family, and shall be disregarded in determining its resources in the month the corrective payment is made and in the following month;

except that no recovery need be attempted or carried out under subparagraph (B) in any case, other than a case involving fraud on the part of the recipient, where (as determined by the State agency in accordance with criteria for determining cost-effectiveness, and with dollar limitations, which shall be prescribed by the Secretary in regulations) the cost of recovery would equal or exceed the amount of the overpayment involved;

(23) provide that by July 1, 1969, the amounts used by the State to determine the needs of individuals will have been adjusted to reflect fully changes in living costs since such amounts were established, and any maximums that the State imposes on the amount of aid paid to families will have been proportionately adjusted;

(24) provide that if an individual is receiving benefits under title XVI [42 USCS §§ 1381 et seq.], then, for the period for which such benefits are received, such individual shall not be regarded as a member of a family for purposes of determining the amount of the benefits of the family under this title [42 USCS §§ 601 et seq.] and his income and resources shall not be counted as income and resources of a family under this title [42 USCS §§ 601 et seq.];

(25) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1137 of this Act [42 USCS § 1320b-7];

(26) provide that, as a condition of eligibility for aid, each applicant or recipient will be required—

(A) to assign the State any rights to support from any other person such applicant may have (i) in his own behalf or in behalf of any other family member for whom the applicant is applying for or receiving aid, and (ii) which have accrued at the time such assignment is executed,

(B) to cooperate with the State (i) in establishing the paternity of a child born out of wedlock with respect to whom aid is claimed, and (ii) in obtaining support payments for such applicant and for a child with respect to whom such aid is claimed, or in obtaining any other payments or property due such applicant or such child, unless (in either case) such applicant or recipient is found to have good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the child on whose behalf aid is claimed; and that, if the relative with whom a child is living is found to be ineligible because of failure to comply with the requirements of subparagraphs (A) and (B) of this paragraph, any aid for which such child is eligible will be provided in the form of protective payments as described in section 406(b)(2) [42 USCS § 606(b)(2)] (without regard to clauses (A) through (D) of such section) unless the State agency, after making reasonable efforts, is unable to locate an appropriate individual to whom such payments can be made;

(27) provide that the State has in effect a plan approved under part D [42 USCS §§ 651 et seq.] and operates a child support program in substantial compliance with such plan;

(28) provide that, in determining the amount of aid to which an eligible family is entitled, any portion of the amounts collected in any particular month as child support pursuant to a plan approved under part D [42 USCS §§ 651 et seq.], and retained by the State under section 457 [42 USCS § 657], which (under the State plan approved under this part [42 USCS §§ 601 et seq.] as in effect both during July 1975 and during that particular month) would not have caused a reduction in the amount of aid paid to the family if such amounts had been paid directly to the family, shall be added to the amount of aid otherwise payable to such family under the State plan approved under this part [42 USCS §§ 601 et seq.];

(29) [Repealed]

(30) at the option of the State, provide for the establishment and operation, in accordance with an (initial and annually updated) advance automatic data processing planning document approved under subsection (d), of an automated statewide management information system designed effectively and efficiently, to assist management in the administration of the State plan for aid to families with dependent children

approved under this part [42 USCS §§ 601 et seq.], so as (A) to control and account for (i) all the factors in the total eligibility determination process under such plan for aid (including but not limited to (I) identifiable correlation factors (such as social security numbers, names, dates of birth, home addresses, and mailing addresses (including postal ZIP codes), of all applicants and recipients of such aid and the relative with whom any child who is such an applicant or recipient is living) to assure sufficient compatibility among the systems of different jurisdictions to permit periodic screening to determine whether an individual is or has been receiving benefits from more than one jurisdiction, (II) checking records of applicants and recipients of such aid on a periodic basis with other agencies, both intra- and inter-State, for determination and verification of eligibility and payment pursuant to requirements imposed by other provisions of this Act), (ii) the costs, quality, and delivery of funds and services furnished to applicants for and recipients of such aid, (B) to notify the appropriate officials of child support, food stamp, social service, and medical assistance programs approved under title XIX [42 USCS §§ 1396 et seq.] whenever the case becomes ineligible or the amount of aid or services is changed, and (C) to provide for security against unauthorized access to, or use of, the data in such system;

(31) provide that, in making the determination for any month under paragraph (7), the State agency shall take into consideration so much of the income of the dependent child's stepparent living in the same home as such child as exceeds the sum of (A) the first \$75 of the total of such stepparent's earned income for such month (or such lesser amount as the Secretary may prescribe in the case of an individual not engaged in fulltime employment or not employed throughout the month), (B) the State's standard of need under such plan for a family of the same composition as the stepparent and those other individuals living in the same household as the dependent child and claimed by such stepparent as dependents for purposes of determining his Federal personal income tax liability but whose needs are not taken into account in making the determination under paragraph (7), (C) amounts paid by the stepparent to individuals not living in such household and claimed by him as dependents for purposes of determining his Federal personal income tax liability, and (D) payments by such stepparent of alimony or child support with respect to individuals not living in such household;

(32) provide that no payment of aid shall be made under the plan for any month if the amount of such payment, as determined in accordance with the applicable provisions of the plan and of this part [42 USCS §§ 601 et seq.], would be less than \$10, but an individual with respect to whom a payment of aid under the plan is denied solely by reason of this paragraph is deemed to be a recipient of aid but shall not be eligible to participate in a community work experience program;

(33) provide that in order for any individual to be considered a dependent child, a caretaker relative whose needs are to be taken into

account in making the determination under paragraph (7), or any other person whose needs should be taken into account in making such a determination with respect to the child or relative, such individual must be either (A) a citizen, or (B) an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law (including any alien who is lawfully present in the United States as a result of the application of the provisions of section 207(c) of the Immigration and Nationality Act [8 USCS § 1157(c)] (or of section 203(a)(7) of such Act [8 USCS § 1153(a)(7)] prior to April 1, 1980), or as a result of the application of the provisions of section 208 or 212(d)(5) of such Act [8 USCS §§ 1158, 1182(d)(5)]);

(34) provide that both the standard of need applied to a family and the amount of aid determined to be payable, when not a whole dollar amount, shall be rounded to the next lower whole dollar amount;

(35) at the option of the State, provide—

(A) that as a condition of eligibility for aid under the State plan of any individual claiming such aid who is required to register pursuant to paragraph (19)(A) (or who would be required to register under paragraph (19)(A) but for clause (iii) thereof), including all such individuals or only such groups, types, or classes thereof as the State agency may designate for purposes of this paragraph, such individual will be required to participate in a program of employment search—

(i) beginning at the time he applies for such aid (or an application including his need is filed) and continuing for a period (prescribed by the State) of not more than eight weeks (but this requirement may not be used as a reason for any delay in making a determination of an individual's eligibility for aid or in issuing a payment to or in behalf of any individual who is otherwise eligible for such aid); and

(ii) at such time or times after the close of the period prescribed under clause (i) as the State agency may determine but not to exceed a total of 8 weeks in any 12 consecutive months;

(B) that any individual participating in a program of employment search under this paragraph will be furnished such transportation and other services, or paid (in advance or by way of reimbursement) such amounts to cover transportation costs and other expenses reasonably incurred in meeting requirements imposed on him under this paragraph, as may be necessary to enable such individual to participate in such program; and

(C) that, in the case of an individual who fails without good cause to comply with requirements imposed upon him under this paragraph, the sanctions imposed by paragraph (19)(F) shall be applied in the same manner as if the individual had made a refusal of the type which would cause the provisions of such paragraph (19)(F) to be applied (except that the State may at its option, for purposes of this paragraph, reduce the period for which such sanctions would otherwise be in effect);

(36) provide, at the option of the State, that in making the determination for any month under paragraph (7), the State agency shall not include as income any support or maintenance assistance furnished to or on behalf of the family which (as determined under regulations of the Secretary by such State agency as the chief executive officer of the State may designate) is based on need for such support and maintenance, including assistance received to assist in meeting the costs of home energy (including both heating and cooling), and which is (A) assistance furnished in kind by a private nonprofit agency, or (B) assistance furnished by a supplier of home heating oil or gas, by an entity whose revenues are primarily derived on a rate-of-return basis regulated by a State or Federal governmental entity, or by a municipal utility providing home energy;

(37) provide that, in any case where a family has ceased to receive aid under the plan because (by reason of paragraph (8)(B)(ii)(II)) the provisions of paragraph (8)(A)(iv) no longer apply, such family shall be considered for purposes of title XIX [42 USCS §§ 1396 et seq.], to be receiving aid to families with dependent children under such plan for a period of 9 months after the last month for which the family actually received such aid; and the State may at its option extend such period by an additional period of up to 6 months in the case of a family that would be eligible during such additional period to receive aid under the plan (without regard to this paragraph) if such paragraph (8)(A)(iv) applied; and

(38) provide that in making the determination under paragraph (7) with respect to a dependent child and applying paragraph (8), the State agency shall (except as otherwise provided in this part [42 USCS §§ 601 et seq.]) include—

(A) any parent of such child, and

(B) any brother or sister of such child, if such brother or sister meets the conditions described in clauses (1) and (2) of section 406(a) [42 USCS § 606(a)], if such parent, brother, or sister is living in the same home as the dependent child, and any income of or available for such parent, brother, or sister shall be included in making such determination and applying such paragraph with respect to the family (notwithstanding section 205(j) [42 USCS § 405(j)], in the case of benefits provided under title II [42 USCS §§ 401 et seq.]); and

(39) provide that in making the determination under paragraph (7) with respect to a dependent child whose parent or legal guardian is under the age selected by the State pursuant to section 406(a)(2) [42 USCS § 606(a)(2)], the State agency shall (except as otherwise provided in this part [42 USCS §§ 601 et seq.]) include any income of such minor's own parents or legal guardians who are living in the same home as such minor and dependent child, to the same extent that income of a stepparent is included under paragraph (31).

The Secretary may waive any of the requirements imposed under or in connection with paragraphs (13) and (14) of this subsection to the extent

necessary to make such requirements compatible with the corresponding reporting and budgeting requirements by the Food Stamp Act of 1977 [7 USCS §§ 2011 et seq.].

(b) **Approval by Secretary.** The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes as a condition of eligibility for aid to families with dependent children, a residence requirement which denies aid with respect to any child residing in the State (1) who has resided in the State for one year immediately preceding the application for such aid, or (2) who was born within one year immediately preceding the application, if the parent or other relative with whom the child is living has resided in the State for one year immediately preceding the birth.

(c) **Compilation of data; publishing of findings; reports to Congress.** The Secretary shall, on the basis of his review of the reports received from the States under paragraph (15) of subsection (a), compile such data as he believes necessary and from time to time publish his findings as to the effectiveness of the programs developed and administered by the States under such paragraph. The Secretary shall annually report to the Congress (with the first such report being made on or before July 1, 1970) on the programs developed and administered by each State under such paragraph (15).

(d) **Payments treated as earned income.** (1) For purposes of paragraphs (7) and (8) of subsection (a), any refund of Federal income taxes made by reason of section 32 of the Internal Revenue Code of 1954 [26 USCS § 32] (relating to earned income credit) and any payment made by an employer under section 3507 of such Code [26 USCS § 3507] (relating to advance payment of earned income credit) shall be considered earned income.

(2) In any case in which such advance payments for a taxable year made by all employers to an individual under section 3507 of such Code [26 USCS § 3507] exceed the amount of such individual's earned income credit allowable under section 32 of such Code [26 USCS § 32] for such year, so that such individual is liable under section 32(g) of such Code [26 USCS § 43(g)] for a tax equal to such excess, such individual's benefit amount must be appropriately adjusted so as to provide payment to such individual of an amount equal to the amount of the benefits lost by such individual on account of such excess advance payments.

(e) **Approval of automatic data processing planning document; review of management information systems.** (1) The Secretary shall not approve the initial and annually updated advance automatic data processing planning document, referred to in subsection (a)(30), unless he finds that such document, when implemented, will generally carry out the objectives of the statewide management system referred to in such subsection, and such document—

(A) provides for the conduct of, and reflects the results of, requirements analysis studies, which include consideration of the program

Addendum 8

GRANTS FOR DEPENDENT CHILDREN

42 USCS § 606

taken into account in making need determination. *Drysdale v Spirito* (1982, CA1 Mass) 689 F2d 252.

Recipients of social security benefits in form of AFDC that have been convicted of criminal fraud practiced on county welfare board for deliberately misstating their income sources while qualifying for AFDC benefits may not be denied such benefits in the future as form of

recoupment, however recoupments may be allowed in form of reduced payments. *A. v Riti* (1974, DC NJ) 377 F Supp 1046.

No federal regulation allows payment of AFDC payments directly to housing authority to be credited toward recipients, delinquent rental. *Housing Authority of Newark v Commissioner, Dept. of Institutions & Agencies* (1975) 136 NJ Super 136, 345 A2d 322.

§ 606. Definitions

When used in this part [42 USCS §§ 601 et seq.]—

(a) The term "dependent child" means a needy child (1) who has been deprived of parental support or care by reason of the death, continued absence from the home (other than absence occasioned solely by reason of the performance of active duty in the uniformed services of the United States), or physical or mental incapacity of a parent, and who is living with his father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece, in a place of residence maintained by one or more of such relatives as his or their own home, and (2) who is (A) under the age of eighteen, or (B) at the option of the State, under the age of nineteen and a full-time student in a secondary school (or in the equivalent level of vocational or technical training), if, before he attains age nineteen, he may reasonably be expected to complete the program of such secondary school (or such training);

(b) The term "aid to families with dependent children" means money payments with respect to a dependent child or dependent children, or, at the option of the State, a pregnant woman but only if it has been medically verified that the child is expected to be born in the month such payments are made or within the three-month period following such month of payment, and who, if such child had been born and was living with her in the month of payment, would be eligible for aid to families with dependent children, and includes (1) money payments to meet the needs of the relative with whom any dependent child is living (and the spouse of such relative if living with him and if such relative is the child's parent and the child is a dependent child by reason of the physical or mental incapacity of a parent or is a dependent child under section 407 [42 USCS § 607]), and (2) payments with respect to any dependent child (including payments to meet the needs of the relative, and the relative's spouse, with whom such child is living, and the needs of any other individual living in the same home if such needs are taken into account in making the determination under section 402(a)(7) [42 USCS § 602(a)(7)]) which do not meet the preceding requirements of this subsection, but which would meet such requirements except that such payments are made to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such child or relative, or are made on behalf of such child or relative directly to a person

Addendum 9



GEN(19)EA-16-1-1;5-16

Region VIII
Federal Office Building
1961 Stout Street
Denver CO 80294

JUL 25 1985

**HEALTH CARE FINANCING ADMINISTRATION
REGIONAL IDENTICAL LETTER #85-61**

TO: Medicaid State Agencies

SUBJECT: Standard Filing Unit and Child Support Income Policy

The purpose of this letter is to clarify the effect that certain parts of Section 2640 of the Deficit Reduction Act (DRA) have on Medicaid eligibility determinations. Specifically, a question was raised regarding whether the provisions in Section 2640 which require the inclusion of siblings as members of the filing unit and require deeming of income from grandparents not in the filing unit to grandchildren in the unit conflict with Section 1902(a)(17) of the Act and implementing regulations at 42 CFR 435.602.

Inclusion of siblings as members of the filing unit is not prohibited under Section 1902(a)(17) or any other provision of Title XIX. On the other hand, deeming of income from a grandparent outside the assistance unit to a grandchild is prohibited under Section 1902(a)(17)(D). Therefore, a grandchild denied AFDC solely because of grandparent deeming is eligible for Medicaid under 42 CFR 435.113. Section 435.113 requires State to provide Medicaid to individuals who would be eligible for AFDC except for an eligibility requirement used in the AFDC program that is specifically prohibited under Title XIX.

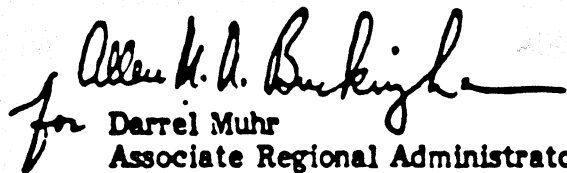
Section 1902(a)(17) of the act provides that the State plan "include reasonable standards...for determining eligibility and the extent of medical assistance under the plan which do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under such plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21..." In addition, regulations at 42 CFR 435.711 require that the financial requirements and methodologies of the State's Title IV-A plan be used to determine eligibility for AFDC-related categorically needy. Similarly, Section 1902(a)(10)(C) of the Act requires the AFDC financial methodologies to be employed in determining eligibility for AFDC-related medically needy persons.

Consideration of a child's and a sibling's income when a member of the assistance unit is not in conflict with Section 1902(a)(17) or any other Title XIX statutory provision. As Section 2640 of DRA is interpreted by the AFDC program, this provision merely specifies who must apply for assistance. It does not change the income determination methodology, which has always taken into account the income and needs of all members of the filing unit in determining the eligibility of the unit. Thus, the sibling's income is considered in determining his or her own eligibility as part of a unit and the siblings are not considered "financially responsible" for each other as that term is used in the context of Section 1902(a)(17)(D). Under this interpretation, Section 1902(a)(17)(D) does not prohibit the application of this requirement. Furthermore, Section 1902(a)(10)(C) of the act and 42 CFR 435.711 require this financial methodology of the AFDC program to be applied in determining eligibility for the AFDC-related categorically needy and medically needy.

On the other hand, Section 1902(a)(17) specifically prohibits deeming of income from a grandparent outside the assistance unit to grandchildren in the unit. (In the case of the grandparent who is a member of the filing unit, the policy set forth in the preceding paragraph would apply; that is, consideration of income from grandparents in the same household who are considered members of the same filing unit is not prohibited by the Medicaid program.) Since 42 CFR 435.113 requires Medicaid coverage of individuals who are denied AFDC because of requirements that are prohibited under Title XIX, grandchildren who are denied AFDC solely because of income deemed from a grandparent who is outside the assistance unit are eligible under 42 CFR 435.113. While 42 CFR 435.113 may authorize Medicaid coverage of the grandchild, the minor parent who is eligible for AFDC because of income deemed from his or her parent is not eligible under 42 CFR 435.113. Such deeming is not prohibited under Section 1902(a)(17)(D) of the Act and is in fact required under 42 CFR 435.712.

If you have questions regarding this issue please call Bernadette Quevedo (303)844-6216.

Sincerely yours,

for Allen H. A. Buckingham

Darrel Muhr
Associate Regional Administrator
Division of Program Operations

Addendum 10

ADDENDUM 10

824

PUBLIC LAW 86-778—SEPT. 13, 1960

[74 STAT.

Public Law 86-778 *Kerr-Mills Act*

September 13, 1960
(H. R. 12580)

AN ACT

To extend and improve coverage under the Federal Old-Age, Survivors, and Disability Insurance System and to remove hardships and inequities, improve the financing of the trust funds, and provide disability benefits to additional individuals under such system; to provide grants to States for medical care for aged individuals of low income; to amend the public assistance and maternal and child welfare provisions of the Social Security Act; to improve the unemployment compensation provisions of such Act; and for other purposes.

Social Security
Amendments of
1960.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act, divided into titles and sections according to the following table of contents, may be cited as the "Social Security Amendments of 1960".

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 - (c) Retroactive coverage.
 - (d) Policemen and firemen.
 - (e) Limitation on States' liability for employer (and employee) contributions in certain cases.
 - (f) Statute of limitations for State and local coverage.
 - (g) Municipal and county hospitals.
 - (h) Validation of coverage for certain Mississippi teachers.
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- Sec. 103. Extension of the program to Guam and American Samoa.
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- Sec. 203. Payment of burial expenses.
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- Sec. 205. Survivors of individuals who died prior to 1940 and of certain other individuals.
- Sec. 206. Crediting of quarters of coverage for years before 1951.
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TITLE I—COVERAGE

EXTENSION OF TIME FOR MINISTERS TO ELECT COVERAGE

26 USC 1402.

SEC. 101. (a) Clause (B) of section 1402(e)(2) of the Internal Revenue Code of 1954 (relating to time for filing waiver certificate) is amended by striking out "1956" and inserting in lieu thereof "1959".

Pool, p. 927.

(b) Section 1402(e)(3) of such Code (relating to effective date of certificate) is amended to read as follows:

"(3) (A) EFFECTIVE DATE OF CERTIFICATE.—A certificate filed pursuant to this subsection shall be effective for the taxable year immediately preceding the earliest taxable year for which, at the time the certificate is filed, the period for filing a return (including any extension thereof) has not expired, and for all succeeding taxable years. An election made pursuant to this subsection shall be irrevocable.

"(B) Notwithstanding the first sentence of subparagraph (A), if an individual filed a certificate on or before the date of enactment of this subparagraph which (but for this subparagraph) is effective only for the first taxable year ending after 1956 and all succeeding taxable years, such certificate shall be effective for his first taxable year ending after 1955 and all succeeding taxable years if—

"(i) such individual files a supplemental certificate after the date of enactment of this subparagraph and on or before April 15, 1962,

26 USC 1401.

"(ii) the tax under section 1401 in respect of all such individual's self-employment income (except for underpayments of tax attributable to errors made in good faith) for his first taxable year ending after 1955 is paid on or before April 15, 1962, and

"(iii) in any case where refund has been made of any such tax which (but for this subparagraph) is an overpayment, the amount refunded (including any interest paid under section 6611) is repaid on or before April 15, 1962.

26 USC 6611.

26 USC 6401.

The provisions of section 6401 shall not apply to any payment or repayment described in this subparagraph."

(c) Section 1402(e) of such Code is further amended by adding at the end thereof the following new paragraph:

26 USC 1402.

"(5) **OPTIONAL PROVISION FOR CERTAIN CERTIFICATES FILED ON OR BEFORE APRIL 15, 1962.**—In any case where an individual has derived earnings, in any taxable year ending after 1954 and before 1960, from the performance of service described in subsection (c) (4), or in subsection (c) (5) (as in effect prior to the enactment of this paragraph) insofar as it related to the performance of service by an individual in the exercise of his profession as a Christian Science practitioner, and has reported such earnings as self-employment income on a return filed on or before the date of the enactment of this paragraph and on or before the due date prescribed for filing such return (including any extension thereof)—

"(A) a certificate filed by such individual (or a fiduciary acting for such individual or his estate, or his survivor within the meaning of section 205(c) (1) (C) of the Social Security Act) after the date of the enactment of this paragraph and on or before April 15, 1962, may be effective, at the election of the person filing such certificate, for the first taxable year ending after 1954 and before 1960 for which such a return was filed, and for all succeeding taxable years, rather than for the period prescribed in paragraph (3), and

42 USC 405.

"(B) a certificate filed by such individual on or before the date of the enactment of this paragraph which (but for this subparagraph) is ineffective for the first taxable year ending after 1954 and before 1959 for which such a return was filed shall be effective for such first taxable year, and for all succeeding taxable years, provided a supplemental certificate is filed by such individual (or a fiduciary acting for such individual or his estate, or his survivor within the meaning of section 205(c) (1) (C) of the Social Security Act) after the date of the enactment of this paragraph and on or before April 15, 1962,

but only if—

"(i) the tax under section 1401 in respect of all such individual's self-employment income (except for underpayments of tax attributable to errors made in good faith), for each such year ending before 1960 in the case of a certificate described in subparagraph (A) or for each such year ending before 1959 in the case of a certificate described in subparagraph (B), is paid on or before April 15, 1962, and

26 USC 1401.

"(ii) in any case where refund has been made of any such tax which (but for this paragraph) is an overpayment, the amount refunded (including any interest paid under section 6611) is repaid on or before April 15, 1962.

The provisions of section 6401 shall not apply to any payment or repayment described in this paragraph."

(d) In the case of a certificate or supplemental certificate filed pursuant to section 1402(e) (3) (B) or (5) of the Internal Revenue Code of 1954—

Supra.

(1) for purposes of computing interest, the due date for the payment of the tax under section 1401 which is due for any taxable year ending before 1959 solely by reason of the filing of a certificate which is effective under such section 1402(e) (3) (B) or (5) shall be April 15, 1962;

- (2) the statutory period for the assessment of any tax for any such year which is attributable to the filing of such certificate shall not expire before the expiration of 8 years from such due date; and
- 26 USC 6651. (3) for purposes of section 6651 of such Code (relating to addition to tax for failure to file tax return), the amount of tax required to be shown on the return shall not include such tax under section 1401.
- 26 USC 1401. Post. p. 933. (e) The provisions of section 205(c)(5)(F) of the Social Security Act, insofar as they prohibit inclusion in the records of the Secretary of Health, Education, and Welfare of self-employment income for a taxable year when the return or statement including such income is filed after the time limitation following such taxable year, shall not be applicable to earnings which are derived in any taxable year ending before 1960 and which constitute self-employment income solely by reason of the filing of a certificate which is effective under section 1402(e)(3)(B) or (5) of the Internal Revenue Code of 1954.
- Act. pp. 926, 927. (f) The amendments made by this section shall be applicable (except as otherwise specifically indicated therein) only with respect to certificates (and supplemental certificates) filed pursuant to section 1402(e) of the Internal Revenue Code of 1954 after the date of the enactment of this Act; except that no monthly benefits under title II of the Social Security Act for the month in which this Act is enacted or any prior month shall be payable or increased by reason of such amendments, and no lump-sum death payment under such title shall be payable or increased by reason of such amendments in the case of any individual who died prior to the date of the enactment of this Act.
- 26 USC 1402. 42 USC 401 et seq.

STATE AND LOCAL GOVERNMENTAL EMPLOYEES

Delegation by Governor of Certification Functions

- 42 USC 418. SEC. 102. (a)(1) Section 218(d)(3) of the Social Security Act is amended by inserting “, or an official of the State designated by him for the purpose,” after “the governor of the State”.
- (2) Section 218(d)(7) of such Act is amended by inserting “(or an official of the State designated by him for the purpose)” after “by the governor”, and by inserting “(or the official so designated)” after “if the governor”.

Employees Transferred From One Retirement System to Another

(b)(1) Section 218(d)(6)(C) of the Social Security Act is further amended by adding at the end thereof the following new sentence: “If, in the case of a separate retirement system which is deemed to exist by reason of subparagraph (A) and which has been divided into two divisions or parts pursuant to the first sentence of this subparagraph, individuals become members of such system by reason of action taken by a political subdivision after coverage under an agreement under this section has been extended to the division or part thereof composed of positions of individuals who desire such coverage, the positions of such individuals who become members of such retirement system by reason of the action so taken shall be included in the division or part of such system composed of positions of members who do not desire such coverage if (i) such individuals, on the day before becoming such members, were in the division or part of another separate retirement system (deemed to exist by reason of subparagraph (A)) composed of positions of members of such system who do not desire coverage under an agreement under this

section, and (ii) all of the positions in the separate retirement system of which such individuals so become members and all of the positions in the separate retirement system referred to in clause (i) would have been covered by a single retirement system if the State had not taken action to provide for separate retirement systems under this paragraph."

(2) The amendment made by paragraph (1) shall apply in the case of transfers of positions (as described therein) which occur on or after the date of enactment of this Act. Such amendment shall also apply in the case of such transfers in any State which occurred prior to such date, but only upon request of the Governor (or other official designated by him for the purpose) filed with the Secretary of Health, Education, and Welfare before July 1, 1961; and, in the case of any such request, such amendment shall apply only with respect to wages paid on and after the date on which such request is filed.

Retroactive Coverage

(c) (1) Section 218(f) (1) of the Social Security Act is amended by striking out all that follows the first semicolon and inserting in lieu thereof the following: "except that such date may not be earlier than the last day of the sixth calendar year preceding the year in which such agreement or modification, as the case may be, is agreed to by the Secretary and the State."

42 USC 418.

(2) Section 218(d) (6) (A) of such Act is amended by adding at the end thereof the following new sentence: "Where a retirement system covering positions of employees of a State and positions of employees of one or more political subdivisions of the State, or covering positions of employees of two or more political subdivisions of the State, is not divided into separate retirement systems pursuant to the preceding sentence or pursuant to subparagraph (C), then the State may, for purposes of subsection (f) only, deem the system to be a separate retirement system with respect to any one or more of the political subdivisions concerned and, where the retirement system covers positions of employees of the State, a separate retirement system with respect to the State or with respect to the State and any one or more of the political subdivisions concerned."

(3) The amendment made by paragraph (1) shall apply in the case of any agreement or modification of an agreement under section 218 of the Social Security Act which is agreed to on or after January 1, 1960; except that in the case of any such agreement or modification agreed to before January 1, 1961, the effective date specified therein shall not be earlier than December 31, 1955. The amendment made by paragraph (2) shall apply in the case of any such agreement or modification which is agreed to on or after the date of the enactment of this Act.

Policemen and Firemen

(d) Section 218(p) of the Social Security Act is amended by inserting "Hawaii," after "Georgia,"; and by striking out "Washington, or Territory of Hawaii" and inserting in lieu thereof "Virginia, or Washington".

**Limitation on States' Liability for Employer (and Employee)
Contributions in Certain Cases**

42 USC 418.

(e) (1) Section 218(e) of the Social Security Act is amended by inserting "(1)" immediately after "(e)", by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and by adding at the end thereof the following new paragraph:

"(2) Where—

"(A) an individual in any calendar year performs services to which an agreement under this section is applicable (i) as the employee of two or more political subdivisions of a State or (ii) as the employee of a State and one or more political subdivisions of such State; and

26 USC 3111.

"(B) such State provides all of the funds for the payment of those amounts referred to in paragraph (1)(A) which are equivalent to the taxes imposed by section 3111 of the Internal Revenue Code of 1954 with respect to wages paid to such individual for such services; and

"(C) the political subdivision or subdivisions involved do not reimburse such State for the payment of such amounts or, in the case of services described in subparagraph (A)(ii), for the payment of so much of such amounts as is attributable to employment by such subdivision or subdivisions;

then, notwithstanding paragraph (1), the agreement under this section with such State may provide (either in the original agreement or by a modification thereof) that the amounts referred to in paragraph (1)(A) may be computed as though the wages paid to such individual for the services referred to in clause (A) of this paragraph were paid by one political subdivision for services performed in its employ; but the provisions of this paragraph shall be applicable only where such State complies with such regulations as the Secretary may prescribe to carry out the purposes of this paragraph. The preceding sentence shall be applicable with respect to wages paid after an effective date specified in such agreement or modification, but in no event with respect to wages paid before (i) January 1, 1957, in the case of an agreement or modification which is mailed or delivered by other means to the Secretary before January 1, 1962, or (ii) the first day of the year in which the agreement or modification is mailed or delivered by other means to the Secretary, in the case of an agreement or modification which is so mailed or delivered on or after January 1, 1962."

Amo. p. 929.

(2) Section 218(f) (1) of such Act is amended by striking out "Any agreement" and inserting in lieu thereof "Except as provided in subsection (e) (2), any agreement".

Statute of Limitations for State and Local Coverage

(f) (1) Section 218 of the Social Security Act is amended by adding at the end thereof the following new subsections:

"Time Limitation on Assessments

"(q) (1) Where a State is liable for an amount due under an agreement pursuant to this section, such State shall remain so liable until the Secretary is satisfied that the amount due has been paid to the Secretary of the Treasury.

"(2) Notwithstanding paragraph (1), a State shall not be liable for an amount due under an agreement pursuant to this section, with respect to the wages paid to individuals, after the expiration of the latest of the following periods—

"(A) three years, three months, and fifteen days after the year in which such wages were paid, or

"(B) three years after the date on which such amount became due, or

"(C) three years, three months, and fifteen days after the year following the year in which this subsection is enacted, unless prior to the expiration of such period the Secretary makes an assessment of the amount due.

"(3) For purposes of this subsection and section 205(c), an assessment of an amount due is made when the Secretary mails or otherwise delivers to the State a notice stating the amount he has determined to be due under an agreement pursuant to this section and the basis for such determination.

42 USC 408.

"(4) An assessment of an amount due made by the Secretary after the expiration of the period specified in paragraph (2) shall nevertheless be deemed to have been made within such period if—

"(A) before the expiration of such period (or, if it has previously been extended under this paragraph, of such period as so extended), the State and the Secretary agree in writing to an extension of such period (or extended period) and, subject to such conditions as may be agreed upon, the Secretary makes the assessment prior to the expiration of such extension; or

"(B) within the 365 days immediately preceding the expiration of such period (or extended period) the State pays to the Secretary of the Treasury less than the correct amount due under an agreement pursuant to this section with respect to wages paid to individuals in any calendar quarters as members of a coverage group, and the Secretary of Health, Education, and Welfare makes the assessment, adjusted to take into account the amount paid by the State, no later than the 365th day after the day the State made payment to the Secretary of the Treasury; but the Secretary of Health, Education, and Welfare shall make such assessment only with respect to the wages paid to such individuals in such calendar quarters as members of such coverage group; or

"(C) pursuant to subparagraph (A) or (B) of section 205(c) (5) he includes in his records an entry with respect to wages for an individual, but only if such assessment is limited to the amount due with respect to such wages and is made within the period such entry could be made in such records under such subparagraph.

"(5) If the Secretary allows a claim for a credit or refund of an overpayment by a State under an agreement pursuant to this section, with respect to wages paid or alleged to have been paid to an individual in a calendar year for services as a member of a coverage group, and if as a result of the facts on which such allowance is based there is an amount due from the State, with respect to wages paid to such individual in such calendar year for services performed as a member of a coverage group, for which amount the State is not liable by reason of paragraph (2), then notwithstanding paragraph (2) the State shall be liable for such amount due if the Secretary makes an assessment of such amount due at the time of or prior to notification to the State of the allowance of such claim. For purposes of this paragraph and paragraph (6), interest as provided for in subsection (j) shall not be included in determining the amount due.

"(6) The Secretary shall accept wage reports filed by a State under an agreement pursuant to this section or regulations of the Secretary thereunder, after the expiration of the period specified in paragraph

(2) or such period as extended pursuant to paragraph (4), with respect to wages which are paid to individuals performing services as employees in a coverage group included in the agreement and for payment in connection with which the State is not liable by reason of paragraph (2), only if the State—

“(A) pays to the Secretary of the Treasury the amount due under such agreement with respect to such wages, and

“(B) agrees in writing with the Secretary of Health, Education, and Welfare to an extension of the period specified in paragraph (2) with respect to wages paid to all individuals performing services as employees in such coverage group in the calendar quarters designated by the State in such wage reports as the periods in which such wages were paid. If the State so agrees, the period specified in paragraph (2), or such period as extended

42 USC 418.

“(ii) wage reports filed by a State pursuant to an agreement under section 218 or regulations of the Secretary thereunder; or

Amo., p. 930.

“(iii) assessments of amounts due under an agreement pursuant to section 218, if such assessments are made within the period specified in subsection (q) of such section, or allowances of credits or refunds of overpayments by a State under an agreement pursuant to such section; except that no amount of self-employment income of an individual for any taxable year (if such return or statement was filed after the expiration of the time limitation following the taxable year) shall be included in the Secretary's records pursuant to this subparagraph;”

(3) (A) The amendments made by paragraphs (1) and (2) shall become effective on the first day of the second calendar year following the year in which this Act is enacted.

Amo., p. 933.

(B) In any case in which the Secretary of Health, Education, and Welfare has notified a State prior to the beginning of such second calendar year that there is an amount due by such State, that such State's claim for a credit or refund of an overpayment is disallowed, or that such State has been allowed a credit or refund of an overpayment, under an agreement pursuant to section 218 of the Social Security Act, then the Secretary shall be deemed to have made an assessment of such amount due as provided in section 218(q) of such Act or notified the State of such allowance or disallowance, as the case may be, on the first day of such second calendar year. In such a case the 90-day limitation in section 218(s) of such Act shall not be applicable with respect to the assessment so deemed to have been made or the notification of allowance or disallowance so deemed to have been given the State. However, the preceding sentences of this subparagraph shall not apply if the Secretary makes an assessment of such amount due or notifies the State of such allowance or disallowance on or after the first day of the second calendar year following the year in which this Act is enacted and within the period specified in section 218(q) of the Social Security Act or the period specified in section 218(r) of such Act, as the case may be.

Amo., p. 932.

Municipal and County Hospitals

(g) Section 218(d)(6)(B) of the Social Security Act is amended by adding at the end thereof the following new sentence: “If a re-

(2) any employee in the office of the county superintendent of education or the county school supervisor, or in the office of the principal of any county or municipal public elementary or secondary school in the State; and

(3) any individual licensed to serve in the capacity of teacher who is engaged in any educational capacity in any day or night school conducted under the supervision of the State department of education as a part of the adult education program provided for under the laws of Mississippi or under the laws of the United States.

Justices of the Peace and Constables in the State of Nebraska

(i) Notwithstanding any provision of section 218 of the Social Security Act, the agreement with the State of Nebraska entered into pursuant to such section may, at the option of such State, be modified so as to exclude services performed within such State by individuals as justices of the peace or constables, if such individuals are compensated for such services on a fee basis. Any modification of such agreement pursuant to this subsection shall be effective with respect to services performed after an effective date specified in such modification, except that such date shall not be earlier than the date of enactment of this Act.

42 USC 418.

Teachers in the State of Maine

(j) Section 816 of the Social Security Amendments of 1958 is amended by striking out "July 1, 1960" and inserting in lieu thereof "July 1, 1961".

72 Stat. 1040.
42 USC 418 note.

Certain Employees in the State of California

(k) Notwithstanding any provision of section 218 of the Social Security Act, the agreement with the State of California heretofore entered into pursuant to such section may at the option of such State be modified, at any time prior to 1962, pursuant to subsection (c) (4) of such section 218, so as to apply to services performed by any individual who, on or after January 1, 1957, and on or before December 31, 1959, was employed by such State (or any political subdivision thereof) in any hospital employee's position which, on September 1, 1954, was covered by a retirement system, but which, prior to 1960, was removed from coverage by such retirement system if, prior to July 1, 1960, there have been paid in good faith to the Secretary of the Treasury, with respect to any of the services performed by such individual in any such position, amounts equivalent to the sum of the taxes which would have been imposed by sections 3101 and 3111 of the Internal Revenue Code of 1954 if such services had constituted employment for purposes of chapter 21 of such Code at the time they were performed. Notwithstanding the provisions of subsection (f) of such section 218 such modification shall be effective with respect to (1) all services performed by such individual in any such position on or after January 1, 1960, and (2) all such services, performed before such date, with respect to which amounts equivalent to such taxes have, prior to the date of enactment of this subsection, been paid.

26 USC 3101.
3111.
26 USC 3101 et
seq.

**Inclusion of Texas Among States Which Are Permitted To Divide
Their Retirement Systems Into Two Parts for Purposes of Obtain-
ing Social Security Coverage Under Federal-State Agreement**

Amo. p. 928.

(1) Section 218(d)(6)(C) of the Social Security Act is amended by inserting "Texas," before "Vermont".

EXTENSION OF THE PROGRAM TO GUAM AND AMERICAN SAMOA

*P. o. l. pp. 937,
947.*

Sec. 103. (a) (1) (A) The next to the last sentence of section 202(i) of the Social Security Act is amended by striking out "Puerto Rico, or the Virgin Islands" and inserting in lieu thereof "the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa".

(B) The last sentence of such section 202(i) is amended by striking out "any of such States, or the District of Columbia" and inserting in lieu thereof "any State".

*64 Stat. 488; 66
Stat. 776.
42 USC 402 note.*

(2) Section 101(d) of the Social Security Act Amendments of 1950 and section 5(e)(2) of the Social Security Act Amendments of 1952 are each amended by striking out "Puerto Rico or the Virgin Islands" and inserting in lieu thereof "the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa".

42 USC 403.

(b) Section 203(k) of the Social Security Act is amended by striking out "Puerto Rico, or the Virgin Islands" and inserting in lieu thereof "the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa", and by striking out "Puerto Rico and the Virgin Islands" and inserting in lieu thereof "the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa".

42 USC 410.

(c) Section 210(a)(7) of such Act is amended to read as follows:

"(7) Service performed in the employ of a State, or any political subdivision thereof, or any instrumentality of any one or more of the foregoing which is wholly owned thereby, except that this paragraph shall not apply in the case of—

42 USC 418.

"(A) service included under an agreement under section 218,

"(B) service which, under subsection (k), constitutes covered transportation service, or

"(C) service in the employ of the Government of Guam or the Government of American Samoa or any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, performed by an officer or employee thereof (including a member of the legislature of any such Government or political subdivision), and, for purposes of this title—

"(i) any person whose service as such an officer or employee is not covered by a retirement system established by a law of the United States shall not, with respect to such service, be regarded as an officer or employee of the United States or any agency or instrumentality thereof, and

"(ii) the remuneration for service described in clause (i) (including fees paid to a public official) shall be deemed to have been paid by the Government of Guam or the Government of American Samoa or by a political subdivision thereof or an instrumentality of any one or more of the foregoing which is wholly owned thereby, whichever is appropriate;"

(d) Section 210(a) of such Act is further amended—

42 USC 410.

(1) by striking out “or” at the end of paragraph (16),

(2) by striking out the period at the end of paragraph (17) and inserting in lieu thereof “; or”, and

(3) by adding at the end thereof the following new paragraph:

“(18) Service performed in Guam by a resident of the Republic of the Philippines while in Guam on a temporary basis as a nonimmigrant alien admitted to Guam pursuant to section 101(a)(15)(H)(ii) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)(H)(ii)).”

66 Stat. 166.

(e) Section 210(h) of such Act is amended to read as follows:

“State

“(h) The term ‘State’ includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.”

(f) Section 210(i) of such Act is amended to read as follows:

“United States

“(i) The term ‘United States’ when used in a geographical sense means the States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.”

42 USC 411.

(g)(1) Section 211(a) of such Act is amended by striking out the period at the end of paragraph (7) and inserting in lieu thereof “; and”, and by inserting after paragraph (7) the following new paragraph:

“(8) The term ‘possession of the United States’ as used in sections 931 (relating to income from sources within possessions of the United States) and 932 (relating to citizens of possessions of the United States) of the Internal Revenue Code of 1954 shall be deemed not to include the Virgin Islands, Guam, or American Samoa.”

26 USC 931, 932.

(2) Clauses (v) and (vi) in the last sentence of section 211(a) of such Act are each amended by striking out “paragraphs (1) through (6)” and inserting in lieu thereof “paragraphs (1) through (6) and paragraph (8)”.

(h) Section 211(b) of such Act is amended by striking out the last two sentences and inserting in lieu thereof the following:

“An individual who is not a citizen of the United States but who is a resident of the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa shall not, for the purposes of this subsection, be considered to be a nonresident alien individual.”

(i) Section 218(b)(1) of such Act is amended by inserting “, Guam, or American Samoa” immediately before the period at the end thereof.

42 USC 418, 419.

(j)(1) Section 219 of such Act is repealed.

Repeals.

(2)(A) Section 210(j) of such Act is repealed.

(B) Subsections (k) through (o) of section 210 of such Act are redesignated as subsections (j) through (n), respectively.

(C) Sections 202(i), 215(h)(1), and 217(e)(1), and the last paragraph of section 209, are each amended by striking out “section 210(m)(1)” and inserting in lieu thereof “section 210(l)(1)”.

42 USC 402, 415, 417, 409.

(D) Section 202(t)(4)(D) of such Act is amended—

(i) by striking out “section 210(m)(2)”, “section 210(m)(3)”, and “section 210(m)(2) and (3)” and inserting in lieu thereof “section 210(l)(2)”, “section 210(l)(3)”, and “section 210(l)(2) and (3)”, respectively; and

- (ii) by striking out "section 210(n)" each place it appears and inserting in lieu thereof "section 210(m)".
- 42 USC 405, 409. (E) Section 205(p)(1) of such Act is amended by striking out "subsection (m)(1)" and inserting in lieu thereof "subsection (l)(1)".
- (F) Section 209(j) of such Act is amended by striking out "section 210(k)(3)(C)" and inserting in lieu thereof "section 210(j)(3)(C)".
- (G) Section 218(c)(6)(C) of such Act is amended by striking out "section 210(l)" and inserting in lieu thereof "section 210(k)".
- 42 USC 411. (3) Section 211(a)(6) of such Act is amended to read as follows:
- "(6) A resident of the Commonwealth of Puerto Rico shall compute his net earnings from self-employment in the same manner as a citizen of the United States but without regard to the provisions of section 933 of the Internal Revenue Code of 1954;"
- 26 USC 931.
26 USC 1402. (k)(1) Section 1402(a) of the Internal Revenue Code of 1954 (relating to definition of net earnings from self-employment) is amended by striking out the period at the end of paragraph (8) and inserting in lieu thereof "; and", and by inserting after paragraph (8) the following new paragraph:
- "(9) the term 'possession of the United States' as used in sections 931 (relating to income from sources within possessions of the United States) and 932 (relating to citizens of possessions of the United States) shall be deemed not to include the Virgin Islands, Guam, or American Samoa."
- 26 USC 931, 932. (2) Clauses (v) and (vi) in the last sentence of such section 1402(a) are each amended by striking out "paragraphs (1) through (7)" and inserting in lieu thereof "paragraphs (1) through (7) and paragraph (9)".
- (1) The last sentence of section 1402(b) of such Code (relating to definition of self-employment income) is amended by striking out "the Virgin Islands or a resident of Puerto Rico" and inserting in lieu thereof "the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa".
- 26 USC 1402. (m) Section 1403(b)(2) of such Code (relating to cross references) is amended by inserting ", Guam, American Samoa," after "Virgin Islands".
- 26 USC 3121. (n) Section 3121(b)(7) of such Code (relating to definition of employment) is amended to read as follows:
- "(7) service performed in the employ of a State, or any political subdivision thereof, or any instrumentality of any one or more of the foregoing which is wholly owned thereby, except that this paragraph shall not apply in the case of—
- "(A) service which, under subsection (j), constitutes covered transportation service, or
- "(B) service in the employ of the Government of Guam or the Government of American Samoa or any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, performed by an officer or employee thereof (including a member of the legislature of any such Government or political subdivision), and, for purposes of this title with respect to the taxes imposed by this chapter—
- "(i) any person whose service as such an officer or employee is not covered by a retirement system established by a law of the United States shall not, with respect to such service, be regarded as an employee of the United States or any agency or instrumentality thereof, and
- "(ii) the remuneration for service described in clause (i) (including fees paid to a public official) shall be deemed to have been paid by the Government of Guam

or the Government of American Samoa or by a political subdivision thereof or an instrumentality of any one or more of the foregoing which is wholly owned thereby, whichever is appropriate;”.

(o) Section 3121(b) of such Code is further amended—

26 USC 3121.

(1) by striking out “or” at the end of paragraph (16),

(2) by striking out the period at the end of paragraph (17) and inserting in lieu thereof “; or”, and

(3) by adding at the end thereof the following new paragraph:

“(16) service performed in Guam by a resident of the Republic of the Philippines while in Guam on a temporary basis as a non-immigrant alien admitted to Guam pursuant to section 101(a)(15)(H)(ii) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)(H)(ii)).”

(p) Section 3121(e) of such Code (relating to definition of State, United States, and citizen) is amended to read as follows:

66 Stat. 166.

“(e) STATE, UNITED STATES, AND CITIZEN.—For purposes of this chapter—

“(1) STATE.—The term ‘State’ includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

“(2) UNITED STATES.—The term ‘United States’ when used in a geographical sense includes the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

An individual who is a citizen of the Commonwealth of Puerto Rico (but not otherwise a citizen of the United States) shall be considered, for purposes of this section, as a citizen of the United States.”

(q) (1) Subchapter C of chapter 21 of such Code (general provisions relating to tax under Federal Insurance Contributions Act) is amended by redesignating section 3125 as section 3126, and by inserting after section 3124 the following new section:

26 USC 3121-3125.

“SEC. 3125. RETURNS IN THE CASE OF GOVERNMENTAL EMPLOYEES IN GUAM AND AMERICAN SAMOA.

“(a) GUAM.—The return and payment of the taxes imposed by this chapter on the income of individuals who are officers or employees of the Government of Guam or any political subdivision thereof or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, and those imposed on such Government or political subdivision or instrumentality with respect to having such individuals in its employ, may be made by the Governor of Guam or by such agents as he may designate. The person making such return may, for convenience of administration, make payments of the tax imposed under section 8111 with respect to the service of such individuals without regard to the \$4,800 limitation in section 3121(a)(1).

26 USC 3111.

“(b) AMERICAN SAMOA.—The return and payment of the taxes imposed by this chapter on the income of individuals who are officers or employees of the Government of American Samoa or any political subdivision thereof or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, and those imposed on such Government or political subdivision or instrumentality with respect to having such individuals in its employ, may be made by the Governor of American Samoa or by such agents as he may designate. The person making such return may, for convenience of administration, make payments of the tax imposed under section 8111 with respect to the service of such individuals without regard to the \$4,800 limitation in section 3121(a)(1).”

(2) The table of sections for such subchapter C is amended by striking out

"Sec. 8125. Short title."

and inserting in lieu thereof:

"Sec. 8125. Returns in the case of governmental employees in Guam and American Samoa."

"Sec. 8126. Short title."

26 USC 6205.

(r) (1) Section 6205(a) of such Code (relating to adjustment of tax) is amended by adding at the end thereof the following new paragraph:

"(3) GUAM OR AMERICAN SAMOA AS EMPLOYER.—For purposes of this subsection, in the case of remuneration received during any calendar year from the Government of Guam, the Government of American Samoa, a political subdivision of either, or any instrumentality of any one or more of the foregoing which is wholly owned thereby, the Governor of Guam, the Governor of American Samoa, and each agent designated by either who makes a return pursuant to section 3125 shall be deemed a separate employer."

Acta, p. 939.

26 USC 6413.

(2) Section 6413(a) of such Code (relating to adjustment of tax) is amended by adding at the end thereof the following new paragraph:

"(3) GUAM OR AMERICAN SAMOA AS EMPLOYER.—For purposes of this subsection, in the case of remuneration received during any calendar year from the Government of Guam, the Government of American Samoa, a political subdivision of either, or any instrumentality of any one or more of the foregoing which is wholly owned thereby, the Governor of Guam, the Governor of American Samoa, and each agent designated by either who makes a return pursuant to section 3125 shall be deemed a separate employer."

(3) Section 6413(c) (2) of such Code (relating to applicability of special rules to certain employment taxes) is amended by adding at the end thereof the following new subparagraphs:

"(D) GOVERNMENTAL EMPLOYEES IN GUAM.—In the case of remuneration received from the Government of Guam or any political subdivision thereof or from any instrumentality of any one or more of the foregoing which is wholly owned thereby, during any calendar year, the Governor of Guam and each agent designated by him who makes a return pursuant to section 3125(a) shall, for purposes of this subsection, be deemed a separate employer."

"(E) GOVERNMENTAL EMPLOYEES IN AMERICAN SAMOA.—In the case of remuneration received from the Government of American Samoa or any political subdivision thereof or from any instrumentality of any one or more of the foregoing which is wholly owned thereby, during any calendar year, the Governor of American Samoa and each agent designated by him who makes a return pursuant to section 3125(b) shall, for purposes of this subsection, be deemed a separate employer."

(4) The heading of such section 6413(c) (2) is amended by striking out "AND EMPLOYEES OF CERTAIN FOREIGN CORPORATIONS" and inserting in lieu thereof "EMPLOYEES OF CERTAIN FOREIGN CORPORATIONS, AND GOVERNMENTAL EMPLOYEES IN GUAM AND AMERICAN SAMOA".

(s) Section 7213 of such Code (relating to unauthorized disclosure of information) is amended by redesignating subsection (d) as subsection (e) and by inserting after subsection (c) the following new subsection:

"(d) DISCLOSURES BY CERTAIN DELEGATES OF SECRETARY.—All provisions of law relating to the disclosure of information, and all provisions of law relating to penalties for unauthorized disclosure of in-

formation, which are applicable in respect of any function under this title when performed by an officer or employee of the Treasury Department are likewise applicable in respect of such function when performed by any person who is a 'delegate' within the meaning of section 7701(a)(12)(B)."

Intra

(t) Section 7701(a)(12) of such Code (relating to definition of delegate) is amended to read as follows:

"(12) DELEGATE.—

"(A) IN GENERAL.—The term 'Secretary or his delegate' means the Secretary of the Treasury, or any officer, employee, or agency of the Treasury Department duly authorized by the Secretary (directly, or indirectly by one or more redelegations of authority) to perform the function mentioned or described in the context, and the term 'or his delegate' when used in connection with any other official of the United States shall be similarly construed.

"(B) PERFORMANCE OF CERTAIN FUNCTIONS IN GUAM OR AMERICAN SAMOA.—The term 'delegate', in relation to the performance of functions in Guam or American Samoa with respect to the taxes imposed by chapters 2 and 21, also includes any officer or employee of any other department or agency of the United States, or of any possession thereof, duly authorized by the Secretary (directly, or indirectly by one or more redelegations of authority) to perform such functions."

26 USC 1401
1403, 3101 et seq.

(u) Section 30 of the Organic Act of Guam (48 U.S.C., sec. 1421h) is amended by inserting before the period at the end thereof the following: "; except that nothing in this Act shall be construed to apply to any tax imposed by chapter 2 or 21 of the Internal Revenue Code of 1954".

64 Stat. 392

(v) (1) The amendments made by subsection (a) shall apply only with respect to reinterments after the date of the enactment of this Act. The amendments made by subsections (b), (e), and (f) shall apply only with respect to service performed after 1960; except that insofar as the carrying on of a trade or business (other than performance of service as an employee) is concerned, such amendments shall apply only in the case of taxable years beginning after 1960. The amendments made by subsections (d), (i), (o), and (p) shall apply only with respect to service performed after 1960. The amendments made by subsections (h) and (l) shall apply only in the case of taxable years beginning after 1960. The amendments made by subsections (c), (n), (q), and (r) shall apply only with respect to (1) service in the employ of the Government of Guam or any political subdivision thereof, or any instrumentality of any one or more of the foregoing wholly owned thereby, which is performed after 1960 and after the calendar quarter in which the Secretary of the Treasury receives a certification by the Governor of Guam that legislation has been enacted by the Government of Guam expressing its desire to have the insurance system established by title II of the Social Security Act extended to the officers and employees of such Government and such political subdivisions and instrumentalities, and (2) service in the employ of the Government of American Samoa or any political subdivision thereof or any instrumentality of any one or more of the foregoing wholly owned thereby, which is performed after 1960 and after the calendar quarter in which the Secretary of the Treasury receives a certification by the Governor of American Samoa that the Government of American Samoa desires to have the insurance system established by such title II extended to the officers and employees of such Government and such political subdivisions and instrumentalities. The amendments made by subsections (g)

42 USC 401 et
seq.

26 USC 932.
26 USC 1401-
1403.
42 USC 411.

and (k) shall apply only in the case of taxable years beginning after 1960, except that, insofar as they involve the nonapplication of section 932 of the Internal Revenue Code of 1954 to the Virgin Islands for purposes of chapter 2 of such Code and section 211 of the Social Security Act, such amendments shall be effective in the case of all taxable years with respect to which such chapter 2 (and corresponding provisions of prior law) and such section 211 are applicable. The amendments made by subsections (j), (s), and (t) shall take effect on the date of the enactment of this Act; and there are authorized to be appropriated such sums as may be necessary for the performance by any officer or employee of functions delegated to him by the Secretary of the Treasury in accordance with the amendment made by such subsection (t).

(2) The amendments made by subsections (c) and (n) shall have application only as expressly provided therein, and determinations as to whether an officer or employee of the Government of Guam or the Government of American Samoa or any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, is an employee of the United States or any agency or instrumentality thereof within the meaning of any provision of law not affected by such amendments, shall be made without any inferences drawn from such amendments.

Amo. p. 937.

42 USC 401 of
SSC

(3) The repeal (by subsection (j) (1)) of section 219 of the Social Security Act, and the elimination (by subsections (e), (f), (h), (j) (2), and (j) (3)) of other provisions of such Act making reference to such section 219, shall not be construed as changing or otherwise affecting the effective date specified in such section for the extension to the Commonwealth of Puerto Rico of the insurance system under title II of such Act, the manner or consequences of such extension, or the status of any individual with respect to whom the provisions so eliminated are applicable.

SERVICE OF PARENT FOR SON OR DAUGHTER

42 USC 410.

SEC. 104. (a) Section 210 (a) (3) of the Social Security Act is amended to read as follows:

"(3) (A) Service performed by an individual in the employ of his spouse, and service performed by a child under the age of twenty-one in the employ of his father or mother;

"(B) Service not in the course of the employer's trade or business, or domestic service in a private home of the employer, performed by an individual in the employ of his son or daughter;"

26 USC 3121.

(b) Section 3121(b) (3) of the Internal Revenue Code of 1954 (relating to definition of employment) is amended to read as follows:

"(3) (A) service performed by an individual in the employ of his spouse, and service performed by a child under the age of 21 in the employ of his father or mother;

"(B) service not in the course of the employer's trade or business, or domestic service in a private home of the employer, performed by an individual in the employ of his son or daughter;"

(c) The amendments made by subsections (a) and (b) shall apply only with respect to services performed after 1960.

EMPLOYEES OF NONPROFIT ORGANIZATIONS

SEC. 105. (a) (1) The first sentence of section 3121(k) (1) (A) of the Internal Revenue Code of 1954 (relating to waiver of exemption by religious, charitable, and certain other organizations) is amended by striking out "and that at least two-thirds of its employees concur in the filing of the certificate".

(2) The second sentence of such section 3121(k)(1)(A) is amended by inserting "(if any)" after "each employee".

Amia, p. 942

(3) Section 3121(k)(1)(E) of such Code is amended by striking out the last two sentences and inserting in lieu thereof: "An organization which has so divided its employees into two groups may file a certificate pursuant to subparagraph (A) with respect to the employees in either group, or may file a separate certificate pursuant to such subparagraph with respect to the employees in each group."

26 USC 312L

(b)(1) If—

(A) an individual performed service in the employ of an organization after 1950 with respect to which remuneration was paid before July 1, 1960, and such service is excepted from employment under section 210(a)(8)(B) of the Social Security Act,

42 USC 410.

(B) such service would have constituted employment as defined in section 210 of such Act if the requirements of section 3121(k)(1) of the Internal Revenue Code of 1954 (or corresponding provisions of prior law) were satisfied,

(C) such organization paid before August 11, 1960, any amount, as taxes imposed by sections 3101 and 3111 of the Internal Revenue Code of 1954 (or corresponding provisions of prior law), with respect to such remuneration paid by the organization to the individual for such service,

26 USC 310 L
311L

(D) such individual (or a fiduciary acting for such individual or his estate, or his survivor (within the meaning of section 205(c)(1)(C) of the Social Security Act)) requests that such remuneration be deemed to constitute remuneration for employment for purposes of title II of the Social Security Act, and

42 USC 405.

(E) the request is made in such form and manner, and with such official, as may be prescribed by regulations made by the Secretary of Health, Education, and Welfare,

42 USC 401 or
669

then, subject to the conditions stated in paragraphs (2), (3), and (4), the remuneration with respect to which the amount has been paid as taxes shall be deemed to constitute remuneration for employment for purposes of title II of the Social Security Act.

(2) Paragraph (1) shall not apply with respect to an individual unless the organization referred to in paragraph (1)(A)—

(A) on or before the date on which the request described in paragraph (1) is made, has filed a certificate pursuant to section 3121(k)(1) of the Internal Revenue Code of 1954 (or corresponding provisions of prior law), or

(B) no longer has any individual in its employ for remuneration at the time such request is made.

(3) Paragraph (1) shall not apply with respect to an individual who was in the employ of the organization referred to in paragraph (2)(A) at any time during the 24-month period following the calendar quarter in which the certificate was filed, unless the organization paid an amount as taxes under sections 3101 and 3111 of the Internal Revenue Code of 1954 (or corresponding provisions of prior law) with respect to remuneration paid by the organization to the employee during some portion of such 24-month period.

(4) If credit or refund of any portion of the amount referred to in paragraph (1)(C) (other than a credit or refund which would be allowed if the service constituted employment for purposes of chapter 21 of the Internal Revenue Code of 1954) has been obtained, paragraph (1) shall not apply with respect to the individual unless the amount credited or refunded (including any interest under section 6611) is repaid before January 1, 1963.

26 USC 3101 or
669

26 USC 661L

(5) If—

42 USC 401 et seq. (A) any remuneration for service performed by an individual is deemed pursuant to paragraph (1) to constitute remuneration for employment for purposes of title II of the Social Security Act,

(B) such individual performs service, on or after the date on which the request is made, in the employ of the organization referred to in paragraph (1)(A), and

Am. R. 942.

(C) the certificate filed by such organization pursuant to section 3121(k)(1) of the Internal Revenue Code of 1954 (or corresponding provisions of prior law) is not effective with respect to service performed by such individual before the first day of the calendar quarter following the quarter in which the request is made,

42 USC 410.

26 USC 3121.

then, for purposes of clauses (ii) and (iii) of section 210 (a)(8)(B) of the Social Security Act and of clauses (ii) and (iii) of section 3121(b)(8)(B) of the Internal Revenue Code of 1954, such individual shall be deemed to have become an employee of such organization (or to have become a member of a group described in section 3121(k)(1)(E) of such Code) on the first day of the calendar quarter following the quarter in which the request is made.

68 Stat. 1098.

(6) Section 403(a) of the Social Security Amendments of 1954 is amended by striking out "filed in such form and manner" and inserting in lieu thereof "filed on or before the date of the enactment of the Social Security Amendments of 1960 and in such form and manner".

26 USC 1402.

(c)(1) Section 1402 of such Code is further amended by adding at the end thereof the following new subsection:

"(g) TREATMENT OF CERTAIN REMUNERATION ERRONEOUSLY REPORTED AS NET EARNINGS FROM SELF-EMPLOYMENT.—If—

"(1) an amount is erroneously paid as tax under section 1401, for any taxable year ending after 1954 and before 1962, with respect to remuneration for service described in section 3121(b)(8) (other than service described in section 3121(b)(8)(A)), and such remuneration is reported as self-employment income on a return filed on or before the due date prescribed for filing such return (including any extension thereof),

42 USC 405.

"(2) the individual who paid such amount (or a fiduciary acting for such individual or his estate, or his survivor (within the meaning of section 205(c)(1)(C) of the Social Security Act)) requests that such remuneration be deemed to constitute net earnings from self-employment,

"(3) such request is filed after the date of the enactment of this paragraph and on or before April 15, 1962,

"(4) such remuneration was paid to such individual for services performed in the employ of an organization which, on or before the date on which such request is filed, has filed a certificate pursuant to section 3121(k), and

"(5) no credit or refund of any portion of the amount erroneously paid for such taxable year as tax under section 1401 (other than a credit or refund which would be allowable if such tax were applicable with respect to such remuneration) has been obtained before the date on which such request is filed or, if obtained, the amount credited or refunded (including any interest under section 6011) is repaid on or before such date,

26 USC 6611, 3121 et seq.

then, for purposes of this chapter and chapter 21, any amount of such remuneration which is paid to such individual before the calendar quarter in which such request is filed (or before the succeeding quarter if such certificate first becomes effective with respect to services performed by such individual in such succeeding quarter), and with re-

spect to which no tax (other than an amount erroneously paid as tax) has been paid under chapter 21, shall be deemed to constitute net earnings from self-employment and not remuneration for employment. For purposes of section 3121(b)(8)(B)(ii) and (iii), if the certificate filed by such organization pursuant to section 3121(k) is not effective with respect to services performed by such individual on or before the first day of the calendar quarter in which the request is filed, such individual shall be deemed to have become an employee of such organization (or to have become a member of a group described in section 3121(k)(1)(E)) on the first day of the succeeding quarter."

26 USC 3101 et
seq.

26 USC 312L

Amia, p. 943.

Amia, p. 944.

42 USC 401 et
seq.

(2) Remuneration which is deemed under section 1402(g) of the Internal Revenue Code of 1954 to constitute net earnings from self-employment and not remuneration for employment shall also be deemed, for purposes of title II of the Social Security Act, to constitute net earnings from self-employment and not remuneration for employment. If, pursuant to the last sentence of section 1402(g) of the Internal Revenue Code of 1954, an individual is deemed to have become an employee of an organization (or to have become a member of a group) on the first day of a calendar quarter, such individual shall likewise be deemed, for purposes of clause (ii) or (iii) of section 210(a)(8)(B) of the Social Security Act, to have become an employee of such organization (or to have become a member of such group) on such day.

42 USC 410.

(d)(1) The amendments made by subsection (a) shall apply only with respect to certificates filed under section 3121(k)(1) of the Internal Revenue Code of 1954 after the date of the enactment of this Act.

(2) No monthly benefits under title II of the Social Security Act for the month in which this Act is enacted or any prior month shall be payable or increased by reason of the provisions of subsections (b) and (c) of this section or the amendments made by such subsections, and no lump-sum death payment under such title shall be payable or increased by reason of such provisions or amendments in the case of any individual who died prior to the date of the enactment of this Act.

AMERICAN CITIZEN EMPLOYEES OF FOREIGN GOVERNMENTS AND INTERNATIONAL ORGANIZATIONS

SEC. 106. (a) Section 211(c)(2) of the Social Security Act is amended to read as follows:

42 USC 411.

"(2) The performance of service by an individual as an employee, other than—

"(A) service described in section 210(a)(14)(B) performed by an individual who has attained the age of eighteen,

"(B) service described in section 210(a)(16),

"(C) service described in section 210(a)(11), (12), or (15) performed in the United States by a citizen of the United States, and

"(D) service described in paragraph (4) of this subsection;"

(b) Section 1402(c)(2) of the Internal Revenue Code of 1954 (relating to definition of trade or business) is amended to read as follows:

26 USC 1402.

"(2) the performance of service by an individual as an employee, other than—

"(A) service described in section 3121(b)(14)(B) performed by an individual who has attained the age of 18,

"(B) service described in section 3121(b)(16),

26 USC 3121

Act, p. 936.

"(C) service described in section 3121(b) (11), (12), or (15) performed in the United States (as defined in section 3121(e) (2)) by a citizen of the United States, and

"(D) service described in paragraph (4) of this subsection;"

42 USC 403

(c) The amendments made by this section shall apply only with respect to taxable years ending on or after December 31, 1960; except that for purposes of section 203 of the Social Security Act, the amendment made by subsection (a) shall apply only with respect to taxable years (of the individual performing the service involved) beginning after the date of the enactment of this Act.

TITLE II—ELIGIBILITY FOR BENEFITS

CHILDREN BORN OR ADOPTED AFTER ONSET OF PARENT'S DISABILITY

42 USC 402

SEC. 201. (a) Section 202(d) (1) (C) of the Social Security Act is amended to read as follows:

"(C) was dependent upon such individual—

"(i) if such individual is living, at the time such application was filed,

"(ii) if such individual has died, at the time of such death,

or

"(iii) if such individual had a period of disability which continued until he became entitled to old-age or disability insurance benefits, or (if he has died) until the month of his death, at the beginning of such period of disability or at the time he became entitled to such benefits,"

(b) Section 202 (d) (1) of such Act is further amended by adding at the end thereof the following new sentence: "In the case of an individual entitled to disability insurance benefits, the provisions of clause (i) of subparagraph (C) of this paragraph shall not apply to a child of such individual unless he (A) is the natural child or stepchild of such individual (including such a child who was legally adopted by such individual) or (B) was legally adopted by such individual before the end of the twenty-four month period beginning with the month after the month in which such individual most recently became entitled to disability insurance benefits, but only if (i) proceedings for such adoption of the child had been instituted by such individual in or before the month in which began the period of disability of such individual which still exists at the time of such adoption or (ii) such adopted child was living with such individual in such month."

(c) The amendments made by this section shall apply as though this Act had been enacted on August 28, 1958, and with respect to monthly benefits under section 202 of the Social Security Act for months after August 1958 based on applications for such benefits filed on or after August 28, 1958.

CONTINUED DEPENDENCY OF STEPCHILD ON NATURAL FATHER

Act, p. 952

SEC. 202. (a) Section 202(d) (3) of the Social Security Act is amended by striking out subparagraph (C), and by striking out "or" at the end of subparagraph (B) and inserting in lieu thereof a period.

(b) The amendments made by subsection (a) shall apply with respect to monthly benefits under section 202 of the Social Security Act for months beginning with the month in which this Act is enacted, but only if an application for such benefits is filed in or after such month.

PAYMENT OF BURIAL EXPENSES

SEC. 203. (a) The second and third sentences of sections 202(i) of the Social Security Act are amended to read as follows: "If there is no such person, or if such person dies before receiving payment, then such amount shall be paid—

"(1) if all or part of the burial expenses of such insured individual which are incurred by or through a funeral home or funeral homes remains unpaid, to such funeral home or funeral homes to the extent of such unpaid expenses, but only if (A) any person who assumed the responsibility for the payment of all or any part of such burial expenses files an application, prior to the expiration of two years after the date of death of such insured individual, requesting that such payment be made to such funeral home or funeral homes, or (B) at least 90 days have elapsed after the date of death of such insured individual and prior to the expiration of such 90 days no person has assumed responsibility for the payment of any of such burial expenses;

"(2) if all of the burial expenses of such insured individual which were incurred by or through a funeral home or funeral homes have been paid (including payments made under clause (1)), to any person or persons, equitably entitled thereto, to the extent and in the proportions that he or they shall have paid such burial expenses; or

"(3) if any part of the amount payable under this subsection remains after payments have been made pursuant to clauses (1) and (2), to any person or persons, equitably entitled thereto, to the extent and in the proportions that he or they shall have paid other expenses in connection with the burial of such insured individual, in the following order of priority: (A) expenses of opening and closing the grave of such insured individual, (B) expenses of providing the burial plot of such insured individual, and (C) any remaining expenses in connection with the burial of such insured individual.

No payment (except a payment authorized pursuant to clause (1) (A) of the preceding sentence) shall be made to any person under this subsection unless application therefor shall have been filed, by or on behalf of such person (whether or not legally competent), prior to the expiration of two years after the date of death of such insured individual, or unless such person was entitled to wife's or husband's insurance benefits, on the basis of the wages and self-employment income of such insured individual, for the month preceding the month in which such individual died."

(b) The amendment made by subsection (a) shall apply—

(1) in the case of the death of an individual occurring on or after the date of the enactment of this Act, and

(2) in the case of the death of an individual occurring prior to such date, but only if no application for a lump-sum death payment under section 202(i) of the Social Security Act is filed on the basis of such individual's wages and self-employment income prior to the third calendar month beginning after such date.

FULLY INSURED STATUS

42 USC 414.

SEC. 204. (a) Section 214(a) of the Social Security Act is amended to read as follows:

“Fully Insured Individual

“(a) The term ‘fully insured individual’ means any individual who had not less than—

“(1) one quarter of coverage (whenever acquired) for each three of the quarters elapsing—

“(A) after (i) December 31, 1950, or (ii) if later, December 31 of the year in which he attained the age of twenty-one, and

“(B) prior to (i) the year in which he died, or (ii) if earlier, the year in which he attained retirement age, except that in no case shall an individual be a fully insured individual unless he has at least six quarters of coverage; or

“(2) forty quarters of coverage; or

“(3) in the case of an individual who died prior to 1951, six quarters of coverage;

not counting as an elapsed quarter for purposes of paragraph (1) any quarter any part of which was included in a period of disability (as defined in section 216(i)) unless such quarter was a quarter of coverage. When the number of elapsed quarters referred to in paragraph (1) is not a multiple of three, such number shall, for purposes of such paragraph, be reduced to the next lower multiple of three.”

Post, pp. 968, 969.

42 USC 401 of 42 USC 415.

(b) The primary insurance amount (for purposes of title II of the Social Security Act) of any individual who died after 1939 and prior to 1951 shall be determined as provided in section 215(a) (2) of such Act.

68 Stat. 1085, 42 USC 415 note.

(c) Section 109(b) of the Social Security Amendments of 1954 is amended by inserting immediately before the period at the end of such subsection “and in or prior to the month in which the Social Security Amendments of 1960 are enacted”.

(d) (1) The amendments made by subsections (a) and (b) of this section shall be applicable (A) in the case of monthly benefits under title II of the Social Security Act for months after the month in which this Act is enacted, on the basis of applications filed in or after such month, (B) in the case of lump-sum death payments under such title with respect to deaths occurring after such month, and (C) in the case of an application for a disability determination with respect to a period of disability (as defined in section 216(i) of the Social Security Act) filed after such month.

(2) For the purposes of determining (A) entitlement to monthly benefits under title II of the Social Security Act for the month in which this Act is enacted and prior months with respect to the wages and self-employment income of an individual and (B) an individual's closing date prior to 1960 under section 215(b) (3) (B) of the Social Security Act, the provisions of section 214(a) of the Social Security Act in effect prior to the date of the enactment of this Act and the provisions of section 109 of the Social Security Amendments of 1954 in effect prior to such date shall apply.

Post, p. 961.
Supra.

SURVIVORS OF INDIVIDUALS WHO DIED PRIOR TO 1940 AND OF CERTAIN OTHER INDIVIDUALS

SEC. 205. (a) Subsections (d)(1), (e)(1), (g)(1), and (h)(1) of section 202 of the Social Security Act are each amended by striking out "after 1939".

*Amia, p. 946.
Post, p. 969.
42 USC 402.*

(b) That part of section 202(f)(1) of such Act which precedes subparagraph (A) is amended by striking out "after August 1950".

(c) The primary insurance amount (for purposes of title II of the Social Security Act) of any individual who died prior to 1940, and who had not less than six quarters of coverage (as defined in section 213 of such Act), shall be computed under section 215(a)(2) of such Act.

*42 USC 401 et
seq.
42 USC 412.*

(d) The preceding provisions of this section and the amendments made thereby shall apply only in the case of monthly benefits under title II of the Social Security Act for months after the month in which this Act is enacted, on the basis of applications filed in or after such month.

CREDITING OF QUARTERS OF COVERAGE FOR YEARS BEFORE 1951

SEC. 206. (a) Section 213(a)(2) of the Social Security Act is amended by striking out all that precedes "\$3,600 in the case of a calendar year after 1950 and before 1955" in clause (ii) of subparagraph (B) and inserting in lieu thereof the following:

"(2) The term 'quarter of coverage' means a quarter in which the individual has been paid \$50 or more in wages (except wages for agricultural labor paid after 1954) or for which he has been credited (as determined under section 212) with \$100 or more of self-employment income, except that—

42 USC 412.

"(i) no quarter after the quarter in which such individual died shall be a quarter of coverage, and no quarter any part of which was included in a period of disability (other than the initial quarter and the last quarter of such period) shall be a quarter of coverage;

"(ii) if the wages paid to any individual in any calendar year equal \$3,000 in the case of a calendar year before 1951, or".

(b)(1) Except as provided in paragraph (2), the amendment made by subsection (a) shall apply only in the case of monthly benefits under title II of the Social Security Act, and the lump-sum death payment under section 202 of such Act, based on the wages and self-employment income of an individual—

(A) who becomes entitled to benefits under section 202(a) or 223 of such Act on the basis of an application filed in or after the month in which this Act is enacted; or

42 USC 423.

(B) who is (or would, but for the provisions of section 215(f)(6) of the Social Security Act, be) entitled to a recomputation of his primary insurance amount under section 215(f)(2)(A) of such Act on the basis of an application filed in or after the month in which this Act is enacted; or

42 USC 412.

(C) who dies without becoming entitled to benefits under section 202(a) or 223 of the Social Security Act, and (unless he dies a currently insured individual but not a fully insured individual (as those terms are defined in section 214 of such Act)) without leaving any individual entitled (on the basis of his wages and self-employment income) to survivor's benefits or a lump-sum death payment under section 202 of such Act on the basis of an application filed prior to the month in which this Act is enacted; or

(D) who dies in or after the month in which this Act is enacted and whose survivors are (or would, but for the provisions of sec-

42 USC 415.

Post, p. 963.

42 USC 402.

68 Stat. 1071.
42 USC 415 note.

tion 215(f) (6) of the Social Security Act, be) entitled to a recomputation of his primary insurance amount under section 215(f) (4) (A) of such Act; or

(E) who dies prior to the month in which this Act is enacted and (i) whose survivors are (or would, but for the provisions of section 215(f) (6) of the Social Security Act, be) entitled to a recomputation of his primary insurance amount under section 215(f) (4) (A) of such Act, and (ii) on the basis of whose wages and self-employment income no individual was entitled to survivor's benefits or a lump-sum death payment under section 202 of such Act on the basis of an application filed prior to the month in which this Act is enacted (and no individual was entitled to such a benefit, without the filing of an application, for any month prior to the month in which this Act is enacted); or

(F) who files an application for a recomputation under section 102(f) (2) (B) of the Social Security Amendments of 1954 in or after the month in which this Act is enacted and is (or would, but for the fact that such recomputation would not result in a higher primary insurance amount, be) entitled to have his primary insurance amount recomputed under such subparagraph; or

(G) who dies and whose survivors are (or would, but for the fact that such recomputation would not result in a higher primary insurance amount for such individual, be) entitled, on the basis of an application filed in or after the month in which this Act is enacted, to have his primary insurance amount recomputed under section 102(f) (2) (B) of the Social Security Amendments of 1954.

Post, pp. 968.
969.

(2) The amendment made by subsection (a) shall also be applicable in the case of applications for disability determination under section 216(i) of the Social Security Act filed in or after the month in which this Act is enacted.

Ante, p. 948.

(3) Notwithstanding any other provision of this subsection, in the case of any individual who would not be a fully insured individual under section 214(a) of the Social Security Act except for the enactment of this section, no benefits shall be payable on the basis of his wages and self-employment income for any month prior to the month in which this Act is enacted.

TIME NEEDED TO ACQUIRE STATUS OF WIFE, CHILD, OR HUSBAND IN CERTAIN CASES

42 USC 416.

SEC. 207. (a) Section 216(b) of the Social Security Act is amended by striking out "not less than three years immediately preceding the day on which her application is filed" and inserting in lieu thereof "not less than one year immediately preceding the day on which her application is filed".

Post, p. 962.

(b) The first sentence of section 216(e) of such Act is amended to read as follows: "The term 'child' means (1) the child or legally adopted child of an individual, and (2) a stepchild who has been such stepchild for not less than one year immediately preceding the day on which application for child's insurance benefits is filed or (if the insured individual is deceased) the day on which such individual died."

(c) Section 216(f) of such Act is amended by striking out "not less than three years immediately preceding the day on which his application is filed" and inserting in lieu thereof "not less than one year immediately preceding the day on which his application is filed".

(d) The amendments made by this section shall apply only with respect to monthly benefits under section 202 of the Social Security Act for months beginning with the month in which this Act is enacted, on the basis of applications filed in or after such month.

42 USC 402.

MARRIAGES SUBJECT TO LEGAL IMPEDIMENT

SEC. 208. (a) Section 216(h)(1) of the Social Security Act is amended by inserting "(A)" after "(1)", and by adding at the end thereof the following new subparagraph:

42 USC 416.

"(B) In any case where under subparagraph (A) an applicant is not (and is not deemed to be) the wife, widow, husband, or widower of a fully or currently insured individual, or where under subsection (b), (c), (f), or (g) such applicant is not the wife, widow, husband, or widower of such individual, but it is established to the satisfaction of the Secretary that such applicant in good faith went through a marriage ceremony with such individual resulting in a purported marriage between them which, but for a legal impediment not known to the applicant at the time of such ceremony, would have been a valid marriage, and such applicant and the insured individual were living in the same household at the time of the death of such insured individual or (if such insured individual is living) at the time such applicant files the application, then, for purposes of subparagraph (A) and subsections (b), (c), (f), and (g), such purported marriage shall be deemed to be a valid marriage. The provisions of the preceding sentence shall not apply (i) if another person is or has been entitled to a benefit under subsection (b), (c), (e), (f), or (g) of section 202 on the basis of the wages and self-employment income of such insured individual and such other person is (or is deemed to be) a wife, widow, husband, or widower of such insured individual under subparagraph (A) at the time such applicant files the application, or (ii) if the Secretary determines, on the basis of information brought to his attention, that such applicant entered into such purported marriage with such insured individual with knowledge that it would not be a valid marriage. The entitlement to a monthly benefit under subsection (b), (c), (e), (f), or (g) of section 202, based on the wages and self-employment income of such insured individual, of a person who would not be deemed to be a wife, widow, husband, or widower of such insured individual but for this subparagraph, shall end with the month before the month (i) in which the Secretary certifies, pursuant to section 205 (i), that another person is entitled to a benefit under subsection (b), (c), (e), (f), or (g) of section 202 on the basis of the wages and self-employment income of such insured individual, if such other person is (or is deemed to be) the wife, widow, husband, or widower of such insured individual under subparagraph (A), or (ii) if the applicant is entitled to a monthly benefit under subsection (b) or (c) of section 202, in which such applicant entered into a marriage, valid without regard to this subparagraph, with a person other than such insured individual. For purposes of this subparagraph, a legal impediment to the validity of a purported marriage includes only an impediment (i) resulting from the lack of dissolution of a previous marriage or otherwise arising out of such previous marriage or its dissolution, or (ii) resulting from a defect in the procedure followed in connection with such purported marriage."

42 USC 405.

(b) Section 216(h)(2) of such Act is amended by inserting "(A)" after "(2)", and by adding at the end thereof the following new subparagraph:

"(B) If an applicant is a son or daughter of a fully or currently insured individual but is not (and is not deemed to be) the child of such insured individual under subparagraph (A), such applicant

shall nevertheless be deemed to be the child of such insured individual if such insured individual and the mother or father, as the case may be, of such applicant went through a marriage ceremony resulting in a purported marriage between them which, but for a legal impediment described in the last sentence of paragraph (1) (B), would have been a valid marriage."

Amo., p. 930.

(c) Section 216(e) of such Act is amended by adding at the end thereof the following new sentence: "For purposes of clause (2), a person who is not the stepchild of an individual shall be deemed the stepchild of such individual if such individual was not the mother or adopting mother or the father or adopting father of such person and such individual and the mother or adopting mother, or the father or adopting father, as the case may be, of such person went through a marriage ceremony resulting in a purported marriage between them which, but for a legal impediment described in the last sentence of subsection (h)(1)(B), would have been a valid marriage."

Amo., p. 931.

Amo., p. 946.

(d) Section 202(d)(3) of such Act (as amended by section 202 of this Act) is amended by adding after and below subparagraph (B) the following new sentence:

Amo., p. 931.

"For purposes of this paragraph, a child deemed to be a child of a fully or currently insured individual pursuant to section 216(h)(2)(B) shall, if such individual is the child's father, be deemed to be the legitimate child of such individual."

(e) Where—

42 USC 402.

(1) one or more persons were entitled (without the application of section 202(j)(1) of the Social Security Act) to monthly benefits under section 202 of such Act for the month before the month in which this Act is enacted on the basis of the wages and self-employment income of an individual; and

(2) any person is entitled to benefits under subsection (b), (c), (d), (e), (f), or (g) of section 202 of the Social Security Act for any subsequent month on the basis of such individual's wages and self-employment income and such person would not be entitled to such benefits but for the enactment of this section; and

42 USC 403.

(3) the total of the benefits to which all persons are entitled under section 202 of the Social Security Act on the basis of such individual's wages and self-employment income for such subsequent month is reduced by reason of the application of section 203(a) of such Act,

then the amount of the benefit to which each person referred to in paragraph (1) of this subsection is entitled for such subsequent month shall not, after the application of such section 203(a), be less than the amount it would have been (determined without regard to section 301) if no person referred to in paragraph (2) of this subsection was entitled to a benefit referred to in such paragraph for such subsequent month on the basis of such wages and self-employment income of such individual.

Post., p. 962.

42 USC 401 or seq.

(f) The amendments made by the preceding provisions of this section shall be applicable (1) with respect to monthly benefits under title II of the Social Security Act for months beginning with the month in which this Act is enacted on the basis of an application filed in or after such month, and (2) in the case of a lump-sum death payment under such title based on an application filed in or after such month, but only if no person, other than the person filing such application, has filed an application for a lump-sum death payment under such title prior to the date of the enactment of this Act with respect to the death of the same individual.

PENALTY DEDUCTIONS UNDER FOREIGN WORK TEST

SEC. 209. (a) The subsection of section 203 of the Social Security Act redesignated as subsection (g) by section 211(c) of this Act is amended by striking out "(b) or (c)" wherever it appears and inserting in lieu thereof "(c)"; and by striking out "(other than an event specified in subsection (b)(1) or (c)(1))".

Amos.

(b) No deduction shall be imposed on or after the date of the enactment of this Act under section 203(f) of the Social Security Act, as in effect prior to such date, on account of failure to file a report of an event described in section 203(c) of such Act, as in effect prior to such date; and no such deduction imposed prior to such date shall be collected after such date.

EXTENSION OF FILING PERIOD FOR HUSBAND'S, WIDOWER'S, OR PARENT'S BENEFITS IN CERTAIN CASES

SEC. 210. (a) In the case of any husband who would not be entitled to husband's insurance benefits under section 202(c) of the Social Security Act except for the enactment of this Act, the requirement in section 202(c)(1)(C) of the Social Security Act relating to the time within which proof of support must be filed shall not apply if such proof of support is filed within two years after the month in which this Act is enacted.

42 USC 402.

(b) In the case of any widower who would not be entitled to widower's insurance benefits under section 202(f) of the Social Security Act except for the enactment of this Act, the requirement in section 202(f)(1)(D) of the Social Security Act relating to the time within which proof of support must be filed shall not apply if such proof of support is filed within two years after the month in which this Act is enacted.

Amos. p. 949.

(c) In the case of any parent who would not be entitled to parent's insurance benefits under section 202(h) of the Social Security Act except for the enactment of this Act, the requirement in section 202(h)(1)(B) of the Social Security Act relating to the time within which proof of support must be filed shall not apply if such proof of support is filed within two years after the month in which this Act is enacted.

INCREASE IN THE EARNED INCOME LIMITATION

SEC. 211. (a) Subsection (b) of section 203 of the Social Security Act is amended to read as follows:

42 USC 403.

"Deductions On Account of Work

"(b) Deductions, in such amounts and at such time or times as the Secretary shall determine, shall be made from any payment or payments under this title to which an individual is entitled, and from any payment or payments to which any other persons are entitled on the basis of such individual's wages and self-employment income, until the total of such deductions equals—

"(1) such individual's benefit or benefits under section 202 for any month, and

"(2) if such individual was entitled to old-age insurance benefits under section 202(a) for such month, the benefit or benefits of all other persons for such month under section 202 based on such individual's wages and self-employment income, if for such month he is charged with excess earnings, under the provisions of subsection (f) of this section, equal to the total of benefits referred to in clauses (1) and (2). If the excess earnings

so charged are less than such total of benefits, such deductions with respect to such month shall be equal only to the amount of such excess earnings. If a child who has attained the age of 18 and is entitled to child's insurance benefits, or a person who is entitled to mother's insurance benefits, is married to an individual entitled to old-age insurance benefits under section 202(a), such child or such person, as the case may be, shall, for the purposes of this subsection and subsection (f), be deemed to be entitled to such benefits on the basis of the wages and self-employment income of such individual entitled to old-age insurance benefits. If a deduction has already been made under this subsection with respect to a person's benefit or benefits under section 202 for a month, he shall be deemed entitled to payments under such section for such month for purposes of further deductions under this subsection, and for purposes of charging of each person's excess earnings under subsection (f), only to the extent of the total of his benefits remaining after such earlier deductions have been made. For purposes of this subsection and subsection (f)—

"(A) an individual shall be deemed to be entitled to payments under section 202 equal to the amount of the benefit or benefits to which he is entitled under such section after the application of subsection (a) of this section, but without the application of the penultimate sentence thereof; and

"(B) if a deduction is made with respect to an individual's benefit or benefits under section 202 because of the occurrence in any month of an event specified in subsection (c) or (d) of this section or in section 222(b), such individual shall not be considered to be entitled to any benefits under such section 202 for such month."

42 USC 422.

42 USC 403.

(b) Subsection (c) of section 203 of such Act is amended to read as follows:

"Deductions on Account of Noncovered Work Outside the United States or Failure to Have Child in Care

"(c) Deductions, in such amounts and at such time or times as the Secretary shall determine, shall be made from any payment or payments under this title to which an individual is entitled, until the total of such deductions equals such individual's benefit or benefits under section 202 for any month—

"(1) in which such individual is under the age of seventy-two and on seven or more different calendar days of which he engaged in noncovered remunerative activity outside the United States; or

"(2) in which such individual, if a wife under age sixty-five entitled to a wife's insurance benefit, did not have in her care (individually or jointly with her husband) a child of her husband entitled to a child's insurance benefit and such wife's insurance benefit for such month was not reduced under the provisions of section 202(g); or

Post, p. 957.

"(3) in which such individual, if a widow entitled to a mother's insurance benefit, did not have in her care a child of her deceased husband entitled to a child's insurance benefit; or

"(4) in which such individual, if a former wife divorced entitled to a mother's insurance benefit, did not have in her care a child of her deceased former husband who (A) is her son, daughter, or legally adopted child and (B) is entitled to a child's insurance benefit on the basis of the wages and self-employment income of her deceased former husband.

For purposes of paragraphs (2), (3), and (4) of this subsection, a child shall not be considered to be entitled to a child's insurance benefit for any month in which an event specified in section 222(b) occurs with respect to such child. No deduction shall be made under this

subsection from any child's insurance benefit for the month in which the child entitled to such benefit attained the age of eighteen or any subsequent month."

(c) Section 203 of such Act is amended by redesignating subsections (d), (e), (f), (g), and (h) as subsections (e), (f), (g), (h), and (i), respectively, and by inserting after subsection (c) the following new subsection:

42 USC 403.

"Deductions From Dependents' Benefits on Account of Noncovered Work Outside the United States by Old-Age Insurance Beneficiary

"(d) (1) Deductions shall be made from any wife's, husband's, or child's insurance benefit, based on the wages and self-employment income of an individual entitled to old-age insurance benefits, to which a wife, husband, or child is entitled, until the total of such deductions equals such wife's, husband's, or child's insurance benefit or benefits under section 202 for any month in which such individual is under the age of seventy-two and on seven or more different calendar days of which he engaged in noncovered remunerative activity outside the United States.

42 USC 402.

"(2) Deductions shall be made from any child's insurance benefit to which a child who has attained the age of eighteen is entitled, or from any mother's insurance benefit to which a person is entitled, until the total of such deductions equals such child's insurance benefit or benefits or mother's insurance benefit or benefits under section 202 for any month in which such child or person entitled to mother's insurance benefits is married to an individual who is entitled to old-age insurance benefits and on seven or more different calendar days of which such individual engaged in noncovered remunerative activity outside the United States."

(d) The subsection of section 203 of such Act redesignated as subsection (e) by subsection (c) of this section is amended to read as follows:

"Occurrence of More Than One Event

"(e) If more than one of the events specified in subsections (c) and (d) and section 222(b) occurs in any one month which would occasion deductions equal to a benefit for such month, only an amount equal to such benefit shall be deducted."

42 USC 422.

(e) The subsection of section 203 of such Act redesignated as subsection (f) by subsection (c) of this section is amended to read as follows:

"Months to Which Earnings Are Charged

"(f) For purposes of subsection (b)—

"(1) The amount of an individual's excess earnings (as defined in paragraph (3)) shall be charged to months as follows: There shall be charged to the first month of such taxable year an amount of his excess earnings equal to the sum of the payments to which he and all other persons are entitled for such month under section 202 on the basis of his wages and self-employment income (or the total of his excess earnings if such excess earnings are less than such sum), and the balance, if any, of such excess earnings shall be charged to each succeeding month in such year to the extent, in the case of each such month, of the sum of the payments to which such individual and all other persons are entitled for such month under section 202 on the basis of his wages and self-employment income, until the total of such excess has been so charged. Where an individual is entitled to benefits under section

202(a) and other persons are entitled to benefits under section 202(b), (c), or (d) on the basis of the wages and self-employment income of such individual, the excess earnings of such individual for any taxable year shall be charged in accordance with the provisions of this subsection before the excess earnings of such persons for a taxable year are charged to months in such individual's taxable year. Notwithstanding the preceding provisions of this paragraph, no part of the excess earnings of an individual shall be charged to any month (A) for which such individual was not entitled to a benefit under this title, (B) in which such individual was age seventy-two or over, (C) in which such individual, if a child entitled to child's insurance benefits, has attained the age of 18, or (D) in which such individual did not engage in self-employment and did not render services for wages (determined as provided in paragraph (5) of this subsection) of more than \$100.

"(2) As used in paragraph (1), the term 'first month of such taxable year' means the earliest month in such year to which the charging of excess earnings described in such paragraph is not prohibited by the application of clauses (A), (B), (C), and (D) thereof.

"(3) For purposes of paragraph (1) and subsection (b), an individual's excess earnings for a taxable year shall be his earnings for such year in excess of the product of \$100 multiplied by the number of months in such year, except that of the first \$300 of such excess (or all of such excess if it is less than \$300), an amount equal to one-half thereof shall not be included. The excess earnings as derived under the preceding sentence, if not a multiple of \$1, shall be reduced to the next lower multiple of \$1.

"(4) For purposes of clause (D) of paragraph (1)—

"(A) An individual will be presumed, with respect to any month, to have been engaged in self-employment in such month until it is shown to the satisfaction of the Secretary that such individual rendered no substantial services in such month with respect to any trade or business the net income or loss of which is includible in computing (as provided in paragraph (5) of this subsection) his net earnings or net loss from self-employment for any taxable year. The Secretary shall by regulations prescribe the methods and criteria for determining whether or not an individual has rendered substantial services with respect to any trade or business.

"(B) An individual will be presumed, with respect to any month, to have rendered services for wages (determined as provided in paragraph (5) of this subsection) of more than \$100 until it is shown to the satisfaction of the Secretary that such individual did not render such services in such month for more than such amount.

"(5) (A) An individual's earnings for a taxable year shall be (i) the sum of his wages for services rendered in such year and his net earnings from self-employment for such year, minus (ii) any net loss from self-employment for such year.

"(B) In determining an individual's net earnings from self-employment and his net loss from self-employment for purposes of subparagraph (A) of this paragraph and paragraph (4), the provisions of section 211, other than paragraphs (1), (4), and (5) of subsection (c), shall be applicable; and any excess of income over deductions resulting from such a computation shall be his net earnings from self-employment and any excess of deductions over income so resulting shall be his net loss from self-employment.

"(C) For purposes of this subsection, an individual's wages shall be computed without regard to the limitations as to amounts of remuneration specified in subsections (a), (g)(2), (g)(3), (h)(2), and (j) of section 209; and in making such computation services which do not constitute employment as defined in section 210, performed within the United States by the individual as an employee or performed outside the United States in the active military or naval service of the United States, shall be deemed to be employment as so defined if the remuneration for such services is not includible in computing his net earnings or net loss from self-employment.

Amo. pp. 937.
938.

"(6) For purposes of this subsection, wages (determined as provided in paragraph (5)(C)) which, according to reports received by the Secretary, are paid to an individual during a taxable year shall be presumed to have been paid to him for services performed in such year until it is shown to the satisfaction of the Secretary that they were paid for services performed in another taxable year. If such reports with respect to an individual show his wages for a calendar year, such individual's taxable year shall be presumed to be a calendar year for purposes of this subsection until it is shown to the satisfaction of the Secretary that his taxable year is not a calendar year.

"(7) Where an individual's excess earnings are charged to a month and the excess earnings so charged are less than the total of the payments (without regard to such charging) to which all persons are entitled under section 202 for such month on the basis of his wages and self-employment income, the difference between such total and the excess so charged to such month shall be paid (if it is otherwise payable under this title) to such individual and other persons in the proportion that the benefit to which each of them is entitled (without regard to such charging, without the application of section 202(k)(3), and prior to the application of section 203(a)) bears to the total of the benefits to which all of them are entitled."

42 USC 402.

(f) The subsection of section 203 of such Act redesignated as subsection (h) by subsection (c) of this section is amended (1) by striking out "paragraph (4) of subsection (e)" wherever it appears and inserting in lieu thereof "paragraph (5) of subsection (f)", (2) by striking out in subparagraph (B) of paragraph (1) "paragraph (3) of subsection (g)" and inserting in lieu thereof "paragraph (3) of this subsection", (3) by striking out "(b)(1)" wherever it appears and inserting in lieu thereof "(b)", and (4) by striking out in paragraph (3) "suspend the payment" and insert in lieu thereof "suspend the total or less than the total payment".

Amo. p. 965.

(g) The subsection of section 203 of such Act redesignated as subsection (i) by subsection (c) of this section is amended by striking out "subsection (b), (f), or (g) of this section" and inserting in lieu thereof "subsection (b), (c), (g), or (h) of this section".

(h) Subsection (l) of section 203 of such Act is amended by striking out "subsection (f) or (g)(1)(A)" and inserting in lieu thereof "subsection (g) or (h)(1)(A)".

42 USC 403.

(i) The last sentence of section 202(n)(1) of such Act is amended by striking out "Section 203 (b) and (c)" and inserting in lieu thereof "Section 203 (b), (c), and (d)".

(j)(1) Clause (A) of section 202(q)(5) of such Act is amended by striking out "paragraph (1) or (2) of" and by inserting before the comma at the end thereof "or paragraph (1) of section 203(c)".

(2) Clause (B) of such section 202(q)(5) is amended by striking out "paragraph (1) or (2) of section 203(b), under section 203(c)"

and inserting in lieu thereof "section 203(b), under section 203(c)(1), under section 203(d)(1)".

42 USC 402.

(k)(1) Clause (A) of section 202(q)(6) of such Act is amended by striking out "section 203(b)(1) or (2), under section 203(c)" and inserting in lieu thereof "section 203(b), under section 203(c)(1), under section 203(d)(1)".

(2) Clause (D) of such section 202(q)(6) is amended by striking out "paragraph (1) or (2) of" and by inserting immediately before the period "or paragraph (1) of section 203(c)".

(l) Section 202(i)(7) of such Act is amended by striking out "Subsections (b) and (c) of section 203" and inserting in lieu thereof "Subsections (b), (c), and (d) of section 203".

(m) Section 208(a)(3) of such Act is amended by striking out "section 203(e)" and inserting in lieu thereof "section 203(f)".

(n) Section 215(g) of such Act is amended by striking out "203(a)" and inserting in lieu thereof "203(a) and deductions under section 203(b)".

45 USC 228c.

(o)(1) Section 3(e) of the Railroad Retirement Act of 1937 is amended by striking out "subsections (f) and (g)(2) of section 203 of the Social Security Act" and inserting in lieu thereof "subsections (g) and (h)(2) of section 203 of the Social Security Act".

45 USC 228c.

(2) Section 5(i)(1)(ii) of the Railroad Retirement Act of 1937 is amended—

(A) by striking out "section 203(e)" each place it appears and inserting in lieu thereof "section 203(f)";

(B) by striking out "section 203(g)(3)" and inserting in lieu thereof "section 203(h)(3)"; and

(C) by striking out "earnings" each place it appears and inserting in lieu thereof "excess earnings".

Act, p. 951.

(p) Section 203(c), (d), (e), (g), and (i) of the Social Security Act as amended by this Act shall be effective with respect to monthly benefits for months after December 1960.

(q) Section 203(b), (f), and (h) of the Social Security Act as amended by this Act shall be effective with respect to taxable years beginning after December 1960.

(r) Section 203(l) of the Social Security Act as amended by this Act, to the extent that it applies to section 203(g) of the Social Security Act as amended by this Act, shall be effective with respect to monthly benefits for months after December 1960 and, to the extent that it applies to section 203(h)(1)(A) of the Social Security Act as amended by this Act, shall be effective with respect to taxable years beginning after December 1960.

Supra.

(s) The amendments made by subsections (i), (j), (k), (l), (m), (n), and (o) of this section, to the extent that they make changes in references to provisions of section 203 of the Social Security Act, shall take effect in the manner provided in subsections (p) and (q) of this section for the provisions of such section 203 to which the respective references so changed relate.

(t) In any case where—

(1) an individual has earnings (as defined in section 203(e)(4) of the Social Security Act as in effect prior to the enactment of this Act) in a taxable year which begins before 1961 and ends in 1961 (but not on December 31, 1961), and

(2) such individual's spouse or child entitled to monthly benefits on the basis of such individual's self-employment income has excess earnings (as defined in section 203(f)(3) of the Social Security Act as amended by this Act) in a taxable year which begins after 1960, and

(8) one or more months in the taxable year specified in paragraph (2) are included in the taxable year specified in paragraph (1), then, if a deduction is imposed against the benefits payable to such individual with respect to a month described in paragraph (8), such spouse or child, as the case may be, shall not, for purposes of subsections (b) and (f) of section 203 of the Social Security Act as amended by this Act, be entitled to a payment for such month.

TITLE III—BENEFIT AMOUNTS

INCREASE IN INSURANCE BENEFITS OF CHILDREN OF DECEASED WORKERS

SEC. 801. (a) The second sentence of section 202(d)(2) of the Social Security Act is amended to read as follows: "Such child's insurance benefit for each month shall, if such individual has died in or prior to such month, be equal to three-fourths of the primary insurance amount of such individual."

42 USC 402.

(b) The amendment made by this section shall apply only with respect to monthly benefits under section 202 of the Social Security Act for months after the second month following the month in which this Act is enacted.

(c) Where—

(1) one or more persons were entitled (without the application of section 202(j)(1) of the Social Security Act) to monthly benefits under section 202 of such Act for the second month following the month in which this Act is enacted on the basis of the wages and self-employment income of a deceased individual (but not including any person who became so entitled by reason of section 208 of this Act); and

42 USC 408.

(2) no person, other than (i) those persons referred to in paragraph (1) of this subsection (ii) those persons who are entitled to benefits under section 202 (d), (e), (f), or (g) of the Social Security Act but would not be so entitled except for the enactment of section 208 of this Act, is entitled to benefits under such section 202 on the basis of such individual's wages and self-employment income for any subsequent month or for any month after the second month following the month in which this Act is enacted and prior to such subsequent month; and

Amo. p. 949.

(3) the total of the benefits to which all persons referred to in paragraph (1) of this subsection are entitled under section 202 of the Social Security Act on the basis of such individual's wages and self-employment income for such subsequent month exceeds the maximum of benefits payable, as provided in section 203(a) of such Act, on the basis of such wages and self-employment income,

Amo. p. 953.

then the amount of the benefit to which each such person referred to in paragraph (1) of this subsection is entitled for such subsequent month shall be determined—

(4) in case such person is entitled to benefits under section 202 (e), (f), (g), or (h), as though this section and section 208 had not been enacted, or

(5) in case such person is entitled to benefits under section 202(d), as though (i) no person is entitled to benefits under section 202 (e), (f), (g), or (h) for such subsequent month, and (ii) the maximum of benefits payable, as described in paragraph (8), is such maximum less the amount of each person's benefit for such month determined pursuant to paragraph (4).

MAXIMUM FAMILY BENEFITS IN CERTAIN CASES

42 USC 403.

SEC. 302. (a) Section 203(a)(3) of the Social Security Act is amended—

(1) by striking out “and is not less than \$68, then such total of benefits shall not be reduced to less than the smaller of” and inserting in lieu thereof “, then such total of benefits shall not be reduced to less than \$19.10 if such primary insurance amount is \$66, to less than \$102.40 if such primary insurance amount is \$67, to less than \$106.50 if such primary insurance amount is \$68, or, if such primary insurance amount is higher than \$68, to less than the smaller of”; and

(2) by striking out “the last figure in column V of the table appearing in section 215(a)” and inserting in lieu thereof “the amount determined under this subsection without regard to this paragraph, or \$206.60, whichever is larger”.

42 USC 402, 423.

Pool, p. 967.

(b) The amendments made by subsection (a) shall apply only in the case of monthly benefits under section 202 or section 223 of the Social Security Act for months after the month following the month in which this Act is enacted, and then only (1) if the insured individual on the basis of whose wages and self-employment income such monthly benefits are payable became entitled (without the application of section 202(j)(1) or section 223(b) of such Act) to benefits under section 202(a) or section 223 of such Act after the month following the month in which this Act is enacted, or (2) if such insured individual died before becoming so entitled and no person was entitled (without the application of section 202(j)(1) or section 223(b) of such Act) on the basis of such wages and self-employment income to monthly benefits under title II of the Social Security Act for the month following the month in which this Act is enacted or any prior month.

COMPUTATIONS AND RECOMPUTATIONS OF PRIMARY INSURANCE AMOUNTS

42 USC 415.

SEC. 303. (a) Section 215(b) of the Social Security Act is amended to read as follows:

“(b)(1) For the purposes of column III of the table appearing in subsection (a) of this section, an individual’s ‘average monthly wage’ shall be the quotient obtained by dividing—

“(A) the total of his wages paid in and self-employment income credited to his ‘benefit computation years’ (determined under paragraph (2)), by

“(B) the number of months in such years.

“(2)(A) The number of an individual’s ‘benefit computation years’ shall be equal to the number of elapsed years (determined under paragraph (8) of this subsection), reduced by five; except that the number of an individual’s benefit computation years shall in no case be less than two.

“(B) An individual’s ‘benefit computation years’ shall be those computation base years, equal in number to the number determined under subparagraph (A), for which the total of his wages and self-employment income is the largest.

“(C) For the purposes of subparagraph (B), ‘computation base years’ include only calendar years occurring—

“(i) after December 31, 1950, and

“(ii) prior to the year in which the individual became entitled to old-age insurance benefits or died, whichever first occurred; except that the year in which the individual became entitled to old-age insurance benefits or died, as the case may be, shall be included as a computation base year if the Secretary determines, on the basis of

evidence available to him at the time of the computation of the primary insurance amount for such individual, that the inclusion of such year would result in a higher primary insurance amount. Any calendar year all of which is included in a period of disability shall not be included as a computation base year.

"(3) For the purposes of paragraph (2), an individual's 'elapsed years' shall be the number of calendar years—

"(A) after (i) December 31, 1950, or (ii) if later, December 31 of the year in which he attained the age of twenty-one, and

"(B) prior to (i) the year in which he died, or (ii) if earlier, the first year after December 31, 1960, in which he both was fully insured and had attained retirement age.

For the purposes of the preceding sentence, any calendar year any part of which was included in a period of disability shall not be included in such number of calendar years.

"(4) The provisions of this subsection shall be applicable only in the case of an individual with respect to whom not less than six of the quarters elapsing after 1950 are quarters of coverage, and—

"(A) who becomes entitled to benefits after December 1960 under section 202(a) or section 223; or

"(B) who dies after December 1960 without being entitled to benefits under section 202(a) or section 223; or

"(C) who files an application for a recomputation under subsection (f)(2)(A) after December 1960 and is (or would, but for the provisions of subsection (f)(6), be) entitled to have his primary insurance amount recomputed under subsection (f)(2)(A); or

"(D) who dies after December 1960 and whose survivors are (or would, but for the provisions of subsection (f)(6), be) entitled to a recomputation of his primary insurance amount under subsection (f)(4).

"(5) In the case of any individual—

"(A) to whom the provisions of this subsection are not made applicable by paragraph (4), but

"(B) (i) prior to 1961, met the requirements of this paragraph (including subparagraph (E) thereof) as in effect prior to the enactment of the Social Security Amendments of 1960, or (ii) after 1960, meets the conditions of subparagraph (E) of this paragraph as in effect prior to such enactment,

then the provisions of this subsection as in effect prior to such enactment shall apply to such individual for the purposes of column III of the table appearing in subsection (a) of this section."

(b) Section 215(c)(2)(B) of such Act is amended to read as follows:

"(B) to whom the provisions of neither paragraph (4) nor paragraph (5) of subsection (b) are applicable."

(c)(1) Section 215(d)(1)(A) of such Act is amended to read as follows:

"(A) In the computation of such benefit, such individual's average monthly wage shall (in lieu of being determined under section 209(f) of this title as in effect prior to the enactment of such amendments) be determined as provided in subsection (b) of this section (but without regard to paragraphs (4) and (5) thereof), except that for the purposes of paragraphs (2)(C)(i) and (3)(A)(i) of subsection (b), December 31, 1936, shall be used instead of December 31, 1950."

(2) Section 215(d)(1)(C) of such Act is amended by striking out "any part" and inserting in lieu thereof "all"; and by striking out the last sentence thereof.

42 USC 402, 423.

42 USC 415.

42 USC 413.

(3) Section 215(d)(2)(B) of such Act is amended by striking out "paragraph (5)" and inserting in lieu thereof "paragraph (4)".

(4) Section 215(d) of such Act is further amended by adding at the end thereof the following new paragraph:

"(3) The provisions of this subsection as in effect prior to the enactment of the Social Security Amendments of 1960 shall be applicable in the case of an individual who meets the requirements of subsection (b)(5) (as in effect after such enactment) but without regard to whether such individual has six quarters of coverage after 1950."

42 USC 402.

(d)(1) Effective with respect to individuals who become entitled to benefits under section 202(a) of the Social Security Act after 1960, section 215(e)(3) of such Act is amended to read as follows:

"(3) if an individual has self-employment income in a taxable year which begins prior to the calendar year in which he becomes entitled to old-age insurance benefits and ends after the last day of the month preceding the month in which he becomes so entitled, his self-employment income in such taxable year shall not be counted in determining his benefit computation years, except as provided in subsection (f)(3)(C)."

(2) Effective with respect to individuals who meet any of the subparagraphs of paragraph (4) of section 215(b) of the Social Security Act, as amended by this Act, section 215(e) of the Social Security Act is further amended by inserting "and" after the semicolon at the end of paragraph (2) and by striking out paragraph (4).

(e)(1) Effective with respect to applications for recomputation under section 215(f)(2) of the Social Security Act filed after 1960, section 215(f)(2) of such Act is amended by striking out "1954" the first time it appears and inserting in lieu thereof "1960", and by striking out "no earlier than six months" in subparagraph (A)(iii).

(2) Section 215(f)(2)(B) of such Act is amended to read as follows:

"(B) A recomputation pursuant to subparagraph (A) shall be made—

"(i) only as provided in subsection (a)(1), if the provisions of subsection (b), as amended by the Social Security Amendments of 1960, were applicable to the last previous computation of the individual's primary insurance amount, or

"(ii) as provided in subsection (a)(1) and (3), in all other cases.

Such recomputation shall be made as though the individual became entitled to old-age insurance benefits in the month in which he filed the application for such recomputation, except that if clause (i) of this subparagraph is applicable to such recomputation, the computation base years referred to in subsection (b)(2) shall include only calendar years occurring prior to the year in which he filed his application for such recomputation."

(3) Section 215(f)(3) of such Act is amended to read as follows:

"(3)(A) Upon application by an individual—

"(i) who became entitled to old-age insurance benefits under section 202(a) after December 1960, or

"(ii) whose primary insurance amount was recomputed as provided in paragraph (2)(B)(ii) of this subsection on the basis of an application filed after December 1960,

the Secretary shall recompute his primary insurance amount if such application is filed after the calendar year in which he became entitled to old-age insurance benefits or in which he filed application for the recomputation of his primary insurance amount under clause (ii) of this sentence, whichever is the later. Such recomputation under this subparagraph shall be made as provided in subsection (a)(1) and (3)

of this section, except that such individual's computation base years referred to in subsection (b) (2) shall include the calendar year referred to in the preceding sentence. Such recomputation under this subparagraph shall be effective for and after the first month for which his last previous computation of his primary insurance amount was effective, but in no event for any month prior to the twenty-fourth month before the month in which the application for such recomputation is filed.

"(B) In the case of an individual who dies after December 1960 and—

"(i) who, at the time of death was not entitled to old-age insurance benefits under section 202(a), or

42 USC 402.

"(ii) who became entitled to such old-age insurance benefits after December 1960, or

"(iii) whose primary insurance amount was recomputed under paragraph (2) of this subsection on the basis of an application filed after December 1960, or

"(iv) whose primary insurance amount was recomputed under paragraph (4) of this subsection,

the Secretary shall recompute his primary insurance amount upon the filing of an application by a person entitled to monthly benefits or a lump-sum death payment on the basis of such individual's wages and self-employment income. Such recomputation shall be made as provided in subsection (a) (1) and (3) of this section, except that such individual's computation base years referred to in subsection (b) (2) shall include the calendar year in which he died in the case of an individual who was not entitled to old-age insurance benefits at the time of death or whose primary insurance amount was recomputed under paragraph (4) of this subsection, or in all other cases, the calendar year in which he filed his application for the last previous computation of his primary insurance amount. In the case of monthly benefits, such recomputation shall be effective for and after the month in which the person entitled to such monthly benefits became so entitled, but in no event for any month prior to the twenty-fourth month before the month in which the application for such recomputation is filed.

"(C) In the case of an individual who becomes entitled to old-age insurance benefits in a calendar year after 1960, if such individual has self-employment income in a taxable year which begins prior to such calendar year and ends after the last day of the month preceding the month in which he became so entitled, the Secretary shall recompute such individual's primary insurance amount after the close of such taxable year and shall take into account in determining the individual's benefit computation years only such self-employment income in such taxable year as is credited, pursuant to section 212, to the year preceding the year in which he became so entitled. Such recomputation shall be effective for and after the first month in which he became entitled to old-age insurance benefits."

42 USC 412.

(4) (A) Section 215(f) (4) of such Act is amended by striking out "1954" in the first sentence and inserting in lieu thereof "1960", and by striking out the second and third sentences and inserting in lieu thereof the following: "If the recomputation is permitted by subparagraph (A), the recomputation shall be made (if at all) as though he had filed application for a recomputation under paragraph (2) (A) in the month in which he died. If the recomputation is permitted by subparagraph (B), the recomputation shall take into account only the wages and self-employment income which were considered in the last previous computation of his primary insurance amount and the compensation (described in section 205(o)) paid to him in the years in which such wages were paid or to which such self-employment income was credited."

42 USC 406.

Amo. p. 963.

(B) Effective in the case of deaths occurring on or after the date of the enactment of this Act, the first sentence of such section 215 (f) (4) is further amended by striking out "(without the application of clause (iii) thereof)".

*42 USC 423.
Pool, p. 967.*

(f) Effective with respect to individuals who become entitled to benefits under section 223 of the Social Security Act after 1960, section 223(a) (2) of such Act (as amended by section 402(b) of this Act) is amended to read as follows:

42 USC 415.

"(2) Such individual's disability insurance benefit for any month shall be equal to his primary insurance amount for such month determined under section 215 as though he had attained retirement age in—

"(A) the first month of his waiting period, or

"(B) in any case in which clause (ii) of paragraph (1) of this subsection is applicable, the first month for which he becomes entitled to such disability insurance benefits,

and as though he had become entitled to old-age insurance benefits in the month in which he filed his application for disability insurance benefits. For the purposes of the preceding sentence, in the case of a woman who both was fully insured and had attained retirement age in or before the first month referred to in subparagraph (A) or (B) of such sentence, as the case may be, the elapsed years referred to in section 215(b) (3) shall not include the first year in which she both was fully insured and had attained retirement age, or any year thereafter."

Amo. p. 961.

(g) (1) In the case of any individual who both was fully insured and had attained retirement age prior to 1961 and (A) who becomes entitled to old-age insurance benefits after 1960, or (B) who dies after 1960 without being entitled to such benefits, then, notwithstanding the amendments made by the preceding subsections of this section, the Secretary shall also compute such individual's primary insurance amount on the basis of such individual's average monthly wage determined under the provisions of section 215 of the Social Security Act in effect prior to the enactment of this Act with a closing date determined under section 215(b) (3) (B) of such Act as then in effect, but only if such closing date would have been applicable to such computation had this section not been enacted. If the primary insurance amount resulting from the use of such an average monthly wage is higher than the primary insurance amount resulting from the use of an average monthly wage determined pursuant to the provisions of section 215 of the Social Security Act, as amended by the Social Security Amendments of 1960, such higher primary insurance amount shall be the individual's primary insurance amount for purposes of such section 215. The terms used in this subsection shall have the meaning assigned to them by title II of the Social Security Act.

*42 USC 401 et
seq.*

*Pool, pp. 967,
968.*

42 USC 402.

(2) Notwithstanding the amendments made by the preceding subsections of this section, in the case of any individual who was entitled (without regard to the provisions of section 223(b) of the Social Security Act) to a disability insurance benefit under such section 223 for the month before the month in which he became entitled to an old-age insurance benefit under section 202(a) of such Act, or in which he died, and such disability insurance benefit was based upon a primary insurance amount determined under the provisions of section 215 of the Social Security Act in effect prior to the enactment of this Act, the Secretary shall, in applying the provisions of such section 215(a) (except paragraph (4) thereof), for purposes of determining benefits payable under section 202 of such Act on the basis of such individual's wages and self-employment income, determine such individual's average monthly wage under the provisions of section 215 of the Social Security Act in effect prior to the enactment of this Act.

The provisions of this paragraph shall not apply with respect to any such individual, entitled to such old-age insurance benefits, (i) who applies, after 1960, for a recomputation (to which he is entitled) of his primary insurance amount under section 215(f)(2) of such Act, or (ii) who dies after 1960 and meets the conditions for a recomputation of his primary insurance amount under section 215(f)(4) of such Act.

Amo. pp. 962, 963.

(h) In any case where application for recomputation under section 215(f)(3) of the Social Security Act is filed on or after the date of the enactment of this Act with respect to an individual for whom the last previous computation of the primary insurance amount was based on an application filed prior to 1961, or who died before 1961, the provisions of section 215 of such Act as in effect prior to the enactment of this Act shall apply except that—

Amo. p. 962.

(1) such recomputation shall be made as provided in section 215(a) of the Social Security Act (as in effect prior to the enactment of this Act) and as though such individual first became entitled to old-age insurance benefits in the month in which he filed his application for such recomputation or died without filing such an application, and his closing date for such purposes shall be as specified in such section 215(f)(3); and

(2) the provisions of section 215(b)(4) of the Social Security Act (as in effect prior to the enactment of this Act) shall apply only if they were applicable to the last previous computation of such individual's primary insurance amount, or would have been applicable to such computation if there had been taken into account—

Amo. p. 961.

(A) his wages and self-employment income in the year in which he became entitled to old-age insurance benefits or filed application for the last previous recomputation of his primary insurance amount, where he is living at the time of the application for recomputation under this subsection, or

(B) his wages and self-employment income in the year in which he died without becoming entitled to old-age insurance benefits, or (if he was entitled to such benefits) the year in which application was filed for the last previous computation of his primary insurance amount or in which he died, whichever first occurred, where he has died at the time of the application for such recomputation.

If the primary insurance amount of an individual was recomputed under section 215(f)(3) of the Social Security Act as in effect prior to the enactment of this Act, and such amount would have been larger if the recomputation had been made under such section as modified by this subsection, then the Secretary shall recompute such primary insurance amount under such section as so modified, but only if an application for such recomputation is filed on or after the date of the enactment of this Act. A recomputation under the preceding sentence shall be effective for and after the first month for which the last previous recomputation of such individual's primary insurance amount under such section 215 was effective, but in no event for any month prior to the twenty-fourth month before the month in which the application for a recomputation is filed under the preceding sentence.

(i)(1) In the case of an application for a recomputation under section 215(f)(2) of the Social Security Act filed after 1954 and prior to 1961, the provisions of section 215(f)(2) of such Act in effect prior to the enactment of this Act shall apply.

(2) In the case of an individual who died after 1954 and prior to 1961 and who was entitled to an old-age insurance benefit under sec-

42 USC 402.
Amo. p. 963.

tion 202(a) at the time of his death, the provisions of section 215(f) (4) of the Social Security Act in effect prior to the enactment of this Act shall apply.

Amo. p. 960.

(j) In the case of an individual whose average monthly wage is computed under the provisions of section 215(b) of the Social Security Act, as amended by this Act, and—

Pool, p. 967.

(1) who is entitled, by reason of the provisions of section 202(j)(1) or section 223(b) of the Social Security Act, to a monthly benefit for any month prior to January 1961, or

(2) who is (or would, but for the fact that such recomputation would not result in a higher primary insurance amount for such individual, be) entitled, by reason of section 215(f) of the Social Security Act, to have his primary insurance amount recomputed effective for a month prior to January 1961,

his average monthly wage as determined under the provisions of such section 215(b) shall be his average monthly wage for the purposes of determining his primary insurance amount for such prior month.

68 Stat. 1070.
42 USC 415, note.

(k) Section 102(f)(2)(B) of the Social Security Amendments of 1954 is amended by inserting after "Social Security Act" in the second sentence thereof "as in effect prior to the enactment of the Social Security Amendments of 1960"; and by striking out "bond" and inserting in lieu thereof "month".

ELIMINATION OF CERTAIN OBSOLETE RECOMPUTATIONS

42 USC 415.

SEC. 304. (a) The first sentence of section 215(f)(5) of the Social Security Act is amended by striking out "after the close of such taxable year by such individual or (if he died without filing such application)" and inserting in lieu thereof the following: "by such individual after the close of such taxable year and prior to January 1961 or (if he died without filing such application and such death occurred prior to January 1961)".

42 USC 415 note.

(b) Section 102(e)(5) of the Social Security Amendments of 1954 is amended by adding at the end thereof the following new subparagraph:

"(D) Notwithstanding the provisions of subparagraphs (A), (B), and (C), the primary insurance amount of an individual shall not be recomputed under such provisions unless such individual files the application referred to in subparagraph (A) or (B) prior to January 1961 or, if he dies without filing such application, his death occurred prior to January 1961."

42 USC 415 note.

(c) Section 102(e)(8) of the Social Security Amendments of 1954 is amended by inserting before the period at the end thereof "but only if such individual files the application referred to in subparagraph (A) of such section prior to January 1961 or (if he dies without filing such application) his death occurred prior to January 1961".

66 Stat. 775.
42 USC 417 note.

(d) Section 5(c)(1) of the Social Security Act Amendments of 1952 is amended by adding at the end thereof the following new sentence: "Notwithstanding the preceding provisions of this paragraph, the primary insurance amount of an individual shall not be recomputed under such provisions unless such individual files the application referred to in clause (A) of the first sentence of this paragraph prior to January 1961 or, if he dies without filing such application, his death occurred prior to January 1961."

TITLE IV—DISABILITY INSURANCE BENEFITS AND THE DISABILITY FREEZE

ELIMINATION OF REQUIREMENT OF ATTAINMENT OF AGE FIFTY FOR DISABILITY INSURANCE BENEFITS

SEC. 401. (a) Section 223(a)(1)(B) of the Social Security Act is amended by striking out “has attained the age of fifty and”. 42 USC 423.

(b) The last sentence of section 223(c)(3) of such Act is amended by striking out the semicolon and all that follows and inserting in lieu thereof a period.

(c) The amendments made by this section shall apply only with respect to monthly benefits under sections 202 and 223 of the Social Security Act for months after the month following the month in which this Act is enacted which are based on the wages and self-employment income of an individual who did not attain the age of fifty in or prior to the month following the month in which this Act is enacted, but only where applications for such benefits are filed in or after the month in which this Act is enacted. 42 USC 402.

ELIMINATION OF THE WAITING PERIOD FOR DISABILITY INSURANCE BENEFITS IN CERTAIN CASES

SEC. 402. (a) Section 223(a)(1) of the Social Security Act is amended by striking out “shall be entitled to a disability insurance benefit for each month, beginning with the first month after his waiting period (as defined in subsection (c)(3)) in which he becomes so entitled to such insurance benefits” and inserting in lieu thereof the following: “shall be entitled to a disability insurance benefit (i) for each month beginning with the first month after his waiting period (as defined in subsection (c)(3)) in which he becomes so entitled to such insurance benefits, or (ii) for each month beginning with the first month during all of which he is under a disability and in which he becomes so entitled to such insurance benefits, but only if he was entitled to disability insurance benefits which terminated, or had a period of disability (as defined in section 216(i)) which ceased, within the 60-month period preceding the first month in which he is under such disability.”. 42 USC 416.

(b) Section 223(a)(2) of such Act is amended to read as follows: 42 USC 416.

(2) Such individual's disability insurance benefit for any month shall be equal to his primary insurance amount for such month determined under section 215 as though he became entitled to old-age insurance benefits in— 42 USC 415.

“(A) the first month of his waiting period, or

“(B) in any case in which clause (ii) of paragraph (1) of this subsection is applicable, the first month for which he becomes so entitled to such disability insurance benefits.”

(c) The first sentence of section 223(b) of such Act is amended to read as follows: “No application for disability insurance benefits shall be accepted as a valid application for purposes of this section (1) if it is filed more than nine months before the first month for which the applicant becomes entitled to such benefits, or (2) in any case in which clause (ii) of paragraph (1) of subsection (a) is applicable, if it is filed more than six months before the first month for which the applicant becomes entitled to such benefits; and any application filed within such nine months' period or six months' period, as the case may be, shall be deemed to have been filed in such first month.”

(d) The second sentence of section 223(b) of such Act is amended by striking out “if he files application therefor” and inserting in lieu

thereof "if he is continuously under a disability after such month and until he files application therefor, and he files such application".

Pub. L. 86-778.

(e) (1) The first sentence of section 216(i)(2) of such Act is amended to read as follows: "The term 'period of disability' means a continuous period (beginning and ending as hereinafter provided in this subsection) during which an individual was under a disability (as defined in paragraph (1)), but only if such period is of not less than six full calendar months' duration or such individual was entitled to benefits under section 223 for one or more months in such period."

42 USC 423.

(2) (A) The fifth sentence of such section 216(i)(2) is amended by inserting "or, in any case in which clause (ii) of section 223(a)(1) is applicable, more than six months before the first month for which such applicant becomes entitled to benefits under section 223," after "(as determined under this paragraph)".

(B) Such section 216(i)(2) is further amended by adding at the end thereof the following new sentence: "Any application for a disability determination which is filed within such three months' period or six months' period shall be deemed to have been filed on such first day or in such first month, as the case may be."

(f) The amendments made by subsections (a) and (b) shall apply only with respect to benefits under section 223 of the Social Security Act for the month in which this Act is enacted and subsequent months. The amendment made by subsection (c) shall apply only in the case of applications for benefits under such section 223 filed after the seventh month before the month in which this Act is enacted. The amendment made by subsection (d) shall apply only in the case of applications for benefits under such section 223 filed in or after the month in which this Act is enacted. The amendment made by subsection (e) shall apply only in the case of individuals who become entitled to benefits under such section 223 in or after the month in which this Act is enacted.

PERIOD OF TRIAL WORK BY DISABLED INDIVIDUAL

42 USC 423.

SEC. 403. (a) Section 222 of the Social Security Act is amended by striking out subsection (c) and inserting in lieu thereof the following:

"Period of Trial Work

42 USC 402.

"(c) (1) The term 'period of trial work', with respect to an individual entitled to benefits under section 223 or 202(d), means a period of months beginning and ending as provided in paragraphs (3) and (4).

"(2) For purposes of sections 216(i) and 223, any services rendered by an individual during a period of trial work shall be deemed not to have been rendered by such individual in determining whether his disability has ceased in a month during such period. For purposes of this subsection the term 'services' means activity which is performed for remuneration or gain or is determined by the Secretary to be of a type normally performed for remuneration or gain.

"(3) A period of trial work for any individual shall begin with the month in which he becomes entitled to disability insurance benefits, or, in the case of an individual entitled to benefits under section 202(d) who has attained the age of eighteen, with the month in which he becomes entitled to such benefits or the month in which he attains the age of eighteen, whichever is later. Notwithstanding the preceding sentence, no period of trial work may begin for any individual prior to the beginning of the month following the month in which this paragraph is enacted; and no such period may begin for an in-

dividual in a period of disability of such individual in which he had a previous period of trial work.

"(4) A period of trial work for any individual shall end with the close of whichever of the following months is the earlier:

"(A) the ninth month, beginning on or after the first day of such period, in which the individual renders services (whether or not such nine months are consecutive); or

"(B) the month in which his disability (as defined in section 223(c)(2)) ceases (as determined after application of paragraph (2) of this subsection).

42 USC 423.

"(5) In the case of an individual who becomes entitled to benefits under section 223 for any month as provided in clause (ii) of subsection (a)(1) of such section, the preceding provisions of this subsection shall not apply with respect to services in any month beginning with the first month for which he is so entitled and ending with the first month thereafter for which he is not entitled to benefits under section 223."

(b) Section 223(a)(1) of such Act is amended by striking out "the first month in which any of the following occurs: his disability ceases, he dies, or he attains the age of sixty-five" and inserting in lieu thereof "whichever of the following months is the earliest: the month in which he dies, the month in which he attains the age of sixty-five, or the third month following the month in which his disability ceases".

Amo. p. 967.

(c) The fourth sentence of section 216(i)(2) of such Act is amended by striking out "the first month in which either the disability ceases or the individual attains the age of sixty-five" and inserting in lieu thereof "the month preceding whichever of the following months is the earliest: the month in which the individual attains age sixty-five or the third month following the month in which the disability ceases".

(d)(1) The first sentence of section 202(d)(1) of such Act is amended by inserting "or" before "attains the age of eighteen and is not under a disability (as defined in section 223(c)) which began before he attained such age" and by striking out "or ceases to be under a disability (as so defined) on or after the day on which he attains age eighteen".

Amo. p. 966.

(2) Such section 202(d)(1) is further amended by inserting after the first sentence the following new sentence: "Entitlement of any child to benefits under this subsection shall also end with the month preceding the third month following the month in which he ceases to be under a disability (as so defined) after the month in which he attains age eighteen."

(e)(1) The amendment made by subsection (a) shall be effective only with respect to months beginning after the month in which this Act is enacted.

(2) The amendments made by subsections (b) and (d) shall apply only with respect to benefits under section 223(a) or 202(d) of the Social Security Act for months after the month in which this Act is enacted in the case of individuals who, without regard to such amendments, would have been entitled to such benefits for the month in which this Act is enacted or for any succeeding month.

(3) The amendment made by subsection (c) shall apply only in the case of individuals who have a period of disability (as defined in section 216(i) of the Social Security Act) beginning on or after the date of the enactment of this Act, or beginning before such date and continuing, without regard to such amendment, beyond the end of the month in which this Act is enacted.

SPECIAL INSURED STATUS TEST IN CERTAIN CASES FOR DISABILITY PURPOSES

SEC. 404. (a) In the case of any individual who does not meet the requirements of section 216(i)(3) of the Social Security Act with respect to any quarter, or who is not insured for disability insurance benefits as determined under section 223(c)(1) of such Act with respect to any month in a quarter, such individual shall be deemed to have met such requirements with respect to such quarter or to be so insured with respect to such month of such quarter, as the case may be, if—

(1) he had a total of not less than twenty quarters of coverage (as defined in section 213 of such Act) during the period ending with the close of such quarter, and

(2) all of the quarters elapsing after 1950 and up to but excluding such quarter were quarters of coverage with respect to him and there were not fewer than six such quarters of coverage.

(b) Subsection (a) shall apply only in the case of applications for disability insurance benefits under section 223 of the Social Security Act, or for disability determinations under section 216(i) of such Act, filed in or after the month in which this Act is enacted, and then only with respect to an individual who, but for such subsection (a), would not meet the requirements for a period of disability under section 216(i) with respect to the quarter in which this Act is enacted or any prior quarter and would not meet the requirements for benefits under section 223 with respect to the month in which this Act is enacted or any prior month. No benefits under title II of the Social Security Act for the month in which this Act is enacted or any prior month shall be payable or increased by reason of the amendment made by such subsection.

TITLE V—EMPLOYMENT SECURITY

PART 1—SHORT TITLE

SEC. 501. This title may be cited as the "Employment Security Act of 1960".

PART 2—EMPLOYMENT SECURITY ADMINISTRATIVE FINANCING AMENDMENTS

AMENDMENT OF TITLE IX OF THE SOCIAL SECURITY ACT

SEC. 521. Title IX of the Social Security Act (42 U.S.C., sec. 1101 and following) is amended to read as follows:

"TITLE IX—MISCELLANEOUS PROVISIONS RELATING TO EMPLOYMENT SECURITY

"EMPLOYMENT SECURITY ADMINISTRATION ACCOUNT

"Establishment of Account

"**SEC. 901.** (a) There is hereby established in the Unemployment Trust Fund an employment security administration account.

"Appropriations to Account

"(b) (1) There is hereby appropriated to the Unemployment Trust Fund for credit to the employment security administration account, out of any moneys in the Treasury not otherwise appropriated, for the fiscal year ending June 30, 1961, and for each fiscal year there-

after, an amount equal to 100 per centum of the tax (including interest, penalties, and additions to the tax) received during the fiscal year under the Federal Unemployment Tax Act and covered into the Treasury.

Post, p. 980.

"(2) The amount appropriated by paragraph (1) shall be transferred at least monthly from the general fund of the Treasury to the Unemployment Trust Fund and credited to the employment security administration account. Each such transfer shall be based on estimates made by the Secretary of the Treasury of the amounts received in the Treasury. Proper adjustments shall be made in the amounts subsequently transferred, to the extent prior estimates (including estimates for the fiscal year ending June 30, 1960) were in excess of or were less than the amounts required to be transferred.

"(3) The Secretary of the Treasury is directed to pay from time to time from the employment security administration account into the Treasury, as repayments to the account for refunding internal revenue collections, amounts equal to all refunds made after June 30, 1960, of amounts received as tax under the Federal Unemployment Tax Act (including interest on such refunds).

"Administrative Expenditures

"(c) (1) There are hereby authorized to be made available for expenditure out of the employment security administration account for the fiscal year ending June 30, 1961, and for each fiscal year thereafter—

"(A) such amounts (not in excess of \$350,000,000 for any fiscal year) as the Congress may deem appropriate for the purpose of—

"(i) assisting the States in the administration of their unemployment compensation laws as provided in title III (including administration pursuant to agreements under any Federal unemployment compensation law, except the Temporary Unemployment Compensation Act of 1958, as amended),

42 USC 501-503.

"(ii) the establishment and maintenance of systems of public employment offices in accordance with the Act of June 6, 1933, as amended (29 U.S.C., secs. 49-49n), and

72 Stat. 171.
42 USC 1400 and
note.

"(iii) carrying into effect section 2012 of title 38 of the United States Code;

48 Stat. 113.

72 Stat. 1221.

"(B) such amounts as the Congress may deem appropriate for the necessary expenses of the Department of Labor for the performance of its functions under—

"(i) this title and titles III and XII of this Act,

42 USC 501-503;
Post, p. 978.

"(ii) the Federal Unemployment Tax Act,

"(iii) the provisions of the Act of June 6, 1933, as amended,

48 Stat. 113.
29 USC 49-49n.
72 Stat. 1221.

"(iv) subchapter II of chapter 41 (except section 2012) of title 38 of the United States Code, and

"(v) any Federal unemployment compensation law, except the Temporary Unemployment Compensation Act of 1958, as amended.

"(2) The Secretary of the Treasury is directed to pay from the employment security administration account into the Treasury as miscellaneous receipts the amount estimated by him which will be expended during a three-month period by the Treasury Department for the performance of its functions under—

"(A) this title and titles III and XII of this Act, including the expenses of banks for servicing unemployment benefit payment and clearing accounts which are offset by the maintenance of balances of Treasury funds with such banks,

Post, p. 966.

“(B) the Federal Unemployment Tax Act, and
“(C) any Federal unemployment compensation law with respect to which responsibility for administration is vested in the Secretary of Labor.

43 USC 1400.

In determining the expenses taken into account under subparagraphs (B) and (C), there shall be excluded any amount attributable to the Temporary Unemployment Compensation Act of 1958, as amended. If it subsequently appears that the estimates under this paragraph in any particular period were too high or too low, appropriate adjustments shall be made by the Secretary of the Treasury in future payments.

“Additional Tax Attributable to Reduced Credits

“(d) (1) The Secretary of the Treasury is directed to transfer from the employment security administration account—

“(A) To the Federal unemployment account, an amount equal to the amount by which—

Post, p. 976.

“(i) 100 per centum of the additional tax received under the Federal Unemployment Tax Act with respect to any State by reason of the reduced credits provisions of section 3302(c) (2) or (3) of such Act and covered into the Treasury for the repayment of advances made to the State under section 1201, exceeds

“(ii) the amount transferred to the account of such State pursuant to subparagraph (B) of this paragraph.

Any amount transferred pursuant to this subparagraph shall be credited against, and shall operate to reduce, that balance of advances, made under section 1201 to the State, with respect to which employers paid such additional tax.

“(B) To the account (in the Unemployment Trust Fund) of the State with respect to which employers paid such additional tax, an amount equal to the amount by which such additional tax received and covered into the Treasury exceeds that balance of advances, made under section 1201 to the State, with respect to which employers paid such additional tax.

If, for any taxable year, there is with respect to any State both a balance described in section 3302(c) (2) of the Federal Unemployment Tax Act and a balance described in section 3302(c) (3) of such Act, this paragraph shall be applied separately with respect to section 3302(c) (2) (and the balance described therein) and separately with respect to section 3302(c) (3) (and the balance described therein).

“(2) The Secretary of the Treasury is directed to transfer from the employment security administration account—

“(A) To the general fund of the Treasury, an amount equal to the amount by which—

43 USC 1400c.

“(i) 100 per centum of the additional tax received under the Federal Unemployment Tax Act with respect to any State by reason of the reduced credit provision of section 104 of the Temporary Unemployment Compensation Act of 1958, as amended, and covered into the Treasury, exceeds

“(ii) the amount transferred to the account of such State pursuant to subparagraph (B) of this paragraph.

“(B) To the account (in the Unemployment Trust Fund) of the State with respect to which employers paid such additional tax, an amount equal to the amount by which—

“(i) such additional tax received and covered into the Treasury, exceeds

"(ii) the total amount restorable to the Treasury under section 104 of the Temporary Unemployment Compensation Act of 1958, as amended, as limited by Public Law 85-457.

42 USC 1490c.
72 Stat. 187.
18 USC 633 note.

"(3) Transfers under this subsection shall be as of the beginning of the month succeeding the month in which the moneys were credited to the employment security administration account pursuant to subsection (b) (2).

"Revolving Fund

"(e) (1) There is hereby established in the Treasury a revolving fund which shall be available to make the advances authorized by this subsection. There are hereby authorized to be appropriated, without fiscal year limitation, to such revolving fund such amounts as may be necessary for the purposes of this section.

"(2) The Secretary of the Treasury is directed to advance from time to time from the revolving fund to the employment security administration account such amounts as may be necessary for the purposes of this section. If the net balance in the employment security administration account as of the beginning of any fiscal year is \$250,000,000, no advance may be made under this subsection during such fiscal year.

"(3) Advances to the employment security administration account made under this subsection shall bear interest until repaid at a rate equal to the average rate of interest (computed as of the end of the calendar month next preceding the date of such advance) borne by all interest-bearing obligations of the United States then forming a part of the public debt; except that where such average rate is not a multiple of one-eighth of 1 per centum, the rate of interest shall be the multiple of one-eighth of 1 per centum next lower than such average rate.

"(4) Advances to the employment security administration account made under this subsection, plus interest accrued thereon, shall be repaid by the transfer from time to time, from the employment security administration account to the revolving fund, of such amounts as the Secretary of the Treasury, in consultation with the Secretary of Labor, determines to be available in the employment security administration account for such repayment. Any amount transferred as a repayment under this paragraph shall be credited against, and shall operate to reduce, any balance of advances (plus accrued interest) repayable under this subsection.

"Determination of Excess and Amount To Be Retained in Employment Security Administration Account

"(f) (1) The Secretary of the Treasury shall determine as of the close of each fiscal year (beginning with the fiscal year ending June 30, 1961) the excess in the employment security administration account.

"(2) The excess in the employment security administration account as of the close of any fiscal year is the amount by which the net balance in such account as of such time (after the application of section 902(b)) exceeds the net balance in the employment security administration account as of the beginning of that fiscal year (including the fiscal year for which the excess is being computed) for which the net balance was higher than as of the beginning of any other such fiscal year.

Post, p. 974.

"(3) If the entire amount of the excess determined under paragraph (1) as of the close of any fiscal year is not transferred to the Federal unemployment account, there shall be retained (as of the beginning of the succeeding fiscal year) in the employment security administration account so much of the remainder as does not increase

the net balance in such account (as of the beginning of such succeeding fiscal year) above \$250,000,000.

"(4) For the purposes of this section, the net balance in the employment security administration account as of any time is the amount in such account as of such time reduced by the sum of—

"(A) the amounts then subject to transfer pursuant to subsection (d), and

"(B) the balance of advances (plus interest accrued thereon) then repayable to the revolving fund established by subsection (e). The net balance in the employment security administration account as of the beginning of any fiscal year shall be determined after the disposition of the excess in such account as of the close of the preceding fiscal year.

**"TRANSFERS BETWEEN FEDERAL UNEMPLOYMENT ACCOUNT AND
EMPLOYMENT SECURITY ADMINISTRATION ACCOUNT**

"Transfers to Federal Unemployment Account

Amo. p. 973.

"SEC. 902. (a) Whenever the Secretary of the Treasury determines pursuant to section 901(f) that there is an excess in the employment security administration account as of the close of any fiscal year, there shall be transferred (as of the beginning of the succeeding fiscal year) to the Federal unemployment account the total amount of such excess or so much thereof as is required to increase the amount in the Federal unemployment account to whichever of the following is the greater:

"(1) \$550,000,000, or

"(2) The amount (determined by the Secretary of Labor and certified by him to the Secretary of the Treasury) equal to four-tenths of 1 per centum of the total wages subject to contributions under all State unemployment compensation laws for the calendar year ending during the fiscal year for which the excess is determined.

"Transfers to Employment Security Administration Account

"(b) The amount, if any, by which the amount in the Federal unemployment account as of the close of any fiscal year exceeds the greater of the amounts specified in paragraphs (1) and (2) of subsection (a) shall be transferred to the employment security administration account as of the close of such fiscal year.

"AMOUNTS TRANSFERRED TO STATE ACCOUNTS

"In General

Post. p. 979.

"SEC. 903. (a)(1) Except as provided in subsection (b), whenever, after the application of section 1203 with respect to the excess in the employment security administration account as of the close of any fiscal year, there remains any portion of such excess, the remainder of such excess shall be transferred (as of the beginning of the succeeding fiscal year) to the accounts of the States in the Unemployment Trust Fund.

"(2) Each State's share of the funds to be transferred under this subsection as of any July 1—

"(A) shall be determined by the Secretary of Labor and certified by him to the Secretary of the Treasury before that date on the basis of reports furnished by the States to the Secretary of Labor before June 1, and

"(B) shall bear the same ratio to the total amount to be so transferred as the amount of wages subject to contributions under such State's unemployment compensation law during the preceding calendar year which have been reported to the State before May 1 bears to the total of wages subject to contributions under all State unemployment compensation laws during such calendar year which have been reported to the States before May 1.

"Limitations on Transfers

“(b) (1) If the Secretary of Labor finds that on July 1 of any fiscal year—

“(A) a State is not eligible for certification under section 303, or

42 USC 503.

“(B) the law of a State is not approvable under section 3304 of the Federal Unemployment Tax Act,

Post, p. 986.

then the amount available for transfer to such State's account shall, in lieu of being so transferred, be transferred to the Federal unemployment account as of the beginning of such July 1. If, during the fiscal year beginning on such July 1, the Secretary of Labor finds and certifies to the Secretary of the Treasury that such State is eligible for certification under section 303, that the law of such State is approvable under such section 3304, or both, the Secretary of the Treasury shall transfer such amount from the Federal unemployment account to the account of such State. If the Secretary of Labor does not so find and certify to the Secretary of the Treasury before the close of such fiscal year then the amount which was available for transfer to such State's account as of July 1 of such fiscal year shall (as of the close of such fiscal year) become unrestricted as to use as part of the Federal unemployment account.

“(2) The amount which, but for this paragraph, would be transferred to the account of a State under subsection (a) or paragraph (1) of this subsection shall be reduced (but not below zero) by the balance of advances made to the State under section 1201. The sum by which such amount is reduced shall—

Post, p. 978.

“(A) be transferred to or retained in (as the case may be) the Federal unemployment account, and

“(B) be credited against, and operate to reduce—

“(i) first, any balance of advances made before the date of the enactment of the Employment Security Act of 1960 to the State under section 1201, and

“(ii) second, any balance of advances made on or after such date to the State under section 1201.

"Use of Transferred Amounts

“(c) (1) Except as provided in paragraph (2), amounts transferred to the account of a State pursuant to subsections (a) and (b) shall be used only in the payment of cash benefits to individuals with respect to their unemployment, exclusive of expenses of administration.

“(2) A State may, pursuant to a specific appropriation made by the legislative body of the State, use money withdrawn from its account in the payment of expenses incurred by it for the administration of its unemployment compensation law and public employment offices if and only if—

“(A) the purposes and amounts were specified in the law making the appropriation,

“(B) the appropriation law did not authorize the obligation of such money after the close of the two-year period which began on the date of enactment of the appropriation law,

"(C) the money is withdrawn and the expenses are incurred after such date of enactment, and

"(D) the appropriation law limits the total amount which may be obligated during a fiscal year to an amount which does not exceed the amount by which (i) the aggregate of the amounts transferred to the account of such State pursuant to subsections (a) and (b) during such fiscal year and the four preceding fiscal years, exceeds (ii) the aggregate of the amounts used by the State pursuant to this subsection and charged against the amounts transferred to the account of such State during such five fiscal years.

For the purposes of subparagraph (D), amounts used by a State during any fiscal year shall be charged against equivalent amounts which were first transferred and which have not previously been so charged; except that no amount obligated for administration during any fiscal year may be charged against any amount transferred during a fiscal year earlier than the fourth preceding fiscal year.

"UNEMPLOYMENT TRUST FUND

"Establishment, etc.

"SEC. 904. (a) There is hereby established in the Treasury of the United States a trust fund to be known as the 'Unemployment Trust Fund', hereinafter in this title called the 'Fund'. The Secretary of the Treasury is authorized and directed to receive and hold in the Fund all moneys deposited therein by a State agency from a State unemployment fund, or by the Railroad Retirement Board to the credit of the railroad unemployment insurance account or the railroad unemployment insurance administration fund, or otherwise deposited in or credited to the Fund or any account therein. Such deposit may be made directly with the Secretary of the Treasury, with any depository designated by him for such purpose, or with any Federal Reserve Bank.

"Investments

"(b) It shall be the duty of the Secretary of the Treasury to invest such portion of the Fund as is not, in his judgment, required to meet current withdrawals. Such investment may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under the Second Liberty Bond Act, as amended, are hereby extended to authorize the issuance at par of special obligations exclusively to the Fund. Such special obligations shall bear interest at a rate equal to the average rate of interest, computed as of the end of the calendar month next preceding the date of such issue, borne by all interest-bearing obligations of the United States then forming part of the public debt; except that where such average rate is not a multiple of one-eighth of 1 per centum, the rate of interest of such special obligations shall be the multiple of one-eighth of 1 per centum next lower than such average rate. Obligations other than such special obligations may be acquired for the Fund only on such terms as to provide an investment yield not less than the yield which would be required in the case of special obligations if issued to the Fund upon the date of such acquisition. Advances made to the Federal unemployment account pursuant to section 1203 shall not be invested.

40 Stat. 288.
31 USC 774.

Post, p. 979.

"Sale or Redemption of Obligations

"(c) Any obligations acquired by the Fund (except special obligations issued exclusively to the Fund) may be sold at the market price, and such special obligations may be redeemed at par plus accrued interest.

"Treatment of Interest and Proceeds

"(d) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Fund shall be credited to and form a part of the Fund.

"Separate Book Accounts

"(e) The Fund shall be invested as a single fund, but the Secretary of the Treasury shall maintain a separate book account for each State agency, the employment security administration account, the Federal unemployment account, the railroad unemployment insurance account, and the railroad unemployment insurance administration fund and shall credit quarterly (on March 31, June 30, September 30, and December 31, of each year) to each account, on the basis of the average daily balance of such account, a proportionate part of the earnings of the Fund for the quarter ending on such date. For the purpose of this subsection, the average daily balance shall be computed—

"(1) in the case of any State account, by reducing (but not below zero) the amount in the account by the balance of advances made to the State under section 1201, and

Post, pp. 978, 979.

"(2) in the case of the Federal unemployment account—

"(A) by adding to the amount in the account the aggregate of the reductions under paragraph (1), and

"(B) by subtracting from the sum so obtained the balance of advances made under section 1203 to the account.

"Payments to State Agencies and Railroad Retirement Board

"(f) The Secretary of the Treasury is authorized and directed to pay out of the Fund to any State agency such amount as it may duly requisition, not exceeding the amount standing to the account of such State agency at the time of such payment. The Secretary of the Treasury is authorized and directed to make such payments out of the railroad unemployment insurance account for the payment of benefits, and out of the railroad unemployment insurance administration fund for the payment of administrative expenses, as the Railroad Retirement Board may duly certify, not exceeding the amount standing to the credit of such account or such fund, as the case may be, at the time of such payment.

"Federal Unemployment Account

"(g) There is hereby established in the Unemployment Trust Fund a Federal unemployment account. There is hereby authorized to be appropriated to such Federal unemployment account a sum equal to (1) the excess of taxes collected prior to July 1, 1946, under title IX of this Act or under the Federal Unemployment Tax Act, over the total unemployment administrative expenditures made prior to July 1, 1946, plus (2) the excess of taxes collected under the Federal Unemployment Tax Act after June 30, 1946, and prior to July 1, 1953, over the unemployment administrative expenditures made after June 30, 1946, and prior to July 1, 1953. As used in this subsection, the term 'unemployment administrative expenditures' means expenditures for grants under title III of this Act, expenditures for the

Ante, p. 976.

42 USC 501-503.

Ante, p. 970.
Post, p. 980.

42 USC 1103
note.

52 Stat. 1103.
45 USC 861.

administration of that title by the Social Security Board, the Federal Security Administrator, or the Secretary of Labor, and expenditures for the administration of title IX of this Act, or of the Federal Unemployment Tax Act, by the Department of the Treasury, the Social Security Board, the Federal Security Administrator, or the Secretary of Labor. For the purposes of this subsection, there shall be deducted from the total amount of taxes collected prior to July 1, 1943, under title IX of this Act, the sum of \$40,561,886.43 which was authorized to be appropriated by the Act of August 24, 1937 (50 Stat. 754), and the sum of \$18,451,846 which was authorized to be appropriated by section 11(b) of the Railroad Unemployment Insurance Act."

AMENDMENT OF TITLE XII OF THE SOCIAL SECURITY ACT

SEC. 522. (a) Title XII of the Social Security Act (42 U.S.C., sec. 1321 and following) is amended to read as follows:

"TITLE XII—ADVANCES TO STATE UNEMPLOYMENT FUNDS

"ADVANCES TO STATE UNEMPLOYMENT FUNDS

Ante, pp. 972,
973.

"SEC. 1201. (a) (1) Advances shall be made to the States from the Federal unemployment account in the Unemployment Trust Fund as provided in this section, and shall be repayable, without interest, in the manner provided in sections 901(d)(1), 903(b)(2), and 1202. An advance to a State for the payment of compensation in any month may be made if—

"(A) the Governor of the State applies therefor no earlier than the first day of the preceding month, and

"(B) he furnishes to the Secretary of Labor his estimate of the amount of an advance which will be required by the State for the payment of compensation in such month.

"(2) In the case of any application for an advance under this section to any State for any month, the Secretary of Labor shall—

"(A) determine the amount (if any) which he finds will be required by such State for the payment of compensation in such month, and

"(B) certify to the Secretary of the Treasury the amount (not greater than the amount estimated by the Governor of the State) determined under subparagraph (A).

The aggregate of the amounts certified by the Secretary of Labor with respect to any month shall not exceed the amount which the Secretary of the Treasury reports to the Secretary of Labor is available in the Federal unemployment account for advances with respect to such month.

"(3) For purposes of this subsection—

"(A) an application for an advance shall be made on such forms, and shall contain such information and data (fiscal and otherwise) concerning the operation and administration of the State unemployment compensation law, as the Secretary of Labor deems necessary or relevant to the performance of his duties under this title,

"(B) the amount required by any State for the payment of compensation in any month shall be determined with due allowance for contingencies and taking into account all other amounts that will be available in the State's unemployment fund for the payment of compensation in such month, and

"(C) the term 'compensation' means cash benefits payable to individuals with respect to their unemployment, exclusive of expenses of administration.

"(b) The Secretary of the Treasury shall, prior to audit or settlement by the General Accounting Office, transfer from the Federal unemployment account to the account of the State in the Unemployment Trust Fund the amount certified under subsection (a) by the Secretary of Labor (but not exceeding that portion of the balance in the Federal unemployment account at the time of the transfer which is not restricted as to use pursuant to section 903(b)(1)).

Ante, p. 975.

"REPAYMENT BY STATES OF ADVANCES TO STATE UNEMPLOYMENT FUNDS

"Sec. 1202. The Governor of any State may at any time request that funds be transferred from the account of such State to the Federal unemployment account in repayment of part or all of that balance of advances, made to such State under section 1201, specified in the request. The Secretary of Labor shall certify to the Secretary of the Treasury the amount and balance specified in the request; and the Secretary of the Treasury shall promptly transfer such amount in reduction of such balance.

"ADVANCES TO FEDERAL UNEMPLOYMENT ACCOUNT

"Sec. 1203. There are hereby authorized to be appropriated to the Federal unemployment account, as repayable advances (without interest), such sums as may be necessary to carry out the purposes of this title. Whenever, after the application of section 901(f)(3) with respect to the excess in the employment security administration account as of the close of any fiscal year, there remains any portion of such excess, so much of such remainder as does not exceed the balance of advances made pursuant to this section shall be transferred to the general fund of the Treasury and shall be credited against, and shall operate to reduce, such balance of advances.

Ante, p. 975.

"DEFINITION OF GOVERNOR

"Sec. 1204. When used in this title, the term 'Governor' includes the Commissioners of the District of Columbia."

(b)(1) No amount shall be transferred on or after the date of the enactment of this Act from the Federal unemployment account to the account of any State in the Unemployment Trust Fund pursuant to any application made under section 1201(a) of the Social Security Act as in effect before such date; except that, if—

(A) some but not all of an amount certified by the Secretary of Labor to the Secretary of the Treasury for transfer to the account of any State was transferred to such account before such date, and

(B) the Governor of such State, after the date of the enactment of this Act, requests the Secretary of the Treasury to transfer all or any part of the remainder to such account, the Secretary of the Treasury shall, prior to audit or settlement by the General Accounting Office, transfer from the Federal unemployment account to the account of such State in the Unemployment Trust Fund the amount so requested or (if smaller) the amount available in the Federal unemployment account at the time of the transfer. No such amount shall be transferred under this paragraph after the one-year period beginning on the date of the enactment of this Act.

(2) For purposes of section 8302(c) of the Federal Unemployment Tax Act and titles IX and XII of the Social Security Act, if any

Post, p. 980.

Ante, pp. 970, 975.

amount is transferred pursuant to paragraph (1) to the unemployment account of any State, such amount shall be treated as an advance made before the date of the enactment of this Act.

AMENDMENTS TO THE FEDERAL UNEMPLOYMENT TAX ACT

Increase in Tax Rate

26 USC 3301.

SEC. 523. (a) Section 3301 of the Internal Revenue Code of 1954 (relating to rate of tax under Federal Unemployment Tax Act) is amended—

- (1) by striking out "1955" and inserting in lieu thereof "1961", and
- (2) by striking out "3 percent" and inserting in lieu thereof "3.1 percent".

Computation of Credits Against Tax

26 USC 3302.

(b) Section 3302 of such Code (relating to credits against tax) is amended by striking out subsection (c) and inserting in lieu thereof the following new subsections:

"(c) LIMIT ON TOTAL CREDITS.—

"(1) The total credits allowed to a taxpayer under this section shall not exceed 90 percent of the tax against which such credits are allowable.

"(2) If an advance or advances have been made to the unemployment account of a State under title XII of the Social Security Act before the date of the enactment of the Employment Security Act of 1960, then the total credits (after applying subsections (a) and (b) and paragraph (1) of this subsection) otherwise allowable under this section for the taxable year in the case of a taxpayer subject to the unemployment compensation law of such State shall be reduced—

"(A) in the case of a taxable year beginning with the fourth consecutive January 1 as of the beginning of which there is a balance of such advances, by 5 percent of the tax imposed by section 3301 with respect to the wages paid by such taxpayer during such taxable year which are attributable to such State; and

"(B) in the case of any succeeding taxable year beginning with a consecutive January 1 as of the beginning of which there is a balance of such advances, by an additional 5 percent, for each such succeeding taxable year, of the tax imposed by section 3301 with respect to the wages paid by such taxpayer during such taxable year which are attributable to such State.

"(3) If an advance or advances have been made to the unemployment account of a State under title XII of the Social Security Act on or after the date of the enactment of the Employment Security Act of 1960, then the total credits (after applying subsections (a) and (b) and paragraphs (1) and (2) of this subsection) otherwise allowable under this section for the taxable year in the case of a taxpayer subject to the unemployment compensation law of such State shall be reduced—

"(A) (i) in the case of a taxable year beginning with the second consecutive January 1 as of the beginning of which there is a balance of such advances, by 10 percent of the tax imposed by section 3301 with respect to the wages paid by such taxpayer during such taxable year which are attributable to such State; and

Ames, pp. 978, 979.

"(ii) in the case of any succeeding taxable year beginning with a consecutive January 1 as of the beginning of which there is a balance of such advances, by an additional 10 percent, for each such succeeding taxable year, of the tax imposed by section 3301 with respect to the wages paid by such taxpayer during such taxable year which are attributable to such State;

Ante, p. 950.

"(B) in the case of a taxable year beginning with the third or fourth consecutive January 1 as of the beginning of which there is a balance of such advances, by the amount determined by multiplying the wages paid by such taxpayer during such taxable year which are attributable to such State by the percentage (if any) by which—

"(i) 2.7 percent, exceeds

"(ii) the average employer contribution rate for such State for the calendar year preceding such taxable year; and

"(C) in the case of a taxable year beginning with the fifth or any succeeding consecutive January 1 as of the beginning of which there is a balance of such advances, by the amount determined by multiplying the wages paid by such taxpayer during such taxable year which are attributable to such State by the percentage (if any) by which—

"(i) the 5-year benefit cost rate applicable to such State for such taxable year or (if higher) 2.7 percent, exceeds

"(ii) the average employer contribution rate for such State for the calendar year preceding such taxable year.

"(d) DEFINITIONS AND SPECIAL RULES RELATING TO SUBSECTION (c).—

"(1) RATE OF TAX DEEMED TO BE 3 PERCENT.—In applying subsection (c), the tax imposed by section 3301 shall be computed at the rate of 3 percent in lieu of 3.1 percent.

"(2) WAGES ATTRIBUTABLE TO A PARTICULAR STATE.—For purposes of subsection (c), wages shall be attributable to a particular State if they are subject to the unemployment compensation law of the State, or (if not subject to the unemployment compensation law of any State) if they are determined (under rules or regulations prescribed by the Secretary or his delegate) to be attributable to such State.

"(3) ADDITIONAL TAXES INAPPLICABLE WHERE ADVANCES ARE REPAYED BEFORE NOVEMBER 10 OF TAXABLE YEAR.—Paragraph (2) or (3) of subsection (c) shall not apply with respect to any State for the taxable year if (as of the beginning of November 10 of such year) there is no balance of advances referred to in such paragraph.

"(4) AVERAGE EMPLOYER CONTRIBUTION RATE.—For purposes of subparagraphs (B) and (C) of subsection (c)(3), the average employer contribution rate for any State for any calendar year is that percentage obtained by dividing—

"(A) the total of the contributions paid into the State unemployment fund with respect to such calendar year, by

"(B) the total of the remuneration subject to contributions under the State unemployment compensation law with respect to such calendar year.

For purposes of subparagraph (C) of subsection (c)(3), if the average employer contribution rate for any State for any calendar year (determined without regard to this sentence) equals or exceeds 2.7 percent, such rate shall be determined by increas-

ing the amount taken into account under subparagraph (A) of the preceding sentence by the aggregate amount of employee payments (if any) into the unemployment fund of such State with respect to such calendar year which are to be used solely in the payment of unemployment compensation.

"(5) 5-YEAR BENEFIT COST RATE.—For purposes of subparagraph (C) of subsection (c) (3), the 5-year benefit cost rate applicable to any State for any taxable year is that percentage obtained by dividing—

"(A) one-fifth of the total of the compensation paid under the State unemployment compensation law during the 5-year period ending at the close of the second calendar year preceding such taxable year, by

"(B) the total of the remuneration subject to contributions under the State unemployment compensation law with respect to the first calendar year preceding such taxable year.

"(6) ROUNDING.—If any percentage referred to in either subparagraph (B) or (C) of subsection (c) (3) is not a multiple of .1 percent, it shall be rounded to the nearest multiple of .1 percent.

"(7) DETERMINATION AND CERTIFICATION OF PERCENTAGES.—The percentage referred to in subsection (c) (3) (B) or (C) for any taxable year for any State having a balance referred to therein shall be determined by the Secretary of Labor, and shall be certified by him to the Secretary of the Treasury before June 1 of such year, on the basis of a report furnished by such State to the Secretary of Labor before May 1 of such year. Any such State report shall be made as of the close of March 31 of the taxable year, and shall be made on such forms, and shall contain such information, as the Secretary of Labor deems necessary to the performance of his duties under this section.

"(8) CROSS REFERENCE.—

"For reduction of total credits allowable under subsection (c), see section 104 of the Temporary Unemployment Compensation Act of 1958."

Effective Date

(c) The amendments made by subsection (a) shall apply only with respect to the calendar year 1961 and calendar years thereafter.

CONFORMING AMENDMENTS

42 USC 801. SEC. 524. (a) Section 801 of the Social Security Act is amended to read as follows:

"APPROPRIATIONS

Amo. p. 971. "SEC. 801. The amounts made available pursuant to section 901(c) (1)(A) for the purpose of assisting the States in the administration of their unemployment compensation laws shall be used as hereinafter provided."

42 USC 1490c. (b) Section 104 of the Temporary Unemployment Compensation Act of 1958, as amended, is amended—

(1) by striking out subsection (b); and

(2) by amending subsection (a) by striking out the heading and "(a)", and by striking out "by December 1" and inserting in lieu thereof "before November 10".

**PART 3—EXTENSION OF COVERAGE UNDER UNEMPLOYMENT
COMPENSATION PROGRAM**

FEDERAL INSTRUMENTALITIES

SEC. 531. (a) Section 3305(b) of the Internal Revenue Code of 1954 is amended to read as follows: 26 USC 3305.

“(b) **FEDERAL INSTRUMENTALITIES IN GENERAL.**—The legislature of any State may require any instrumentality of the United States (other than an instrumentality to which section 3306(c) (6) applies), and the individuals in its employ, to make contributions to an unemployment fund under a State unemployment compensation law approved by the Secretary of Labor under section 3304 and (except as provided in section 5240 of the Revised Statutes, as amended (12 U.S.C., sec. 484), and as modified by subsection (c)), to comply otherwise with such law. The permission granted in this subsection shall apply (A) only to the extent that no discrimination is made against such instrumentality, so that if the rate of contribution is uniform upon all other persons subject to such law on account of having individuals in their employ, and upon all employees of such persons, respectively, the contributions required of such instrumentality or the individuals in its employ shall not be at a greater rate than is required of such other persons and such employees, and if the rates are determined separately for different persons or classes of persons having individuals in their employ or for different classes of employees, the determination shall be based solely upon unemployment experience and other factors bearing a direct relation to unemployment risk; (B) only if such State law makes provision for the refund of any contributions required under such law from an instrumentality of the United States or its employees for any year in the event such State is not certified by the Secretary of Labor under section 3304 with respect to such year; and (C) only if such State law makes provision for the payment of unemployment compensation to any employee of any such instrumentality of the United States in the same amount, on the same terms, and subject to the same conditions as unemployment compensation is payable to employees of other employers under the State unemployment compensation law.”

Idra.

Post, p. 986.

(b) The third sentence of section 3305(g) of such Code is amended by striking out “not wholly” and inserting in lieu thereof “neither wholly nor partially”.

(c) Section 3306(c) (6) of such Code is amended to read as follows:

26 USC 3306.

“(6) service performed in the employ of the United States Government or of an instrumentality of the United States which is—

“(A) wholly or partially owned by the United States, or

“(B) exempt from the tax imposed by section 3301 by virtue of any provision of law which specifically refers to such section (or the corresponding section of prior law) in granting such exemption;”.

Ante, p. 980.

(d) (1) Chapter 23 of such Code is amended by renumbering section 3308 as section 3309 and by inserting after section 3307 the following new section:

26 USC 3308,
3309, 3307.

“SEC. 532. INSTRUMENTALITIES OF THE UNITED STATES.

“Notwithstanding any other provision of law (whether enacted before or after the enactment of this section) which grants to any instrumentality of the United States an exemption from taxation, such instrumentality shall not be exempt from the tax imposed by section 3301 unless such other provision of law grants a specific exemption, by reference to section 3301 (or the corresponding section of prior law), from the tax imposed by such section.”

(2) The table of sections for such chapter is amended by striking out the last line and inserting in lieu thereof the following:

"Sec. 230R. Instrumentalities of the United States.
"Sec. 230U. Short title."

43 USC 1361. (e) So much of the first sentence of section 1501(a) of the Social Security Act as precedes paragraph (1) is amended by striking out "wholly" and inserting in lieu thereof "wholly or partially".

43 USC 1367. (f) The first sentence of section 1507(a) of the Social Security Act is amended by striking out "wholly" and inserting in lieu thereof "wholly or partially".

73 Stat. 390.
12 USC 646f
note.
Amo. p. 983.

(g) Notwithstanding section 203(b) of the Farm Credit Act of 1959, sections 3305(b), 3306(c)(6), and 3308 of the Internal Revenue Code of 1954 and sections 1501(a) and 1507(a) of the Social Security Act shall be applicable, according to their terms, to the Federal land banks, Federal intermediate credit banks, and banks for cooperatives.

AMERICAN AIRCRAFT

36 USC 3306. SEC. 532. (a) So much of section 3306(c) of the Internal Revenue Code of 1954 as precedes paragraph (1) thereof is amended by striking out "or (B) on or in connection with an American vessel" and all that follows down through the phrase "outside the United States," and by inserting in lieu thereof the following: "or (B) on or in connection with an American vessel or American aircraft under a contract of service which is entered into within the United States or during the performance of which and while the employee is employed on the vessel or aircraft it touches at a port in the United States, if the employee is employed on and in connection with such vessel or aircraft when outside the United States,".

(b) Section 3306(c)(4) of such Code is amended to read as follows:

"(4) service performed on or in connection with a vessel or aircraft not an American vessel or American aircraft, if the employee is employed on and in connection with such vessel or aircraft when outside the United States;"

(c) Section 3306(m) of such Code is amended—

(1) by striking out the heading and inserting in lieu thereof the following:

"(m) AMERICAN VESSEL AND AIRCRAFT.—"; and

(2) by striking out the period at the end thereof and inserting in lieu thereof a semicolon and the following: "and the term 'American aircraft' means an aircraft registered under the laws of the United States."

FEEDER ORGANIZATIONS, ETC.

SEC. 533. Section 3306(c)(8) of the Internal Revenue Code of 1954 is amended to read as follows:

36 USC 501. "(8) service performed in the employ of a religious, charitable, educational, or other organization described in section 501(c)(3) which is exempt from income tax under section 501(a);".

FRATERNAL BENEFICIARY SOCIETIES, AGRICULTURAL ORGANIZATIONS, VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATIONS, ETC.

SEC. 534. Section 3306(c)(10) of the Internal Revenue Code of 1954 is amended to read as follows:

"(10)(A) service performed in any calendar quarter in the employ of any organization exempt from income tax under section 501(a) (other than an organization described in section

401(a)) or under section 521, if the remuneration for such service is less than \$50, or

26 USC 401, 521.

“(B) service performed in the employ of a school, college, or university, if such service is performed by a student who is enrolled and is regularly attending classes at such school, college, or university;”.

EFFECTIVE DATE

SEC. 535. The amendments made by this part (other than the amendments made by subsections (e) and (f) of section 531) shall apply with respect to remuneration paid after 1961 for services performed after 1961. The amendments made by subsections (e) and (f) of section 531 shall apply with respect to any week of unemployment which begins after December 31, 1960.

PART 4—EXTENSION OF FEDERAL-STATE UNEMPLOYMENT COMPENSATION PROGRAM TO PUERTO RICO

EXTENSION OF TITLES III, IX, AND XII OF THE SOCIAL SECURITY ACT

SEC. 541. Effective on and after January 1, 1961, paragraphs (1) and (2) of section 1101(a) of the Social Security Act are amended to read as follows:

42 USC 1301.

“(1) The term ‘State’, except where otherwise provided, includes the District of Columbia and the Commonwealth of Puerto Rico, and when used in titles I, IV, V, VII, X, and XIV includes the Virgin Islands and Guam.

Post, p. 987.
42 USC 301, 601,
701, 902, 1201,
1351.

“(2) The term ‘United States’ when used in a geographical sense means, except where otherwise provided, the States, the District of Columbia, and the Commonwealth of Puerto Rico.”

FEDERAL EMPLOYEES AND EX-SERVICEMEN

SEC. 542. (a) (1) Effective with respect to weeks of unemployment beginning after December 31, 1965, section 1503(b) of such Act is amended by striking out “Puerto Rico or”.

42 USC 1363.

(2) Effective with respect to first claims filed after December 31, 1965, paragraph (3) of section 1504 of such Act is amended by striking out “Puerto Rico or” wherever appearing therein.

42 USC 1364.

(b) (1) Effective on and after January 1, 1961 (but only in the case of weeks of unemployment beginning before January 1, 1966)—

42 USC 1362.

(A) Section 1502(b) of such Act is amended by striking out “(b) Any” and inserting in lieu thereof “(b) (1) Except as provided in paragraph (2), any”, and by adding at the end thereof the following new paragraph:

“(2) In the case of the Commonwealth of Puerto Rico, the agreement shall provide that compensation will be paid by the Commonwealth of Puerto Rico to any Federal employee whose Federal service and Federal wages are assigned under section 1504 to such Commonwealth, with respect to unemployment after December 31, 1960 (but only in the case of weeks of unemployment beginning before January 1, 1966), in the same amount, on the same terms, and subject to the same conditions as the compensation which would be payable to such employee under the unemployment compensation law of the District of Columbia if such employee's Federal service and Federal wages had been included as employment and wages under such law, except that if such employee, without regard to his Federal service and Federal wages, has employment or wages sufficient to qualify for any compensation during the benefit year under such law, then payments of compensation under this subsection shall be made only on the basis

Amo. p. 963.

of his Federal service and Federal wages. In applying this paragraph or subsection (b) of section 1503, as the case may be, employment and wages under the unemployment compensation law of the Commonwealth of Puerto Rico shall not be combined with Federal service or Federal wages."

(B) Section 1503(a) of such Act is amended by adding at the end thereof the following: "For the purposes of this subsection, the term 'State' does not include the Commonwealth of Puerto Rico."

(C) Section 1503(b) of such Act is amended by adding at the end thereof the following: "This subsection shall apply in respect of the Commonwealth of Puerto Rico only if such Commonwealth does not have an agreement under this title with the Secretary."

(2) Effective on and after January 1, 1961 (but only in the case of first claims filed before January 1, 1966), section 1504 of such Act is amended by adding after and below paragraph (3) the following: "For the purposes of paragraph (2), the term 'United States' does not include the Commonwealth of Puerto Rico."

(c) Effective on and after January 1, 1961—

(1) section 1503(d) of such Act is amended by striking out "Puerto Rico and", and by striking out "agencies" each place it appears and inserting in lieu thereof "agency"; and

(2) section 1511(e) of such Act is amended by striking out "Puerto Rico or".

43 USC 1371.

Amo. p. 964.

(d) The last sentence of section 1501(a) of such Act is amended to read as follows:

"For the purpose of paragraph (5) of this subsection, the term 'United States' when used in the geographical sense means the States, the District of Columbia, the Commonwealth of Puerto Rico, and the Virgin Islands."

EXTENSION OF FEDERAL UNEMPLOYMENT TAX ACT

26 USC 3304.

SEC. 543. (a) Effective with respect to remuneration paid after December 31, 1960, for services performed after such date, section 8306(j) of the Internal Revenue Code of 1954 is amended to read as follows:

"(j) STATE, UNITED STATES, AND CITIZEN.—For purposes of this chapter—

"(1) STATE.—The term 'State' includes the District of Columbia and the Commonwealth of Puerto Rico.

"(2) UNITED STATES.—The term 'United States' when used in a geographical sense includes the States, the District of Columbia, and the Commonwealth of Puerto Rico.

An individual who is a citizen of the Commonwealth of Puerto Rico (but not otherwise a citizen of the United States) shall be considered for purposes of this section, as a citizen of the United States."

(b) The unemployment compensation law of the Commonwealth of Puerto Rico shall be considered as meeting the requirements of—

26 USC 3304.

(1) Section 8304(a)(2) of the Federal Unemployment Tax Act, if such law provides that no compensation is payable with respect to any day of unemployment occurring before January 1, 1959.

43 USC 963.

(2) Section 8304(a)(3) of the Federal Unemployment Tax Act and section 803(a)(4) of the Social Security Act, if such law contains the provisions required by those sections and if it requires that, on or before February 1, 1961, there be paid over to the Secretary of the Treasury, for credit to the Puerto Rico

account in the Unemployment Trust Fund, an amount equal to the excess of—

- (A) the aggregate of the moneys received in the Puerto Rico unemployment fund before January 1, 1961, over
- (B) the aggregate of the moneys paid from such fund before January 1, 1961, as unemployment compensation or as refunds of contributions erroneously paid.
- (c) Effective on and after January 1, 1961, section 5(b) of the Act of June 6, 1933, as amended (29 U.S.C., sec. 49d(b)), is amended by striking out "Puerto Rico, Guam," and inserting in lieu thereof "Guam".

48 Stat. 114.

TITLE VI—MEDICAL SERVICES FOR THE AGED

AMENDMENTS TO TITLE I OF THE SOCIAL SECURITY ACT

SEC. 601. (a) The heading of title I of the Social Security Act is amended to read as follows:

"TITLE I—GRANTS TO STATES FOR OLD-AGE ASSISTANCE AND MEDICAL ASSISTANCE FOR THE AGED"

(b) Sections 1 and 2 of such Act are amended to read as follows: ⁴² USC 301, 302.

"APPROPRIATION

"SECTION 1. For the purpose (a) of enabling each State as far as practicable under the conditions in such State, to furnish financial assistance to aged needy individuals and of encouraging each State, as far as practicable under such conditions, to help such individuals attain self-care, and (b) of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance on behalf of aged individuals who are not recipients of old-age assistance but whose income and resources are insufficient to meet the costs of necessary medical services, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare (hereinafter referred to as the 'Secretary'), State plans for old-age assistance, or for medical assistance for the aged, or for old-age assistance and medical assistance for the aged.

"STATE OLD-AGE AND MEDICAL ASSISTANCE PLANS

"SEC. 2. (a) A State plan for old-age assistance, or for medical assistance for the aged, or for old-age assistance and medical assistance for the aged must—

"(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

"(2) provide for financial participation by the State;

"(3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan;

"(4) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for assistance under the plan is denied or is not acted upon with reasonable promptness;

"(5) provide such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

"(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

"(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the State plan;

"(8) provide that all individuals wishing to make application for assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

"(9) provide, if the plan includes assistance for or on behalf of individuals in private or public institutions, for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions;

"(10) if the State plan includes old-age assistance—

"(A) provide that the State agency shall, in determining need for such assistance, take into consideration any other income and resources of an individual claiming old-age assistance;

"(B) include reasonable standards, consistent with the objectives of this title, for determining eligibility for and the extent of such assistance; and

"(C) provide a description of the services (if any) which the State agency makes available to applicants for and recipients of such assistance to help them attain self-care, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services; and

"(11) if the State plan includes medical assistance for the aged—

"(A) provide for inclusion of some institutional and some noninstitutional care and services;

"(B) provide that no enrollment fee, premium, or similar charge will be imposed as a condition of any individual's eligibility for medical assistance for the aged under the plan;

"(C) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of such assistance to individuals who are residents of the State but are absent therefrom;

"(D) include reasonable standards, consistent with the objectives of this title, for determining eligibility for and the extent of such assistance; and

"(E) provide that no lien may be imposed against the property of any individual prior to his death on account of medical assistance for the aged paid or to be paid on his behalf under the plan (except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual), and that there shall be no adjustment or recovery (except, after the death of such individual and his surviving spouse, if any, from such individual's estate) of any medical assistance for the aged correctly paid on behalf of such individual under the plan.

"(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes, as a condition of eligibility for assistance under the plan—

"(1) an age requirement of more than sixty-five years; or

"(2) any residence requirement which (A) in the case of applicants for old-age assistance, excludes any resident of the State who has resided therein five years during the nine years immediately preceding the application for old-age assistance and has resided therein continuously for one year immediately preceding the application, and (B) in the case of applicants for medical assistance for the aged, excludes any individual who resides in the State; or

"(3) any citizenship requirement which excludes any citizen of the United States.

"(c) Nothing in this title shall be construed to permit a State to have in effect with respect to any period more than one State plan approved under this title."

(c) Section 8(a) of such Act is amended to read as follows:

42 USC 903.

"SEC. 8. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing October 1, 1960—

"(1) in the case of any State other than Puerto Rico, the Virgin Islands, and Guam, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as old-age assistance under the State plan (including expenditures for insurance premiums for medical or any other type of remedial care or the cost thereof)—

"(A) four-fifths of such expenditures, not counting so much of any expenditure with respect to any month as exceeds the product of \$30 multiplied by the total number of recipients of old-age assistance for such month (which total number, for purposes of this subsection, means (i) the number of individuals who received old-age assistance in the form of money payments for such month, plus (ii) the number of other individuals with respect to whom expenditures were made in such month as old-age assistance in the form of medical or any other type of remedial care); plus

"(B) the Federal percentage (as defined in section 1101(a)(8)) of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditure with respect to any month as exceeds the product of \$65 multiplied by the total number of such recipients of old-age assistance for such month; plus

Post. p. 992.

"(C) the larger of the following: (i) the Federal medical percentage (as defined in section 6(c)) of the amount by which such expenditures exceed the maximum which may be counted under clause (B), not counting so much of any expenditure with respect to any month as exceeds (I) the product of \$77 multiplied by the total number of such recipients of old-age assistance for such month, or (II) if smaller, the total expended as old-age assistance in the form of medical or any other type of remedial care with respect to such month plus the product of \$65 multiplied by such total number of such recipients, or (ii) 15 per centum of the total of the sums expended during such quarter as old-age assistance under the State plan in the form of medical or any other type of remedial care, not counting so much of any expenditure with respect to any month as exceeds the product of \$12 multiplied by the total number of such recipients of old-age assistance for such month; and

"(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to—

"(A) one-half of the total of the sums expended during such quarter as old-age assistance under the State plan (including expenditures for insurance premiums for medical or any other type of remedial care or the cost thereof), not counting so much of any expenditure with respect to any month as exceeds \$35 multiplied by the total number of recipients of old-age assistance for such month; plus

"(B) the larger of the following amounts: (i) one-half of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditure with respect to any month as exceeds (I) the product of \$41 multiplied by the total number of such recipients of old-age assistance for such month, or (II) if smaller, the total expended as old-age assistance in the form of medical or any other type of remedial care with respect to such month plus the product of \$35 multiplied by the total number of such recipients, or (ii) 15 per centum of the total of the sums expended during such quarter as old-age assistance under the State plan in the form of medical or any other type of remedial care, not counting so much of any expenditure with respect to any month as exceeds the product of \$6 multiplied by the total number of such recipients of old-age assistance for such month; and

"(8) in the case of any State, an amount equal to the Federal medical percentage (as defined in section 6(c)) of the total amounts expended during such quarter as medical assistance for the aged under the State plan (including expenditures for insurance premiums for medical or any other type of remedial care or the cost thereof); and

"(4) in the case of any State, an amount equal to one-half of the total of the sums expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan, including services which are provided by the staff of the State agency (or of the local agency administering the State plan in the political subdivision) to applicants for and recipients of old-age assistance to help them attain self-care."

43 USC 991.

(d) Section 8(b)(2)(B) of such Act is amended by striking out "old-age assistance" and inserting in lieu thereof "assistance".

(e) Section 4 of such Act is amended by striking out "State plan for old-age assistance which has been approved" and inserting in lieu thereof "State plan which has been approved under this title".

42 USC 304.

(f) (1) Section 6 of such Act is amended by striking out "but does not include" and all that follows and inserting in lieu thereof "but does not include—

42 USC 306.

"(1) any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases, or

"(2) any such payments to any individual who has been diagnosed as having tuberculosis or psychosis and is a patient in a medical institution as a result thereof, or

"(3) any such care in behalf of any individual, who is a patient in a medical institution as a result of a diagnosis that he has tuberculosis or psychosis, with respect to any period after the individual has been a patient in such an institution, as a result of such diagnosis, for forty-two days."

(2) Section 6 is further amended by inserting "(a)" immediately after "SEC. 6." and by adding after such section 6 the following new subsections:

"(b) For purposes of this title, the term 'medical assistance for the aged' means payment of part or all of the cost of the following care and services for individuals sixty-five years of age or older who are not recipients of old-age assistance but whose income and resources are insufficient to meet all of such cost—

"(1) inpatient hospital services;

"(2) skilled nursing-home services;

"(3) physicians' services;

"(4) outpatient hospital or clinic services;

"(5) home health care services;

"(6) private duty nursing services;

"(7) physical therapy and related services;

"(8) dental services;

"(9) laboratory and X-ray services;

"(10) prescribed drugs, eyeglasses, dentures, and prosthetic devices;

"(11) diagnostic, screening, and preventive services; and

"(12) any other medical care or remedial care recognized under State law;

except that such term does not include any such payments with respect to—

"(A) care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases; or

"(B) care or services for any individual, who is a patient in a medical institution as a result of a diagnosis of tuberculosis or psychosis, with respect to any period after the individual has been a patient in such an institution, as a result of such diagnosis, for forty-two days.

"(c) For purposes of this title, the term 'Federal medical percentage' for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 80 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (i) the Federal medical percentage shall in no case be less than 50 per centum or more than 80 per centum, and (ii) the Federal medical per-

Amo.

centage for Puerto Rico, the Virgin Islands, and Guam shall be 50 per centum. The Federal medical percentage for any State shall be determined and promulgated in accordance with the provisions of subparagraph (B) of section 1101(a)(8) (other than the proviso at the end thereof); except that the Secretary shall, as soon as possible after enactment of the Social Security Amendments of 1960, determine and promulgate the Federal medical percentage for each State—

“(1) for the period beginning October 1, 1960, and ending with the close of June 30, 1961, which promulgation shall be based on the same data with respect to per capita income as the data used by the Secretary in promulgating the Federal percentage (under section 1101(a)(8)) for such State for the fiscal year ending June 30, 1961 (which promulgation of the Federal medical percentage shall be conclusive for such period), and

“(2) for the period beginning July 1, 1961, and ending with the close of June 30, 1963, which promulgation shall be based on the same data with respect to per capita income as the data used by the Secretary in promulgating the Federal percentage (under section 1101(a)(8)) for such State for such period (which promulgation of the Federal medical percentage shall be conclusive for such period).”

INCREASE IN LIMITATIONS ON ASSISTANCE PAYMENT TO PUERTO RICO, THE VIRGIN ISLANDS, AND GUAM

42 USC 1305.

SEC. 602. Section 1108 of the Social Security Act is amended by—

Amo. p. 909.

(1) striking out “\$8,500,000” and inserting in lieu thereof “\$9,000,000, of which \$500,000 may be used only for payments certified with respect to section 3(a)(2)(B)”;

(2) striking out “\$300,000” and inserting in lieu thereof “\$315,000, of which \$15,000 may be used only for payments certified in respect to section 3(a)(2)(B)”;

(3) striking out “\$400,000” and inserting in lieu thereof “\$420,000, of which \$20,000 may be used only for payments certified in respect to section 3(a)(2)(B)”;

(4) striking out “titles I, IV, X, and XIV”, and inserting in lieu thereof “titles I (other than section 3(a)(3) thereof), IV, X, and XIV”.

TECHNICAL AMENDMENT

SEC. 603. (a) Section 618 of the Revenue Act of 1951 (65 Stat. 569) is amended by striking out “title I” and inserting in lieu thereof “title I (other than section 3(a)(3) thereof)”.

(b) The amendment made by subsection (a) shall take effect October 1, 1960.

EFFECTIVE DATES

SEC. 604. The amendments made by section 601 of this Act shall take effect October 1, 1960, and the amendments made by section 602 shall be effective with respect to fiscal years ending after 1960.

TITLE VII—MISCELLANEOUS

INVESTMENT OF TRUST FUNDS

42 USC 401.

SEC. 701. (a) Section 201(c) of the Social Security Act is amended by inserting after the third sentence the following new sentence: “The Board of Trustees shall meet not less frequently than once each six months.”

(b) Section 201(c)(3) of such Act is amended to read as follows:

“(3) Report immediately to the Congress whenever the Board of Trustees is of the opinion that the amount of either of the Trust Funds is unduly small;”

(c) Section 201(c) of such Act is further amended by striking out the period at the end of paragraph (4) and inserting in lieu thereof “; and”, and by inserting after paragraph (4) the following new paragraph:

“(5) Review the general policies followed in managing the Trust Funds, and recommend changes in such policies, including necessary changes in the provisions of the law which govern the way in which the Trust Funds are to be managed.”

(d) Section 201(d) of such Act is amended to read as follows:

42 USC 401.

“(d) It shall be the duty of the Managing Trustee to invest such portion of the Trust Funds as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under the Second Liberty Bond Act, as amended, are hereby extended to authorize the issuance at par of public-debt obligation for purchase by the Trust Funds. Such obligations issued for purchase by the Trust Funds shall have maturities fixed with due regard for the needs of the Trust Funds and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of four years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest of such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.”

40 Stat. 288.
31 USC 774.

(e) Section 201(e) of such Act is amended by striking out “special obligations” each place it appears and inserting in lieu thereof “public-debt obligations”.

42 USC 401.

(f) The amendments made by this section shall take effect on the first day of the first month beginning after the date of the enactment of this Act.

SURVIVAL OF ACTIONS

SEC. 702. (a) Section 205(g) of the Social Security Act is amended by adding at the end thereof the following new sentence: “Any action instituted in accordance with this subsection shall survive notwithstanding any change in the person occupying the office of Secretary or any vacancy in such office.”

42 USC 405.

(b) The amendment made by subsection (a) shall apply to actions which are pending in court on the date of the enactment of this Act or are commenced after such date.

PERIODS OF LIMITATION ENDING ON NONWORK DAYS

Amo. p. 961.

SEC. 703. Section 216 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"Periods of Limitation Ending on Nonwork Days

"(j) Where this title, any provision of another law of the United States (other than the Internal Revenue Code of 1954) relating to or changing the effect of this title, or any regulation issued by the Secretary pursuant thereto provides for a period within which an act is required to be done which affects eligibility for or the amount of any benefit or payment under this title or is necessary to establish or protect any rights under this title, and such period ends on a Saturday, Sunday, or legal holiday, or on any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive order, then such act shall be considered as done within such period if it is done on the first day thereafter which is not a Saturday, Sunday, or legal holiday or any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive order. For purposes of this subsection, the day on which a period ends shall include the day on which an extension of such period, as authorized by law or by the Secretary pursuant to law, ends. The provisions of this subsection shall not extend the period during which benefits under this title may (pursuant to section 202(j)(1) or 223(b)) be paid for months prior to the day application for such benefits is filed, or during which an application for benefits under this title may (pursuant to section 202(j)(2) or 223(b)) be accepted as such."

ADVISORY COUNCIL ON SOCIAL SECURITY FINANCING

42 USC 401a.

SEC. 704. (a) Section 116(e) of the Social Security Amendments of 1956 is amended to read as follows:

"(e) During 1963, 1966, and every fifth year thereafter, the Secretary shall appoint an Advisory Council on Social Security Financing, with the same functions, and constituted in the same manner, as prescribed in the preceding subsections of this section. Each such Council shall report its findings and recommendations, as prescribed in subsection (d), not later than January 1 of the second year after the year in which it is appointed, after which date such Council shall cease to exist, and such report and recommendations shall be included in the annual report of the Board of Trustees to be submitted to the Congress not later than the March 1 following such January 1."

(b) Section 116 of the Social Security Amendments of 1956 is further amended by adding at the end thereof the following new subsection:

"(f) The Advisory Council appointed under subsection (e) during 1963 shall, in addition to the other findings and recommendations it is required to make, include in its report its findings and recommendations with respect to extensions of the coverage of the old-age, survivors, and disability insurance program, the adequacy of benefits under the program, and all other aspects of the program."

MEDICAL CARE GUIDES AND REPORTS FOR PUBLIC ASSISTANCE AND MEDICAL ASSISTANCE FOR THE AGED

SEC. 705. Title XI of the Social Security Act is amended by adding ^{42 USC 1301-} 1313. at the end thereof the following new section:

"MEDICAL CARE GUIDES AND REPORTS FOR PUBLIC ASSISTANCE AND MEDICAL ASSISTANCE FOR THE AGED

"SEC. 1112. In order to assist the States to extend the scope and content, and improve the quality, of medical care and medical services for which payments are made to or on behalf of needy and low-income individuals under this Act and in order to promote better public understanding about medical care and medical assistance for needy and low-income individuals, the Secretary shall develop and revise from time to time guides or recommended standards as to the level, content, and quality of medical care and medical services for the use of the States in evaluating and improving their public assistance medical care programs and their programs of medical assistance for the aged; shall secure periodic reports from the States on items included in, and the quantity of, medical care and medical services for which expenditures under such programs are made; and shall from time to time publish data secured from these reports and other information necessary to carry out the purposes of this section."

TEMPORARY EXTENSION OF CERTAIN SPECIAL PROVISIONS RELATING TO STATE PLANS FOR AID TO THE BLIND

SEC. 706. Section 344(b) of the Social Security Act Amendments ^{42 USC 1302a} of 1950 is amended by striking out "June 30, 1961" and inserting in lieu thereof "June 30, 1964".

MATERNAL AND CHILD WELFARE

SEC. 707. (a)(1)(A) Section 501 of the Social Security Act is amended by striking out "for each fiscal year beginning after June 30, 1958, the sum of \$21,500,000" and inserting in lieu thereof "for each fiscal year beginning after June 30, 1960, the sum of \$25,000,000". ^{42 USC 701.}

(B) Section 502(a)(2) of such Act is amended by striking out "for each fiscal year beginning after June 30, 1958, the Secretary shall allot \$10,750,000 as follows: He shall allot to each State \$60,000 (even though the amount appropriated for such year is less than \$21,500,000), and shall allot each State such part of the remainder of the \$10,750,000" and inserting in lieu thereof "for each fiscal year beginning after June 30, 1960, the Secretary shall allot \$12,500,000 as follows: He shall allot to each State \$70,000 (even though the amount appropriated for such year is less than \$25,000,000), and shall allot each State such part of the remainder of the \$12,500,000". ^{42 USC 702.}

(C) The first sentence of section 502(b) of such Act is amended by striking out "for each fiscal year beginning after June 30, 1958, the sum of \$10,750,000" and inserting in lieu thereof "for each fiscal year beginning after June 30, 1960, the sum of \$12,500,000".

(2)(A) Section 511 of such Act is amended by striking out "for each fiscal year beginning after June 30, 1958, the sum of \$20,000,000" and inserting in lieu thereof "for each fiscal year beginning after June 30, 1960, the sum of \$25,000,000". ^{42 USC 711.}

42 USC 712.

(B) Section 512(a)(2) of such Act is amended by striking out "for each fiscal year beginning after June 30, 1958, the Secretary shall allot \$10,000,000 as follows: He shall allot to each State \$60,000 (even though the amount appropriated for such year is less than \$20,000,000) and shall allot the remainder of the \$10,000,000" and inserting in lieu thereof "for each fiscal year beginning after June 30, 1960, the Secretary shall allot \$12,500,000 as follows: He shall allot to each State \$70,000 (even though the amount appropriated for such year is less than \$25,000,000) and shall allot the remainder of the \$12,500,000".

42 USC 721.

(C) The first sentence of section 512(b) of such Act is amended by striking out "for each fiscal year beginning after June 30, 1958, the sum of \$10,000,000" and inserting in lieu thereof "for each fiscal year beginning after June 30, 1960, the sum of \$12,500,000".

(8)(A) Section 521 of such Act is amended by striking out "for each fiscal year, beginning with the fiscal year ending June 30, 1959, the sum of \$17,000,000" and inserting in lieu thereof "for each fiscal year, beginning with the fiscal year ending June 30, 1961, the sum of \$25,000,000".

42 USC 722.

(B) Section 522(a) such Act is amended by striking out "such portion of \$60,000" and inserting in lieu thereof "\$50,000 or, if greater, such portion of \$70,000".

42 USC 762.

(b)(1)(A) The second sentence of section 502(b) of such Act is amended by inserting "from time to time" after "shall be allotted", and by inserting before the period at the end thereof the following: "; except that not more than 25 per centum of such sums shall be available for grants to State health agencies (administering or supervising the administration of a State plan approved under section 503), and to public or other nonprofit institutions of higher learning (situated in any State), for special projects of regional or national significance which may contribute to the advancement of maternal and child health".

42 USC 763.

42 USC 764.

(B) Section 504(c) of such Act is amended by adding at the end thereof the following new sentence: "Payments of grants for special projects under section 502(b) may be made in advance or by way of reimbursement, and in such installments, as the Secretary may determine; and shall be made on such conditions as the Secretary finds necessary to carry out the purposes of the grants."

42 USC 712.

(2)(A) The second sentence of section 512(b) of such Act is amended by inserting "from time to time" after "shall be allotted", and by inserting before the period at the end thereof the following: "; except that not more than 25 per centum of such sums shall be available for grants to State agencies (administering or supervising the administration of a State plan approved under section 513), and to public or other nonprofit institutions of higher learning (situated in any State), for special projects of regional or national significance which may contribute to the advancement of services for crippled children".

42 USC 714.

(B) Section 514(c) of such Act is amended by adding at the end thereof the following new sentence: "Payments of grants for special projects under section 512(b) may be made in advance or by way of reimbursement, and in such installments, as the Secretary may determine; and shall be made on such conditions as the Secretary finds necessary to carry out the purposes of the grants."

(3) Part 3 of title V of such Act is amended by inserting at the end thereof the following new section:

"RESEARCH OR DEMONSTRATION PROJECTS

"Sec. 526. (a) There are hereby authorized to be appropriated for each fiscal year such sums as the Congress may determine for grants by the Secretary to public or other nonprofit institutions of higher learning, and to public or other nonprofit agencies and organizations engaged in research or child welfare activities, for special research or demonstration projects in the field of child welfare which are of regional or national significance and for special projects for the demonstration of new methods or facilities which show promise of substantial contribution to the advancement of child welfare.

"(b) Payments of grants for special projects under this section may be made in advance or by way of reimbursement, and in such installments, as the Secretary may determine; and shall be made on such conditions as the Secretary finds necessary to carry out the purposes of the grants."

(c) The amendments made by this section shall be effective only with respect to fiscal years beginning after June 30, 1960.

AMENDMENT PRESERVING RELATIONSHIP BETWEEN RAILROAD RETIREMENT AND OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE

SEC. 708. Section 1(q) of the Railroad Retirement Act of 1937 is amended by striking out "1958" and inserting in lieu thereof "1960".

45 USC 228a.

MEANING OF TERM "SECRETARY"

SEC. 709. As used in this Act and the provisions of the Social Security Act amended by this Act the term "Secretary", unless the context otherwise requires, means the Secretary of Health, Education, and Welfare.

AID TO THE BLIND

SEC. 710. (a) Effective for the period beginning with the first day of the calendar quarter which begins after the date of enactment of this Act, and ending with the close of June 30, 1962, clause (8) of section 1002(a) of the Social Security Act is amended to read as follows: "(8) provide that the State agency shall, in determining need, take into consideration any other income and resources of the individual claiming aid to the blind; except that, in making such determination, the State agency shall disregard either (i) the first \$50 per month of earned income, or (ii) the first \$85 per month of earned income plus one-half of earned income in excess of \$85 per month;".

42 USC 1302.

(b) Effective July 1, 1962, clause (8) of such section 1002(a) is amended to read as follows: "(8) provide that the State agency shall, in determining need, take into consideration any other income and resources of the individual claiming aid to the blind; except that, in making such determination, the State agency shall disregard the first \$85 per month of earned income, plus one-half of earned income in excess of \$85 per month;".

Approved September 13, 1960.

Addendum 11

TABLE D.—Estimated progress of supplementary health insurance benefits trust fund
(in millions)

| Calendar year | Contributions | | Benefit payments | Admini- strative ex- penses | Interest on fund | Balance in fund at end of year |
|-------------------------|--|-----------------|------------------|-----------------------------------|---------------------|--------------------------------------|
| | Partici- pante | Govern- ment | | | | |
| | Low cost estimate, 80-percent participation | | | | | |
| 1966 ¹ | \$278 | \$278 | \$185 | \$65 | \$5 | \$285 |
| 1967..... | 680 | 680 | 766 | 75 | 15 | 680 |
| | Low-cost estimate, 85-percent participation | | | | | |
| 1966 ¹ | \$325 | \$325 | \$230 | \$80 | \$5 | \$345 |
| 1967..... | 685 | 685 | 906 | 80 | 20 | 700 |
| | High-cost estimate, 80-percent participation | | | | | |
| 1966 ¹ | \$278 | \$278 | \$380 | \$85 | \$5 | \$210 |
| 1967..... | 680 | 680 | 1,025 | 85 | 10 | 220 |
| | High-cost estimate, 85-percent participation | | | | | |
| 1966 ¹ | \$325 | \$325 | \$310 | \$100 | \$5 | \$345 |
| 1967..... | 685 | 685 | 1,220 | 110 | 10 | 285 |

¹ Contributions would be collected only during the last 6 months of 1966, and benefit payments would likewise be payable only during that period. Administrative expenses shown include both those for the full year 1966 and such expenses as incurred in 1965.

NOTE.—Not included above is the advance appropriation from general revenues that is to provide a contingency reserve during fiscal year 1966-67 (to be used only if needed and to be repayable).

6. IMPROVEMENT AND EXTENSION OF KERR-MILLS PROGRAM

(a) Background

The provision of medical care for the needy has long been a responsibility of the State and local public welfare agencies. In recent years, the Federal Government has assisted the States and localities in carrying this responsibility by participating in the cost of the care provided. Under the original Social Security Act, it was possible for the States, with Federal help, to furnish money to the needy with which they could buy the medical care they needed. Since 1950, the Social Security Act has authorized participation in the cost of medical care provided in behalf of the needy aged, blind, disabled, and dependent children—the so-called vendor payments. This method of providing care has proved popular with the suppliers of medical care, the agencies administering the programs, and the recipients themselves.

Several times since 1950, the Congress has liberalized the provisions of law under which the States administer the State-Federal program of medical assistance for the needy. The most significant enactment was in 1960 when the Kerr-Mills medical assistance for the aged program was authorized. This legislation offers generous Federal matching to enable the States to provide medical care in behalf of aged persons who

have enough income for their basic maintenance but not enough for medical care costs. This program has grown to the point where 40 States and 4 other jurisdictions have such a program and 227,000 aged were aided in December 1964. Furthermore, medical care as a part of the cash maintenance assistance programs has also grown through the years until, at this time, nearly all the States make vendor payments for some items of medical care for at least some of the needy.

Your committee bill is designed to liberalize the Federal law under which States operate their medical assistance programs so as to make medical services for the needy more generally available. To accomplish this objective, your committee bill would establish, effective January 1, 1966, a new title in the Social Security Act—"Title XIX: Grants to the States for Medical Assistance Programs." After an interim period ending June 30, 1967, all vendor payments for medical care, including medical assistance for the aged, would be administered under the provisions of the new title. Until June 30, 1967, States might continue operating under the vendor payment provisions of title I (old-age assistance and medical assistance for the aged), title IV (aid to families with dependent children), title X (aid to the blind), title XIV (aid to the permanently and totally disabled), and title XVI (the combined adult program), or if they wish, they might move as early as January 1, 1966, to the new title. Programs of vendor payments for medical care will continue, as now, to be optional with the States.

(b) State plan requirements

(1) Standard provisions

The provisions in the proposed title XIX contain a number of requirements for State plans which are either identical to the existing provisions of law or are merely conforming changes. These are:

That a plan shall be in effect in all political subdivisions of the State.

That there shall be provided an opportunity for a fair hearing for any individual whose claim for assistance is denied or not acted upon with reasonable promptness.

That the State agency will make such reports as the Secretary may from time to time require.

That there shall be safeguards provided which restrict the use or disclosure of information concerning applicants or recipients to purposes directly connected with the administration of the plan.

That all individuals wishing to make application for assistance under the plan shall have an opportunity to do so and that such assistance shall be furnished with reasonable promptness.

That in determining whether an individual is blind there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select.

That medical assistance will be furnished to individuals who are residents of the State but who are absent therefrom.

(2) Additions to standard provisions

In addition to the requirements for State plans mentioned above, your committee bill contains several other plan requirements which are either new or changed over provisions currently in the law.

The bill provides that there shall be financial participation by the State equal to not less than 40 percent of the non-Federal share of the expenditures under the plan and that effective July 1, 1970, the financial participation by the State shall equal all the non-Federal share. This provision was included to make certain that the lack of availability of local funds for financing of any part of the program not affect the amount, scope, or duration of benefits or the level of administration set by the State. Prior to the 1970 date, your committee will be willing to consider other legislative alternatives to the provisions making the entire non-Federal share a responsibility of the State so long as these alternatives, in maintaining the concept of local participation, assure a consistent statewide program at a reasonable level of adequacy.

The bill contains a provision found in the other public assistance titles of the Social Security Act that the State plan must include such methods of administration as are found by the Secretary to be necessary for the proper and efficient operation of the plan, with the addition of the requirement that such methods must include provisions for utilization of professional medical personnel in the administration of the plan. It is important that State utilize a sufficient number of trained and qualified personnel in the administration of the program including both medical and other professional staff.

Your committee bill provides that the State or local agency administering the State plan under title XIX shall be the same agency which is currently administering either title I (old-age assistance) or that part of title XVI (assistance for the aged, blind, and the disabled, and medical assistance for the aged) relating to the aged. Where the program relating to the aged is State-supervised, the same State agency shall supervise the administration of title XIX. This provision was included because of the need to have the same agency which is most familiar with the administration of assistance (including medical care) to various groups of needy or nearly needy people also administer the medical assistance program. This is an agency with long experience and skill in determination of eligibility. Responsibility can be arranged by a welfare agency for actual provision of medical care by or through a health agency under suitable contractual relationships as some States have done under the MAA program.

Moreover, your committee recognizes that there are other State agencies with responsibilities for the provision of medical care or for various types of rehabilitative services in the States. In order to make certain that there is no duplication of effort and that maximum utilization will be made of the resources available from such other agencies, your committee bill provides that the State's plan must include provisions for entering into cooperative arrangements with State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the States.

Your committee bill also provides that if, on January 1, 1965, and on the date a State submits its title XIX plan, the State agency administering or supervising the administration of the State plan for the blind under title X or title XVI of the Social Security Act is different from the State agency administering or supervising the administration of the plan relating to the aged under title I or title XVI, such blind agency may be designated to administer or supervise the administration of the portion of the title XIX plan which relates to blind individ-

nals. In such case, the portion of the title XIX plan administered or supervised by each agency shall be regarded as a separate plan.

Current provisions of law requiring States to have an agency or agencies responsible for establishing and maintaining standards for the types of institutions included under the State plan have been continued under the bill. Your committee expects that these provisions will be used to bring about progressive improvement in the level of institutional care and services provided to recipients of medical assistance. Standards of care in many medical institutions are not now at a satisfactory level and it is expected that current standards applicable to medical institutions will be improved by the State's standard-setting agency and that these standards will be enforced by the appropriate State body.

Under provisions of your committee bill, the State plan must include such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and that such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipient. This provision was included in order to provide some assurance that the States will not use unduly complicated methods of determining eligibility which have the effect of delaying in an unwarranted fashion the decision on eligibility for medical assistance or that the States will not administer the provisions for services in a way which adversely affects the availability or the quality of the care to be provided. Your committee expects that under this provision, the States will be eliminating unrewarding and unproductive policies and methods of investigation and that they will develop such procedures as will assure the most effective working relationships with medical facilities, practitioners, and suppliers of care and service in order to encourage their full cooperation and participation in the provision of services under the State plan.

(c) Eligibility for medical assistance

Under your committee bill, a State plan to be approved must include provision for medical assistance for all individuals receiving aid or assistance under State plans approved under titles I, IV, X, XIV, and XVI. These people are the most needy in the country and it is appropriate for medical care costs to be met, first, for these people. Thus, under the provisions of the bill, these people will have the first call upon the resources of the States to provide medical care. It is only if this group is provided for that States may include medical assistance to the less needy than those who would be eligible for aid under the various other categories of public assistance.

Under your committee bill, medical assistance made available to persons receiving assistance under title I, IV, X, XIV, or XVI must not be less in amount, duration, or scope than that provided for persons receiving aid under any other of those titles. In other words, the amount, duration, and scope of medical assistance made available must be the same for all such persons. This will assure comparable treatment for all of the needy aided under the federally aided categories of assistance and will eliminate some of the unevenness which has been apparent in the treatment of the medical needs of various groups of the needy.

The bill provides furthermore that as States extend their programs to include assistance for persons who come within the various cate-

gories of assistance except that their income and resources are sufficient to meet their needs for maintenance, the medical assistance given such individuals shall not be greater in amount, duration, or scope than that made available for persons who are recipients of money payments. This was included in order to make sure that the most needy in a State receive no less comprehensive care than those who are not as needy.

Under the bill, if a State extends the program to those persons not receiving assistance under titles I, IV, X, XIV, and XVI, the determination of financial eligibility must be on a basis that is comparable as among the people who, except for their income and resources, would be recipients of money for maintenance under the other public assistance programs. Thus, the income and resources limitation for the aged must be comparable to that set for the disabled and blind and must also have a comparability for that set for families with children who, except for their income and resources, would be eligible for AFDC. The scope, amount, and duration of medical assistance available to each of these groups must be equal.

(d) Determination of need for medical assistance

Your committee bill would make more specific a provision now in the law that in determining eligibility for and the extent of aid under the plan, States must use reasonable standards consistent with the objectives of the titles. Although States may set a limitation on income and resources which individuals may hold and be eligible for aid, they must do so by maintaining a comparability among the various categorical groups of needy people. Whatever level of financial eligibility the State determines to be that which is applicable for the eligibility of the needy aged, for example, shall be comparable to that which the State sets to determine the eligibility for the needy blind and disabled; and must also have a comparability to the standards used to determine the eligibility of those who are to receive medical assistance as needy children and the parents or other relatives caring for them.

Another provision is included that requires States to take into account only such income and resources as (determined in accordance with standards prescribed by the Secretary) are actually available to the applicant or recipient and as would not be disregarded (or set aside for future needs) in determining the eligibility for and the amount of the aid or assistance in the form of money payments for any such applicant or recipient under the title of the Social Security Act most appropriately applicable to him. Income and resources taken into account, furthermore, must be reasonably evaluated by the States. These provisions are designed so that the States will not assume the availability of income which may not, in fact, be available or over-evaluate income and resources which are available. Examples of income assumed include support orders from absent fathers, which have not been paid or contributions from relatives which are not in reality received by the needy individual. The provisions also are designed to assure that whatever is applicable under titles I, IV, X, XIV, and XVI for the disregarding of income or for setting aside of income shall also be applicable in evaluating the income of the individual who is applying for medical assistance under title XIX. Titles I and X now provide for the disregarding of certain income and title IV provides

that income may be set aside for the future needs of the children. Other pertinent provisions for the disregard of income are found in the Economic Opportunity Act and the Food Stamp Act of 1964.

Your committee has heard of hardships on certain individuals by requiring them to provide support and to pay for the medical care needed by relatives. Your committee believes it is proper to expect spouses to support each other and parents to be held accountable for the support of their minor children and their blind or permanently and totally disabled children even though 21 years of age or older. Such requirements for support may reasonably include the payment by such relative, if able, for medical care. Beyond such degree of relationship, however, requirements imposed are often destructive and harmful to the relationships among members of the family group. Thus, States may not include in their plans provisions for requiring contributions from relatives other than a spouse or the parent of a minor child or children over 21 who are blind or permanently and totally disabled. Any contributions actually made by relatives or friends, or from other sources will be taken into account by the State in determining whether the individual applying for medical assistance is, in fact, in need of such assistance.

The bill also contains a provision designed to correct one of the weaknesses identified in the medical assistance for the aged program. Under the current provisions of Federal law, some States have enacted programs which contain a cutoff point on income which determines the financial eligibility of the individual. Thus, an individual with an income just under the specified limit may qualify for all of the aid provided under the State plan. Individuals, however, whose income exceeds the limitation adopted by the State are found ineligible for the medical assistance provided under the State plan even though the excess of the individual's income may be small when compared with the cost of the medical care needed. In order that all States shall be flexible in the consideration of an individual's income, your committee bill requires that the States standards for determining eligibility for and extent of medical assistance shall take into account, except to the extent prescribed by the Secretary, the cost—whether in the form of insurance premiums or otherwise—incurred for medical care or any other type of remedial care recognized under State law. Thus, before an individual is found ineligible for all or part of the cost of his medical needs, the State must be sure that the income of the individual has been measured in terms of both the State's allowance for basic maintenance needs and the cost of the medical care he requires.

The State may require the use of all the excess income of the individual toward his medical expenses, or some proportion of that amount. In no event, however, with respect to either this provision or that described below with reference to the use of deductibles for certain items of medical service, may a State require the use of income or resources which would bring the individual below the test of eligibility under the State plan. If the test of eligibility should be \$2,000 a year, an individual with income in excess of that amount shall not be required to use his income to the extent he has remaining less than \$2,000. This action would reduce the individual below the level determined by the State as necessary for his maintenance.

The bill contains several interrelated provisions which prohibit or limit the imposition of any deduction, cost sharing, or similar charge,

nor of any enrollment fee, premium, or similar charge, under the plan.

No deduction, cost sharing or similar charge may be imposed with respect to inpatient hospital services furnished under the plan. This provision is related to another provision in the bill which requires States to pay reasonable costs for inpatient hospital services provided under the plan. Taken together, these provisions give assurance that the hospital bill incurred by a needy individual shall be paid in full under the provisions of the State plan for the number of days covered and that States may not expect or require the individual to use his income or resources (except such income as exceeds the State's maintenance level) toward that bill. The reasonable cost of inpatient hospital services shall be determined in accordance with standards approved by the Secretary and included in the State plan.

For any other items of medical assistance furnished under the plan, a charge of any kind may be imposed only if the State so chooses, and the charge must be reasonably related to the recipient's income or his income and resources. The same limitations apply in the case of any enrollment fee, premium, or similar charge imposed with respect to inpatient hospital services. The Secretary is given authority to issue standards under this provision, which it is expected will protect the income and resources an individual has which are necessary for his nonmedical needs.

The hospital insurance benefit program included under other provisions of the bill provides for a deductible which must be paid in connection with the individual's claim for hospitalization benefits. Your committee is concerned that hospitalization be readily available to needy persons and that the necessity of their paying deductibles shall not be a hardship on them or a factor which may prevent their receiving the hospitalization they need. For this reason, your committee's bill provides that the States make provisions, for individuals 65 years or older, of the cost of any deductible imposed with respect to individuals under the program established by the hospital insurance provisions of the bill.

A State medical assistance plan may provide for the payment in full of any deductibles or cost sharing under the insurance program established by part B of title XVIII. In the event, however, the State plan provides for the individual to assume a portion of such costs, such portion shall be determined on a basis reasonably related to the individual's income or income and resources and in conformity with standards issued by the Secretary. The Secretary is authorized to issue standards—under this provision which, it is expected, will protect the income and resources of the individual needed for his maintenance—to guide the States. Such standards shall protect the income and resources of the individual needed for his maintenance and provide assurance that the responsibility placed on individuals to share in the cost shall not be an undue burden on them.

Titles I and XVI authorizing the medical assistance for the aged program now provide that the States may not impose a lien against the property of any individual prior to his death on account of medical assistance payments except pursuant to a court judgment concerning incorrect payments, and prohibits adjustment or recovery for amounts correctly paid except from the estate of an aged person after his death and that of his surviving spouse. This provision, under your com-

mittee bill, has been broadened so that such an adjustment or recovery would be made only at a time when there is no surviving child who is under the age of 21 or who is blind or permanently and totally disabled.

(c) Scope and definition of medical services

"Medical assistance" is defined under the bill to mean payment of all or part of the care and services for individuals who would if needy, be dependent under title IV, except for section 406(a)(2), and are under the age of 21, or who are relatives specified in section 406(b)(1) with whom the child is living, or who are 65 years of age and older, blind, or permanently and totally disabled, but whose income and resources are insufficient to meet all their medical care costs. The bill, as do current provisions of law, permits Federal sharing in the cost of medical care provided up to 3 months before the month in which the individual makes application for assistance. Thus, the scope of the program includes not only the aged, blind, disabled, and dependent children as defined in State plans, but also children under the age of 21 (and their caretaker relatives) who come within the scope of title IV, except for need and age, even though they may not be defined as eligible under a particular State plan.

Your committee bill contains a list of services, the first five of which the States are required to include in their plans, if they elect to implement title XIX, and the remainder of which are optional with the States. The required services are:

Inpatient hospital services.

Outpatient hospital services.

Other laboratory and X-ray services.

Skilled nursing home services.

Physicians' services, whether furnished in the office, the patient's home, a hospital, or a skilled nursing home or elsewhere.

In the opinion of your committee, these are the most essential items of service which should be included as a minimum if the medical assistance program is to be of significant help to the individual. These minimum items of service are to become effective July 1, 1967; until then, the State plan must include—as now provided in titles I and XVI—for some institutional and some noninstitutional services.

Other items of medical service which the States may, if they wish include in their plans are:

Medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

Home health care services.

Clinic service.

Private duty nursing service.

Dental service.

Physical therapy and related services.

Prescribed drugs, dentures, prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select.

Other diagnostic, screening, preventive, and rehabilitative services.

Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary.

Addendum 12

MEDICAL ASSISTANCE FOR THE AGED

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might have \$5,000 in the bank. By protecting that "nest egg," the older citizen then has that money available to supplement his usually limited income in meeting his regular living expenses. Success in the preservation of that "nest egg" is very often the decisive factor in the ability of the older citizen to continue independent living. It is impossible to divorce consideration of how the aged person will manage after he is well from consideration of when and what benefits are available to him during illness.

FAMILY RESPONSIBILITY LAWS

An aspect of the means test which has been particularly subject to criticism, is the "family responsibility" provision. Such provisions are found in almost all OAA programs and, in one form or another, in the MAA programs of the following 12 States:

| | |
|---------------|---------------|
| Connecticut | New Hampshire |
| Hawaii | New York |
| Illinois | North Dakota |
| Maine | Pennsylvania |
| Massachusetts | Utah |
| Michigan | Vermont |

The aged applicant filing for MAA in a State which utilizes family responsibility provisions, thereby, in effect, may subject members of his family to a means test—apart from himself.

In all probability, no other condition attached to application for MAA is as upsetting as the requirement that relatives be investigated and interviewed to determine their ability to contribute toward the health expenses of the applicant for MAA. It is not that families are unwilling to take care of their own. Relatives of the applicant may have already been paying a substantial part of the living expenses of their older relative(s). In some instances, MAA help is requested because the applicant knows that the finances of his family are already under heavy strain. When the older person learns that additional financial aid may be demanded of his family, frequently at what he knows will mean severe hardship, he may well and very often does, withdraw or refuse to make application and let his health needs go unmet.

Some informed comments on the connotations and effects of means test medicine were contained in an article¹ on New York's MAA plan written by State Senator George R. Metcalf, chairman of the State's joint legislative committee on health insurance plans:

Any attempt to explain the plan's shortcomings inevitably involves a number of criticisms. Frequently heard is the complaint that Kerr-Mills is a welfare program. Although no person is required to sell, mortgage, assign or otherwise lose his home and household furnishings in order to become eligible for medical care, each applicant has to be approved by a welfare investigator. For the sensitive person who resents being seen at the welfare office, this is a burden which he is unwilling to bear. Furthermore, he objects to the fact that a son or daughter can be asked to pay part of his medical bill as a condition of receiving aid. (A number of elderly persons in Buffalo, when informed of this provision, reportedly told the welfare commissioner, "Please kill my application. . . . I don't want my son questioned.") In addition, many people are too proud to let outsiders know that members of their family are receiving welfare help. As the welfare commissioner pointed out to a reporter for the Buffalo News, "No matter how

¹ "New York's Medicare Plan," *Hospital Topics*, October 1962, p. 24.

badly many people need medical care, when it comes, to applying for welfare, they would rather do without it."

The Metcalf committee held a series of hearings during the latter part of 1962 to consider suggested improvements in the State's MAA program. Strong testimony was presented indicating the negative impact of the family responsibility provision in New York's Kerr-Mills program:

In receiving an application for medical assistance for the aged, the public welfare agency should be in a position to assure the aged applicant that full consideration will be given to all legitimate financial requirements of his children and their families. Otherwise the applicant is apt to withdraw his application and he will go without needed medical care when he is told that half of any surplus his children may have over and above their basic living needs, as well as all savings they may have must be applied toward financing his medical needs before he may be considered eligible for public assistance.

I refer particularly to long-planned and long-maintained savings programs by most present-day families to meet the education needs of their growing children. I have seen instances under the present application of the means test where heavy medical expenditures for grandparents have decimated such savings and have deprived grandchildren of full opportunity for a higher education.²

James R. Dumpson, commissioner of welfare for the city of New York, told the Metcalf committee:

We believe that this failure to broaden the base of care for the medically indigent aged is due to the restrictive nature and scope of the eligibility requirement of the MAA program; specifically, the requirement of relative responsibility, and the unrealistic ceilings on allowed income and resources and the tying of aid to the existence of substantial medical need. *The pursuit of legally responsible relatives has proven to be a financial mirage.* In my opinion, the administrative cost exceeds the financial returns. A sample survey of MAA cases hospitalized in New York City during March and April 1962 revealed that in only about 10 percent of these cases were legally responsible relatives found to be eligible for billing; and of these cases only 25 percent of the hospital bill was collected. If these figures are applied to our annual experience, then about 2.5 percent of the annual MAA hospital care costs of \$40 million or about \$1 million is collectible from relatives. To further pursue these relatives in court would be extremely costly.

We also analyzed the contributions of relatives for the cost of care of MAA recipients in nursing homes and infirmaries of homes for the aged during the month of September 1962. Of the 7,400 such cases, 1,275 were receiving contributions from relatives of \$763,000 annually toward an annual cost of \$21 million. We therefore estimate that the total sums collected from relatives of MAA recipients represents slightly less than 3 percent of the expenditures made in behalf of such persons. *I am convinced that the annual administrative cost of \$4,106,000 of administering the MAA program could be cut in half if we eliminated the relative's responsibility and, most important, I believe that this requirement serves to bar uncounted, truly needy, older persons from seeking medical aid under this program.*³ [Emphasis supplied.]

Commissioner Dumpson then stated: "I therefore strongly support the recommendation that the means test for MAA be limited to the recipient and/or spouse." Of more than incidental interest is the fact that the recommendation was also proposed to the Metcalf committee by the Medical Society of the State of New York—the largest State medical association in the country.

We feel, therefore, that all factors considered, a rather persuasive case has been made for congressional consideration of an amendment to the Kerr-Mills Act which would confine the application of family

² Statement of Louis P. Korth, commissioner of public welfare, Westchester County, at hearing of Joint Legislative Committee on "Health Insurance Plans," Nov. 16, 1962.

³ Statement of James R. Dumpson, welfare commissioner, city of New York, at hearing of Joint Legislative Committee on "Health Insurance Plans," Nov. 16, 1962.

responsibility provisions, in those States using such provisions, to the applicant and/or his spouse.

"Liens" under Kerr-Mills MAA

Misunderstanding surrounds the question of whether the Kerr-Mills legislation prohibits States from applying liens as a means of recovering from the assets of MAA recipients, amounts expended for health care under MAA programs.

It has been stated that no liens can be taken on the property of people receiving help under MAA. However, these statements are only partially true.

The provision in the Kerr-Mills legislation relating to liens under MAA requires that the State plan must—

• • • provide that no lien may be imposed against the property of any individual prior to his death on account of medical assistance for the aged paid or to be paid on his behalf under the plan (except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual), and that there shall be no adjustment or recovery (except, after the death of such individual and his surviving spouse, if any, from such individual's estate) of any medical assistance for the aged correctly paid on behalf of such individual under the plan.⁴

This means that States can—and 9 of them do—extract from the applicant the right to collect from his estate after death by use of post-mortem claims. The 9 States which have such provisions are Connecticut, Illinois, Massachusetts, Michigan, New Hampshire, New York, North Dakota, Oregon, and Utah.

An MAA recipient living in any of the 9 States mentioned, and possessing the type of property to which liens are applicable, in effect shares in part or all of the cost of the MAA assistance received. His share, however, is not due until after his death (or upon the death of his surviving spouse). Inasmuch as his assets were limited initially (in order for him to qualify for MAA), the effect of these post-mortem recovery provisions is to virtually preclude the possibility of the recipient of MAA leaving anything for his heirs. It may be contended that the cost of MAA care should be recovered from the estate of a recipient—that there is no valid justification for an aged person in need of assistance with medical cost to leave anything for his family. Nonetheless, the prospect of a post-mortem claim on his assets can be another major reason for the deferral, or refusal of necessary health care. The principal consideration in such negative situations may be the desire to leave "a little something" for the education of a grandchild or some similar family need.

California, probably in recognition of these problems in usage of family responsibility provisions, recently dropped the requirement in its MAA plan which provided for relatives' responsibility.

OVERRIDING OBJECTION TO THE USE OF LIENS OR CLAIMS

Fifteen States have apparently recognized the basic problem in usage of recovery provisions and do not employ these devices. Nine States, however, do make use of recovery provisions.

⁴ Under old-age assistance, Federal law permits use of current liens and many States make use of such provisions. This should be understood in view of the fact that many MAA recipients are later forced to turn to OAA for help.

Addendum 13



United States
of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 89th CONGRESS, FIRST SESSION

HOUSE OF REPRESENTATIVES

WEDNESDAY, APRIL 7, 1965

The House met at 12 o'clock noon.
The Chaplain, Rev. Bernard Braskamp, D.D., used this word of the Psalmist: *I will hear what God will say, for He will speak peace unto His people.*

O Thou God of all goodness, our minds and hearts frequently turn unto Thee in these days for light and leading, for insight and inspiration.

We find ourselves in the midst of circumstances and crises which are tragic and trying and we are seeking to lay hold of Thy age-long moral and spiritual values for courage and hope.

Grant that in our struggles we may be responsive to Thy commands and be eager to discover and obey Thy will and learn for ourselves the help that there is for us in the power and possibilities of prayer.

May we appreciate more fully the satisfaction and the security we may experience as we join the prophets of old who are the eternal contemporaries of all who love and serve Thee.

Hear us in the name of our blessed Lord. Amen.

THE JOURNAL

The Journal of the proceedings of yesterday was read and approved.

MESSAGE FROM THE SENATE

A message from the Senate by Mr. Arrington, one of its clerks, announced that the Senate had passed without amendment a bill of the House of the following title:

H.R. 4437. An act to authorize appropriations for procurement of vessels and aircraft and construction of shore and offshore establishments for the Coast Guard.

The message also announced that the Senate had passed a bill of the following title, in which the concurrence of the House is requested:

S. 800. An act to authorize appropriations during fiscal year 1966 for procurement of aircraft, missiles, and naval vessels, and research, development, test, and evaluation, for the Armed Forces, and for other purposes.

The message also announced that the Vice President, pursuant to Public Law 86-474, had appointed the following Members on the part of the Senate to the Interparliamentary Union Conference to be held in Dublin, Ireland, April 28 to 29, 1965: Mr. TALMADGE, Mr.

ROBERTSON, Mr. YARBROUGH, Mr. HICKENLOOPER, and Mr. SCOTT.

The message also announced that the Presiding Officer of the Senate, pursuant to Public Law 115, 78th Congress, entitled "An act to provide for the disposal of certain records of the United States Government" had appointed Mr. JOHNSTON and Mr. CARLSON members of the Joint Select Committee on the part of the Senate for the disposition of executive papers referred to in the report of the Archivist of the United States numbered 65-10.

CALL OF THE HOUSE

Mr. HALL. Mr. Speaker, I make the point of order that a quorum is not present.

The SPEAKER. Evidently a quorum is not present.

Mr. ALBERT. Mr. Speaker, I move a call of the House.

A call of the House was ordered.

The Clerk called the roll, and the following Members failed to answer to their names:

(Roll No. 67)

| | | |
|--------------|-------------|---------------|
| Abernathy | Grover | O'Hara, Mich. |
| Ashley | Mathaway | Powell |
| Baldwin | Ichord | Roosevelt |
| Berry | Irwin | Springer |
| Bonner | Jones, Ala. | Stafford |
| Cahill | Long, Md. | Steed |
| Celler | McCulloch | Sweeney |
| Cleveland | McDowell | Toll |
| Evana, Colo. | Mailliard | Ullman |
| Grabowski | Morrison | Williams |

The SPEAKER. On this rollcall 401 Members have answered to their names, a quorum.

By unanimous consent, further proceedings under the call were dispensed with.

THE LATE HONORABLE JAMES A. SHANLEY

Mr. GIAMMO. Mr. Speaker, I ask unanimous consent to address the House for 1 minute.

The SPEAKER. Is there objection to the request of the gentleman from Connecticut?

There was no objection.

Mr. GIAMMO. Mr. Speaker, it is with a great deal of sadness that I take this time to inform my colleagues in the House of the untimely passing of Jim Shanley, a former Congressman from the Third Congressional District of Connecticut, the district which I presently have the honor to represent. Jim Shanley, who was known to so many of the Members here in the House, represented his district from 1935 to 1943, and was

a member of the Committee on Foreign Affairs. He died on Sunday last after a short illness.

Mr. Speaker, I shall ask for time on Tuesday next so that I and other Members of the House may pay our last respects to our very dear and distinguished friend and former colleague, Judge James A. Shanley, of New Haven, Conn.

SOCIAL SECURITY AMENDMENTS OF 1965

Mr. MADDEN. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 322 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. Res. 322

Resolved, That upon the adoption of this resolution it shall be in order to move that the House resolve itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 6675) to provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the old-age, survivors, and disability insurance system, to improve the Federal-State public assistance programs, and for other purposes, and all points of order against said bill are hereby waived. After general debate, which shall be confined to the bill and continue not to exceed ten hours, to be equally divided and controlled by the Chairman and the ranking minority member of the Committee on Ways and Means, the bill shall be considered as having been read for amendment. No amendment shall be in order to said bill except amendments offered by direction of the Committee on Ways and Means. Amendments offered by direction of the Committee on Ways and Means may be offered to the bill at the conclusion of the general debate, but said amendments shall not be subject to amendment. At the conclusion of the consideration of the bill for amendment, the Committee shall rise and report the bill to the House with such amendments as may have been adopted, and the previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions.

Mr. MADDEN. Mr. Speaker, I yield 30 minutes of my time to the gentleman from Ohio (Mr. Brown), and at this time yield myself such time as I may consume.

This rule makes in order H.R. 6675, a comprehensive bill dealing in detail with the manner in which to provide hospital insurance, health benefit, and medical assistance for the aged folks of our Nation.

This legislation has been on the agenda of Congress, in one form or another, for the last 20 years. The members of the Ways and Means Committee are deserving of the highest commendation for the outstanding work they have done over the years to enact a practical bill which will relieve the critical health problem of our older citizens.

Years ago, older folks who were destitute or with insufficient income, property, or means to provide for the health needs in their declining years, were committed to so-called poorhouses, county or city hospitals throughout the land. Over the years, millions of older citizens have spent their declining days in inadequate so-called poorhouses or county institutions in poverty and disgrace until the day that their lives ebbed away.

When I came to Congress 20 years ago, one of the burning issues in my district was the necessity for something to be done to expand hospital and medical care, not only for the older citizens but for many younger families who were unemployed and in need of hospital and medical care. In many areas throughout our Nation during the last 25 to 30 years communities were victims of a pitiful lack of hospital accommodations and, in a great many areas, a scarcity of doctors.

LACK OF MEDICAL SCHOOLS

I well remember after World War II when thousands of boys were returning to civilian life many of them whose education was temporarily interrupted by military service, wanted to enter medical schools throughout our Nation. We found that medical schools and colleges were scarce and also hospital facilities and doctors both in urban and rural areas. I received hundreds of letters from veterans whose applications to medical schools were rejected because of the lack of accommodations. In 1947, I asked one of the trustees of Indiana University why it was that so many boys who had applied from my area to this medical school were rejected and he stated that out of approximately 3,000 applications in 1946, the University's Medical School only had accommodations for 150.

I remember when, in the late 1940's, we had legislation on the floor of the House to appropriate money for hospital and medical school construction, we were always met with organized opposition by the American Medical Association who spent vast sums propagandizing against any aid from the Government to build hospitals, provide money to educate students for the medical profession, or to expand medical services to millions who were suffering by reason of inadequate facilities.

The bill we are considering today, if enacted into law, will be one of the great landmarks of progress taken by our Government in order to help carry out humanitarian considerations which it owes to millions of older folks throughout the land who have devoted their lives to making this Nation of ours the leader of the world.

FINANCING OF ELDERCARE

In the last 20 years, the number of older people in our Nation has almost

tripled. Now, 1 American in every 10 is in the older group and this number is increasing every year. Medical and hospital care is a serious problem for many Americans of all ages but the older folks are more helpless and have more health afflictions. Of the 18 million people over 65, more than half have incomes of less than \$1,000 a year. The average income for two-person families is around \$2,500 per year. Incomes like this will buy very little hospital or medical care. About 6 million Americans over 65 years of age have no assets at all. They are in abject poverty. When an aged husband or wife is hospitalized, the medical bills average around \$800 a year. People over 65 use three times as much hospital care as younger people. Their stay at the hospital is twice as long as the average younger person. Medical costs have increased 63 percent since 1950, and in the same period hospital rooms have gone up 154 percent. Few older folks have savings to meet these skyrocketing hospital and medical costs.

As one reviews the history of medicare legislation and the fact that after 20 years the Congress is about to assume its responsibility to correct one of the most flagrant inequities and humanitarian omissions in correcting an injustice to a large segment of our American citizens.

The recent edition of April 12 Newsweek magazine has an interesting article dealing with this problem. They state in this article that from the period of 1940 to 1960 that taxpaying citizens have increased from 35 to 72 million and the number of citizens over 65 in that 20-year period has increased from 600,000 in 1940 to 12 million in 1960. Our population is increasing annually and through modern scientific discoveries in medicine and surgery; our older folks are increasing in numbers far more rapidly than the similar increase of population of 25 years ago. The problem of medical and hospital care for our older citizens is far more critical than after World War II and will increase by alarming proportions every year unless legislation like we are considering today is enacted into law in an effort to solve this problem of hospital and medical care for the elderly.

MEDICARE BILL

The Rules Committee in reporting this bill out, has provided for 10 hours debate. H.R. 6675, very briefly, covers all persons over 65, with benefits commencing July 1, 1966, with one exception. Up to 60 days of full hospital care per illness, with patient paying only the first \$40. From 20 to 100 days of post-hospital care in an affiliated facility for each spell of illness—this coverage to begin January 1, 1967. Outpatient diagnostic services following payment of \$20 deductible. Posthospital home health services up to 100 visits per spell of illness. Payments made directly to hospitals, and so forth.

Voluntary supplementary plan: Coverage for all persons over 65 enrolling before March 30, 1966, or as they reach 65. In exchange for \$3 monthly premium—\$6 for a couple—enrollees will be covered for 80 percent of these additional

services following payment of \$50 annual deductible: physicians' and surgical services, up to 60 days per illness in a mental hospital—180-day lifetime maximum—up to 100 visits per year for home health services without prior hospitalization, diagnostic tests, X-ray, radium and radioactive isotope therapy, ambulance services under limited conditions, surgical dressings, rental of durable medical equipment, and so forth. Plan to be administered by private companies like Blue Cross. Benefits effective July 1, 1966.

Financing of the basic plan will be through an additional social security tax applying equally to employees, employers and self-employed persons.

AMERICAN MEDICAL ASSOCIATION ELDERCARE

During the 2 days hearing before the Rules Committee several alternative bills, amendments or changes were presented to the pending legislation. The principal substitute was a bill sponsored by the strategy board of the American Medical Association called eldercare. Under this proposal the AMA would let the individual States, who would accept a health program, pay half the costs and administer it themselves. Each State under this bill would decide whom to help, if anyone and how much. This proposal is more or less an extension of the wholly inadequate Kerr-Mills legislation passed by the Congress several years ago which has proven a miserable failure as far as a solution to the Nation's health problem is concerned.

During this time nine States have absolutely refused to pass any legislation under the Kerr-Mills provisions. Out of the 41 States who have made any effort under the Kerr-Mills law, only 7 States have anything like adequate programs and in these 7 States some have omitted essential factors of hospital care for the aged. These seven States have omitted to provide any uniform treatment of older people. During this debate you are going to hear a great deal about eldercare because the political department of AMA has carried on a multimillion-dollar campaign over the Nation through television, radio, mail, and newspapers, misrepresenting the true facts about eldercare. In their propaganda they do not state that eldercare is merely Kerr-Mills all over again with a little window dressing to mislead the American people.

Taken on the basis of official Government reports on the operation of the Kerr-Mills program, if applied in all 50 States, it would enable a maximum of about 3 million elder folks to qualify for benefits. Around 16 million elder folks would get nothing.

The highly financed political campaign of the AMA strategy board so exaggerated and misrepresented the facts about eldercare that the gentleman from Florida, Congressman HAWLSON, one of the two cosponsors of the eldercare bill, publicly condemned the AMA committee for its overenthusiastic and misleading propaganda. To quote Congressman HAWLSON, he stated:

For the AMA to give the impression it provides complete coverage is not so.

He also said:

It just makes it available for the States to provide if they want to.

I am not criticizing the thousands of physicians over the Nation who are not familiar with the true facts. Most of them are openly or privately supporting the medicare bill and opposing the AMA eldercare plan.

I do hope that the Members of the House remain on the floor and listen to the presentation of this legislation by the members of the Ways and Means Committee, which held hearings on medical legislation in every session of Congress for the last 15 or 20 years on medicare legislation.

Chairman Mills and older members of the Ways and Means Committee have devoted many weeks and months to this problem and I do hope that every Member will listen to Chairman Mills when he opens this debate after the House goes into Committee of the Whole. Chairman Mills testified before our committee that this legislation is 100 percent financially sound for the present economic conditions in the Nation and that provisions in future financing were considered and incorporated into this legislation which will protect our social security system indefinitely into the future. Several years ago there was a great deal of argument that the private insurance industry could take care of this need for our elder citizens. When those arguments were surveyed, upon investigation it was found that thousands of aged as policyholders presented their opposition because of so many unreliable insurance companies throughout the Nation cancelling insurance policies when extended illnesses occurred to the insured. Many private insurance companies at that time experimented with combining their resources in order to offer special plans to older citizens on account of the economic situation involved with so many older policyholders. This experiment was a failure.

The American people, during the last dozen years, have become educated and informed on the true facts regarding medicare legislation. A nationwide poll was taken by the Harris people recently on medicare legislation covering rank and file Americans and the return revealed that the American people are for adequate medicare legislation by a margin of 2 to 1.

A LOCAL TAX SAVING BILL

Another angle connected with this legislation which has not been discussed is that millions of younger folks are indirectly being benefited in that they can use their small income for educational purposes instead of leaving grade school or high school to work and provide hospitalization and medical care for their parents. These younger folks will be given an opportunity to meet the problems of this advanced scientific age and be producers and taxpayers instead of eventually becoming members of the unemployed and thus becoming a problem eventually for Government aid and assistance.

Another consideration that did not come out in the hearings has been the

fact that the passage of this legislation will save multimillions of dollars to the American taxpayer in local areas where they are financing county and city hospitals, poorhouses, welfare departments, and other local agencies caring for sick and dependent elder citizens. This morning I telephoned the public welfare department in my district, Lake County, Ind. They informed me that during the first 3 months of 1965, \$290,000 was spent for hospital, medical, and nursing home care for the elder citizens of Lake County. Lake County taxpayers will be relieved eventually of about \$11 million in taxes annually when this legislation gets organized and in full operation.

In closing let me say that the greatest testimonial for this legislation, coupled with the educational legislation passed several weeks ago, was the returns of the recent election of November 5, 1965. By a majority of over 15 million, President Johnson and Vice President Humphrey won an unprecedented victory and the principal plank in their platform was education and medicare. Dozens of new Members—freshmen—are in Congress today, because the American people have finally become informed on these two great national issues—education of our youth and hospital and medicare for our elder citizens.

Mr. BROWN of Ohio. Mr. Speaker, I yield myself 10 minutes.

Mr. Speaker, my colleague on the Rules Committee, the gentleman from Indiana, devoted most of his time to a discussion of the bill, or what he understands may be the bill, and little time to explaining the rule.

The rule bringing this bill to the floor is a closed or a gag rule providing for 10 hours of general debate and permitting the offering of no amendments from the floor except those reported by the Ways and Means Committee itself. It provides for one motion to recommit, either with or without instructions.

I have stood in this well many times in the past in opposition to the voting of closed or gag rules. I have the very firm conviction and belief that within the House of Representatives we have sufficient judgment, wisdom, and ability to pass upon legislation, even in detail, at least as ably as the other legislative body across the Capitol, where there are no restrictions on the offering or consideration of amendments and no limit on the debate on such amendments or on the legislation itself.

I want the record to be made very clear. In the Rules Committee when the question of a rule on this particular bill, H.R. 6675, came up, I moved a substitute for the motion of the gentleman from Indiana (Mr. Madden), who had moved that we report the bill under a closed or gag rule and 10 hours of debate. I moved that we report the bill under an open rule which would give every Member of the House an opportunity to offer any amendment, and a full opportunity for such amendments to be considered and debated on the floor of the House. That motion was voted down.

Then another motion was made as a substitute for the Madden motion, to provide that the so-called Herlong-Cur-

tis bill should be considered in order as an amendment to the bill. That was voted down.

Then, finally, a motion was made to amend the motion of the gentleman from Indiana so that the closed or gag rule would provide for the offering and consideration of H.R. 7057, the so-called Byrnes bill, with which Members are all acquainted, on the floor of the House, so that it might be discussed and debated section by section. That was voted down by a fairly narrow margin.

We now have before us this rule, a closed, gag rule, which means that the House may not work its will and no Member may offer an amendment unless it has the sanction of the Committee on Ways and Means, except in the case of a motion to recommit, which is always reserved as a right to the minority.

Now, I do not know how much time my colleagues have devoted to studying this bill or how much attention has been given to it. I am sure my good friend, the gentleman from Indiana (Mr. Madden), has studied it very carefully, but frankly I do not know all that is in this bill and I cannot answer all the questions that might be asked about it. I am not sure there is anybody in the House who can answer all of the questions that might arise in connection with this legislation. There are 296 pages in this bill. The report alone contains 264 pages. I cannot help but wonder in my own mind as to why the great haste. We were asked to rush it through the Committee on Rules and it was rushed through the Committee on Rules with a day and a half of hearings. It was reported out of the Committee on Ways and Means as it is in its present form without hearings on many sections of the bill, some of them being the most important part of it. I cannot help but wonder why the haste. The insurance and medicare provisions of this bill will not become effective until a year from next July. The increased benefits to those now on the social security rolls will be retroactive to last January 1. That is helpful and can be handled very quickly and should have been handled last year. There is a great deal of mystery to me about this bill, and why it is before us in its present form. I still do not understand—and I have been in Congress for a long, long time—all of these things that are going on. This is a great piece of machinery—this legislative machine here on Capitol Hill—and we have had this bill or a bill like it before the Committee on Ways and Means for a great many years.

In fact, this particular type of bill has been before the Committee on Ways and Means since 1955. Year after year and Congress after Congress, the Committee on Ways and Means, substantially constituted as it is now, has failed and refused to report a medicare bill or to endorse the philosophy and the program that is outlined in this measure. Then suddenly the committee comes out with a bill that covers the waterfront. As somebody described it, it provides for every situation from the cradle to the grave.

As I understand it, there are three or perhaps four important divisions of this bill which we have to consider. Toward one part of the bill there is no argument. That is the part which I think everyone favors. It is the part that gives an increase of 7 percent across the board, with a minimum of \$4 a month, as an increase in social security benefits to those now on the social security rolls. It would enlarge the coverage to give greater protection to widows and children and to certain disabled persons. That section of the bill has a unanimous report from the committee, I believe, and perhaps will in the House.

Another section of the bill applies to hospital and nursing home care. This will be furnished under social security and paid for by increased social security taxes.

Another section of the bill will establish for the first time a new system of voluntary medical insurance, by which individuals over 65, either by having \$3 a month deducted from social security benefits or by paying \$3 into a Federal fund, can be protected against certain medical or surgical expenses and other expenses not covered by the medical care section of the bill.

Finally there is another section of the bill which will not only increase social security taxes to a total of 11.2 percent, paid by the employer and employee equally, but additionally will increase the amount of income taxable for social security purposes first to \$5,600 and then to \$6,600 per year in order to help finance this program.

The total program, as I understood the testimony before the Committee on Rules, would carry an additional cost of \$6.2 or \$6.3 billion. No one is certain in his own mind what the cost will be, because it is now a matter of conjectures and estimates.

The real debate and discussion surrounding this bill in the Committee on Ways and Means and elsewhere is whether or not we should embark upon a new program of paying hospital and nursing home benefits through social security or whether it should be under some other, separate, system.

The gentleman from Wisconsin (Mr. Brawley), the ranking member of the Committee on Ways and Means, has sponsored a bill, H.R. 7057, which provides for all hospitalization, nursing home care, or medical and surgical care to be financed through a voluntary system with a charge levied against the person receiving the benefit, and paid partially out of the Federal Treasury rather than from the payrolls of the employers of the Nation. The bill will be offered not as an amendment, because this rule will not permit the offering of any amendments, or debate except in a general way. It will be offered as a motion to recommit.

I suggest that careful attention be given to the bill itself, because it is a very involved piece of legislation. I also suggest close attention be directed to the motion to recommit.

Mr. Speaker, let me say just one other word in conclusion. Today about one-half of the case mail the average con-

gressional office receives deals with social security cases. If this bill is passed in its present form, because of its intricate and wide coverage, I predict here and now that we will need that fourth office building and additional staff just to answer the inquiries on social security matters. I can see ahead of us a great deal of inquiries from people who believe this legislation is going to give them benefits much greater than a careful study of the bill will convince you that it does give them. It does not give the people what they believe they are going to receive.

I want the Members to listen carefully to the debate concerning the cost to the individual recipient, as well as the cost to the taxpayers for the two programs.

Mr. GROSS. Mr. Speaker, will the gentleman yield?

Mr. BROWN of Ohio. I yield to the gentleman from Iowa.

Mr. GROSS. Is the reason for this gag rule the fear on the part of the majority of the Committee on Ways and Means and the majority of the Committee on Rules that the House would improve the bill, or is it notice to us that we are incompetent to deal with the bill?

Mr. BROWN of Ohio. Well, I am never sure why some people insist on having closed or gag rules. I have never believed in them, and I will permit the gentleman from Iowa to judge for himself the reason.

Mr. Speaker, I yield such time as he may consume to the gentleman from New York (Mr. FINO).

Mr. FINO. Mr. Speaker, over the past 12 years, on numerous occasions, I have spoken on the floor of this House to urge that we liberalize and humanize our social security system. I have introduced bills which would accomplish these results. While we have made progress in improving the system, I feel that we have not gone far enough in eliminating many unjust features still in the law.

Today, this bill—the Social Security Act of 1965—is more than a milestone—it is a landmark in the field of welfare and enlightened social security legislation. We all know that this bill is long overdue, especially the section which provides health insurance for the elderly. The legislative process is often long, and the wheels have turned slowly in this case, but as a result we can be sure that a good, carefully drawn bill has been produced. I will vote for it gladly with a relieved mind. I have been especially concerned about the problems of the elderly for many years. I know what a lengthy illness can do to precious, and essential savings. I know that too many of our elderly citizens fear the first signs of illness, because they are afraid they will not be able to pay the resulting bills, and will have to turn to some form of public assistance for relief. We owe the elderly more than this anxiety about their financial security, an anxiety which will increase as the cost of medical care rises. The Social Security Act of 1965 will give our citizens over 65 some measure of the economic security they deserve.

The bill establishes two coordinated health insurance programs for persons 65 or over. First, a basic plan, which will provide protection against the costs of inpatient hospital services, posthospital extended care, home health services, and outpatient diagnostic services. The bill provides for a deductible which the patient pays, and limits the days of illness which will be covered by the plan in any spell of illness.

This basic plan will be financed through a separate payroll tax and a separate Federal hospital insurance trust fund. Benefits for persons currently over 65 who are not insured under the social security or railroad retirement systems will be financed out of Federal general revenues.

The proposed Social Security Act also establishes a voluntary supplementary plan which would cover a substantial part of the cost of physicians' services and numerous other medical and health services. After an annual deductible of \$50 has been paid by the patient, the plan would cover 80 percent of the patient's bill. Individuals who enroll initially in the plan will pay premiums of \$3 a month, which will be deducted where possible from their social security benefits. The proposed 7-percent, across-the-board increase in benefits which is also contained in the bill would more than cover the monthly premiums for this voluntary health insurance. The Government would match the premium with \$3 paid from general funds. To the greatest extent possible, the benefits will be provided through contracts with carriers who will administer the program. A State would be able to buy into the plan for its public assistance recipients who are receiving cash assistance. This, of course, would be an advantage both for the State and for the individuals concerned.

Now that we have the bill before us we can see that dire warnings about spiraling costs were unfounded. The wage base will be increased to \$5,600 a year beginning January 1, 1966, and to \$6,600 effective in 1971—a step many people have long advocated, and the increase in the payroll tax rate for both employer and employees will only be one-half of 1 percent until 1972, after that rising slowly until in 1987 the health insurance portion of the tax will be four-fifths of 1 percent. This is certainly a reasonable cost for the increased benefits all of us will enjoy.

We must pass this legislation without delay. Hearings have been held twice in the past few years, and certainly no bill has aroused so much support in the country as a whole. The aged are an increasing proportion of the population—their problems will be the problems of all of us, unless something is done to help them. This legislation moves many steps in the right direction.

However, I have been disappointed that the bill has not included a general reform of the social security system. Certainly I support the changes which have been made. But I would go a great deal farther along the path to an equitable, logical system. The bill provides a 7-percent, across-the-board benefit in-

crease, effective retroactively beginning with January 1965. Certainly this increase is long overdue—social security benefits have fallen far behind the rising cost of living, in spite of the urgings of those of us who are aware that the aged have not been allowed to share in our growing prosperity. My bill, H.R. 4774, provides for a 10-percent, across-the-board increase in benefits. I feel that this would supply a much more adequate amount for the millions of beneficiaries who are barely able to meet the price of necessities with their present benefits.

My bill H.R. 2606 would increase the minimum amount of monthly insurance benefit payments to \$50 whereas the present Social Security Amendments of 1965 would increase the minimum to only \$44. It is hard to believe that anyone could consider \$44 a month a decent income. Certainly my bill is considerably more realistic in providing a more reasonable sum for those who must try to live on their social security benefits.

The Social Security Act of 1965 also includes a provision to provide benefits, at an actuarially reduced level, to widows at age 60. The justification for this is obvious: widows, often left alone when they are older and unable to support themselves because of a lack of modern skills, need the income which social security benefits would give them. However, my bill, H.R. 4169, would provide that a widow under retirement age may continue to receive mother's insurance benefits at a reduced rate even though none of her children are under 18. This would especially benefit those widows in their late forties and fifties who have spent their time and energy raising a family, and then are suddenly left without any other income than their comparatively young children can provide. It seems only fair to provide these women with a measure of economic security.

I also suggest that it is time that the retirement age was lowered to keep up with the demands of our modern economy. The unemployment rate remains comparatively high, and many young men and women just out of school are unable to find jobs. Men and women over 50 sometimes need to retire: their health is not good, or they have other pressing reasons why their jobs have become too much for them. It is only logical to provide for these different needs. My bill, H.R. 1693, would give full benefits to men at age 60 and women at age 55.

At the very least, I feel that we should eliminate the penalty—the actuarially reduced benefit—which prevents many men and women who would be helped by relaxation of retirement from leaving their jobs at age 62. Just this small step, which would be relatively inexpensive, would have a beneficial effect on our entire economy.

The bill liberalizes the social security earned income limitations so that the uppermost limit of the band of \$1 reduction in benefits for \$2 in earnings is raised from \$1,700 to \$2,400. Although this is a change for the better, I have urged that the so-called retirement test should be eliminated altogether. It prevents many well-qualified and eager men

and women from holding any but the smallest kind of part-time job. Certainly it is wasteful to prevent such valuable human resources from working at what they are most suited for: retirement should be completely voluntary, and social security benefits, which have, after all, been earned, should not depend on an arbitrary earnings income maximum.

For the past 10 years I have introduced a bill which would extend coverage to dependent brothers and sisters of an individual who dies fully insured. At present, these people, who are unable to support themselves and may be considerably older than the working member of the family, have no way of obtaining benefits if their sole means of support dies. They must often have to turn to public assistance. It is unfortunate that an individual who supports his brother or sister has the added worry about what will happen to them if he dies.

A long-needed reform of the social security system has not been included in this bill. Federal employees should be allowed to join the social security program: at present, they are discriminated against for no logical reason.

Despite the above points, I am strongly in favor of the bill. It contains many provisions which I have suggested for many years. For 12 years I have introduced bills to provide for the payment of children's insurance benefits up to age 22 if they are attending school. At present, children's benefits are cut off when they reach the age of 18. This prevents many of them from attending college or vocational schools, or, in some instances when the mother is in financial need, even finishing high school. Children of deceased, retired, or disabled workers would be included as long as they are full-time students in school. By age 22 the great majority of these children will have finished their education and will be ready to support themselves. This change is certainly essential if we are to succeed in the American ideal that every child shall have the best education for which he is suited. It has been estimated that 295,000 children will benefit under this provision in 1965.

I am also pleased that cash tips have finally been included in the definition of wages. This reform is long overdue; for years service workers, who receive a third or more of their income in tips, have been entitled to only relatively small social security benefits. This change will insure them benefits more comparable to their actual earnings in the years in which they were employed. Employers, in determining wages, always take possible tips into account, and as a consequence the wage will be low.

Many other provisions are worth noting. The Federal share of payments under all State public assistance programs is increased a little more than an average of \$2.50 a month for the needy aged, blind, and disabled. The bill also removes the present restrictions on Federal matching in public assistance programs for needy individuals who are tubercular or psychotic and are in general medical institutions. This should help

both the individuals and the hospitals involved.

The Social Security Act of 1965 also improves and extends the Kerr-Mills program. The bill would establish a new title of the Social Security Act to extend the advantages of an expanded medical assistance program not only to the aged who are indigent but also to needy individuals or the dependent children, blind, permanently and totally disabled programs, and to persons who would qualify under these programs if in sufficient financial need. Kerr-Mills has been found to be a useful way to provide for the basic medical needs of people who desperately need financial help. This section of the 1965 bill would make medical assistance available to more people who need it.

These social security amendments will indeed have far-reaching effects. They will improve the living conditions of 18 million beneficiaries; they will begin the vitally important task of providing health insurance for all aged Americans, whatever their financial conditions. With the passage of this bill we will be facing up to the economic realities of our time and adding a measure of security to our social security system which is in line with those realities. At the same time we will be helping to relieve the consequences of tragedy in millions of American homes. I am happy to support this bill.

Mr. BROWN of Ohio. Mr. Speaker, I yield 5 minutes to the gentleman from Missouri [Mr. HALL].

Mr. HALL. Mr. Speaker, I am appearing before this House as a physician in the Congress to avoid an act of omission, to point out that the rule, House Resolution 322 making in order H.R. 6675, as has been stated by the gentleman from Ohio [Mr. Brown], has no proved need, but at the same time realizing the facts of life and the weight of the Congress to object to no amendments and no points of order from the floor.

Furthermore, I urge support of the motion to recommit with instructions to strike all after the enacting clause and bring back forthwith as a substitute H.R. 7057.

Now, Mr. Speaker, the speculation of the gentleman from Indiana and his non-valid personal opinion concerning many matters other than the rule before us are old saws, worn red herrings being drawn across the trail, that hardly deserve the dignity of acknowledgment. But I submit that this is not the time when we should use the whipping boy of various organizations to bring the physiognomy and visage to a state of "color rubra" by our various expressions in an effort to kick or knock down legislation that will change the state of the Nation.

Mr. Speaker, the majority have the power in this Congress to do that which it wishes and there is no argument about that. So let us not batter again the old worn image of the physicians of America who simply want to take care of people in the best possible way for those people.

Mr. Speaker, it is an error to stand here and quote Whitaker and Baxter as the AMA consultant public relations specialists since, indeed, they have not

worked for the AMA nor been retained by it in any manner or means since the Wagner-Murray-Dingell bill of 1947. We are this out-of-date in some of the statements and the acts of collusion about this organization which, indeed, has been refused television rights in its expression and its desire and its own way to get to the public the hoax of the political promise which, indeed, made the administration itself realize that it could not live with the promise of H.R. 1 made before election time.

This service was rendered, and properly so, by organized medicine. I will leave to the author of the Kerr-Mills Act the statement that only seven States have joined in putting that through their State assemblies. Surely that will be corrected to the figure of 44 States and Territories of our 54 of same, now participating in one degree or another in the existing law of the land, the Kerr-Mills Act. This has been done in spite of opposition from Federal agencies and with the support of medicine and insurers.

The bill now before this House is a bill that was produced in executive session. No public hearings were held in the 89th Congress, thus denying the public and Members of Congress the opportunity to become familiar with this multipaged bill and the report thereon. Even though the administration bill cannot be implemented without the cooperation of physicians, this bill was drafted with no regard for the opinions and comments of those who will be expected to furnish services.

The hospital, State, and Federal evaluation and control committees cannot work without the wholehearted and interested support of the organizations and persons most expert in patient-hospital turnover, and most shunned in developing this hodgepodge bill.

For the same reason—that is, closed hearings—I object to a closed rule. As bad as it may be to write legislation on the floor, it is better than by a small, weighted, and—yes, prejudiced—logic-tight group.

This House is considering a rule for 10 hours of debate. This is a serious matter, and change of the entire concept of medicine for our Nation is at hand.

Recent polls prove the people are unaware of the bill's content and at least these debates will be followed by the news media and the people as the House works its will.

I would have preferred, and did urge before the Committee on Rules, a rule for 30 to 30 hours of debate equally distributed, for full discussion and enlightenment here and across the Nation.

Mr. Speaker, the basis for quality medical care is the voluntary relationship between the doctor and patient. This would begin to disappear as the Government supplants the individual as the purchaser and provider of health services. For the first time this bill provides service benefits in lieu of cash benefits.

Are we to tell the people of America, the senior citizens, that they are not capable of determining this matter as

against a ribbon clerk here in Washington? The result will inescapably be third-party intrusion in the practice of hospitalization and medicine. The physician's judgment would be open to question by others, not responsible for the patient's well-being. His diagnostic and therapeutic decisions would be subject to disapproval by those controlling the expenditure of tax money.

The abuse factor will fill hospital beds, and private patients will be denied or delayed in admission to the end that waiting lists will build up, and another costly crash program of hospital construction will ensue.

As physicians and health facilities become more and more subject to intervention in their work by Government employees, a decline of professionalism will be certain.

America today has the finest physicians in the world, a fact frequently demonstrated over the last decade when the Nobel Prizes have been handed out, by your life expectancy, by those seeking graduate training in this country, or the Anthony Edens, the Dukes of Windsor, the Grace Kelly Rainiers, and many others who come here for medical and surgical care.

This is not merely a controversy over whether Federal Government should tax one group of citizens to provide health care benefits indiscriminately, regardless of need, to another group. This is not merely a disagreement over the best means of providing health care for our older citizens. Rather, this conflict is testing whether art and science of medicine will be permitted to grow and flourish in freedom, and competitively, or whether progress in medicine will be stunted and shriveled by an excess of Government control. Its adoption would be another downward step toward loss of freedom of choice.

It is not the doctors who will suffer under this bill, insofar as their economic standing is concerned; physicians' income would probably be more assured, not less, if the administration's bill is enacted. It is principle, freedom, research, and private insurers who will suffer.

The substitute bill, H.R. 7057, is a voluntary approach to the problem, and it will insure the retention of the high quality of medical care for which America is better known than any other nation on earth.

Mr. Speaker, for the reasons and considerations stated I strongly believe the resolution should be voted down.

Mr. MADDEN. Mr. Speaker, I yield 5 minutes to the gentleman from New York [Mr. KEOGH].

Mr. KEOGH. Mr. Speaker, this is a day which many of us have long awaited. This date will take a historical place in the annals of constructive legislation enacted by the Congress in this century. Just as is true of all the great social advances which have been accomplished, it has taken a number of years and much energy and effort to reach this point. It has, indeed, taken the sincere and persevering efforts of many outstanding men and women.

This momentous and historical legislation which we are about to consider is

a monument to the brilliance, the wisdom, the leadership and, indeed, the outstanding statesmanship of the great and learned chairman of our Committee on Ways and Means, the gentleman from Arkansas. From its inception in 1789, the Committee on Ways and Means has been chaired by many truly able and dedicated men, but I can say with confidence and comfort that that great committee has never had a greater and more able or more dedicated chairman than the gentleman from Arkansas, WILLIAM DAIGH MILLS.

I constantly marvel at his displays of truly brilliant qualities of statesmanship, and in this bill which will take its place alongside the original Social Security Act we have another example of what can be accomplished by such a dedicated and able legislator.

Those of us who have been privileged to sit by his side on the Committee on Ways and Means during the past months and years are deeply aware of those qualities which make him such a leader. It is only through this experience, perhaps, that one can really appreciate the many seemingly insurmountable problems through which he has guided the committee to acceptable and sound solutions. The legislation which we will consider is illustrative of this point. With such leadership the Nation is in sound hands.

Mr. Speaker, may I pay a highly deserved tribute to the ranking Democrat on the committee, the gentleman from California, our colleague [Mr. KING], who has been in the forefront of the fight for adequate medical care for our senior citizens for many years. In addition to earlier measures, he sponsored H.R. 4222 in the 87th Congress, H.R. 3920 in the 88th Congress, and H.R. 1 in this Congress, bill numbers which are familiar to all who have interested themselves in this subject. He deserves the highest commendation and gratitude of all of us. The bill which will undoubtedly pass tomorrow by an overwhelming majority will be a tribute to the deep and sincere compassion of the gentleman from California for the needs of our senior citizens.

Mr. Chairman, may I also observe that many members of the Committee on Ways and Means made meaningful contributions to the development of H.R. 6675. This bill is representative of the legislative process. Its many provisions bear the marks of those who have studied long and assiduously the many facets of the problems involved. To my colleagues on the committee I express my appreciation for the very fine contributions which they have all made to this legislation.

Finally, we would not be here mechanically or so well prepared, Mr. Speaker, were it not for the devoted dedication to duty of the chief counsel of the Committee on Ways and Means, Leo H. Irwin, the assistant chief counsel, John M. Martin, Jr., the minority counsel, William H. Qualey, and our special assistant with respect to this bill, from the Library of Congress, Fred Arner.

Mr. Speaker, much has been said of the time consumed in the hearings be-

fore the Ways and Means Committee. Let it be noted in the Record at this point that in this and the 4 preceding Congresses the Committee on Ways and Means has held public hearings comprising 46 days, at least 641 witnesses who appeared in person and were subjected to cross-examination and whose testimony has been reduced to 13 volumes, comprising some 7,607 pages. Many hundreds of additional statements were submitted for these printed records.

In addition thereto, the Committee on Ways and Means has consumed at least 77 days—both morning and afternoon—in executive session during this period on this subject.

I would point out in addition, Mr. Speaker, we have available on the committee table and in this Chamber, 2 volumes of printed executive hearings conducted in this session comprising nearly 900 pages of the testimony of representatives of such groups as the American Hospital Association, American Medical Association, Blue Cross, Blue Shield, the insurance industry, and so forth.

So, Mr. Speaker, when the House adopts the pending resolution, which it most certainly will, the Committee of the Whole will, in my opinion, witness a debate in the finest traditions of the House, which debate will be dominated by the towering figure of the greatest legislative master of them all, the gentleman from Arkansas, and in which he will be joined by the seemingly confident, obviously conscientious, but fortunately outnumbered minority led by the talented gentleman from Wisconsin.

Mr. Speaker, on the morrow, too, when the evening shadows lengthen, as life has for so many millions of our elder citizens, this bill will pass, and to and of your House, Mr. Speaker, those millions of grateful Americans will say, "Well done; well done."

Mr. MADDEN. Mr. Speaker, I yield 10 minutes to the gentleman from Florida (Mr. PERRY).

Mr. BOOGS. Mr. Speaker, will the gentleman yield?

Mr. PERRY. I yield to the gentleman.

Mr. BOOGS. Mr. Speaker, before the distinguished gentleman from Florida begins his statement, I would like to say that the gentleman from New York (Mr. KROCK) made a very fine statement and he passed out some well-deserved credit to this magnificent piece of legislation. He, of course, was modest and not able to tell of the very, very significant role he has played over the years in bringing this legislation about. I know of no man who has worked harder or diligently or more effectively and more ably on this legislation than the gentleman from New York (Mr. KROCK).

Mr. PERRY. Mr. Speaker, the poet Browning said:

Owe old along with me!
The best is yet to be,
The best of life, for which the first was made.

Mr. Speaker, what this House I believe will do within the next 2 days will contribute much to the realization of that poetic dream.

Within the last 2 weeks, Mr. Speaker, this House shall have made history in the passage of a bill opening doors of educational opportunity far exceeding anything ever known in this blessed land; and I hope by the end of tomorrow, we will have enacted this legislation which will remove the specter of fear of illness from the 19 million citizens of our country 65 years of age and over and remove the concern from the hearts of their children that a 60-day hospitalization would—if it did not jeopardize their very homes—probably exhaust their savings and impose upon them indebtedness burdensome for years ahead.

We all know, Mr. Speaker, that the income of the senior citizens of this country is much below the income of younger people, active in their occupations and earnings. For example, only about 20 percent of the aged have sufficient incomes to pay income tax. Of the aged who are on social security, all but about one-fifth rely on social security benefits as their major source of continuing retirement income.

In respect to assets, the picture is no more favorable. The average financial assets such as bank accounts, securities and the like, liquid assets, are of no significant value as far as the senior citizens are concerned.

In 1962, half of the aged couples of America had financial assets of less than \$1,350 and half of the nonmarried aged had less than \$400 of financial assets.

Now, Mr. Speaker, if one of these senior citizens with that inadequate income and with that kind of financial assets had to go to a hospital for 60 days—who would pay the bill? They do not have the money. It is not currently available from any other public source except the charity of the cities and counties and private institutions and private individuals and relatives of these senior citizens.

In my own district, the story was told me a little while ago of a son going into the home of his aged mother. When he approached the front door he could hear her gasping for breath. He rushed in. It was the aftermath of a recurrent heart attack and he said, "Mother, I must rush you to the hospital."

In her faltering way she said, "I do not have the money to go to a hospital." He said, "Mother, they will take you at Jackson Memorial Hospital and in the hospital you will be provided for." She said, "I do not want to be a charity patient in Jackson Memorial Hospital." And that faithful son said, "All right, Mother, my wife and I will mortgage our home to keep you out of a charity ward and to give you the hospital care which you require."

Imagine how light will be the hearts of the senior citizens of America, as a result of having the assurance that without burdening their children, without being charity patients in local hospitals, without having to rely upon the bounty of their children or their friends, they can go to a hospital for 60 days for one spell of illness, under this bill, and get the care that they require.

We have not only provided that assurance of hospital care for 60 days for each

spell of illness, which may be repeated, upon the certificate of a physician, after a lapse of another period when they have been out of the hospital, another 60 days, and so on, as long as their health needs require. But this bill goes further and for the first time provides medical services also for those over 65 who are ill.

How will that medical service be paid for, primarily? Those who are retired, drawing social security benefits, will get a minimum of \$4 per month under this bill, under the 7 percent across the board increase in their social security benefits; so they will get more than \$3. If they will voluntarily enroll for medical care under this bill, the Government will withhold \$3 it otherwise would give the individual, match that with another \$3, and buy a \$6 a month medical insurance policy to cover the individual, giving surgical services, medical services, diagnostic and therapeutic services, home-care treatment and attention and other benefits.

What a wonderful package it is, therefore, that we will make available to the senior citizens of this land.

There will be an attack, as there have been attacks in the past, upon the payment of these social security taxes by the younger workers. But the figures show that out of every senior couple in this country, at least one of the couples has to go to a hospital for at least once in the remaining days between retirement and death, and the average hospital cost is \$600 to such an individual. This is more than the average any worker will ever pay.

So the children of the senior citizens, the mothers and fathers of America, will have assurance that the burden of that 60-day illness of their parents, or whatever it may be, will not be upon them and that they will have their principal hospital and medical expenses provided for when they reach age 65.

Mr. Speaker, there are things which remain to be done. We do not provide in this bill for the aged chronically ill, as the committee well recognizes. I hope that will be one of the challenges of the future, and that we may find a way for those who have to stay in a hospital or a nursing home for a longer time than allowed by this bill will be succored while in that period of illness and confinement.

Mr. Speaker, in this legislation we deal with nothing less precious than the lives and the health, not to speak of the happiness, of the mothers and fathers of our land. One of the commandments says "Honor thy Father and thy Mother." I know of no way we can better honor the fathers and the mothers of America—those who have borne the burdens of a generation, faced or been willing to face the enemy in war, borne the problems of a nation in peace, and developed a mighty land—than to provide a program so that they will not feel, when they come to the end or almost the end of the day of life, that they are neither neglected nor forgotten. I feel that this bill does honor and does justice to the mothers and fathers of America.

The rule is fair. I hope it will be adopted and that by the end of tomorrow this monumental legislation will

become another of the glorious acts of this great House.

Mr. MADDEN. Mr. Speaker, I move the previous question.

The previous question was ordered.

The SPEAKER. The question is on the resolution.

The question was taken and the Speaker announced that the ayes appeared to have it.

Mr. HALL. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER. The Chair will count. [After counting.] Two hundred and eighteen Members are present, a quorum.

Mr. HALL. Mr. Speaker having exercised due process, I wish to do the same, and I now demand the yeas and nays.

The yeas and nays were refused.

The SPEAKER. The question is on the resolution.

The resolution was agreed to.

Mr. MILLS. Mr. Speaker, I move that the House resolve itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 8675) to provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the old-age, survivors, and disability insurance system, to improve the Federal-State public assistance programs, and for other purposes.

The motion was agreed to.

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the State of the Union for the consideration of the bill H.R. 8675, with Mr. DINGELL in the chair.

The Clerk read the title of the bill.

By unanimous consent, the first reading of the bill was dispensed with.

Mr. MILLS. Mr. Chairman, I yield myself 15 minutes.

Mr. Chairman, we are beginning the consideration, in Committee of the Whole, of H.R. 8675, a bill reported by the Committee on Ways and Means after consideration this year of many, many days in executive session involving a subject matter that has been before the committee for a number of years, a subject matter on which the Committee on Ways and Means has conducted over the course of that time more days of public hearings than on any other matter within the jurisdiction of the Committee on Ways and Means in the same period of time. This was pointed out by the gentleman from New York [Mr. KEOGH], during the debate on the rule a few minutes ago.

Mr. Chairman, the bill, H.R. 8675, involves some matters that have not been in bills submitted in prior years to the Committee on Ways and Means as a single package or previously reported by the Committee on Ways and Means.

It is significant, however, Mr. Chairman, that the bill, H.R. 8675, contains all except one of the provisions that were in the bill last year that was reported from the committee providing for social

security amendments and which the House passed by an overwhelming vote, as I recall, with only eight Members voting against that bill. At that time the committee thought it advisable to include a provision to permit firemen and policemen under existing State and local government pension plans so they could elect among themselves to come under social security. That provision was stricken by Senate action in the Finance Committee as it considered the bill last year and is not in this year's bill.

Mr. Chairman, after we met with the other body in conference, we felt it was advisable for us not to include the provision this year on the basis of the feeling that prevailed within the conference on that matter. But with that sole exception everything that you Members who were here last year and who returned to this Congress voted for in the social security amendments of last year is contained in this bill.

Mr. Chairman, I say there is material in it that was not in that bill. There is material in it this time that apparently is more controversial in nature than the material that prompted all Members of the House last year, save eight, to vote for the bill.

I believe with respect to that material which is in the bill, however, there seems to be more misunderstanding and more general statements of disapproval without foundation and fact than we want to permit to continue after we discuss the bill through these 10 hours of general debate.

Let me point out, Mr. Chairman, very briefly what some of the provisions are within the bill, most of which do not involve any controversy whatsoever, for most of these provisions are in a bill that the distinguished gentleman from Wisconsin [Mr. BYRNES] introduced last week in his name that were not controversial in the Ways and Means Committee itself to any great extent.

In bringing to you the contents of this bill permit me to divide the bill into four parts, for each of these four parts constitutes a separate subject matter for a monumental bill within itself.

These four parts are, first, the part dealing with the medical care of our elderly citizens; second, the part dealing with maternal and child health, crippled children, and mentally retarded programs; third, the part revising and improving the benefit and coverage provisions of the old-age, survivors, and disability insurance program and, fourth, the part improving and expanding the public assistance programs themselves.

Now, let us return to the first of these. What, in a brief way, is the committee bill proposing to do with respect to health insurance and medical care of those over 65? The bill divides in that respect into three parts. There is within the bill what we have called a basic plan providing protection against the cost of hospital and nursing home care, financed through a separate payroll tax and using a separate trust fund.

The proposed basic hospital insurance would be provided—on the basis of a new section in title II of the act—for

people aged 65 and over who are entitled to monthly social security benefits or to annuities under the Railroad Retirement Act. In addition, people who are now aged 65 or will reach age 65 within the next few years and who are not insured under the social security or railroad programs would nevertheless be covered under the basic plan. In July 1968, when the program would become effective, about 17 million people aged 65 and over who are eligible for social security or railroad retirement benefits, and about 2 million aged who would be covered under a special transitional provision, would have the proposed basic hospital insurance.

Included under the special provision would be all uninsured people who have reached 65 before 1968. As to persons reaching 65 after 1967, they would have to have the quarters of coverage that are indicated in the following table:

Quarters of coverage required for OASI cash benefits as compared to hospital insurance

| Year attains age 65 | Men | | Women | |
|---------------------|------|--------------------|-------|--------------------|
| | OASI | Hospital Insurance | OASI | Hospital Insurance |
| 1967 or before.... | 6-16 | 0 | 6-12 | 0 |
| 1968..... | 17 | 0 | 14 | 0 |
| 1969..... | 18 | 0 | 15 | 0 |
| 1970..... | 19 | 12 | 16 | 12 |
| 1971..... | 20 | 13 | 17 | 13 |
| 1972..... | 21 | 14 | 18 | (7) |
| 1973..... | 22 | 15 | 19 | |
| 1974..... | 23 | (7) | | |

¹ Same as OASI.

As indicated in the table, by 1974 the quarter coverage required for cash benefits and hospitalization insurance benefits will be the same and the transitional provision will phase out.

Together, these two groups comprise virtually the entire aged population. The persons not protected would be Federal employees who retired after July 1, 1960, and have had the opportunity to come under the liberal provisions of the Federal Employees Health Benefits Act of 1959. Others excluded would be aliens who have not been residents of the United States for 10 years and certain subversives.

Currently, 93 percent of the people reaching age 65 are eligible for benefits under social security or railroad retirement and this percentage will rise to close to 100 percent as the program matures. Thus, over the long run virtually all older people will earn entitlement for the proposed hospital insurance.

Persons entitled to benefits under the hospital insurance plan would be eligible to have payments made for inpatient hospital care and for important additional benefits covering posthospital extended care, posthospital home health services, and certain outpatient hospital diagnostic studies.

Benefits would be payable for covered hospital and related health services furnished beginning July 1, 1966. Posthospital extended care benefits would be effective January 1, 1967.

The second part of the medical package provides for a voluntary supplementary program providing and making

available money for the payment of physicians' fees and other medical and health services, which would be financed through a small monthly premium paid by the individual, equally matched by an amount from the general funds of the Treasury of the United States.

The voluntary supplementary plan would provide protection that builds upon the protection provided by the hospital insurance plan. It would cover physicians' services, additional home health visits, care in psychiatric hospitals, and a variety of medical and other services not covered under the hospital insurance plan. The beneficiary would pay the first \$50 of expenses he incurs each year for services of the type covered under the plan. Above this deductible amount, the plan would pay 80 percent of the reasonable costs in the case of services provided by an institution or home health agency and 80 percent of reasonable charges for other covered services, with 20 percent being paid by the beneficiary.

Benefits under the supplementary plan would be provided for:

First. Physicians' services, including surgery, consultation, and home, office, and institutional calls.

Second. Medical and other health services. These would include:

(a) Diagnostic X-ray and laboratory tests and other diagnostic tests;

(b) X-ray, radium, and radioactive isotope therapy;

(c) Surgical dressings, splints, casts, and other devices for reduction of fractures and dislocations;

(d) Rental of durable medical equipment, such as iron lungs, oxygen tents, hospital beds, and wheelchairs;

(e) Prosthetic devices (other than dental) which replace all or part of an internal body organ;

(f) Ambulance services with limitations;

(g) Braces and artificial legs, arms, and eyes.

Third. Inpatient psychiatric hospital services for up to 60 days during a spell of illness—subject to a lifetime maximum of 180 days.

Fourth. Home health services for up to 100 visits during a calendar year—without a requirement of prior hospitalization.

The \$50 deductible would be applied on a calendar year basis, except that expenses the individual incurred in the last 3 months of the preceding calendar year would be counted as satisfying the deductible if they had been counted toward the deductible in that year. This special carryover provision would avoid requiring persons with substantial costs at the end of 1 year to meet the deductible perhaps early in the next year as though they had had no prior bills.

The third part of this medical package results from the thinking in the Ways and Means Committee last year and largely consists of the tentative decisions that were taken at that time for drafting purposes within the committee.

That has to do with the expansions and improvement of the existing program of medical assistance for the aged. We have made very material improve-

ments within that program, permitting the States to continue to provide better benefits to more needy people and permitting the Federal Government to assist the States with respect to the financing of these benefits.

We have made provision, Mr. Chairman, within the framework of that program, to assist the States not only with respect to the medical problems of those who are 65 and over, but we have made provision to help them with respect to the costs of the medical expenses for the blind, for the disabled, and for families with dependent children. These are now provided in some form or other, and under varying formulas in some five titles of the Social Security Act. We have grouped those into one program, and we place that in the new title of the Social Security Act, title XIX.

The provision of medical care for the needy has long been a responsibility of the State and local public welfare agencies. In recent years, the Federal Government has assisted the States and localities in carrying this responsibility by participating in the cost of the care provided. Under the original Social Security Act, it was possible for the States, with Federal help, to furnish money to the needy with which they could buy the medical care they needed. Since 1950, the Social Security Act has authorized participation in the cost of medical care provided in behalf of the needy aged, blind, disabled, and dependent children—the so-called vendor payments. This method of providing care has proved popular with the suppliers of medical care, the agencies administering the programs, and the recipients themselves.

Several times since 1950, the Congress has liberalized the provisions of law under which the States administer the State-Federal program of medical assistance for the needy. The most significant enactment was in 1960 when the Kerr-Mills medical assistance for the aged program was authorized. This legislation offers generous Federal matching to enable the States to provide medical care in behalf of aged persons who have enough income for their basic maintenance but not enough for medical care costs. This program has grown to the point where 40 States and 4 other jurisdictions have such a program and 227,000 aged were aided in December 1964. Furthermore, medical care as a part of the cash maintenance assistance programs has also grown through the years until, at this time, nearly all the States make vendor payments for some items of medical care for at least some of the needy.

H.R. 6675 is designed to liberalize the Federal law under which States operate their medical assistance programs so as to make medical services for the needy more generally available. After an interim period ending June 30, 1967, all vendor payments for medical care, including medical assistance for the aged, would be administered under the provisions of the new title. Until June 30, 1967, States might continue operating under the vendor payment provisions of title I, old-age assistance and medical

assistance for the aged; title IV, aid to families with dependent children; title X, aid to the blind; title XIV, aid to the permanently and totally disabled; and title XVI, the combined adult program, or if they wish, they might move as early as January 1, 1966, to the new title. Programs of vendor payments for medical care will continue, as now, to be optional with the States.

I will pass to the second part of the bill as we have divided it this morning for the purposes of discussion. That has to do with services for the mentally retarded, and for the maternal and child health and crippled children's programs. There we have added to the amount of money that we will provide the States from the Federal Treasury to assist with respect to these problems of our children.

The third part of the bill dealing with amendments and improvements of the Federal old-age, survivors, and disability insurance program again has to be broken down, for there are several very important amendments in this part of the bill. We are providing an across-the-board increase in the amount of benefits that we pay under social security by 7 percent, with a minimum, so that no retired worker or widow, age 65 or over would receive less than a \$4 increase in his social security check. We are making that provision retroactive to the 1st of January 1965, because that was the date for the commencement of increases in such benefits under the legislation that passed both branches of the Congress last year, but did not emerge from the conference.

Second, we are continuing benefits to children up to age 22, where now they discontinue at age 18, provided that the child is attending a school. We provide actuarially reduced benefits for widows at age 60. And we are liberalizing the definition of disability and providing for payment for the sixth month of the waiting period for disability insurance benefits. This to me is one of the more important elements within the amendments to the old-age, survivors, and disability insurance program.

We are for the first time providing to some 355,000 people 72 years of age and older what we call a transitional benefit for people who have had—or their husbands have had—some connection with the program but for some reason or other not sufficient connection with the work force to qualify under the present more stringent eligibility requirements. We are providing for them this transitional benefit. There are about 355,000 of those people still living who would benefit. We are increasing the amount an individual is permitted to earn and continue to draw some part of his social security benefit without losing all of that benefit.

There are many amendments in addition to those that I have discussed, including the coverage of self-employed physicians, including cash tips as wages for the purpose of social security, liberalizing the income treatment for self-employed farmers, improving certain State and local coverage provisions, exempting certain religious groups opposed to insurance, and revising the tax

schedule and the earnings base so as to fully finance these changes we are making, and thus assuring that these programs are going to continue to be maintained on an actuarially sound basis.

The fourth point of the bill is equally important, equally important to those that are involved and affected by it, for under this part of the bill we are increasing the Federal matching share for the needy aged, the blind, the disabled, and families with dependent children.

The bill provides for an increase in the payments to public assistance recipients, effective January 1, 1966. The formula determining the Federal share of assistance payments is liberalized by increasing the Federal proportion of the payments in the first step of the formula and by raising the ceiling on Federal sharing in the second step of the formula. For the adult categories—OAA, APTD, AB, and for the combined program for the aged, blind, and disabled—the formula is changed from twenty-nine thirty-fifths of the first \$35 of the average assistance payment to thirty-one thirty-sevenths of the first \$37 of the average assistance payment. The ceiling is raised on the average payments from \$70 a month to \$75 a month. The provisions in the formula under titles I and XVI adding \$15 to the ceiling for vendor medical care payments in which there can be Federal participation and otherwise recognizing medical payments are not affected by this formula change, except that the steps of the statutory formula are rearranged to improve their equitable application.

For the program of AFDC, the formula change made in the bill would be from fourteen-sevenths of the first \$17 of the average payment per recipient to five-sixths of the first \$18 of the average assistance payment. The ceiling is raised from \$30 a month to \$32 a month. Under the bill, there would be an increase in Federal payments averaging about \$2.50 a month for the needy recipients in the adult assistance categories and an increase of about \$1.25 a month for the needy children and the adults caring for them. The level of aid provided the needy justifies this modest increase.

We are eliminating limitations on Federal participation in public assistance to aged individuals in tuberculosis and mental disease hospitals under certain conditions. We are affording the States broader latitude in disregarding certain earnings in determining need for aged recipients of public assistance. And we are making other improvements in the public assistance titles of the Social Security Act.

Let me briefly refer to the magnitude of this bill by looking to the scope of it, seeing the numbers of people who are affected directly and immediately by this legislation.

Under the basic plan, that is under the hospital insurance program for persons aged 65 or over, it is estimated that some 17 million insured individuals and some 3 million individuals who are not insured under social security or railroad retirement would qualify on July 1, 1966, for protection against the cost of

those hospital benefits that we make available under the basic plan.

Then under the voluntary supplementary plan, it is estimated that of the 19 million eligible aged today, maybe 80 to 95 percent will participate. This means approximately 15 to 18 million individuals would be benefited by that part of the medical program.

The CHAIRMAN. The time of the gentleman from Arkansas has expired. Mr. MILLS. Mr. Chairman, I yield myself 10 additional minutes.

Under the medical assistance for the needy provision of the bill, we anticipate that some 8 million people under State programs with the Federal Government assisting will receive medical protection and be benefited thereby.

Then under the old-age, survivors, and disability insurance part, where we make amendments that I have referred to, there are 20 million people today who will receive increased benefits as a result of the 7-percent across-the-board increase in their cash benefit payments.

There are 295,000 children who will benefit under the provision allowing them to receive benefits when they continue in school up to age 22.

There are 185,000 widows who we anticipate will participate at age 60, with an actuarially reduced benefit.

There are some 355,000 of these people 72 years and older who will be eligible to receive the transitional social security benefit for the first time.

There are about 155,000 workers and dependents who will receive eligibility as a result of our change in definition under the disability benefit program.

The heading "Committee Bill Costs More for Less Protection Than Republican Proposal," which appears in the minority report seems worthy of comment. If it proves to be true, my friends on the minority do, indeed, have a remarkable program.

To overcome my initial skepticism, I requested a comment on the figures presented by the minority members from the chief actuary of the Social Security Administration. The melancholy reply was what I had feared. In the health care area, as in most other areas, you only get what you pay for. If the Republican proposal provides more, it has got to cost more. Or to put it in Mr. Myers' words:

Quite obviously, it is impossible for more benefits to be given under one proposal than another and, at the same time, for the first proposal to cost less than the second one. In brief, the errors in the analysis that is made in this section arise from comparing costs for groups of different size and from cost estimates that are on different bases.

Mr. Myers concludes that if the two programs are compared under similar assumptions, the Republican proposal would involve benefit disbursement costs some \$700 million more in the first full year of operation than of the cost of the basic hospital insurance plan and the voluntary supplementary plan combined in the committee bill. Perhaps the relative costs of the programs can be best shown in percent of payroll—fully realizing that the minority plan and the

committee's supplementary plan are to be financed by a combination of individual contribution and general revenue—and in monthly per capita costs:

| | Long-range level (percent) | Monthly per capita (1st year) |
|------------------------------|----------------------------|-------------------------------|
| Committee Bill: | | |
| Basic hospital..... | 1.28 | \$36 |
| Voluntary supplementary..... | .40 | 8 |
| Total..... | 1.72 | 46 |
| Republican Bill: | | |
| Voluntary..... | 2.51 | 59 |
| Comprehensive..... | | |

In order that the record reflect cost estimates on both the committee and minority proposals prepared under comparable assumptions, I would like to place in the Record a number of memorandums from Mr. Myers relative to their cost aspects:

MEMORANDUM OF APRIL 1, 1965

From: Robert J. Myers.

Subject: Appraisal of comparative cost estimates for health insurance proposals in "Separate Views of the Republicans" section of the House report on the Social Security Amendments of 1965.

On page 245 of the above report, a comparison is made of the estimated costs for the health insurance benefits under H.R. 8675 with those under the Republican proposal. The essence of the analysis made there is that "the committee bill costs more for less protection than the Republican proposal."

Quite obviously, it is impossible for more benefits to be given under one proposal than another and, at the same time, for the first proposal to cost less than the second one. In brief, the errors in the analysis that is made in this section arise from comparing costs for groups of different size and from cost estimates that are on different bases.

The section states that the cost for the first full year of operation (calendar year 1967) is \$3.42 billion for H.R. 8675, and \$2.90 billion for the Republican proposal. These figures are stated to be on the assumption of 80-percent participation in the programs. However, the figure of \$3.42 billion for H.R. 8675 consists of \$1.13 billion for the supplementary health insurance benefits plan on an 80-percent participation basis, and of \$2.30 billion for the hospital insurance plan that is on a virtually 100-percent basis.

I do not know the source of the last-mentioned figure since it does not relate either to contributions or to benefit payments plus administrative expenses, the former being estimated at \$2.60 billion and the latter being estimated at \$2.36 billion—both figures being shown on page 251. It is incorrect to use the contribution figure as a basis for the analysis because it involves a certain amount of advance funding. If, then, we use the figure for benefits and administrative expenses, it should be reduced by 30 percent so as to be on a comparable basis with that for the Republican proposal, which assumes 80-percent participation. On this basis, the cost for H.R. 8675 is \$2.93 billion (80 percent or \$2.26 billion for the hospital insurance program, plus \$1.13 billion for the supplementary health insurance benefits program).

This adjusted cost figure of \$2.93 billion for H.R. 8675 is virtually the same as that shown in the section for the Republican proposal, even though the latter really has a higher benefit cost. The explanation for this difference is that the cost estimate given for the Republican proposal is not on the same conservative basis as that for H.R. 8675, both

parts of which are estimated under high-cost assumptions. On the other hand, the cost estimate for the Republican proposal is an intermediate-cost estimate, which I made in my memorandum of February 26. A cost estimate for the Republican proposal that is comparable with the cost estimate for H.R. 9675 shows a total cost of \$3.60 billion, as compared with the \$2.90 billion shown in the report (the high-cost estimate being from my memorandum of February 9).

Thus, on a comparable basis, both as to degree of participation and as to actuarial cost assumptions, the Republican proposal has a higher cost for benefit payments and administrative expenses than H.R. 9675—as should properly be the case because of the more extensive benefit protection provided (for example, it includes benefits with respect to drugs, private-duty nursing, extremely long periods of hospitalization, etc.).

The cost analysis for the Republican proposal derives the "cost to be financed by taxpayers," which is the result of subtracting the premium contributions from the total cost of the program. The result would, of course, be different when comparable bases are used—for the reasons indicated previously. However, I question the significance of this concept because there is really little difference between the premium contributions made by persons currently eligible for the benefits and the contributions for hospital insurance made by workers, most of whom are under age 65, who will ultimately receive hospital benefit protection if they attain age 65.

The cost analysis in this section also derives a net cost figure assuming 100-percent participation. If the high-cost estimate basis is used, following the conservative financing approach underlying H.R. 9675, the total annual benefit cost would be \$4.55 billion. To obtain the net cost to general revenues, offset against this would be the premium contributions of \$1.25 billion and the recoupment of the tax revenue loss from medical deductions in the income tax of \$0.25 billion, or a net cost of \$3.05 billion—as compared with \$1.80 billion shown in this section. My figure does not include—as does the \$1.80 billion—any reduction in Federal costs for OAA and MAA, since the provisions therefor in the bill require that State and local government funds for public assistance programs should not be reduced over present levels. Accordingly, there would be no savings in Federal funds in this connection. It is proper to follow this procedure since the Republicans have stated that they support the amendments in H.R. 9675 relating to the Kerr-Mills program.

ROBERT J. MYERS.

MEMORANDUM OF APRIL 2, 1965

From: Robert J. Myers.

Subject: Cost estimate for financing the Republican proposal for health insurance benefits for persons aged 65 and over on a contributory social insurance basis.

This memorandum will present a cost estimate for financing the health insurance benefits under the Republican proposal through a social insurance approach that would use the same earnings bases as those in H.R. 9675. The Republican proposal is contained in H.R. 4351 and companion bills. The cost estimate made here for that proposal is on the same conservative assumptions as those used for the cost estimate for the committee bill.

The estimated level cost of the benefit payments and administrative expenses of the hospital insurance provisions of the committee bill is 1.25 percent of taxable payroll, whereas the corresponding figure for the Republican proposal is 2.21 percent of taxable payroll. If the supplementary health insurance benefits provisions of the committee bill were on a compulsory basis like the hos-

pital insurance provisions (instead of on a voluntary individual-election basis financed by premiums from the beneficiaries and matching Government contributions), the estimated level cost of these benefits, plus that for the hospital insurance provisions would be 172 percent of taxable payroll. Accordingly, the contribution rate schedule for the Republican proposal (combined with an earnings base of \$5,600 in 1966-70 and \$6,800 thereafter) would be as follows for the combined employer-employee rate, as compared with the corresponding schedule for the committee bill (showing both the schedule in the bill for the health insurance benefits and that which would be included if the supplementary health insurance benefits were also included on the same financing basis):

| (In percent) | | | |
|--------------------|----------------|-------------------------------------|---------------------|
| Calendar year | Committee bill | Committee bill, plus HIB provisions | Republican proposal |
| 1966..... | 0.7 | 1.0 | 1.4 |
| 1967-70..... | 1.0 | 1.4 | 1.9 |
| 1971-75..... | 1.1 | 1.6 | 2.0 |
| 1976-79..... | 1.2 | 1.7 | 2.2 |
| 1980-85..... | 1.4 | 2.0 | 2.5 |
| 1986 and after.... | 1.6 | 2.2 | 2.8 |

Estimated progress of health insurance trust fund under Republican proposal if financed in same manner as hospital insurance proposal in committee bill

| (In millions) | | | | | |
|---------------|---------------|------------------|-------------------------|------------------|--------------------------------|
| Calendar year | Contributions | Benefit payments | Administrative expenses | Interest on fund | Balance in fund at end of year |
| 1966..... | \$2,136 | \$1,897 | \$183 | \$34 | \$1,166 |
| 1967..... | 4,954 | 4,254 | 286 | 84 | 1,866 |
| 1968..... | 4,301 | 4,453 | 316 | 81 | 2,080 |
| 1969..... | 4,470 | 4,896 | 326 | 88 | 2,371 |
| 1970..... | 4,666 | 4,197 | 361 | 76 | 2,636 |
| 1971..... | 4,321 | 4,631 | 385 | 84 | 2,945 |
| 1972..... | 4,627 | 4,875 | 408 | 88 | 3,467 |
| 1973..... | 7,180 | 6,280 | 433 | 114 | 4,118 |
| 1974..... | 7,490 | 6,677 | 461 | 120 | 4,850 |
| 1975..... | 7,788 | 6,996 | 464 | 142 | 5,100 |
| 1976..... | 10,996 | 9,145 | 586 | 266 | 6,440 |
| 1977..... | 12,466 | 11,628 | 622 | 425 | 10,801 |
| 1980..... | 14,823 | 14,176 | 1,065 | 891 | 14,686 |

* Including administrative expenses incurred in 1964.

Now, Mr. Chairman, this program costs money. Let us not think for 1 minute that this or any other program can be provided without it costing money. I have been just a little bit concerned about what was said in the report of the minority—that they could do more and provide more benefits for more people for less money than the committee bill did. Very frankly, I do not think you can develop a program with benefits of the same value from the general funds of the Treasury or through the mechanism of a payroll tax and have, if the amount of benefits is exactly the same in either approach, one cost less than the other. It is beyond my comprehension that any of us today are brilliant enough to come forward with a method of providing more benefits to more people and having it cost less money. It just does not sound reasonable or logical to me.

In developing this comprehensive health insurance program for the aged the Committee on Ways and Means was mindful that a program is no better than its administration. The committee proposals reflect a conviction that the administrative challenges brought by this new program can be met by the combined efforts of voluntary organizations and the Government. The

These schedules for the Republican proposal and for the supplementary health insurance benefits proposal are determined from the same cost and financing assumptions as that for the committee bill. The schedules would thus not only meet the cost of the benefit payments and administrative expenses, but also would build up moderate contingency funds. Furthermore, just as is the case with the committee bill, if the earnings base increases after 1971, and if all the other cost assumptions are realized, the contribution rates would not have to increase as much as is indicated in the foregoing schedules.

Under this financing basis, the Republican proposal would have contribution income of \$3.2 billion in calendar year 1966 and disbursements for benefits and administrative expenses of \$2.1 billion (assuming that benefit payments would first be available in July 1966). In calendar year 1967, contribution income would be \$5 billion, while disbursements for benefits and administrative expenses would be about \$4.5 billion.

The attached table shows the estimated progress of the trust fund that would develop under the foregoing contribution schedule under the financing basis and actuarial cost assumptions underlying the hospital insurance provisions of the committee bill.

ROBERT J. MYERS.

governmental part of this challenge will nevertheless remain large. It will fall mainly to the Social Security Administration. We believe that this agency's outstanding record for service and efficiency will be carried forward into the new program.

The Social Security Administration, however, will face a major job of advance planning and preparation to bring the health insurance programs into operation by next year. Extensive negotiations will be required to complete agreements and financial arrangements with fiscal intermediaries, insurance carriers, State agencies, and others. Broad-scale consultation will also be required with professional organizations representing the Nation's hospitals and others who furnish reimbursable health services. Operational policies and recordkeeping procedures will have to be worked out on a scope never before undertaken in the health field. This will entail, among other things, putting into the hands of 19 million aged people information about the two health insurance programs, answering inquiries on the benefits of the voluntary insurance plan, setting up records for those who elect the plan, and preparing and delivering identification cards for all the eligible aged.

In addition to this vast enrollment task, the Social Security Administration will have a tremendous job of taking and developing new claims in order to establish the basic eligibility of the aged who have been uninsured for cash benefits and from all others over 65 who have not yet applied for social security benefits. This will mean a doubling of the normal old-age and survivors disability insurance claims load for a single year, at the same time that changes in the disability insurance law and other social security changes will bring a heavy volume of additional activity into social security district offices.

I am sure the Social Security Administration will stand up to the challenge. I am sure, too, that when this bill becomes law the social security people, as they have so frequently demonstrated in the past, will lose no time in getting on with all the necessary preparations. They are well aware that carrying out the new programs and the improvements in the present one will demand all the talents and skills they can muster. This effort will require that all possible measures—in the Congress and in the Executive branch—be taken to assure that any obstacles that might get in the way of effective administration will be removed. It will be important, for example, that the needed supplemental appropriations, organizational changes, and greatly increased staffing take place just as soon as possible.

One very serious obstacle is the limitation on the number of people of supergrade rank that the Social Security Administration is now permitted. I am referring to the positions above the GS-15 grade. In this organization, which already operates the biggest insurance program of its kind in the world, pays over \$16 billion a year to nearly 20 million people, serves tens of thousands of people daily through a nationwide network of over 600 offices, and requires a staff of 36,000 people to conduct its operations there are today only 15 supergrade positions—2 of which are in the scientific and technical excepted group. This is 1 for every 2,400 employees. In comparison, the Railroad Retirement Board, conducting a somewhat similar program of much smaller scope, has 1 supergrade for every 311 employees—more than 10 times the percentage of supergrades now permitted the Social Security Administration. The Internal Revenue Service has 1 supergrade for every 211 employees. The Civil Service Commission has 1 for every 136. The General Services Administration 1 for every 434, and the General Accounting Office 1 for every 166. None of these agencies has less than 5 times the percentage of supergrades allocated to the Social Security Administration. From these statistics it is clear that the allocation of higher level positions to direct the social security program has failed to keep pace with the rapid growth of the program. This obviously puts the Social Security Administration at a severe competitive disadvantage in its search for qualified and competent personnel not only with private industry but with other agencies of the Government.

This is the situation as it already exists. And now, in enacting this bill, we would be aggravating it seriously if no remedy is provided. If we expect—and we do expect—the Social Security Administration to carry out these new responsibilities in a manner befitting their importance and the needs and proper expectations of the American people, any unnecessary and inequitable handicaps upon the organization ought to be removed without delay. Effective carrying out of the provisions we are making for the health and security of the Nation's senior citizens, and for helping its widows and its orphans, is far too important, and too great a challenge to warrant risking impairment of the job by failing to allow the Social Security Administration enough higher level jobs to attract and retain the required human talents and skills.

As I have indicated, it would take a hundred supergrade jobs, considering the small allowance it now has and the necessary expansion this agency faces, to put it in a comparable position with the General Services Administration and nearly 200 to put it in a comparable position with the Internal Revenue Service. I would not undertake to say the exact number needed but I believe it is clear that the needed increase is large enough to call for special legislation. As one deeply concerned with the smooth and successful carrying out of the far-reaching programs we are acting on today, I hope the appropriate committees of the Congress will see their way clear to promptly consider such legislation which I believe is required to enable the administering agency to do the job in the way we and the people of the country want it done.

I must admit that the benefits in the committee bill cost money—yes, they cost money. Let us see what they cost. Let us see what we are doing in this bill to provide for those costs.

The health care program costs include those for the supplementary program, for the basic program, and for the medical assistance for the aged improvements. The basic program, which I have said is financed by the payroll tax device, will in the first full year of its operation, 1967, produce a cost of \$2,300 million on the basis of using high cost estimates, which we think is the conservative way to determine what something will cost when you have to provide a tax for it.

The voluntary supplementary health benefits program will have a cost out of the Federal Treasury, beginning July 1, 1966, of approximately \$600 million per year, while for the same period there will also be a cost of \$275 million for uninsured persons covered by the hospital insurance program.

The medical assistance for the aged liberalization of the program will cost about \$200 million per year.

The 7-percent across-the-board increase in the old-age and survivors disability insurance benefits payments will produce in the year 1966 additional benefit payments of \$1,400 million.

The child benefits to age 22 when in school will add an additional cost of \$195

million to the old-age survivors disability insurance trust funds in the first year.

The reduced age for widows will cost \$165 million out of those trust funds in the first year. But that is a disappearing item, because over the lifetime of the beneficiary it does not cost any additional amount to the system.

The transitional benefits at age 72 will cost, from the old-age survivors disability insurance trust fund \$140 million additional in the first year.

The changes we have made in the disability insurance program will cost \$105 million in the first year.

The changes we make with respect to the retirement test will cost \$65 million out of the old-age and survivors disability insurance trust funds in the first year.

That means a total from those two trust funds of \$1,905 million in the first year.

Public assistance amendments that increase the amount of Federal participation with the State in cash payments will cost \$150 million per year out of the general fund.

The changes we make in the exclusion of assistance payments to persons in TB and mental hospitals cost \$75 million per year.

The maternal and child health, crippled children part of it will cost \$60 million per year.

The OAA income exemption will have an annual cost of \$1 million.

Under the modified medical assistance for the aged definition, we have added \$2 million per year.

Mental retardation projects will have an annual cost of \$3 million.

That adds up to a total altogether out of the general fund of the Treasury of \$1,366 million per year.

Every dime of that is budgeted as it affects the upcoming fiscal year.

The \$875 million I referred to for payments from general funds with respect to the two health insurance programs, which will begin on July 1, 1966, is unbudgeted because we do not have the budget for the fiscal year 1967 as yet.

Now there is a further point which I should make here: the cost of administration.

Now, how do we propose to pay for the programs? We have increased both the maximum on the amount of earnings that are subject to taxes from \$4,800 to \$5,600 on January 1, 1966, and then again, to \$6,600 on January 1, 1971, and the tax rates that would be applied to those earnings.

We have provided for increases in the tax rates over a period of years, as we have always done in the past, so that the actuary of the Department of Health, Education, and Welfare can tell us, "I can advise you that this program is actuarially sound." As he looks at it, over the forthcoming 75 years, this program of old-age and survivors disability insurance would only be out of balance by only about .08 percent of payroll.

Now as to the health part of the bill. We have worked out a separate tax and a separate trust fund. Let no one mislead you with statements, general in nature as they appear to be, and be not mis-

led by the minority views expressed in the report that this separation is illusory.

Some statements have recently been made that I have, in effect, gone back on my previously expressed position that there must be separation between the cash benefits system and the proposed hospital benefits system. I emphatically state, here and now, that this is not the case. My conviction is that there must be separation and the bill I bring to you reflects this belief. For years I have maintained that the basic difference between the two types of benefits makes it essential that we have two separate systems. During many hours of questioning the Government witnesses before our committee, particularly the Chief Actuary, I brought out the different nature of the cost assumptions which underlie the hospital program as distinguished from the cash program. I pointed out that some assumptions which were conservative under one program had exactly the reverse effect when applied to the other program. Thus, as the committee drew up the bill, at every opportunity I urged that provisions be inserted which would provide meaningful separation between the two systems.

The minority members of the committee have written in the report that this is somewhat illusory and it was stated, at the Rules Committee, that what we have in the bill is just the same arrangement which exists under current law in respect to the disability insurance program and the old-age and survivors insurance program. I respectfully beg to differ. In respect to these two programs under existing law there is no separate tax, merely an allocation of revenues between two trust funds. The fact that this is merely an allocation is illustrated by the bill before you today which provides for a redistribution of the revenues from the combined old-age and survivors disability insurance tax. This new allocation, which will put the disability insurance fund on a sound actuarial basis to make up for some unfavorable cost experience in recent years, would not be possible as to hospital benefits under your committee's bill. Under H.R. 8675 any readjustment of revenue because of either unfavorable or favorable experience will have to be done by a change in the tax rate or earnings base—or both—of the separate hospital insurance tax.

The hospital program will thus be financed from its own tax and there will be no shifting of funds—either way—from the old-age, survivors, and disability program.

Let me once again summarize the separation of program envisioned by this bill by reading from the report on page 48:

First, the schedules of tax rates for old-age, survivors, and disability insurance and for hospital insurance are in separate subsections of the Internal Revenue Code (unlike the situation for old-age and survivors insurance as compared with disability insurance, where there is a single tax rate for both programs, but an allocation thereof into two portions).

Second, the hospital insurance program has a separate trust fund (as is also the case

for old-age and survivors insurance and for disability insurance) and, in addition, has a separate board of trustees from that of the old-age, survivors, and disability insurance system.

Third, the bill provides that income tax withholding statements (forms W-2) shall show the proportion of the total contribution for old-age, survivors, and disability insurance and for hospital insurance that is with respect to the latter.

Fourth, the hospital insurance program would cover railroad employees directly in the same manner as other covered workers, and their contributions would go directly into the hospital insurance trust fund and their benefit payments would be paid directly from this trust fund (rather than directly or indirectly through the railroad retirement system), whereas these employees are not covered by old-age, survivors, and disability insurance (except indirectly through the financial interchange provisions).

Fifth, the financing basis for the hospital insurance system would be determined under a different approach than that used for the old-age, survivors, and disability insurance system, reflecting the different natures of the two programs (by assuming rising earnings levels and rising hospitalization costs in future years instead of level-earnings assumptions and by making the estimates for a 35-year period rather than a 75-year one).

There is always a question of the degree to which to go in separation, but this is a separately enacted tax in an entirely separate section of the Internal Revenue Code. That is not true of the OASI and DI taxes. They are in the same section. They are levied as one tax, with authority to allocate a designated part of the total to the disability insurance trust fund. But there is a great difference in the enactment of a separate tax. There is also a separate trust fund.

The substitute plan proposed by the gentleman from Wisconsin [Mr. BYRNES] would not maintain a separateness of financing between his health insurance plan and the old-age and survivors insurance program. Instead the gentleman from Wisconsin [Mr. BYRNES] would draw some \$200 million a year from the old-age and survivors disability insurance trust fund to help finance his proposed health insurance benefits.

I can assure my colleagues who have had reservations in the past, as I have had reservations in the past about doing anything in any way that might jeopardize the cash benefit program that has developed over the past 30 years and that has become such an important part of every elderly person's life, without any hesitation, without any equivocation, that there is not one single, solitary thing in this bill which would permit or allow for \$1 of the money which is set aside to go into the old-age and survivors disability insurance trust funds to ever get into the hospital insurance trust fund. It just cannot be done. Neither can the hospital insurance trust fund money be put over into the old-age and survivors disability insurance trust funds.

Call it illusory if you want to. We could have gone the full extent of separation. We could have put this hospital insurance program under the administration of an entirely new agency of Government. Then what would the

critics on the outside have said, had we gone to the full extent? They would have accused the Committee on Ways and Means of having set up another elaborate 40,000-person bureaucracy. The expense of that would have been out of the question.

We could have completely separated the tax for purposes of filing the earnings record and paying the tax, but if we had done that, then they would have said that we had put the taxpayers to the unnecessary trouble of having to make two computations of taxes.

But to some it would not make any difference what was done; some argument would have been made that there would not be a separation.

This has been a bone of contention with me—and Members know it—that there must be a separation. I am thoroughly convinced that we have completed that separation in this bill.

Mr. Chairman, let me go back just a bit. On the basis of legislation that has been presented to the Ways and Means Committee, it does not appear that there is much doubt any more in the minds of many that we do have a problem of meeting medical care costs in the United States with respect to certain people in our population. These are our fathers and mothers and our grandparents who are living longer today than did their loved ones before them. We owe that to the great miracles which have been performed by medical science. But in the process of having performed those miracles, problems have resulted. Today's problems, as a result, are certainly greater in magnitude than those the generations before had, because of the greater length of time beyond retirement and before death, and because of the vicissitudes of illness of more and more of these people as a result of the length of their lives.

Thus the problem seems to be established in the minds of most. There is no argument on the part of my distinguished friend from Wisconsin [Mr. BYRNES] that there is this problem, for he introduces a bill to help, with respect to that problem, produced by himself, from that very great capacity that he possesses, and incorporating within his bill everything that is within the committee bill except with respect to the one matter of how do we finance the cost of taking care of this problem.

I have said consistently that I did not think that all of the medical costs that are incurred by those over 65 could be financed only through a payroll tax, because conceivably the payroll tax would be so high finally as to interfere with our capacity to compete in the world, with the payroll tax being charged as a cost of doing business. I have said repeatedly that we cannot run the risk of bankrupting the Federal Treasury once and for all by putting this entire cost upon the general fund of the Treasury. I think that the program has to be dealt with in a combination approach of two things: use of payroll tax and use of general fund revenues. That is what the committee has done. That is the only difference, apparently, that exists today between my distinguished friend

who has offered his bill and the committee's proposition.

Just how do we finance the proposal? Because his proposition would be voluntary, with no compulsion under a payroll tax, it would be financed by the payment of the individual and from the general funds of the Treasury. In total, his plan would be financed just as our supplementary plan would be.

Now, how did we divide the health insurance provisions of H. R. 6675? Which did we put in which pocket and out of what account does it come and why? There are very, very important reasons why we propose to finance the benefits the way we do. It is the way that has been debated completely but which has been disregarded by the very people with whom we were trying to work. What did we do? We picked this single biggest element, namely, the cost of being in a hospital, and we financed that by the payroll tax to let the person during his working years, through small amounts of money paid per week, per month, or per year, make advance payments to that trust fund entirely on his own and from his employer and by the self-employed on their own account.

The CHAIRMAN. The time of the gentleman has expired.

Mr. MILLS. Mr. Chairman, I yield myself 5 additional minutes.

To take care of those expense during his working years so that when he reached retirement at 65 he would not then have to undertake the great burden of defraying the cost of the premium for that particular type of benefit. The proposal differs from H. R. 1. We took out of it every scintilla of payment to a physician—every scintilla of payment to a physician. Every safeguard has been placed so that no physician can be paid out of the trust fund created by the payment of a payroll tax. Now, what is it that you understood or that I understood had so greatly disturbed this great, wonderful medical profession that we have here in the United States? That we would finally, in time, put physicians' fees under a system where there would be a payroll tax, because they felt that if ever we did that, we would in time regulate the relationship between the physician and the patient by saying that this physician you can go to and this physician is not on our list; or by saying that we will pay out of this fund only this amount in the way of physicians' fees and thus control and regulate physicians' fees.

Now, what have we done? In this committee bill in that respect we have done the same, identical thing that the gentleman from Wisconsin has done in his bill. And yet I understand that many of you have received telegrams as late as this morning urging you to vote for his motion to recommit because there is something unholy about the committee bill, whereas his bill, from their point of view, is perfect. How do we treat the physicians in both bills?

In both bills in the same identical way. Under both they would be paid out of the fund established under the voluntary enrollment program. In both instances the physicians would be paid

from the same type of fund in the same, identical manner. And how would we pay them? In identically the same way. Not a payroll tax, but money contributed by the individual participant who would enroll after he got to be 65 and put up half of it, with the Treasury, out of its general funds, putting up the other half.

I thought that was exactly what it would take. I thought that was exactly what was required to remove this threat to medical practice in the United States and regardless of what anybody on the outside says to you, we have done it—we have done it. There is nobody in this Congress, I do not care who he is, who is any more cognizant or any more desirous of not changing the orderly practice of medicine than the gentleman speaking to you today. I am convinced in my own mind, as much as I have ever been convinced of anything, that there is not one solitary thing in this committee bill that carries any threat to the medical profession of this country that could not be said equally of the bill offered by the gentleman from Wisconsin [Mr. BYRNES]. And I do not think there is anything in either bill that jeopardizes the profession in any way. Why? How are we going to handle this thing? We are not going to deal with physicians direct; there is no intention to deal with them direct; there is no intention to tell them what they may charge their patients; we are not going to say to a patient, "You have got to go to Dr. X; you cannot go to Dr. Y."

How are we going to pay them? We are going to contract with somebody—Blue Shield, insurance companies, or other insurance carriers, and we express the desire that it be more than one. We should divide the program up somehow and let various organizations handle it—they are the ones who are going to pay the bills. But we even go to this extent because we recognize the sensitiveness of this issue: We say, "We will leave to the election of the doctors, whether they are paid directly by the insurer, or whether the insurer pays the amount to the patient and the patient then pays the doctor."

If there is a doctor in your area who does not like the insurer and who does not want to have anything to do with it and does not want to carry its check to the bank, all he has to do is say to his patient, "You accept the benefit payment for this service, and you and I will settle the bill."

And, what if the doctor says that what the insurer is paying, before he ever operates, is not sufficient to satisfy him? He might say "My fee is so much, \$2,000, but this cost that you are indemnified against is only \$1,000." What then? We pay 80 percent of that \$1,000 to the patient, and the patient pays the doctor \$2,000, including the payment under the plan. If in the community where he lives, the sum of \$1,000 is the customary prevailing and reasonable fee against which we are indemnifying the patient, the doctor still makes the arrangement with his patient, or the patient makes it with his doctor to pay the difference.

Thus, Mr. Chairman, we have done everything that our minds were capable of conceiving to eliminate what appeared

to us to be justifiable fears without these changes that we make.

Mr. Chairman, now very briefly—because it would take hours to discuss it all, but I have very briefly discussed even the medical portions of this bill—I would want you to know that finally it has been possible for us, after all these years, to develop a proposition that I could wholeheartedly and conscientiously, with every bit of the energy at my command, support. That has not been the case with reference to propositions in the past. Here, Mr. Chairman, I believe we have finally worked out a satisfactory and reasonable solution of an entire problem, not just a partial solution of a major problem. I feel that we have done it in a way, Mr. Chairman, that will commend it to the people for whom we do it and that they will realize that in spite of all that has been said in the past, in spite of all the ways that have been suggested in the past, finally the Committee on Ways and Means has produced the proper way to do it and that is the way that good legislation is developed.

Mr. Chairman, there is not a member of the Committee on Ways and Means whom I could not name today who has not made a major contribution to this bill by the inclusion of ideas of his own.

Mr. Chairman, where did we get the idea of the supplementary health benefits plan? Out of that fertile brain of the distinguished gentleman from Wisconsin [Mr. BYRNES].

Where did we get this idea and that idea? Out of the fertile brain of some other Democratic member or some other Republican member of the Committee on Ways and Means.

My distinguished friend, the gentleman from Virginia [Mr. BROOKS], right at the last moment called to our attention a situation about which none of us had thought. However, as a result of the gentleman's many years of experience on the Committee on the Post Office and Civil Service, he thought about it. It was fair and equitable, and we put it in.

Mr. Chairman, every member of the committee has made his contribution. On top of that, Mr. Chairman, the people in the Department of Health, Education, and Welfare worked with us faithfully from morning until night through all of these many days during which we have been in hearings and executive session and have made their contribution.

Mr. Chairman, those on the legislative counsel's staff of the House of Representatives and those who are staff members of both the joint committee and of the Committee on Ways and Means on both sides of the aisle have made their contribution.

Therefore, Mr. Chairman, I believe that there is sufficient ground within this bill for all of us to take pride and take credit.

I would suggest, therefore, that when tomorrow comes, we not toy with the bill by considering a motion to recommit, but that we take the bill as reported to the House from the Committee on Ways and Means and pass this bill as we have passed every other bill dealing with amendments to the Social Security

Act in the past—by an overwhelming majority.

SUMMARY OF MAJOR PROVISIONS OF H.R. 6676

Mr. Chairman, I will include at this point for the convenience of the members a summary of the major provisions of H.R. 6676:

BRIEF OVERALL SUMMARY

The bill establishes two coordinated health insurance programs for persons 65 or over under the Social Security Act: (1) A basic plan providing protection against the costs of hospital and related care, financed through a separate payroll tax and trust fund; and (2) a voluntary supplementary plan covering payments for physicians' and other medical and health services financed through small monthly premiums by individual participants matched equally by a Federal Government general revenue contribution.

Undergirding the two new insurance programs would be a greatly expanded medical care program for the needy and the medically needy. This program would combine all the vendor medical provisions for the aged, blind, disabled, and families with dependent children now in five titles of the Social Security Act under a uniform program and matching formula in a single new title. The Federal matching share for cash payments for these needy persons would also be increased; services for maternal and child health, crippled children, and the mentally retarded would be expanded; a 5-year program of special project grants to provide comprehensive health care and services for needy children of school age, or preschool, would be authorized, and present limitations on Federal participation in public assistance to aged individuals in tuberculosis or mental disease hospitals would be removed under certain conditions.

With respect to the old-age, survivors, and disability insurance system the bill would increase benefits by 7 percent across the board with a \$4 minimum increase for a worker, cover certain currently uncovered occupations and wages (doctors, and income from tips), continue benefits to age 22 for certain children in school, provide social security tax exemption of self-employment income of certain religious groups opposed to insurance, provide actuarially reduced benefits for widows at age 60, and pay benefits, on a transitional basis, to certain persons currently 72 or over now ineligible; liberalize the definition for disability insurance benefits, increase the amount an individual is permitted to earn without suffering full deductions from benefits, revise the tax schedule, and increase the earnings counted for benefit and tax purposes so as to fully finance the changes made, and make certain changes in allocations to the old-age and survivors insurance and disability insurance trust funds.

MORE DETAILED SUMMARY

1. Health insurance for the aged

The bill would add a new title XVIII to the Social Security Act establishing two related health insurance programs for persons 65 or over: (1) A basic plan providing protection against the costs of hospital and related care, and (2) a voluntary supplementary plan covering payments for physicians' services and other medical and health services to cover certain areas not covered by the basic plan.

The basic plan would be financed through a separate payroll tax and separate trust fund. Benefits for persons currently over 65 who are not insured under the social security and railroad retirement systems would be financed out of Federal general revenues.

Enrollment in the supplementary plan would be voluntary and would be financed by small monthly premium (\$5 per month initially) paid by enrollees and an equal

amount supplied by the Federal Government out of general revenues. The premiums for social security and railroad retirement beneficiaries who voluntarily enroll would be deducted from their monthly insurance benefits. Uninsured persons desiring the supplemental plan would make the periodic premium payments to the Government. State welfare programs could arrange for uninsured assistance recipients to be covered.

A. Basic Plan

General description: Basic protection, financed through a separately identified payroll tax, would be provided against the costs of inpatient hospital services, posthospital extended care, posthospital home health services, and outpatient hospital diagnostic services for social security and railroad retirement beneficiaries when they attain age 65. The same protection, financed from general revenues, would be provided under a special transitional provision for essentially all people who are now aged 65, or who will reach age 65 before 1968, but who are not eligible for social security or railroad retirement benefits.

Benefits would be first effective on July 1, 1966 (except for services in extended care facilities which would be effective on January 1, 1967).

Benefits: The services for which payment would be made under the basic plan include—

1. Inpatient hospital services for up to 60 days in each spell of illness with the patient paying a \$40 deductible amount; hospital services would include all those ordinarily furnished by a hospital for its inpatients; however, payment would not be made for private duty nursing or for the hospital services of physicians except services provided by interns or residents in training under approved teaching programs;

2. Posthospital extended care (in a facility having an arrangement with a hospital for the timely transfer of patients and for furnishing medical information about patients) after the patient is transferred from a hospital (after at least a 3-day stay) for up to 20 days in each spell of illness; 3 additional days will be added to the 20 days for each day that the person's hospital stay was less than 60 days (up to a maximum of 80 additional days)—the overall maximum for posthospital extended care could thus be 100 days in each spell of illness;

3. Outpatient hospital diagnostic services with the patient paying a \$20 deductible amount for each diagnostic study (that is, for diagnostic services furnished to him by the same hospital during a 30-day period); if, within 20 days after receiving such services the individual is hospitalized as an inpatient in the same hospital, the deductible he paid for outpatient diagnostic services (up to \$20) would be credited against the inpatient hospital deductible (\$40); and

4. Posthospital home health services for up to 100 visits, after discharge from a hospital (after at least a 3-day stay) or extended care facility and before the beginning of a new spell of illness. Such a person must be in the care of a physician and under a plan established by a physician within 14 days of discharge calling for such services. These services would include intermittent nursing care, therapy, and the part-time services of a home health aide. The patient must be homebound, except that when equipment is used the individual could be taken to a hospital or extended care facility or rehabilitation center to receive some of these covered home health services in order to get the advantage of the necessary equipment.

No service would be covered as posthospital extended care or as outpatient diagnostic or posthospital home health services if it is of a kind that could not be covered if it were furnished to a patient in a hospital.

A spell of illness would be considered to begin when the individual enters a hospital and to end when he has not been an inpatient of a hospital or extended care facility for 60 consecutive days.

The deductible amounts for inpatient hospital and outpatient hospital diagnostic services would be increased if necessary to keep pace with increases in hospital costs, but no such increase would be made before 1969. For reasons of administrative simplicity, increases in the hospital deductible will be made only when a \$5 change is called for and the outpatient deductible will change in \$2.50 steps.

Basis of reimbursement: Payment of bills under the basic plan would be made to the providers of service on the basis of the "reasonable cost" incurred in providing care for beneficiaries.

Administration: Basic responsibility for administration would rest with the Secretary of Health, Education, and Welfare. The Secretary would use appropriate State agencies and private organizations (nominated by providers of services) to assist in the administration of the program. Provision is made for the establishment of an Advisory Council which would advise the Secretary on policy matters in connection with administration.

Financing: Separate payroll taxes to finance the basic plan, paid by employers, employees, and self-employed persons, would be earmarked in a separate hospital insurance trust fund established in the Treasury. The amount of earnings (wage base) subject to the new payroll taxes would be the same as for purposes of financing social security cash benefits. The same contribution rate would apply equally to employers, employees, and self-employed persons and would be as follows:

| | Percent |
|--------------------------|---------|
| 1966..... | 0.25 |
| 1967-72..... | .50 |
| 1973-75..... | .65 |
| 1976-79..... | .60 |
| 1980-85..... | .70 |
| 1987 and thereafter..... | .80 |

The taxable earnings base for the health insurance tax would be \$5,600 a year for 1966 through 1970 and would thereafter be increased to \$6,600 a year.

The schedule of contribution rates is based on estimates of cost which assume that the earnings base will not be increased above \$6,600. If Congress, in later years, should increase the base above \$5,600, the tax rates established can be reduced under the cost assumptions underlying the bill.

The cost of providing basic hospital and related benefits to people who are not social security or railroad retirement beneficiaries would be paid from general funds of the Treasury.

B. Voluntary Supplementary Plan

General description: A package of benefits supplementing those provided under the basic plan would be offered to all persons 65 and over on a voluntary basis. Individuals who enrolled initially would pay premiums of \$3 a month (deducted, where possible, from social security or railroad retirement benefits). The Government would match this premium with \$3 paid from general funds. Since the minimum increase in cash social security benefits for retired workers under the bill would be \$4 a month (\$6 a month for man and wife receiving benefits on the same earnings record), the benefit increase would fully cover the amount of monthly premiums.

Enrollment: Persons aged 65 before January 1, 1966, will have an opportunity to enroll in an enrollment period which begins on the first day of the second month after the month of enactment and ends March 31, 1966.

Persons attaining age 65 subsequent to December 31, 1965, will have enrollment periods of 7 months beginning 3 months before attaining 65.

In the future general enrollment periods will be from October to December 31, in each odd year. The first such period will be October 1 to December 31, 1967.

No person may enroll more than 3 years after close of first enrollment period in which he could have enrolled.

There will be only one chance to reenroll for persons who are in the plan but drop out, and reenrollment must occur within 3 years of termination of previous enrollment.

Coverage may be terminated (1) by the individual filing notice during enrollment period, or (2) by the Government, for non-payment of premiums, after a grace period.

A State would be able to provide the supplementary insurance benefits to its public assistance recipients who are receiving cash assistance if it chooses to do so.

Benefits will be effective beginning July 1, 1966.

Benefits: The voluntary supplementary insurance plan would cover physicians' services, home health services, hospital services in psychiatric institutions, and numerous other medical and health services in and out of medical institutions.

There would be an annual deductible of \$50. Then the plan would cover 80 percent of the patient's bill (above the deductible) for the following services:

1. Physicians' and surgeons' services, whether furnished in a hospital, clinic, office, in the home, or elsewhere;

2. Hospital care for 60 days in a spell of illness in a mental hospital (180-day lifetime maximum);

3. Home health services (with no requirement of prior hospitalization) for up to 100 visits during each calendar year;

4. Additional medical and health services, whether provided in or out of a medical institution, including the following:

(a) Diagnostic X-ray and laboratory tests, electrocardiograms, basal metabolism readings, electroencephalograms, and other diagnostic tests;

(b) X-ray, radium, and radioactive isotope therapy;

(c) Ambulance services (under limited conditions); and

(d) Surgical dressings and splints, casts, and other devices for reduction of fractures and dislocations, rental of durable medical equipment such as iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home; prosthetic devices (other than dental) which replace all or part of an internal body organ; braces and artificial legs, arms, eyes, etc.

There would be a special limitation on outside-the-hospital treatment of mental, psychoneurotic, and personality disorders. Payment for such treatment during any calendar year would be limited, in effect, to \$250 or 80 percent of the expense, whichever is smaller.

Administration by carriers. Deal for reimbursement: The Secretary of Health, Education, and Welfare would be required, to the extent possible, to contract with carriers to carry out the major administrative functions relating to the medical aspects of the program such as determining rates of payments under the program, holding and disbursing funds for benefit payments, and determining compliance and assisting in utilization review. No contract is to be entered into by the Secretary unless he finds that the carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent. The contract must provide that the carrier take necessary action to see that where payments are on a cost basis (to institutional providers of service), the cost is reasonable cost. Cor-

respondingly, where payments are on a charge basis (to physicians or others furnishing noninstitutional services), the carrier must see that such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the other policyholders and subscribers of the carrier. Payment by the carrier for physicians' services will be made on the basis of a receipted bill, or on the basis of an assignment under the terms of which the reasonable charge will be the full charge for the service.

Financing: Aged persons who enroll in the supplemental plan would pay monthly premiums of \$3. Where the individual is currently receiving monthly social security or railroad retirement benefits, the premiums would be deducted from his benefits.

The Government would help finance the supplementary plan through a payment from general revenues of \$3 a month per enrollee. To provide an operating fund at the beginning of the supplementary plan, and to establish a contingency reserve, a Government appropriation would be available (on a repayable basis) equal to \$18 per aged person estimated to be eligible in July 1966 when the supplementary plan goes into effect.

The individual and Government contributions would be placed in a separate trust fund for the supplementary plan. All benefit and administrative expenses under the supplementary plan would be paid from this fund.

The provision in the income tax law which limits medical expense deductions to amounts in excess of 3 percent of adjusted gross income for persons under 65 would be reconstituted for persons 65 and over. Thus, provision is made for partial or full recovery of the Government contribution from enrolled persons with incomes high enough to require them to pay income taxes. A special deduction (for taxpayers who itemize deductions) of one-half of premiums for medical care insurance would be added, however, which would be applicable to taxpayers of all ages. Such special deduction could not exceed \$250 per year.

Premium rates for enrolled persons (and the matching Government contribution) would be increased from time to time in the event that costs rise, but not more often than once every 2 years. The premium rate for a person who enrolls after the first period when enrollment was open to him would be increased by 10 percent for each full year he stayed out of the program. It would also be increased for any period that he had terminated his coverage.

C. Costs of the Basic and Supplementary Plans

Benefits under both plans would first become payable for services furnished in July 1966, except for services in extended care facilities, for which benefits would first become payable in January 1967.

Basic plan: Benefits under the basic plan would be about \$10 billion for the 6-month period in 1966 and about \$2.2 billion in 1967. Contribution income for those years would be about \$1.8 and \$2.6 billion, respectively. The costs for the uninsured (paid from general funds) would be about \$278 million per year for early years.

Supplementary plan: Costs of the supplementary plan would depend on how many of the aged enrolled.

If 80 percent of the eligible aged enrolled, benefit costs of the supplementary plan would be about \$195 million to \$260 million in the 6 months of 1966 and about \$785 million to \$1.02 billion in 1967. Premium income from enrollees for those years would be about \$278 and \$440 million, respectively. The matching Government contribution would be the same.

If 94 percent of the eligible aged enrolled, benefit costs of the supplementary plan would be about \$390 to \$510 million in 1966

and about \$905 million to \$1.22 billion in 1967. Premium income from enrollees for those years would be about \$325 and \$665 million, respectively. The Government contribution would be the same.

II. Improvement and extension of Kerr-Mills program

Purpose and scope: In order to provide a more effective Kerr-Mills program and to extend its provisions to other needy persons, the bill would establish a single and separate medical care program to replace the differing provisions for the needy which currently are found in five titles of the Social Security Act.

The new title (XIX) would extend the advantages of an expanded medical assistance program not only to the aged who are indigent but also to needy individuals on the dependent children, blind, and permanently and totally disabled programs and to persons who would qualify under those programs if in sufficient financial need.

Inclusion of the medically indigent aged would be optional with the States but if they are included comparable groups of blind, disabled, and parents and children must also be included if they need help in meeting necessary medical costs. Moreover, the amount and scope of benefits for the medically indigent could not be greater than that of recipients on the cash assistance programs.

The current provisions of law in the various public assistance titles of the act providing vendor medical assistance would terminate upon the adoption of the new program by the State but no later than June 30, 1967.

Scope of medical assistance: Under existing law, the State must provide "some institutional and noninstitutional care" under the medical-assistance-for-the-aged program. There are no minimum benefit requirements at all under the other public assistance vendor medical programs. The bill would require that by July 1, 1967, for the new program a State must provide inpatient hospital services, outpatient hospital services, other laboratory and X-ray services, skilled nursing home services, and physicians' services (whether furnished in the office, the patient's home, a hospital, or a skilled nursing home) in order to receive Federal participation in vendor medical payments. Other items of medical service would be optional with the States.

Eligibility: Improvements would be effected in the program for the needy elderly by requiring that the States must provide a flexible income test which takes into account medical expenses and does not provide rigid income standards which arbitrarily deny assistance to people with large medical bills. In the same spirit the bill provides that no deductible, cost sharing, or similar charge may be imposed by the State as to hospitalization under its program and that any such charge on other medical services must be reasonably related to the recipient's income or resources. Also important is the requirement that elderly needy people on the State programs be provided assistance to meet the deductibles that are imposed by the new basic program of hospital insurance. Also where a portion of any deductible or cost sharing required by the supplementary voluntary program is met by a State program it must be done so in a manner reasonably related to the individual's income and resources. No income can be imputed to an individual unless actually available; and the financial responsibility of an individual for an applicant may be taken into account only if the applicant is the individual's spouse or child who is under age 21 or blind or disabled.

Increased Federal matching: The Federal share of medical assistance expenditures under the new program would be determined upon a uniform formula with no maximum on the amount of expenditure which would be subject to participation. This currently

is done for the medical assistance for the aged program. The Federal share, which varies in relation to a State's per capita income, would be increased over current medical assistance for the aged matching so that States at the national average would receive 85 percent rather than 80 percent, and States at the lowest level could receive as much as 85 percent as contrasted with 80 percent under existing law.

In order to receive any additional Federal funds as a result of expenditures under the new program, the States would need to continue their own expenditures at their present rate. For a specified period, any State that did not reduce its own expenditures would be assured of at least a 8-percent increase in Federal participation in medical care expenditures. As to professional medical personnel, the bill would provide a 75-percent Federal share as compared with the 60-60 Federal-State sharing for other administrative expenses.

Administration: The State agency administering the new program would have to be the same as that administering the old-age assistance program. As some States have done under existing law, such an agency could delegate its function relating to the medical aspects of the program to the State health agency. The bill specifically provides as a State plan requirement that cooperative agreements be entered into with State agencies providing health services and vocational rehabilitation services looking toward maximum utilization of these services in the provision of medical assistance under the plan. Effective date: January 1, 1966.

Cost: It is estimated that the new program will increase the Federal Government's contribution about \$200 million in a full year of operation over that in the programs operated under existing law.

III. Child health program amendments

Maternal and child health and crippled children: The bill would increase the amount authorized for maternal and child health services over current authorizations by \$5 million for fiscal year 1966 and by \$10 million in each succeeding fiscal year, as follows:

| Fiscal year | Existing law | Under bill |
|----------------|--------------|--------------|
| 1966 | \$40,000,000 | \$45,000,000 |
| 1967 | 40,000,000 | 50,000,000 |
| 1968 | 45,000,000 | 55,000,000 |
| 1969 | 45,000,000 | 65,000,000 |
| 1970 and after | 50,000,000 | 60,000,000 |

The authorizations for crippled children's service would be increased by the same amounts. Such increases would assist the States, in both these programs, in moving toward the goal of extending services with a view of making them available to children in all parts of the State by July 1, 1978.

Crippled children-training personnel: The bill would also authorize \$5 million for the fiscal year 1967, \$10 million for fiscal 1968, and \$17.5 million for each succeeding fiscal year to be for grants to institutions of higher learning for training professional personnel for health and related care of crippled children, particularly mentally retarded children and children with multiple handicaps.

Health care for needy children: A new provision is added authorizing the Secretary of Health, Education, and Welfare to carry out a 5-year program of special project grants to provide comprehensive health care and services for children of school age, or for preschool children, particularly in areas with concentrations of low-income families. The grants would be to State health agencies, to the State agencies administering the crippled children's program, to any school of medicine (with appropriate participation by a school of dentistry), and any teaching hospital affiliated with such school, to pay not to exceed 75 percent of the cost of the project. Projects would provide screening, diagnosis,

preventive services, treatment, correction of defects, and aftercare, including dental services, for children in low-income families.

An appropriation of \$15 million would be authorized for the fiscal year ending June 30, 1966; \$35 million for the fiscal year ending June 30, 1967; \$40 million for the fiscal year ending June 30, 1968; \$45 million for the fiscal year ending June 30, 1969; and \$50 million for the fiscal year ending June 30, 1970.

Mental retardation planning: This title would authorize grants totaling \$2,750,000 for each of 2 fiscal years—the fiscal year ending June 30, 1966, and the fiscal year ending June 30, 1967. The grants would be available during the year for which the appropriation is authorized and during the succeeding fiscal year until June 30, 1968. They are for the purpose of assisting States to implement and follow up on plans and other steps to combat mental retardation authorized under section 1701 of the Social Security Act.

IV. Old-age, survivors, and disability insurance amendments

Benefits

1. Seven percent, across-the-board benefit increase in old-age, survivors, and disability insurance benefits: The bill provides a 7-percent, across-the-board benefit increase, effective retroactively beginning with January 1965, with a minimum increase of \$4 for retired workers age 65 and older. These increases will be made for the 30 million social security beneficiaries now on the rolls.

Monthly benefits for workers who retire at or after 65 would be increased to a new minimum of \$44 (now \$40) and to a new maximum of \$135.90 (now \$127). In the future, creditable earnings under the increase in the contribution and benefit base to \$5,600 a year (now \$4,800) would make possible a maximum benefit of \$149.90.

The maximum amount of benefits payable to a family on the basis of a single earnings record would be related to the worker's average monthly earnings at all earnings levels. Under present law, there is a \$254 limit on family benefits which operates over a wide range of average monthly earnings. Under the bill, until 1971, the family maximum would be \$312.

Under the second-step increase in the wage base to \$8,600 to be effective in 1971, also provided in the bill, the worker's primary insurance amount would range from a minimum of \$44 to a future possible maximum of \$167.90 a month. Maximum family benefits up to \$368 would also be payable.

2. Payment of child's insurance benefits to children attending school or college after attainment of age 18 and up to age 22: The bill includes the provision adopted by both House and Senate last year which would continue to pay a child's insurance benefit until the child reaches age 22, provided the child is attending public or accredited schools, including a vocational school or a college, as a full-time student after he reaches age 18. Children of deceased, retired, or disabled workers would be included. No mother's or wife's benefits would be payable on the basis of a child who has attained age 18 but is in school.

This provision will be effective January 1, 1968. It is estimated that 295,000 children will be able to receive benefits for a typical school month in 1968 as a result of this provision.

3. Benefits for widows at age 60: The bill would provide the option to widows of receiving benefits beginning at age 60 with the benefits payable to those who claim them before age 62 being actuarially reduced to take account of the longer period over which they will be paid. Under present law, full widow's benefits and actuarially reduced worker's and wife's benefits are payable at age 62.

This provision, adopted by both Houses last year, would be effective for the second month after the month of enactment. It is esti-

mated that 185,000 widows will be able to get benefits immediately under this provision.

4. Amendment of disability program: (a) Definition: The bill would eliminate the present requirement that a worker's disability must be expected to result in death or to be of long-continued and indefinite duration, and instead provide that an insured worker would be eligible for disability benefits if he has been totally disabled throughout a continuous period of at least 6 calendar months. Benefits payable by reason of this change would be paid for the second month following the month of enactment.

(b) Waiting period: The waiting period during which an individual must be under a disability prior to entitlement to benefits is reduced by 1 month by the bill. It provides that disability benefits would be payable beginning with the last month of the 6-month waiting period rather than with the first month after the 6-month waiting period as under existing law. This change would be applicable to all cases in which the last month of the waiting period occurs after the month of enactment.

It is estimated some 185,000 disabled workers and dependents will be benefited by these provisions.

Certain changes are also made in the provision terminating disability benefits and waiving subsequent waiting periods so as to make them more restrictive when applied to shorter term disabilities.

(c) Entitlement to disability benefits after entitlement to benefits payable on account of age: Under the bill, a person who becomes entitled before age 65 to a benefit payable on account of old age could later become entitled to disability insurance benefits.

(d) Allocation of contribution income between OASI and DI trust funds: Under the bill, an additional one-fourth of 1 percent of taxable wages and three-sixteenths of 1 percent of taxable self-employment income would be allocated to the disability insurance trust fund, bringing the total allocation to three-fourths of 1 percent and nine-sixteenths of 1 percent, respectively, beginning in 1966.

5. Benefits to certain persons at age 72 or over: The bill would liberalize the eligibility requirements by providing a basic benefit of \$35 at age 72 or over to certain persons with a minimum of three quarters of coverage which can be acquired at any time since the beginning of the program in 1937. To accomplish this, a new concept of "transitional insured" status is provided. Present law requires a minimum of six quarters of coverage in employment or self-employment.

(a) Men and women workers: The concept of "transitional insured" status which would make an individual eligible for an old-age or wife's benefit provides that the oldest workers will receive benefits with only three quarters of coverage, under the bill. These three quarters may have been acquired at any time since the inception of the program in 1937. For those who are not quite so old, the quarters of coverage requirement would increase until the requirement merges with the present minimum requirement of six quarters.

The following table illustrates the operation of the "transitional insured" status provision for workers:

| Workers benefits ¹ | | | |
|-------------------------------|-------------------------------|---------------|-------------------------------|
| Men | | Women | |
| Age (in 1965) | Quarters of coverage required | Age (in 1965) | Quarters of coverage required |
| 70 or over | 3 | 70 or over | 3 |
| 71 | 4 | 71 | 4 |
| 72 | 5 | 72 | 5 |
| 73 or younger | 6 or more | 73 or younger | 6 or more |

¹ Benefits will not be payable, however, until age 72.

(b) Widows: Any widow who is age 72 or over in 1966, if her husband died or reached age 65 in 1954 or earlier, can get a widow's benefit if her husband had at least three quarters of coverage. Present law requires six quarters.

If the husband died or reached 65 in 1955, the requirement is four quarters. If he died or reached 65 in 1956, the requirement would be five quarters. If he died or reached 65 in 1957 or later, the minimum requirement

would be six quarters, the same as present law.

For widows reaching age 72 in 1967 and 1968, there is a "grading in" of coverage requirement of four or five quarters of coverage, respectively. Widows reaching age 72 in 1969 or after would be subject to the requirements of existing law of six or more quarters of coverage.

The table below sets forth the requirements as to widows:

Insured status provisions with respect to widow's benefits as to quarters of coverage required

| Year of husband's death (or attainment of age 65, if earlier) | Present quarters required | Proposed quarters required for widow attaining age 72 in— | | |
|---|---------------------------|---|--------------|--------------|
| | | 1964 or before | 1967 | 1968 |
| 1954 or before..... | 6..... | 2..... | 4..... | 4..... |
| 1955..... | 6..... | 4..... | 4..... | 4..... |
| 1956..... | 6..... | 5..... | 5..... | 5..... |
| 1957 or after..... | 6 or more... | 6 or more... | 6 or more... | 6 or more... |

(c) Basic benefits: Men and women workers who would be eligible under the above-described provisions for workers would receive a basic benefit of \$35 a month. A wife, aged 72 or over (and who attains that age before 1969) would receive one-half of this amount, \$17.50. No other dependents' basic benefits would be provided under these provisions.

Widows would receive \$35 a month under the above-described provision.

These provisions would become effective for the second month after the month of enactment, at which time an estimated 355,000 persons would be able to start receiving benefits.

6 Retirement test: The bill liberalizes the social security earned income limitation so that the uppermost limit of the "band" of \$1 reduction in benefits for \$2 in earnings is raised from \$1,700 to \$2,400. Under existing law the first \$1,200 a year in earnings is wholly exempted, and there is a \$1 reduction in benefits for each \$2 of earnings up to \$1,700 and \$1 for \$1 above that amount. The bill would increase the \$1 for \$2 "band" so that it would apply between \$1,200 and \$2,400, with \$1 for \$1 reductions above \$2,400. This change is effective as to taxable years ending after 1965.

The bill also exempts certain royalties received in or after the year in which a person reaches age 65 from copyrights and patents obtained before age 65 from being counted as earnings for purposes of this test effective as to taxable years beginning after 1964.

7. Wife's and widow's benefits for divorced women: The bill would authorize payments of wife's and widow's benefits to the divorced wife aged 62 or over of a retired, deceased, or disabled worker if she had been married to the worker for at least 20 years before the date of the divorce and if her divorced husband was making (or was obligated by a court to make) a substantial contribution to her support when he became entitled to benefits, became disabled, or died. The bill would also provide that a wife's benefits would not terminate when the woman and her husband are divorced if the marriage has been in effect for 20 years. Provision is also made for the reestablishment of benefit rights for a widow or a wife who remarries and the subsequent marriage lasts less than 20 years. These changes are effective as to second month following month of enactment.

8. Adoption of child by retired worker: The bill would change the provisions relating to the payment of benefits to children who are adopted by old-age insurance beneficiaries to require that as to any adoption after the worker becomes entitled to an old-age benefit (1) the child be living with the worker (or adoption proceedings have begun) in or before the month when application

for old-age benefits is filed; (2) the child be receiving one-half of his support for a year before the worker's entitlement; and (3) the adoption be completed within 2 years after the worker's entitlement.

COVERAGE

The following coverage provisions (contained in the House-passed bill last year) were included:

1. Physicians and interns: Self-employed physicians would be covered for taxable years ending after December 31, 1965. Interns would be covered beginning on January 1, 1966, on the same basis as other employees working for the same employer.

2. Farmers: Provisions of existing law with respect to the coverage of farmers would be amended to provide that farm operators whose annual gross earnings are \$2,400 or less (instead of \$1,800 or less as in existing law) can report either their actual net earnings or 90 percent (as in present law) of their gross earnings. Farmers whose annual gross earnings are over \$2,400 would report their actual net earnings if over \$1,600, but if actual net earnings are less than \$1,600, they may instead report \$1,600. (Present law provides that farmers whose annual gross earnings are over \$1,800 report their actual net earnings if over \$1,200, but if actual net earnings are less than \$1,200, they may report \$1,200.) This change would be effective for taxable years beginning after December 31, 1965.

3. Cash tips: Coverage of cash tips received by an employee in the course of his employment as wages would be provided, effective as to tips received after 1965.

(a) Reporting of tips: The employee would be required to report to his employer in writing the amount of tips received and the employer would report the employee's tips along with the employee's regular wages. The employee's report to his employer would include tips paid to him through the employer as well as those received directly from customers of the employer. Tips received by an employee which do not amount to a total of \$30 a month in connection with his work for any one employer would not be covered and would not be reported.

(b) Tax on tips: The employer would be required to withhold social security taxes only on tips reported by the employee to him. Unlike the provision in last year's House bill, the employer would be required to withhold income tax on such reported tips. The employer would be responsible for the social security tax on tips only if the employee reported the tips to him within 10 days after the end of the month in which the tips were received. The employer will be permitted to gear these new procedures into his usual payroll periods. The employer would pay over his own and the employee's share of the tax on these tips and would include the tips

with his regular reports of wages. If at the time the employee report is due (or, in cases where the report is made earlier—if between the making of the report and the time it is due), the employer does not have unpaid wages or remuneration of the employee under his control sufficient to cover the employee's share of the social security tax applicable to the tips reported, the employee will pay his share of the tax with his report.

If the employee does not report his tips to his employer within 10 days after the end of the month involved, the employer would have no liability. In such a case the employee alone would be liable not only for the amount of the employee tax but also an additional amount equal to the employer tax.

4. State and local government employees: Alaska and Kentucky would be added to the list of States which may cover State and local government employees under the divided retirement system provision. This provision allows current employees desiring to do so to elect coverage; future employees are covered compulsorily.

Another opportunity would be provided, through 1966, for the election of coverage by people who originally did not choose coverage under the divided retirement system provision.

Coverage would be made available to certain hospital employees in California whose positions were removed from a State or local government retirement system.

New coverage provisions in the bill (not contained in last year's bill) are:

1. District of Columbia employees: Coverage would be extended to employees of the District of Columbia who are not covered by a retirement system. About 600 substitute teachers would be involved. The District of Columbia Commissioners also could shift the coverage of temporary and intermittent employees from the civil service retirement system to social security. The earliest date on which coverage could become effective would be the first day of the calendar quarter following the calendar quarter of enactment.

2. Exemption of certain religious sects: Members of certain religious faiths may be exempt from social security self-employment taxes and coverage upon application which would be accompanied by a waiver of benefit rights. An individual eligible for the exemption must be a member of a recognized religious sect (or a division of a sect) who is an adherent of the established teachings of such sect by reason of which he is conscientiously opposed to acceptance of the benefits of any private or public insurance, making payments in the event of death, disability, old-age, or retirement, or making payments toward the cost of, or providing services for, medical care (including the benefits of any insurance system established by the Social Security Act). The Secretary of Health, Education, and Welfare must find that such sect has such teachings and has been in existence at all times since December 31, 1950, and that it is the practice for members of such sect to make provision for their dependent members which, in the Secretary's judgment, is reasonable in view of their general level of living. The exemption for previous years (taxable years ending prior to December 31, 1965) must be filed by April 15, 1966. The exemption would be effective as early as taxable years beginning after December 31, 1960.

3. Nonprofit organizations: Nonprofit organizations could provide coverage for employees retroactively for up to 5 years (1 year under present law); also, validation of certain erroneously reported wages would be permitted.

miscellaneous

1. Filing of proof: Extends indefinitely the period of filing of proof of support for dependent husbands, widowers and parents' benefits, and lump-sum death payments

where good cause exists for failure to file within initial 3-year period.

2. Automatic recomputation of benefits: The benefits of people on the rolls would be recomputed automatically each year to take account of any covered earnings that the worker might have had in the previous year that would increase his benefit amount. Under existing law there are various require-

ments, including filing of an application and earnings of over \$1,200 a year after entitlement.

3. Military wage credits: Replaces present provision authorizing reimbursement of trust funds out of general revenue for gratuitous social security wage credits for servicemen so that such payments will be spread over the next 30 years (now 10 years).

pleased and well satisfied if he would have earlier limited it to two and said: "Let us consider two separate monumental aspects of this bill. First. That part making necessary changes in the old-age, survivors, and disability insurance sections, the cash benefit program, and the various welfare programs; and, second, another bill dealing with the medical care proposals." It seems to me that the House and its Members should have some opportunity to really work their will on this legislation.

The medical provisions should stand or fall on their own merits, and the amendments to the old-age, survivors, and disability insurance system, the cash benefit program, should stand or fall on the merits of those amendments. But as it is we are forced to accept the bad with the good, or reject the good with the bad.

This is not, in my judgment, a good way for a democratic body—and I use a small "d"—to function. It is not the way to get a full expression of the will of the House of Representatives.

I proposed earlier this year when the committee first began its consideration of this matter, that we consider and consider promptly amendments to the old-age and survivors disability insurance system and the other welfare programs, and get that on its way. We had already done the groundwork on that. We had passed in this House last year a bill providing necessary amendments and changes. It had gone through the Senate; it had been practically through conference; we could have acted speedily, and it could have been enacted into law long before this. In fact, I might review just a little history to point out that the amendments to the old-age survivors disability insurance sections of this bill could have been passed last fall if the word had not come down, and the insistence made that "Oh, no, you have to tie all of these together because of the fear that the medical part of this program could not stand on its own merits."

Let me point out this at the very beginning, that we on the committee, Democrats and Republicans alike, are in general agreement with respect to those provisions in the bill as reported by the committee relating to the old-age and survivors system, the disability system, and even as far as the Kerr-Mills system is concerned. That is not to say we have agreed on everything that is in the bill today, but generally we could have accepted them and they could have passed this House without a dissenting vote if we had limited it to that.

Yes, and we are in agreement in the committee, Democrats and Republicans alike, that our aged people face a problem with respect to providing for their medical care. We acknowledged that as far back as 1950, when we authorized the Federal Government to participate in subsidizing the benefit payments made by States to certain of its aged people who were in need.

We recognized it again when we enacted in the first instance the Kerr-Mills bill, and we still recognize that this is a problem of our older people.

Number of persons immediately affected and amount of additional benefits in the full year 1966

| | | |
|--|---------------------------------|--|
| 7 percent benefit increase (34 minimum in primary benefit) | 20 million persons | \$1.4 billion. |
| Child's benefit to age 22 if in school | 700,000 children | \$193 million. |
| Reduced age for widows | 185,000 widows | \$165 million (no long-range charge to system because of actuarial reduction). |
| Reduction in eligibility requirement for certain persons aged 72 or over | 265,000 persons | \$140 million. |
| Liberalization of disability definition | 145,000 workers, and dependents | \$105 million. |
| Liberalization of retirement test | 265 million | \$85 million. |

FINANCING OF OASDI AMENDMENTS

The benefit provisions of the bill are financed by (1) an increase in the earnings base from \$4,800 to \$5,600 (effective January 1, 1966), and \$6,600 (effective 1971), and (2) a revised tax rate schedule.

The tax rate schedule under existing law and revised schedule provided by the bill for OASDI programs follow:

| Year | Employer-employee rate (each) | | Self-employed rate | |
|----------------|-------------------------------|------|--------------------|------|
| | | | | |
| | Present law | Bill | Present law | Bill |
| 1965 | 4.25 | 4.25 | 4.4 | 4.4 |
| 1966 | 4.125 | 4.0 | 4.2 | 4.0 |
| 1967 | 4.125 | 4.0 | 4.2 | 4.0 |
| 1968 | 4.025 | 4.0 | 4.0 | 4.0 |
| 1969-72 | 4.025 | 4.4 | 4.0 | 4.0 |
| 1973 and after | 4.025 | 4.8 | 4.0 | 7.0 |

V. Public assistance amendments

1. Increased assistance payments: The Federal share of payments under all State public assistance programs is increased a little more than an average of \$2.50 a month for the needy aged, blind, and disabled and an average of about \$1.25 for needy children, effective January 1, 1966. This is brought about by revising the matching formula for the needy aged, blind, and disabled (and for the adult categories in title XVI) to provide a Federal share of \$31 out of the first \$37 (now twenty-nine thirty-fifths of the first \$35) up to a maximum of \$75 (now \$70) per month per individual on an average basis. The bill revises matching formula for aid to families with dependent children so as to provide a Federal share of five-sixths of the first \$18 (now fourteen-seventeenth of the first \$17) up to a maximum of \$32 (now \$30). A provision is included so that States will not receive additional Federal funds except to the extent they pass them on to individual recipients. Effective January 1, 1966. Cost: About \$160 million a year.

2. Tubercular and mental patients: Removes exclusion from Federal matching in old-age assistance and medical assistance for the aged programs (and for combined program, title XVI) as to aged individuals who are patients in institutions for tuberculosis or mental diseases or who have been diagnosed as having tuberculosis or psychosis and, as a result, are patients in a medical institution. Requires as condition of Federal participation in such payments to, or for, mental patients certain agreements and arrangements to assure that better care results from the additional Federal money. Provides that States will receive no more in Federal funds under this provision than they increase their expenditures for mental health purposes under public health and public welfare programs. Also removes restrictions as

to Federal matching for needy blind and disabled who are tubercular or psychotic and are in general medical institutions. Effective January 1, 1966. Cost: About \$75 million a year.

3. Protective payments to third persons: Adds a provision for protective payments to third persons on behalf of old-age assistance recipients (and recipients on combined title XVI program) unable to manage their money because of physical or mental incapacity. Effective January 1, 1966.

4. Earnings exemption under old-age assistance: Increase earnings exemption under old-age assistance program (and for aged in the combined program) so that a State may, at its option, exempt the first \$20 (now \$10) and one-half of the next \$60 (now \$40) of a recipient's monthly earnings. Effective January 1, 1966. Cost: About \$1 million first year.

5. Definition of medical assistance for aged: Modifies definition of medical assistance for the aged so as to allow Federal sharing as to old-age assistance recipients for the month they are admitted to or discharged from a medical institution. Effective July 1, 1965. Cost: About \$2 million.

6. Retroactive benefit increase: The bill adds provision which would allow the States to disregard so much of the OASDI benefit increase as is attributable to its retroactive effective date.

7. Economic Opportunity Act earnings exemption: The bill also provides a grace period for action by States that have not had regular legislative sessions, whose public assistance statutes now prevent them from disregarding earnings of recipients received under the Economic Opportunity Act.

8. Judicial review of State denials: The bill provides for judicial review of the denial of approval by the Secretary of Health, Education, and Welfare of State public assistance plans and amendments and of his action under such programs for noncompliance with State plan conditions in the Federal law.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield myself 15 minutes.

Mr. Chairman, I regret that we must consider a bill of this proportion, dealing as it does with such sensitive and far-reaching matters, all in one bill. As a result, we are required to consider the good and the bad, with no opportunity to separate, as it were, the wheat from the chaff. Instead of considering one single bill, Mr. Chairman, we should be considering at a minimum two separate bills. The chairman of the Committee on Ways and Means has suggested that it could even be divided further when he states there are four monumental sections to this omnibus bill we are considering. I would have been well

We all feel, Democrats and Republicans alike, that something should be done, that action is called for. Our difference, and it is an important difference, is as to how. How do we do it? How do we meet the problems of these people in a way that is best for them and is best for this Nation and in the best interests of all of our people?

Let me, in my discussion of the bill before us and the issue before us, say a few words about the changes that have been made in the basic Social Security Act. I am most pleased at some of the changes that are made because they are changes that I have been advocating for some time. We finally are moving in this bill to correct what I consider to be some very serious inequities and some injustices.

I would mention first the benefit level. It was last year when this matter of increasing the level of benefits under the old-age and survivors and disability insurance was under consideration that I proposed, and in fact moved in the committee that the benefit level be increased by 7 percent. We were told at that time by the administration, and this position was supported by the majority on the committee, that it had to be held to a 5-percent increase and that it had to be held there in order to accommodate a medical care program under the social security system.

Do not forget that history because it is important to remember when the proponents of the committee bill say the medical program can have no effect on the cash benefits, that we do not have to worry about superimposing a medical care program on the old-age and survivors insurance system.

It was as recent as last year that we were told—yes; the cost of living has increased 7 or 8 percent since we last increased the cash benefit level, but you cannot increase benefits by 7 percent and still have enough of the payroll tax left to finance a medical care program under social security.

That, my friends, is what is also going to happen again in the future if we tie a hospitalization program to the old-age and survivors insurance system, as is done in this bill as reported by the committee.

There is going to come a day when you will recognize the need for increased cash benefits in that program and you will be foreclosed from doing so because you will have preempted the payroll tax and the source of revenue from that source for the purposes of medical care, and you will not have sufficient left to do what should be done with respect to cash benefits.

I am pleased at the change that is involved in this bill over the bill last year, and I am pleased by the 7-percent increase.

There is a provision in this bill and the chairman has referred to it, of paying benefits on a transitional basis to certain persons 72 years of age and over who are not now eligible for cash benefits. We have had, in my judgment, a very serious inequity in the old-age and survivors insurance system in that we completely ignored the plight of many

of our older people, a large percentage of whom are widows, who because they were born too soon, you might say, or because the Congress acted too late, do not receive the benefits of the old age and survivors insurance system.

In 1960 I first introduced in the 86th Congress a bill to provide benefits for these people. I am most pleased today to see the committee at least in part moving to solve this problem by the provision that has been added to the bill to include and provide benefits for those over 72 years of age in certain circumstances.

Another item that was of some interest to me and which I encouraged the committee to include—and I think I can at least take some credit for having it included—is the item providing for increasing the amount an individual is permitted to earn without losing benefits. That was not in the bill when it was sent to us by the administration. It was not in the King-Anderson bill and it was not in the preliminary draft of the bill that was submitted to the committee prior to the final action. But we did insert in the bill, during the latter days, this provision increasing the amount an individual can earn and still not lose his cash benefits.

Then also there is a provision that I would point out that liberalizes the income treatment for the self-employed farmer. This corrects a problem I brought to the attention of the committee last year.

Then there is another provision that I think we all should be acquainted with because it is of considerable significance and also moves toward the correction of a problem which I have felt existed in our tax laws through the years. This is not an item relating specifically to our aged and to those over 65. This is an item that relates to all of our people. It is the provision which will permit a person no matter what his age, in determining his income tax and his tax liability, to deduct 50 percent of the cost of the premiums for a health insurance policy up to a maximum deduction of \$250 without being limited by the 3-percent floor. This provision moves in the direction of encouraging our people to provide insurance against the risks of medical costs.

I first proposed legislation to remedy this problem in 1962, in the 87th Congress. I believe it will be of considerable help and encouragement toward greater expansion of private insurance for the mass of our population, and therefore a move in the right direction.

Now let me come to the parts of the bill which are in controversy, to that part of the bill which the proponents are unwilling to let stand on its own feet and rise or fall on its own merits, but which they have to tie to the now controversial amendments to the Social Security Act.

Perhaps I could best discuss this aspect of the bill and the problem by pointing out in the first instance what I would propose to replace the provisions of the bill as reported by the committee relating to medical care for the aged over 65.

The bill I propose, which I have introduced, includes all of the social security

amendments, all of the public welfare amendments, all of the amendments to the Kerr-Mills Act, to which I have, however, added specifically the option for the States to adopt the eldercare program. The only difference between the bill I have proposed and will offer as a substitute and the bill as reported by the committee is in the approach to the problem of health insurance for the aged.

The substitute bill provides a program of health insurance which is admittedly the most comprehensive available today. The substitute adopts the approach used by the private insurance industry and it is patterned after the system of insurance that we have provided for our own Federal employees. The benefits are patterned on the high option of the Government-wide indemnity contract negotiated between the Civil Service Commission and private carriers for the benefit of Federal employees. It makes no distinction between medical services in the hospital or out of the hospital and it thus avoids placing unnecessary reliance on hospitalization, as I feel the committee bill does, which is the area admittedly where the costs are the greatest and the most likely to rise in the future.

The program is also patterned after the program we make available to our Federal employees in that we provide for a sharing of premium costs. The individual participates on a voluntary basis. He has the choice as to whether he wants to take the insurance policy or not. He pays a part of the premium costs. The Federal Government pays the balance of the premium costs.

For parts 1 and 2 of title I of the committee bill—these are the sections which provide for the hospitalization and related medical services—I substitute a single comprehensive program of Federal insurance. The program incorporates the medical program of the committee bill into a single package of benefits, with more extensive coverage—yes, and a savings in costs.

Now, there is nothing complicated about the proposal. We rely upon and adopt the procedures which are followed by private carriers in their contracts with the Civil Service Commission for our Federal employees.

The CHAIRMAN. The time of the gentleman has again expired.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield myself 10 additional minutes.

All persons aged 65 or over would be eligible—eligible on a uniform basis—for insurance and protection equivalent to the Government-wide indemnity benefit plan of the Federal Government. Their participation would be voluntary. There would be no means test. Enrollment would be during an initial enrollment period followed by periodic enrollment periods. This is the same system we use for our own Federal employees. For those under social security or the railroad retirement, enrollment would be exercised by the assignment of a premium contribution or a checkoff against the individual's current social security benefits. Those not under social security, would execute an application accompanying it with their initial premium

contribution. State agencies would be granted an option to purchase the insurance for their old-age assistance and medical assistance for the aged recipients at a group rate. Premium contributions by the individual would be based on the cash benefits which they receive under the OASDI.

Premium contributions by individuals would be based upon the cash benefits which they receive under the OASI system. The premium would be 10 percent of the minimum social security benefit and 5 percent of the balance. Those receiving the lowest social security benefits would pay the least. The average premium contribution on the basis of the bills' benefit levels would be \$6.50 per month per person.

Persons not under social security would pay a premium equivalent to the maximum contribution of an individual under social security. The remainder of the cost of the insurance would be paid by the Federal Government out of general revenues.

Benefits would be paid out of a National Health Insurance Fund. The fund would receive as deposits the contributions of individuals, assignments from the social security system and railroad retirement board on behalf of individuals who have authorized a checkoff of their cash benefits. State contributions for OAA and MAA recipients, and annual appropriations from the Federal Treasury.

The Secretary of the Treasury would administer the fund.

The insurance program would be administered by the Department of Health, Education, and Welfare, which would be charged with general administration, recordkeeping, and so forth, but would not process the claims or bills of hospitals, physicians, and the like.

The Surgeon General would contract with private agencies, Blue Cross-Blue Shield, for example, which would process and pay the claims of those furnishing services and would then be reimbursed from the National Health Insurance Fund.

The Surgeon General would contract with private agencies and insurers just like we do in the Federal health insurance plan, which would then pay the claims of those furnishing the services, such as doctors and hospitals, and would be then reimbursed from the National Insurance Fund.

The chairman has suggested and others have suggested that this is a more costly method. It is not a more costly method. I hope we can show you in terms of cost to the Government—in terms of cost to the taxpayers—that we offer a plan here which is less costly to the taxpayers than that of the committee bill.

Let me say this: The estimates of the cost of this program have been made by the chief actuary of the Department of Health, Education, and Welfare, who has also made the estimates of the cost of the committee bill. On February 9, shortly after I introduced the bill embodying the provisions of this alternative plan, the actuary, in whom I have a great deal of confidence, estimated that this

program would cost on an average of \$20 a month for each participant. That is the premium you would have to charge if the program were fully financed by premiums.

On February 16, a week later, however, the same actuary gave us an estimate of \$16. Now I am told that if the same assumptions were used that have been used in estimating the cost of the committee bill, the estimate might be back up to \$20 per month. There has been a new estimate of the cost of our program on the same actuarial basis, using the same conservative assumptions; and the estimate now comes to a benefit level cost of approximately \$20 per month per individual. That is the benefit side.

But where do we have the savings? Where is the difference in the cost between the two plans? In the first place, the program I advocate is voluntary, whereas the hospitalization program under the committee bill is compulsory.

The voluntary aspect of the program automatically reduces the cost; it reduces the cost of the voluntary program of supplemental benefits in the committee. I believe, the estimate of utilization under that program is something like 85 or 90 percent.

Mr. MILLS. Eighty to ninety-five percent.

Mr. BYRNES of Wisconsin. Eighty to ninety-five percent; that is the estimate that is used for the voluntary system in the committee bill. Of course, as you reduce the number of people participating, the basic cost is reduced; and, using the same fundamental estimate of utilization for our overall package, the general revenue cost is \$2 billion a year. The premium cost is \$1 billion. So you come to a benefit cost of \$3 billion and you come to a taxpayer cost of \$2 billion under the comprehensive bill that I have proposed.

Let us look at the cost of the committee bill. We have to look at both packages; not just the hospital package, and not just the doctors' service package. What is the combined cost in dollars to the taxpayers. As far as cost to the taxpayers is concerned it is \$2,860 million under the present estimate of which \$835 million is from the general fund, and \$1,255 billion is from the payroll tax. They tell you how sufficient it is to have a proposal that would finance hospital benefits out of the general fund, which is programed separately and is not tied in with social security.

Let me call your attention to the fact that the hospital program, largely financed by the payroll tax, still uses an appropriation from the general fund to finance a part of the hospital program. For the first full year of operation the estimate—and the tables appear in the committee report—shows that the cost to the general fund will be \$275 million in that year for the hospitalization program.

This in effect is the manner in which the hospitalization program is financed: For those over 65 today who are drawing a social security cash benefit, their hospitalization will be financed from the payroll tax; for those over 65 who are not eligible for social security benefits,

their hospitalization will be financed from the general fund.

Now, Mr. Chairman, I ask you, if the medical care program is separate from the social security system and the payroll tax, how can you draw a distinction between those who have already retired who are not drawing a social security benefit and those who are?

Mr. Chairman, you cannot logically draw such a distinction. There is none. Those presently retired have had no connection with the tax for hospitalization which is imposed under the committee bill. This is true whether they are drawing social security benefits or not. Why then should their hospital benefits be financed on a different basis?

The CHAIRMAN. The time of the gentleman from Wisconsin has again expired.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield myself 5 additional minutes.

But where do you end up? Where do you end up as you add up the cost of the committee bill?

The cost of the hospital and the voluntary supplemental services under the committee bill in the first full year of operation is \$2.8 billion of taxpayers' funds, either payroll taxpayers or general taxpayers. Under our substitute, the total cost as far as the general taxpayer is concerned in the first full year of operation is \$2 billion. There is where the difference in cost is, Mr. Chairman, and it is there in black and white. We do not have to do any searching for it. A large part of the savings results from the fact that the substitute program is on a voluntary basis. Hospitalization under the committee bill is compulsory. In addition the substitute bill is contributory. I believe experts in the field will agree that the contributory factor is a substantial element in reducing abuses; namely, excessive utilization of benefits.

Then, finally, Mr. Chairman, I would also point out that the bill I propose provides for a special recoupment of the subsidy from those who are well able to pay the full cost of their subsidy. We do it by way of a special tax applied to those people with an individual income of over \$5,000 a year and we recoup \$10 for each \$100 of income in excess of \$5,000 up to a recoupment of \$100 which represents the amount of subsidy contained in the policy that they purchase from the Government. Therefore, no one can contend that we are providing a benefit for the rich and a benefit to those who can well afford to take care of themselves.

But may I point this out, Mr. Chairman? My objection to the committee bill is not on the basis of the cost. My objection is to the means used to finance the benefits; namely, the payroll tax.

The committee bill would finance the major cost of medical care for the aged—the hospitalization program—through the social security system. One hundred percent of that cost will be paid for by today's workers—and tomorrow's workers—for 19 million persons over age 65. These 19 million persons will pay nothing. This amounts to approximately

two-thirds of the total cost of the combined package of benefits.

The administration bill would finance the balance of its package—the medical services—one-half out of general revenues and one-half by premium contributions.

In summary, the committee bill finances two-thirds of the cost through the social security system, one-sixth of the cost through general revenues, and one-sixth of the cost by premium contributions.

The substitute bill would finance two-thirds of the cost through the general revenues and one-third of the cost by premium contributions.

The committee bill would finance the major cost of medical care for the aged and the hospitalization program through the social security system, and you cannot get away from it.

The chairman of the Committee on Ways and Means has suggested that because they are stated separately that there is a practical separation. Mr. Chairman, we did the same thing in establishing the disability program a number of years ago. We know what that tax is producing in revenue. We know how much it is short, if it is short.

We just recently in the committee discussed the whole issue of what we had to do in order to bring the tax up and balance out the disability part of the system, because we keep separate records.

Mr. MILLS. Mr. Chairman, will my friend yield to me at that point?

Mr. BYRNES of Wisconsin. Yes, I yield to the gentleman from Arkansas.

Mr. MILLS. Permit me to ask the gentleman if the statement I made was not correct, that the OASI and the DI taxes are levied together, and then an allocation is made between the OASI and the DI trust funds?

We have done exactly that very thing in this bill before the committee today with regard to those two programs, but it could not happen with respect to the hospital insurance tax.

Mr. BYRNES of Wisconsin. It is bound to, when you are assessing it against the same taxpayer, on the same basis; you are combining the taxes. Look at the tables in your committee report. You have done that.

Mr. MILLS. No, we did not combine it. There is no combined table in the report except in the minority views. It is in an entirely separate section of the Internal Revenue Code, and there cannot be a transfer to one from the other. The proceeds of the hospital insurance trust fund have to be kept legally separate. The gentleman knows we did not do that with respect to the disability program. In the latter case, we provide for separation of funds, not a separation of tax.

Mr. BYRNES of Wisconsin. I know the gentleman has gone to great lengths to make it appear that there has been a separation; but wait and see, when this bill is enacted the tax that will be applied against the employees and the employers will be the total tax, a tax assessed to take care of the hospitalization and the tax that is required, the percentage rate that is required, to take

care of the old-age survivors and disability insurance system. There is not going to be any separation, in point of fact, at the taxpayer level or even in the Treasury. When it comes to keeping records, sure, you will know what each fund has collected, but we know that today on the disability side.

Mr. MILLS. I think the gentleman is talking about one point with respect to separation, and I am talking about another point. We do not go to the extent, and the gentleman is right, as I said a few minutes ago to him, of requiring the taxpayer to make two separate computations. I am talking about separation of the tax and the trust fund from the point of view of the preservation of the OASDI Trust Funds from any inroads or intrusion by the Hospital Insurance Trust Fund. The gentleman must admit that. Permit me to again refer to page 48 of the report which reads:

The hospital insurance program would be completely separate from the old-age, survivors, and disability insurance system in several ways, although the earnings base would be the same under both programs. First, the schedules of tax rates for old-age, survivors, and disability insurance and for hospital insurance are in separate subsections of the Internal Revenue Code (unlike the situation for old-age and survivors insurance as compared with disability insurance, where, there is a single tax rate for both programs, but an allocation thereof into two portions). Second, the hospital insurance program has a separate trust fund (as is also the case for old-age and survivors insurance and for disability insurance) and, in addition, has a separate Board of Trustees from that of the old-age, survivors, and disability insurance system. Third, the bill provides that income tax withholding statements (forms W-2) shall show the proportion of the total contribution for old-age, survivors, and disability insurance and for hospital insurance that is with respect to the latter. Fourth, the hospital insurance program would cover railroad employees directly in the same manner as other covered workers, and their contributions would go directly into the hospital insurance trust fund and their benefit payments would be paid directly from this trust fund (rather than directly or indirectly through the railroad retirement system), whereas these employees are not covered by old-age, survivors, and disability insurance (except indirectly through the financial interchange provisions). Fifth, the financing basis for the hospital insurance system would be determined under a different approach than that used for the old-age, survivors, and disability insurance system, reflecting the different nature of the two programs (by assuming rising earnings levels and rising hospitalization costs in future years instead of level-earnings assumptions and by making the estimates for a 25-year period rather than a 75-year one).

Mr. BYRNES of Wisconsin. You have made provision so as to prevent borrowing from the other funds. I recognize that. But the same thing exists today with respect to the disability insurance fund, they have to come back for an increase in the tax rate if they run short.

Mr. MILLS. What do we do? In the case of the disability fund, we allocate from the total tax of OASDI an amount in addition to that. That could not happen under this bill for the hospital insurance trust fund.

Mr. BYRNES of Wisconsin. I understand you are not doing it, but when you come down to the nub of the question you are tying it into the social security taxpayer. You have the same taxpayer, you have the same rate base.

Mr. MILLS. What about the railroad employees? They are not under social security, yet they are taxed, and the employers taxed for this purpose.

Mr. BYRNES of Wisconsin. That is of little consequence as far as I am concerned, and as far as practicability is concerned, whether it runs through the railroad retirement system, then gets into the Treasury, or whether it goes directly from the railroad and the employee into that fund. The difference, Mr. Chairman, as far as I am concerned, and I think any practical person who looks at it must admit it, the effect is you are tying this into the social security system. You can put in gimmicks that look like you are separating it, you can do all of the rationalization you want to, but you still have them both tied together.

The mere fact, Mr. Chairman, that you are going to deny hospitalization benefits to those who become 65 after 1968 unless they have paid social security taxes shows how you tie the two programs together. You cannot qualify for health benefits without also qualifying for the cash benefits under social security. If you are eligible for cash benefits you are eligible for hospital benefits.

My primary concern—and I am certain the chairman of our committee shares that concern—is to protect cash benefits under social security. That is the foremost and basic need of the elderly. Cash benefits will be secure only so long as we do not overburden the payroll tax system which is used to finance those benefits.

The payroll tax is a very regressive tax. It can be carried to the breaking point. Let me just read you from the speech which the chairman of our committee made as recently as September 28 last year. He said:

I have always maintained that at some point there is a limit to the amount of a worker's wages, or the earnings of a self-employed person, that can reasonably be expected to finance the social security system. Not only is this a gross income tax, but it adds to the cost of American goods and services and thus affects our competitive position. I do not believe that the American people will support unlimited taxation in the area of social security.

Again in December of last year, he added a note of caution. Because he so well summarizes my views of the dangers inherent in such a tax, I would like to read a paragraph from that speech:

I hasten to add, however, that the concept of a payroll tax cannot be judged adequately without reference to what kind of payroll tax. A major point to be considered in this regard is, what effect does the tax proposed have prospectively on other sources of revenue. Specifically in regard to the aged, we must remember that the primary needs of our senior citizens are for adequate cash benefits. The amount must be sufficient to produce a dignified standard of living when added to other spendable assets characteristic of the aged. Further, the

amount must be raised periodically to keep in step with decreasing purchasing power of the dollar. A payroll tax to pay for health benefits, as I have stated before, should not be added to or harnessed with one to pay for cash benefits. Health expenses are less predictable and they are rising considerably faster. Within a tight coupling, the cash benefit would in all probability, be compromised and the danger increased of stressing health care at the expense of the root-factors of food, shelter, and clothing.

If we pass the committee bill, we will be taking an unprecedented step in the field of social security. We will be tying into the social security system a service benefit. Not the payment of a specified amount of dollars at some future date, but payment for a specified service—hospitalization—regardless of what that service might cost.

That is why I am unalterably opposed to financing hospitalization through the social security system. You have been told that this is a separate tax with a separate fund, and everyone will know what the hospitalization program costs in terms of the payroll tax.

Once we embark on the program, will that make any difference?

I would like to remind you again that we followed precisely the same format when we set up disability benefits under social security. What has happened?

Today, the disability benefit and the regular cash benefit are linked together—we call it the old-age survivors and disability insurance system—OASDI.

Once we tie the hospitalization program to the payroll tax we are only kidding ourselves when we say that it can be separated from the cash benefits.

The same worker, the same employer, the same wage, all must finance both programs. Every percentage point that we levy as a tax for hospital benefits means that much less available as a tax to finance cash benefits. That is the crux of the matter.

No one can honestly say that in levying this tax to finance hospital benefits we are not jeopardizing our ability at some future date to provide for an increase in cash benefits. And I happen to believe—and I believe our chairman shares my belief—that the most important consideration should be our ability to maintain cash benefits at a level which will preserve the purchasing power of those benefits to our aged citizens.

Mr. MILLS. Mr. Chairman, will the gentleman yield?

Mr. BYRNES of Wisconsin. I yield to the gentleman from Arkansas.

Mr. MILLS. Does my friend who sees such a threat to the OASDI program, which I do not see, see no danger at all to the general fund in his proposal?

Mr. BYRNES of Wisconsin. There is no question that we all have to cope with a most serious problem as far as the fiscal situation of our Nation is concerned, but that fiscal situation faces us whether the funds come through the general fund or payroll taxes. It is a burden we are placing on our taxpayers. The decision is apparently made that we are going to have a program for our older people that is going to be subsidized by the taxpayers of this country. That subsidy will be in the neighborhood

of between \$2 and \$3 billion a year. That is the burden; that is the problem. You can raise it from the regressive payroll tax or on an ability-to-pay base. We can use the most regressive tax we have, which is what the committee bill proposes, falling on the workers and the low-income people, or you can rely on the progressive tax rates which we use for our general fund.

Mr. MILLS. I am sure the gentleman and I are in accord that these benefits will grow in cost in the future for no other reason than the growing number of our people over 65, but has the gentleman no fears at all of the growth of a program under the general funds of the Treasury compared to the growth of a program under dedicated or trust fund taxes?

Mr. BYRNES of Wisconsin. I would say to the gentleman I would have less concern where the program remains flexible than I would where a program is rigid as far as the practical opportunity of Congress to revise the benefit package or the method of financing. Under the payroll tax, an erroneous concept has been sold to the people that they have paid for their benefits, that they have bought something as a matter of right, under such a concept there is no flexibility to make changes because the people tell you, "We have bought this, and you cannot make any change except to liberalize it."

Under the alternative we propose, you can change the contributions by the individual and the benefit package to the individual at each period of enrollment. You can maintain flexibility, just as you do today with respect to the insurance program for Federal employees. We would not discontinue having a program of hospital and medical care benefits for Federal employees, but we do have an opportunity to change either the nature of the package or the contributions or the subsidy that will be provided. I say to you as far as I am concerned, I see more protection for the future in something that has flexibility as compared to something that is rigid.

Mr. MILLS. Mr. Chairman, will the gentleman yield?

Mr. BYRNES of Wisconsin. I yield to the gentleman.

Mr. MILLS. The social security old-age, survivors, and disability system is actuarially sound and has been for the last 30 years. How many times have we had a balanced budget of the general fund of the Treasury into which the gentleman proposes to put this system? I am trying to say this, to emphasize the point I have made repeatedly—a payroll tax will tend to limit the growth of the benefit and will tend to do so to a greater extent than will be the case if that benefit cost is placed in the general fund of the Treasury.

Mr. BYRNES of Wisconsin. I just disagree with the gentleman. There should be no more reason for a limitation based on who the taxpayers happen to be or to whether you put it on a regressive tax basis or put it on a progressive tax basis. It seems to me that justice requires we put it on the basis of those

most able to pay rather than on those who are least able to pay.

Mr. Chairman, I have used more time than I should. I would summarize by saying that the differences of opinion—the point of conflict in our whole discussion is with reference to the medical provisions as contained in the committee bill. I propose a voluntary system instead of a compulsory system. I propose a contributory system. I propose that it be financed not on the regressive payroll tax but that it be financed on the basis of our progressive tax system. I propose a system that is more comprehensive as far as the benefits are concerned.

Under the alternative proposal, the matter of need is recognized by a recoupment provision. We make sure that you are not just giving a gratuity to those who are well able to take care of their own medical needs.

Mr. JONES of Missouri. Mr. Chairman, will the gentleman yield?

Mr. BYRNES of Wisconsin. I yield briefly to the gentleman.

Mr. JONES of Missouri. The gentleman brought out a minute ago the benefits cost being estimated by the actuary at \$20 a month. Will the gentleman explain that a little clearer to me? I cannot get that through my head.

Mr. BYRNES of Wisconsin. That is the benefit package.

Mr. JONES of Missouri. What do you mean by the benefit package? Do you mean that is the cost of service to be rendered to the person who enters the hospital and that that will average out at the rate of \$20 a month?

Mr. BYRNES of Wisconsin. No, no.

Mr. JONES of Missouri. That is what I want to find out.

Mr. BYRNES of Wisconsin. If you were to sell a particular package of insurance benefits, which provides for many days in the hospital and coverage of doctor bills, drugs, and the like, you would have to charge a premium of \$16 to \$20 a month. That is what we are talking about—the premium cost.

Mr. JONES of Missouri. But you are not going to collect that much under the additional money that is going to be raised by the increases in payroll taxes; are you?

Mr. BYRNES of Wisconsin. The gentleman is talking about the provisions in the committee bill. I am talking about my substitute. There is no payroll tax involved in the substitute. Now suppose an individual pays a premium an average premium of \$6.50 a month. The balance is subsidized out of the general revenues. On this basis of 80 to 90 percent of utilization or participation by the group over 65 years of age and the cost would average out about \$2 billion of Government subsidy and about \$1 billion of premium cost to the group.

Mr. JONES of Missouri. In other words, am I to understand, and let me get this straight—am I to understand you are saying that a premium of \$20 a month will provide hospitalization, drugs, and doctor bills?

Mr. BYRNES of Wisconsin. Yes, sir.

Mr. JONES of Missouri. I thank the gentleman.

Mr. BYRNES of Wisconsin. The same program that is provided for our Federal employees.

I would hope that this committee in this House would exercise its good judgment in saying:

First. Let us do nothing that would jeopardize in any degree our ability to maintain the cash benefit program which is the underlying basis of protection that our older people rely on.

Second. Let us do something for our aged people and make sure that there are none of our older people who want for medical care and that they have assurance they will have their medical needs taken care of.

If we are to do those two things, then we will vote for the substitute as opposed to the bill reported by the committee.

Mr. MILLS. Mr. Chairman, I yield 20 minutes to the distinguished gentleman from California [Mr. KING].

Mr. Chairman, will the gentleman yield to me?

Mr. KING of California. I am pleased to yield.

Mr. MILLS. I wanted to take this occasion to pay deserved tribute to the gentleman from California.

It has been my privilege to sit next to the gentleman for several years on the Committee on Ways and Means. I know of no one for whom I have a deeper affection or any greater respect and higher regard than the gentleman from California. Throughout the years we have served on the committee together—while I have been the chairman and he has been the ranking Democrat—it has been a source of great satisfaction to me to know that at all times I have had his full and complete cooperation. I wanted the membership of the House and the people of the country to know that he has made a major contribution in the development of the legislation which is presently before the House. In fact, many of the provisions he introduced in his bill, H.R. 1, in addition to the provision which is in the bill on the basic plan for hospitalization insurance with which he is most closely identified, are contained in the pending bill.

The gentleman has made many contributions in many fields, but I doubt if he has made any greater contribution over than in the development of this bill, H.R. 6675.

I want it to be known that I had such a feeling about the gentleman's contribution and the part that he played in this matter over the years that, after the committee directed me to introduce the committee bill—that is why it is in my name, because I happen to be chairman of the committee and the committee directed me to do so—I asked the gentleman from California to introduce an identical bill accompanying this one—H.R. 6676—because certainly he is entitled to the commendation of the American people as much as any man here today for much of what is in this bill.

I take my hat off to him again. I have done so on many occasions in the past.

In spite of all the many admirable features of the gentleman, I must say his intense loyalty to his purpose, to his

people, to his country, and particularly to his colleagues here impresses me as much as any other of his many fine attributes.

Mr. Chairman, will the gentleman yield further?

Mr. KING of California. I am pleased to yield.

Mr. MILLS. My distinguished friend from Wisconsin was very kind to yield and I appreciated the fact that he did, though I took too much of his time. He and I so often find ourselves in agreement that it is difficult for me to find us in disagreement factually about two matters in this bill. One has to do with the question of separation of hospital insurance from the present social security insurance system itself. We went into the matter in the report on pages 33 and 48, as my friend from California knows, and pointed out five distinct differences in the operation of the OASDI system and this new program of hospital insurance.

My friend used an argument to say that they were one and the same because the hospital insurance matter included a lot of people not under social security.

I think he misled me as to what he meant, or maybe he misspoke himself, because I did not quite understand that as the reason. The fact that more people are in the health insurance program than the social security program I do not believe is a justifiable argument for saying the two are identical.

Mr. BYRNES of Wisconsin. Mr. Chairman, will the gentleman from California yield to me?

Mr. KING of California. I yield to the gentleman.

Mr. BYRNES of Wisconsin. I am sorry I did not make myself clear.

Mr. MILLS. You did to everyone but me, I am sure.

Mr. BYRNES of Wisconsin. What I was pointing out to the chairman was that we have today a group of people who are over 65 who are not under social security or railroad retirement—the so-called uninsured. Under the committee bill they will all be made eligible and are all automatically eligible except—for a reason that I cannot quite understand—except for Federal employees who retired after July 1, 1960, the effective date of the Federal Employee Health Benefits Act of 1959. They are the only people put in a separate category, and you say, "No, you cannot qualify for hospitalization, but everybody else over 65 is going to be eligible for hospitalization."

Mr. MILLS. But that is not the case.

Mr. BYRNES of Wisconsin. But the cost of the benefits for those over age 65 is not all paid out of the same source of revenue. The bill makes a distinction in how you are going to pay for some of these people. For those who are drawing social security benefits, the benefits are paid out of funds derived from the payroll tax levied under the hospitalization program, but for those who are not drawing a social security benefit, the benefits are paid out of the general fund. My point is, if the hospitalization program is separated from the social security system—and none of these people over age

65 will have paid 1 cent of the tax imposed for the hospitalization phase of this program—then why should their benefits be paid from two different sources of revenue? Why should any of the benefits be paid out of general revenues if it is not tied in with the social security system?

Mr. MILLS. The gentleman put his finger on one of the very things that points up the difference between the hospital insurance trust fund and the old-age, survivors, and disability insurance trust fund. The fact that we take more people into the hospital program than are eligible under social security should be convincing to the gentleman that there is some distinction.

Mr. BYRNES of Wisconsin. Why do you pay the benefits from a different source?

Mr. MILLS. Because they come from different areas. Some come from railroad retirement, some come from social security, and some—the uninsured—come without any coverage under either program. My friend knows we have taken in far more people than are just eligible for social security benefits.

Now, will my friend from California yield further?

Mr. KING of California. I am pleased to yield to the gentleman.

Mr. MILLS. The other point of disagreement is in regard to cost estimates and assumptions. The gentleman said that his program, so far as the general fund and the Treasury are concerned, would cost \$2 billion in the first year. I thought I understood him to say that it represented a per capita cost of \$20 per month for a person who went into the system. Was that the figure the gentleman used—\$240 a year?

Mr. BYRNES of Wisconsin. That would be the highest cost estimate.

Mr. MILLS. That is right.

Mr. BYRNES of Wisconsin. There is an intermediate cost estimate of \$16 per month and a low cost; \$20 is the high cost.

Mr. MILLS. We used the high-cost estimate for the committee bill, and I wanted to ask the gentleman about that. The gentleman would still let them pay \$6 per month out of their pocket for the health benefits?

Mr. BYRNES of Wisconsin. An average payment would be \$6.50.

Mr. MILLS. That would be the average payment?

Mr. BYRNES of Wisconsin. Yes.

Mr. MILLS. That would produce something like \$1.22 billion of revenue per year, as I estimate it.

Mr. BYRNES of Wisconsin. That is at 100 percent. The gentleman is using 100 percent.

Mr. MILLS. No. That is at 90 percent participation. It is 90 percent, because 90 percent of the total population aged 65 or over adds up to 17 million people, and I am just multiplying here \$240 by 17 million, and I come up with a total cost of \$4.08 billion in the first full year of operation.

If we take from that the amount that the persons themselves will contribute, Mr. Myers tells us in his memorandum to you and to the committee that was

sent us while we were in executive session, using the high-cost estimates now, however, that your program providing benefits and taking care of administrative expenses, would cost the general funds of the Treasury in its first year of operation \$2.86 billion, not the \$2 billion the gentleman comes up with when he uses intermediate cost estimates.

Mr. BYRNES of Wisconsin. Why do we not just quote from the letter of February 26, taking the third paragraph of the letter, where Mr. Myers estimates the cost of my program?

Mr. MILLS. But what I wanted to point out is that maybe some of the basis for this conclusion of the gentleman from Wisconsin that I just could not anticipate or understand or believe, that you can do more under one program than you do under another program, but that the program that does the most is going to cost the least. Maybe that results from the fact that in one instance a high-cost estimate is used, while in the other instance an intermediate-cost estimate is used, and in the other a low-cost estimate is used. If you do that, you can get a program providing a lot more benefits that appears to cost less, but the facts are that they are going to cost whatever they cost, and we are going to have to make it available from some source.

I am somewhat amazed by the inferences from the separate views of the minority in the committee report that the hospital benefits program is not adequately financed by the bill. The minority states that there are safety factors in the cash benefits system, but that this is not the case as to the hospital benefits program. This is strange because the minority members were at the very committee meetings where, time after time, I requested that additional safety factors be placed in the assumptions.

The current assumptions as to hospital utilization, both in the early years and over the long run, reflect these added safety factors. The actuarial assumption that the earnings base would be kept up to date was replaced with an assumption that the base will not rise after 1971. This is very conservative, and if the base is subsequently raised by Congress above this amount, the tax rate can be reduced under this conservative assumption. As to the future increases in hospital costs relative to wages, the committee assumption is more conservative than that presented by the actuaries representing the insurance industry.

To put this all into perspective, I would like to insert into the Record at this point a memorandum from Robert J. Myers, chief actuary of the social security system, whose competency and integrity is unquestioned by Members on both sides of the aisle, commenting on the safety factors in the bill. He states, in summary:

The actuarial cost estimates for the hospital insurance system that would be established by H.R. 6675 are based on assumptions that are not only reasonable, but also conservative (in the sense that they tend to be either "high-cost" assumptions or else assumptions that have a built-in safety margin in regard to future changes in economic conditions).

The memorandum is as follows:

April 1, 1965.

From: Robert J. Myers.

Subject: Principal aspects of actuarial assumptions underlying cost estimates for hospital insurance benefits of H.R. 6675.

The actuarial cost estimates for the hospital insurance system that would be established by H.R. 6675 are based on assumptions that are not only reasonable, but also conservative (in the sense that they tend to be either "high-cost" assumptions or else assumptions that have a built-in safety margin in regard to future changes in economic conditions). This may be indicated by considering the four most important cost factors involved in these estimates—namely, hospital utilization rates, the current level of reimbursable average daily hospitalization costs, future trend of hospitalization costs, and future changes in the maximum taxable earnings base for the program. Each of these factors will be considered in turn.

A. Hospital utilization rates: The rates used in the current cost estimates are 20 percent higher than those used in the cost estimates for the administration proposal of 1965 in the initial years of operation, and 10 percent higher in the long run. The rates used previously were reasonable and were developed from extensive analysis of survey data, with appropriate adjustments being made for the effect of "insurance benefits" being available to the entire eligible population and for deceased persons who were omitted from the survey.

B. Current level of reimbursable average daily hospitalization costs: The 1966 figure used as the base point has been projected from the most recently available actual data (for 1963) by assuming that hospitalization costs would increase at the same average rate as in the past decade, even though there is clear evidence that the rate of increase has slackened off some. The downward adjustments that have been made in the basic data obtained from the American Hospital Association have been analyzed further on the basis of a number of sources of information, and I believe that the aggregate effect is that the reduction made is conservative.

As compared with the procedure for previous estimates for Hospital Insurance proposals, the current method in regard to this factor is more conservative. This is the case because it begins with the estimated figure that will actually occur in the first year of operation, rather than with the lower figure based on an earlier year; namely, that for the earnings assumptions for estimating the contribution income (1963).

C. Future trend of hospitalization costs: It is assumed that hospitalization costs will increase more rapidly than the general level of wages in the first 5 years—namely, by the same average differential that has prevailed on the average in 1954-63, even though there has been clear evidence of a downward trend (i.e., the rate of increase of hospitalization costs becoming more nearly the same as the rate of increase of the general wage level). After the first 5 years of operation, the differential of the increase in hospitalization costs over the increase in wages is assumed to lessen, and following 1975, hospitalization costs and wages are assumed to rise at the same rate. This is a much more conservative assumption than was used in earlier cost estimates for administration proposals—namely, that over the long run, from the

The adjustments have been made to allow for the inclusion of non-reimbursable items (such as the cost of operating restaurants and gift shops, the cost of outpatient clinics, etc.), the lower average daily cost for persons aged 65 and over (because of their longer average stays), and the adjustment to allow for inclusion of all physicians' services.

inception of the program, hospitalization costs would increase at exactly the same rate as wages. Also, it is somewhat more conservative than the corresponding assumptions recommended by the Advisory Council on Social Security Financing, and slightly more conservative than the assumptions that the insurance business made in its estimates.

D. Future changes in maximum taxable earnings base for program: The conservative assumption is made that, despite the assumption that the general wage level will rise by 3 percent annually during the 25-year period considered in the cost estimates, the maximum taxable earnings base will not be changed from the pertinent provisions in the bill (namely, an earnings base of \$5,600 in 1966-70 and of \$6,600 thereafter). In essence, this is a built-in safety factor in the hospital insurance program, because it seems most likely that if wages continue to rise steadily after 1971, then at some time thereafter the earnings base will be adjusted upward. Under such circumstances, the contribution schedule developed could, if all other cost assumptions are exactly realized, be reduced.

In all cost estimates made previously, it was assumed that the earnings base would be increased from time to time in a proportionate manner with changes in the general earnings level. If such changes did not occur, then the cost of the program would be higher than in the estimate.

Finally, it may be mentioned that there is still another conservative element in the cost estimates that is present both in regard to H.R. 6675 and also has always been present—namely, that the proposals are to be financed by a certain amount of advance funding, rather than being on a completely (or nearly) pay-as-you-go basis. Thus, for example, under H.R. 6675, in the first year of operation the estimated contributions are 61 percent in excess of benefit payments. In the next 3 years of operation, this differential averages about 18 percent each year.

ROBERT J. MYERS.

I would think that the gentleman would better proceed in a more conservative fashion on the basis of a high-cost estimate for his program, just as we have used in the committee bill. If he does, the first-year cost will not be \$2 billion out of general revenues, but rather a higher figure—by \$860 million in the first full year of operation.

Mr. BYRNES of Wisconsin. Mr. Chairman, I hate to use so much of the time of the gentleman from California, but I do think the gentleman is perfectly right, that we should get this whole cost matter thrashed out so everybody understands it.

Mr. MILLS. That is right.

Mr. BYRNES of Wisconsin. If the gentleman will allow for half a minute, I should like to quote the last estimate made by the actuary, in a letter dated February 26. I believe this is the last estimate.

Mr. MILLS. April 5 is the last I have. It refers to the one of February 26.

Mr. BYRNES of Wisconsin. Mr. Myers is talking about the cost estimates for the Byrnes bill—revised. This is the third paragraph in the memorandum which is at the heart of it. It says:

If there were 100 percent participation, in Federal cost for the first full year of operation (which could be assumed to be fiscal year 1966 to 1967) it is estimated at \$3.4 billion, while the participants themselves would contribute about \$1,350 million. With 80 percent participation, the Government

cost would be \$1.9 billion while the participants would pay \$1 billion; and with 80 percent participation the corresponding figure would be \$1.3 billion and \$0.6 billion, respectively.

I point out in my remarks that it is not anticipated that you would have 100 percent participation under a voluntary program. We have people who already have a system that is adequate for their needs and would not participate.

All I can do, Mr. Chairman, is cite to you the language of the actuary on whom you rely and, frankly, on whom we rely. At least we do not have a difference of opinion of two different actuaries.

Mr. MILLS. We have the same actuary, and we all have great confidence in him. I want to suggest that when we get back in the House, the gentleman, at this particular point in the Record, insert the memorandums from the actuary dated February 9 and 26. And let me at the same time include what he has supplied me in the form of a memorandum dated April 5, 1965, in which he says that if we use high-cost estimates—compared to the intermediate-cost estimate used in the memorandum of February 26—for your plan on a 90-percent assumption of enrollment, and high-cost estimates for the committee plan, that we bring the costs of the two together on a comparable basis.

Mr. BYRNES of Wisconsin. I would certainly like to see the revised estimate. I thought I was receiving the material relating not only to the cost of my bill but the cost of the committee program. I did not know that there was an undercover change in the estimates. I relied on the first two estimates made by the actuary.

Mr. MILLS. This is the same actuary that the gentleman has great confidence in. If the gentleman will let me explain the April 5 memorandum I have, it does nothing more than refer to the February 6 and 26 memorandums and explains those memorandums with relationship to a high-cost actuarial estimate as we asked for toward the end on the committee bill. I will show this to the gentleman, and I will also show him a memorandum prepared today that uses the same \$6.50 average monthly premium payable by the participants that the gentleman cites, instead of the average premium of \$6 that is used in the April 5 memorandum. I include at this point in the Record the memorandums of Mr. Myers dated February 9, February 26, April 5, and April 7:

MEMORANDUM OF FEBRUARY 9, 1965

From: Robert J. Myers.
Subject: Cost estimate for the Byrnes bill.

This memorandum will present a cost estimate for the first full year of operation of the Byrnes bill, H.R. 4351, which would establish a program of voluntary comprehensive health insurance for all persons aged 65 or over. In making a cost estimate for this proposal, it is impossible to predict with any exactitude what proportion of the eligible persons will actually elect to participate. Three different participation assumptions are made—namely, 100 percent, 80 percent, and 60 percent. Although it is recognized that complete 100 percent participation will never be possible because of the parallel existence of the plan for persons under the

civil service retirement program and because of low-income persons not on old-age assistance but who could possibly qualify for medical assistance for the aged under an adequate State plan not electing to participate.

If there were 100-percent participation, the Federal cost for the first full year of operation is estimated at \$3.3 billion, while the participants themselves would contribute about \$1¼ billion. With 80 percent participation, the Government cost would be \$2.6 billion, while the participants would pay \$1 billion, and with 60 percent participation the corresponding figures would be \$1.7 billion and \$0.6 billion, respectively.

It should be mentioned that dollar costs in future years will be increasingly higher than those for the first full year of operation. As to the participant contributions, this will be the case because of the larger number of eligible persons and because of higher benefit amounts (since those currently coming on the roll tend to have somewhat larger benefits than those who retired in previous years). The Government cost would increase at a more rapid rate than the cost for participants because of the anticipated more rapid rate of increase of medical costs than will be true for wages, which in turn will increase more rapidly than benefit amounts.

One of the cost aspects of the proposal should be mentioned—namely, the increased cost to the OASDI system as a result of the liberalization of the earnings test. In fact, an amount of benefit equal to the monthly health contribution is made exempt from the earnings test for all persons aged 65 and over (regardless of whether or not retired). The estimated level-cost of this change in the earnings test is 0.07 percent of taxable payroll.

ROBERT J. MYERS.

MEMORANDUM OF FEBRUARY 26, 1965

From: Robert J. Myers.
Subject: Cost estimate for the Byrnes bill.

This memorandum will present a cost estimate for the first full year of operation of the Byrnes bill, H.R. 4351, which would establish a program of voluntary comprehensive health insurance for all persons aged 65 or over, effective January 1, 1966. In making a cost estimate for this proposal, it is impossible to predict with any exactitude what proportion of the eligible persons will actually elect to participate. Three different participation assumptions are made; namely, 100 percent, 80 percent, and 60 percent. Although it is recognized that complete 100-percent participation will never be possible because of the parallel existence of the plan for persons under the civil service retirement program and because of low-income persons not on old-age assistance but who could possibly qualify for medical assistance for the aged under an adequate State plan not electing to participate.

The current cost estimate uses a figure of \$16 per capita for benefits and administrative expenses (or 79 percent above the H.R. 1 cost of about \$9). It may be noted the insurance industry uses a figure of \$19.40 for the Byrnes bill—\$18.80 for benefit costs, plus 5 percent for administrative expenses (or 85 percent above its estimate of \$12.80 for H.R. 1).

If there were 100-percent participation, the Federal cost for the first full year of operation (which could be assumed to be fiscal year 1966-67) is estimated at \$3.4 billion, while the participants themselves would contribute about \$1¼ billion. With 80-percent participation, the Government cost would be \$1.9 billion, while the participants would pay \$1 billion, and with 60-percent participation the corresponding figures would be \$1.3 and \$0.6 billion, respectively.

It should be mentioned that dollar costs in future years will be increasingly higher

than those for the first full year of operation. As to the participant contributions, this will be the case because of the larger number of eligible persons and because of higher benefit amounts (since those currently coming on the roll tend to have somewhat larger benefits than those who retired in previous years). The Government cost would increase at a more rapid rate than the cost for participants because of the anticipated more rapid rate of increase of medical costs than will be true for wages, which in turn will increase more rapidly than benefit amounts.

One of the cost aspects of the proposal should be mentioned; namely, the increased cost to the OASDI system as a result of the liberalization of the earnings test. In fact, an amount of benefit equal to the monthly health contribution is made exempt from the earnings test for all persons aged 65 and over (regardless of whether or not retired). The estimated level cost of this change in the earnings test is 0.07 percent of taxable payroll.

ROBERT J. MYERS.

MEMORANDUM OF APRIL 5, 1965

From: Robert J. Myers.
Subject: Cost estimate for the Byrnes bill H.R. 7057.

This memorandum will present a cost estimate for the first full year of operation of the Byrnes bill, H.R. 7057, which would establish a program of voluntary comprehensive health insurance for all persons aged 65 or over, as well as make revisions in the OASDI program. I have presented cost estimates for the almost identical proposal that Mr. BRAUN of Wisconsin made previously, as contained in H.R. 4351, for which I gave cost estimates in my memos of February 6 and 26. I am assuming a participation rate of 90 percent, since this is what Mr. BRAUN of Wisconsin hypothesizes in his explanation of the bill in the CONGRESSIONAL RECORD for April 1, pages 6784-6785.

Under this participation assumption, there would be about 17 million persons who would participate in the program in the first full year of operation. The average contribution from the participants would be about \$6 per month (higher than the figure of \$5.50 used previously, because of the increase in the OASDI cash benefits resulting from title III of the bill). Accordingly, the annual rate of contributions from the participants would be \$1.22 billion.

According to an intermediate-cost estimate, the monthly per capita cost of the benefits and administrative expenses would be \$16 (as per my memorandum of February 26), so that the total annual cost would be \$3.26 billion, thus leaving \$2.04 billion as the cost from general revenues. On the other hand, if the per capita cost assumptions are high-cost ones (as per my memorandum of February 6)—thus paralleling the cost assumptions used for H.R. 6675—the annual cost for benefits and administrative expenses would be \$4.08 billion, thus making the cost from general revenues be \$2.86 billion. This figure may be contrasted with the estimate of \$2 billion given in Mr. BRAUN's statement, which apparently is thus based on intermediate-cost assumptions that are not consistent with those in the cost estimates underlying H.R. 6675.

ROBERT J. MYERS.

MEMORANDUM OF APRIL 7, 1965

From: Robert J. Myers.
Subject: Cost estimate for the Byrnes bill, H.R. 7057, on basis of average participant payment of \$6.50 per month.

This memorandum will present a cost estimate for the first full year of operation of the Byrnes bill, H.R. 7057, which would establish a program of voluntary comprehensive health insurance for all persons aged 65 or over, as well as make revisions in the OASDI

program, on the basis that the average monthly premium payments from participants will be \$6.50. I have presented cost estimates for the almost identical proposal that Mr. Branca made previously as contained in H.R. 4351, for which I gave cost estimates in my memo of February 6 and 26 and in my memo of April 5, which was based on an average participant payment of \$6. I am assuming a participation rate of 90 percent, since this is what Mr. Branca hypothesized in his explanation of the bill in the CONGRESSIONAL RECORD for April 3, page 6784-6786.

Under this participation assumption, there would be about 17 million persons who would participate in the program in the first full year of operation. Accordingly, the annual rate of contributions from the participants would be \$1.33 billion.

According to an intermediate-cost estimate, the monthly per capita cost of the benefits and administrative expenses would be \$16 (as per my memorandum of February 26), so that the total annual cost would be \$3.26 billion, thus leaving \$1.93 billion as the cost from general revenues. On the other hand, if the per capita cost assumptions are high-cost ones (as per my memorandum of February 6)—thus paralleling the cost assumptions used for H.R. 4675—the annual cost for benefits and administrative expenses would be \$4.08 billion, thus making the cost from general revenues be \$2.75 billion. This figure may be contrasted with the estimate of \$2 billion given in Mr. Branca's statement, which apparently is thus based on intermediate-cost assumptions that are not consistent with those in the cost estimates underlying H.R. 4675.

ROBERT J. MYERS.

Mr. MILLS. Mr. Chairman, how much time has the gentleman from California consumed?

The CHAIRMAN. The gentleman from California has consumed 14 minutes.

Mr. MILLS. Theoretically he has, but the Record will show differently.

Mr. Chairman, I yield to the gentleman 14 additional minutes.

Mr. KING of California. Mr. Chairman, I hesitated to join in this discussion. I thought that I had a simple answer. I am not often asked for my opinion, but in this case I could say that a voluntary program doing less for fewer people would certainly cost less and I do not think you have to be a mathematician to arrive at that conclusion.

Mr. Chairman, the legislation which this House will pass tomorrow as debate ends—and in my opinion it will pass overwhelmingly—is the culmination of many years of public-spirited effort by many sincere and dedicated men, some of whom are here today but others of whom have passed from this scene. One thing, I believe, all of these people have had in common is a sincere and deep-seated desire to help their fellowman and a compassion for those who by fate or circumstance beyond their control face problems with which the average frugal aged citizen in this automated age are unable to cope.

One thing which is understood by openminded and farsighted legislators, and, indeed, all fairminded men of the times, is that society and our economy do not ever stand still. If Government is to keep pace with the demands of the times, then Government must develop those programs and policies which are

necessary to meet the emerging needs of our citizens. So it is with this legislation today. Here we have a monument to what ultimately can be done in the face of very great inertia on the part of many and despite extended and, at times, vociferous overt opposition from those forces which always oppose change.

Those who have already spoken, including our brilliant chairman of the Committee on Ways and Means, our colleague WILSON MILLS, have discussed in detail the changes which this legislation would make in existing law and the new programs which it will place on the statute books. I do not, therefore, feel called upon to consume the time of my fellow legislators by repeating the details of what has already been so ably discussed. What I do hope to achieve by these few brief remarks is to instill in my colleagues a sense of the importance of this day to our times and to the future and the ramifications which this legislation will have in the months and years to come.

It seems, in one sense, that it has been only a brief period of years since I first sponsored this legislation even after those who had gone before me had worked for passage of somewhat similar programs. I well recall in the late 1940's and early 1950's the efforts of my esteemed late colleague on the Committee on Ways and Means, the Honorable John Dingell, whose distinguished son, I am proud to note, is now sitting as Chairman of the Committee of the Whole House on the State of the Union who so proudly carries on today that oldtime Dingell tradition in the House of Representatives. I also well recall the courageous and extended battle fought for legislation similar to this by our colleague, the Honorable Aime Forand. In 1957, Aime Forand introduced what became known nationwide as the Forand bill, and he immediately became the target of extended and widespread abuse on the part of those who are today fighting the legislation which this House will pass.

From 1957 until this Congress, the Committee on Ways and Means on numerous occasions conducted hearings, both public and executive, on Aime Forand's bill and then, subsequently, on the similar legislation which I have had the honor to sponsor. In those hearings and some areas of the public press and in certain trade publications, I think all of you are aware that I became the target of a considerable amount of abuse. Perhaps only those Members who attended our most recent public hearings on this subject in the Congress just concluded will recall my comments when the representatives of the American Medical Association appeared and testified. At that time, I stated that what they had just said with regard to my bill was consistent with what they had been saying since similar legislation was first introduced and that the only real difference in their position was that a new set of figures had been devised to attempt to prove their case. At that time, I further recalled that the posture of opposition was one not unfamiliar to the American Medical Association since they had been consistent in opposing

measures not only of this nature but also such laudable extensions of the Social Security Act as the Social Security Amendments of 1956 which for the first time provided disability insurance benefits. As I said at that time, I have never objected to fair criticism of anything which I have espoused, but the type of critical comment which was issued from some quarters of the American Medical Association far surpassed which we all except as within the bounds of reasonable critical comment.

However, I do not wish to dwell on that sort of thing. What I do want to do is to lend a sense of history to what we are doing today, by briefly reviewing the development of our social security system, and then to again say why this program in this bill is necessary.

HISTORY OF SOCIAL SECURITY PROGRAM

The 1935 social security legislation provided only old-age insurance benefits, and these were paid only to the worker himself. The amendments of 1939 put the protection of the program on a family basis by adding monthly benefits for the worker's dependents and survivors. Not only the aged and retired worker but his widow as well could therefore look to an assured but modest income in old age. The 1939 amendments also provided that the monthly benefits that were to be paid under the social security system should be paid beginning in 1940, and in this way realized the potential of social insurance to provide full-rate benefits without awaiting the buildup of huge reserves many years in the future as under private insurance.

During the 1950's, adjustments were made in the benefits and the earnings base of the program that were needed to keep social security in step with our economy. Also, the coverage of the program was greatly improved during the past decade. In 1956, benefits were provided for disabled workers between the ages of 50 to 65. These benefits were, of course, made immediately effective for workers who had become disabled previously. In 1958 benefits were added for dependents of disabled workers; and in 1960 the law was changed to provide benefits to disabled workers at any age and to their dependents.

NUMBER OF PERSONS INSURED

At the beginning of 1965 over 92 million people had worked long enough to be insured under the program, with the result that 9 out of 10 people now becoming 65 will be eligible for monthly benefits under social security when they retire. In the years to come, over 95 percent of the elderly will be insured. The total number of people of all ages receiving monthly benefits is now about 21 million—more than the number of people who live in my State of California, our Nation's most populous State. Benefits now total over \$16 billion a year.

HEALTH BENEFITS A LOGICAL EXTENSION

While social insurance has evolved from a program of old-age security to one protecting orphans and their mothers and the disabled and their dependents, it still has its major impact in old

age. Ironically, it is in the old-age security part of the program that the greatest gap in protection now exists—the absence of any provision for meeting large health costs.

Protection against the health costs in old age is a logical and necessary extension of the retirement protection furnished by the present social security program. Monthly cash benefits can meet the regular recurring expenses of food, clothing, and shelter but such benefits alone cannot give economic security in old age. It is also necessary that older people have protection against the unpredictable and unbudgetable costs of expensive illness. A person may go on for a long time with little in the way of medical expenses, and then in a very short period have a hospital bill running into thousands of dollars. Cash benefits are not a practical way to meet this need. The only way that effective retirement protection can be furnished is through a combination of a cash benefit and insurance against the costs of major illness. Our country's system of social insurance simply cannot do the job it was set up to do until it provides this dual protection.

The legislation now before us would close the last remaining gap in the social insurance protection of the older American. I am proud that I have been privileged to have introduced H.R. 1—as well as its predecessors—and thus to play a part in bringing the needed health cost protection to our elderly citizens.

While virtually every committee member has contributed to the development of the health benefits legislation, one man, the gentleman from Arkansas, Chairman Mills, deserves major credit as the architect of this monumental proposal.

As the Members of this body know, the chairman does not sponsor legislation which has not received the most careful and painstaking consideration. During the more than 7 years he has served as chairman of the Committee on Ways and Means, Mr. Mills has seen to it that every piece of legislation bearing his name represents the best thinking, the best construction, the best techniques for dealing with the problem at hand. He has examined every view that has been offered in connection with this proposal by both proponents and opponents and explored with painstaking care every comment and criticism. All of this has been distilled with the intent to retain only the most constructive suggestions. The result is one which, like social security itself, embodies values and ideals with which few in this body can seriously dispute. The bill before us will, I am certain, be a lasting monument to Chairman Mills' expertise, his energy, and his skill as a legislative craftsman.

We also owe a debt of gratitude to Secretary Celebrezze, Assistant Secretary Wilbur J. Cohen, Commissioner of Social Security Robert M. Ball, and Chief Actuary Robert J. Myers. These men worked diligently with the committee and were of great assistance in developing a proposal which would be socially

desirable, medically and actuarially sound, and administratively feasible.

NATURE OF THE HEALTH BENEFITS PROPOSAL

The health benefits legislation recommended by the committee would utilize various resources which can, each in its own way, contribute the most to combat the insecurity that stems from high health costs in old age. The health insurance provisions of the bill would establish two separate programs—one basic, the other supplementary; one compulsory, the other voluntary; one financed through a special tax on earnings, the other financed through premiums and general revenue contributions.

The basic plan would provide hospital insurance protection for virtually all older people. Because of the relatively high cost of hospital insurance for older people, provision is made for workers to pay in advance, before they reach age 65, toward the cost of their benefits just as they now pay while working toward their cash social security benefits.

Coverage under the basic plan would be provided in a fashion like that of the present social security system, because hospital costs pose so widespread a threat to the economic security of elderly people that it should be certain that virtually all the aged will have hospital insurance protection. Medical expenses for hospitalized aged people are five times greater than for the aged not hospitalized. Nine out of ten aged people who reach age 65 will be hospitalized at least once—two out of three, at least twice—before they die.

In addition to meeting hospital care costs, payments would be made under the basic program for less intensive services and levels of care appropriate to the hospitalized patient's needs as his condition changes, and which can be substituted in many cases for inpatient hospital care. These ancillary benefits would cover posthospital care in an extended care facility and posthospital home health services. In addition, outpatient diagnostic studies would be covered.

With the cost of the individual's old-age hospital benefit protection financed during his working years, he would be in a position to make a substantial contribution in old age toward the relatively low-cost supplementary protection which would be provided by the bill on a voluntary basis.

The voluntary supplementary plan would meet the costs of physicians' services and provide other benefits which are designed to build upon and fit together with the protection that would be afforded the aged under the basic hospital insurance program. The combined coverage of the two insurance programs would result in protection for the elderly of a quality that only a few older people can now afford.

Coverage of physicians' services would be a particularly valuable supplement to the hospital insurance provided under the basic plan. According to the National Health Survey, payments for physicians' services represent about 30 percent of private health expenditures for aged persons. The annual \$50 deductible under the supplementary plan would

limit physicians' coverage under that plan to cases where costs are appreciable.

ADMINISTRATION

In developing the basic and the supplemental plans, a great deal of thought was given to their administration. The conclusions reached represent, I believe, a reasonable approach which promises to be efficient and, because of the selection of private organizations to carry out some of the more sensitive tasks, acceptable to the providers of health services.

In assigning administrative functions it was recognized that each of the services covered under the basic program is provided by institutions or organizations which are accustomed to receive payment on a cost basis for the services they furnish from Blue Cross organizations and from public agencies and programs. The committee concluded that it would be feasible to provide in the administration of the basic program for the use of fiscal intermediaries selected by hospitals and other providers of services.

This would permit the same organizations or agencies which now reimburse providers of services on a cost basis to be used to perform a similar function under the basic hospital insurance program.

On the other hand, the services selected for coverage under the supplementary plan are primarily those provided by individuals or organizations that are paid for their services on the basis of established charges. The bill provides for payments to physicians on a charge basis to be made by private carriers under contract with the Secretary. The private carrier would have the responsibility for determining the amount that physicians and others who would furnish services covered by the supplementary plan should be paid.

While an important role would be reserved for private organizations, I fully expect the Department of Health, Education, and Welfare to exercise leadership in seeing to it that these federally financed programs are being carried out with efficiency, that the rights of beneficiaries and providers of health care are observed and that high quality in medical care for the aged is a primary goal.

BENEFITS AND BENEFIT BASE

While health insurance for the aged is the major achievement of this legislation, it is monumental also in its provision of improved protection for the totally disabled, in its recognition of the plight of the orphaned child of college age, in its improvement of the fiscal framework of the program by going far to reestablish a proper base of earnings to be taxed for its support, in its recognition of the need of the average and higher earners to have more of their earnings credited toward future protection, and in its great improvement in the provisions for medical and other aid to the poverty stricken of the Nation. For all these improvements, too, Chairman Mills and others will deserve the gratitude of many.

CONCLUSION

Mr. Chairman, the health benefits proposal represents a practical solution to

a particularly difficult problem. It would provide the extensive health cost protection that older people need—thus overcoming perhaps the strongest objection that our friends from the American Medical Association have raised in connection with some of the proposals with which I have been associated in the past.

This broad protection would be financed in a way that would enable the individual to contribute substantially to the cost of his protection. This contribution from the worker means that he can expect the benefits to be paid as a matter of right and in a manner that safeguards his dignity and privacy. Also, because the benefits and the contributions are so closely connected, an attitude of responsibility toward the cost of program changes will be preserved where they might have been lost had benefits been provided largely or entirely from general revenues.

Finally, the State-Federal programs of medical assistance for the needy aged, relieved of a substantial part of their burden and otherwise strengthened by the proposed legislation, will be better able to meet the medical needs and other needs of our indigent elderly citizens.

This three-way approach promises to make financial security in old age an obtainable goal for the great majority of older Americans in a way that should be acceptable to all. This monumental approach deserves the support of every Member of this House.

What greater satisfaction could there be for those of us privileged to serve in this distinguished body than to know we have provided a means of securing the benefits of the accomplishments and tremendous strides that have been made in modern medicine for millions of our older citizens.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield 20 minutes to the gentleman from Missouri [Mr. CURTIS].

Mr. CURTIS. Mr. Chairman, I opposed the rule, before the Rules Committee and here on the floor, on two grounds: First, there is not the climate in this country or in this House to conduct an intelligent debate on this subject, and, second, because the House and the Committee on Ways and Means did not gain the knowledge, not having done the necessary research in this area, to conduct a meaningful debate.

I might add a third reason, that it is very obvious that this is not a debate. There is no decision going to be made in the well of the House. This is a farce. There are scarcely 100 Members on the floor of the House now. There were not 100 here at the time the gentleman from California [Mr. KEO], the author of the bill, was making his remarks. There was not even a quorum of Members during the discussion of the chairman of the committee, for the simple reason—and this is not said in criticism, I might say of the Members of the House who are not present, although I might say it is a commendation for those of you who are here; it is not criticism for this reason—everyone knows that the decision has been made outside the well of the House.

The Congress in this instance is no longer a study and a deliberative body. This is a rubberstamp operation, just as

we saw last week. These decisions have been made, possibly wisely or unwisely, through a different process for rendering judgments in our society. So I am not going to take a great deal of time indulging in this farce because what I might say, even though it might have merit and might bring out some wisdom, makes no difference, any more than what the chairman of the committee had to say makes any difference, or the gentleman from Wisconsin.

Mr. ARENDS. Mr. Chairman, I make the point of order that a quorum is not present.

The CHAIRMAN. The Chair will count. Eighty-six Members are present, not a quorum. The Clerk will call the roll.

The Clerk called the roll, and the following Members failed to answer to their names:

| (Roll No. 66) | | |
|---------------|---------------|---------------|
| Ashley | Duncan, Oreg. | Roosevelt |
| Baldwin | Evins, Tenn. | Smith, Calif. |
| Berry | Jones, Ala. | Springer |
| Boiling | Mailliard | Stallbaum |
| Bonner | Moorhead | Steed |
| Daddario | Morrison | Sweeney |
| Dent | Powell | Teague, Tex. |
| Diggs | Rhodes, Ariz. | Toll |

Accordingly, the Committee rose; and the Speaker pro tempore (Mr. ALBERT) having assumed the chair, Mr. DRUGILL, Chairman of the Committee of the Whole House on the State of the Union, reported that that Committee having had under consideration the bill H.R. 6675, and finding itself without a quorum, he had directed the roll to be called, when 409 Members responded to their names, a quorum, and he submitted herewith the names of the absentees to be spread upon the Journal.

The Committee resumed its sitting.

The CHAIRMAN. The Chair recognizes the gentleman from Missouri [Mr. CURTIS].

Mr. CURTIS. Mr. Chairman, before the rollcall I was making the point that, in my judgment, this matter was not ready for debate and deliberation on the floor of the House. The point is well made, because the Members themselves have already made up their minds as to what they are going to do; apparently they know what is in these 296 pages. In my judgment we do not know these things and we cannot, of course, move forward with any intelligent discussion of the bill.

There are reasons for that. The point was made by the gentleman from California [Mr. KEO], and also during the debate on the rule by the gentleman from Indiana, that the propaganda of the American Medical Association had confused the issue. This point was raised in the Rules Committee, and I stated that perhaps there has been some confusion by this propaganda. But even a more serious problem is the climate created by the propaganda campaign which has gone on for years, financed, I would point out, contrary to the law, by Federal tax money and the use of Federal employees' time in order to promote it. I am referring to the action of certain employees of the Department of Health, Education, and Welfare. I have made these charges of lobbying with Federal funds on numerous occasions.

I have documented them. There is no question but what the matter is confused as far as the public is concerned, and as far as the Members of Congress are concerned. The Government's propaganda is such that the people have been given a constant dose of misinformation rather than accurate information.

Let me go on to the second part, which is equally serious, and that is that this committee, the Committee on Ways and Means on which I serve, is not in a position to present accurate information to the House that will enable it to conduct an intelligent debate on this very important and controversial issue. As the gentleman from Wisconsin [Mr. BYRNES] stated, the issue of controversy, of course, is in the area of health care.

The Committee on Ways and Means did bring out a bill last year in regard to improvement of the social security program and, as has been pointed out, this passed the House almost unanimously. One part of this bill therefore contains matter about which there was adequate study and discussion in the Committee on Ways and Means. The committee was in a position to present that matter to the House for proper debate and its full consideration. But the controversial aspects of this present bill are not ready for debate and deliberation. That was very well demonstrated at the time the gentleman from California [Mr. KEO], had the floor, and the chairman of the Committee on Ways and Means [Mr. MILLS], engaged in a colloquy with the gentleman from Wisconsin [Mr. BYRNES], in regard to the cost estimates of one important health aspect of the bill. The gentleman from Arkansas [Mr. MILLS], referred to some later figures on cost estimates, dated around April 5, as I recall. I am a member of this Committee on Ways and Means, and I have never seen these new cost estimates. I might say I doubt if anyone else on the committee has seen these new cost estimate figures.

When we began hearings there were discussions behind closed doors on January 27. There has been a constant revision upward of the cost estimates, but all of this was done behind closed doors. The chairman of the Committee on Ways and Means knows I have a very high regard for him, although we have a fundamental difference of opinion on the procedures the committee followed in trying to look into the aspects of this very controversial issue.

I urged that there should be open hearings and people with knowledge in our society on this subject should be given the opportunity to come before us. This was not a military operation we were studying. This was a matter of public information, and it should have been of great interest to the public and to the press, if they have been inclined to report it, for example, to report the colloquy which went on between the actuary of the committee, for whom I have a great regard, and the actuary of some of the health insurance companies. And after this, the actuaries revise their estimates on this. But the public does not have any knowledge on this. Many of

the Members of the Committee on Ways and Means know nothing about it. The Members of the House know little about it. The Members are permitted to vote for or against a label, not a piece of legislation.

Mr. HALL. Mr. Chairman, will the gentleman yield?

Mr. CURTIS. I yield to the gentleman from Missouri.

Mr. HALL. Is it not true that at one time the same actuarial calculations for the original King-Anderson or administration hospital care bill were found by the chairman of the Ways and Means Committee itself to be 100 percent off base?

Mr. CURTIS. It is more than 100 percent. It is difficult trying to figure out what the costs in this area would be, and there is still serious dispute on the part of health actuaries as to whether we are still not underestimating the cost in the H.R. 1 part of the bill, let alone the cost in the Byrnes package, either as contained in the bill or the Byrnes package as contained in the motion to recommit.

Mr. HALL. Is that not true because we are dealing with service benefits instead of cash benefits?

Mr. CURTIS. That is the problem. We are fundamentally changing the concept of social security, one which has been a cash program, to one which is a hybrid, which includes cash and certain services. But how can we estimate what services will cost over a period of years?

There were witnesses that we failed to hear. Let me pin this point down. The chairman of the committee told the House how many hours of hearings the Ways and Means Committee has had over the past years on this general subject. Indeed we have, but each time we held these hearings they were in relation to a particular bill. After we held the hearings we concluded that these were ill conceived proposals and did not stand up under the kind of testimony we received. So we have had version after version of King-Anderson proposals, we are now at about the tenth version. We have not had public hearings on this new bill, H.R. 1 the tenth version. No one who is knowledgeable on this subject has had an opportunity of testifying on it publicly.

It is true that we did call in a few expert witnesses—quite limited I might say—and there are some hearings now available, if the House is interested in looking at some of the testimony. This is quite limited testimony. But this is a far cry from calling in the very industries and professions that are responsible for our having the greatest health care system of any society in the world. Our problem in the field of health care for the aged, as I often point out, is not the result of failure—it is the result of success. We have been so successful in our society and in our methods of handling health care not just for the aged but for our entire society that people are living 10 or 15 years longer. It is success in this field that has created the problem—the economic problem that we are now trying to cope with. But it is not the failure of our health care system. It is

its success. The people responsible are the drug industry, the hospitals, the doctors, the health insurance companies, the nursing homes, the visiting nurses, businesses or labor organizations with their pension plan programs. It is hard for this body to realize, I believe, that these groups most of which have opposed this kind of legislation and have recommended that we not move forward in this way were not permitted to testify before us so we received no benefit from their advice or their criticism under cross-examination—and I might add with the advice of rebuttal witnesses on the part of those who might disagree with them. This is the committee process. This is the way the Congress is supposed to gather knowledge and wisdom on an issue to apply it to its solution. But these were not the procedures that we followed and we do not have the benefit of the advice that these groups could give. The advice we have received has been received largely on an ad personam basis by the chairman of the committee, for which I commend him and to some degree by the gentleman from Wisconsin [Mr. BYRNES] and myself to a very limited degree to the extent that we could personally meet and talk with these people in our offices. But that is not the committee process. If the chairman of the committee wants to interrogate the top people in the Blue Cross in regard to a program, let him do so so that the rest of us on the committee can get the benefit of those discussions because these are not easy matters. This is a committee process. But we are before the House today without that benefit.

Mr. LANDRUM. Mr. Chairman, will the gentleman yield?

Mr. CURTIS. I yield to the gentleman.

Mr. LANDRUM. I am reluctant to challenge the gentleman's statement.

Mr. CURTIS. I should think you would be.

Mr. LANDRUM. But I went to the committee this year as a new member and I participated in the hearings over there for a great number of days—I do not know just how many. But as I recall, there were between 2 and 3 weeks devoted to hearing experts from the insurance industry; Blue Cross and Blue Shield; the Hospital Association; the American Medical Association, which was represented by, among others, its president, Dr. Donovan Ward; the American Nursing Home Association, the pathologists, the labor unions, and so on. I do know that it took two rather thick volumes to print these hearings. In addition, we received a great volume of written communications including material from drug industry representatives, physicians, hospitals, and others.

Mr. CURTIS. Yes; I saw you there.

Mr. LANDRUM. And I listened intently and questioned for a little bit of the time officers from various carriers of insurance in particular, including Blue Cross and Blue Shield. I listened intently to the actuaries from that organization and to the president of that organization as well as to the actuaries from the insurance industry. I listened to what the Social Security Administra-

tor and the social security chief actuary had to say and I heard the gentleman question them, and I listened to a lot of his questioning and received a great deal of benefit from it.

Mr. CURTIS. All right, I want to thank the gentleman. But the point I made is still accurate. I did point out that there were a limited amount of expert witnesses called in before the committee. I pointed it out, if the gentleman had been paying attention—and if he would pay attention now—that there were some limited hearings that had been published that would show some of this information. But I am trying to point out the procedures that did go on, and I know the gentleman would recognize this.

Mr. HALL. Mr. Chairman, will the gentleman yield?

Mr. CURTIS. I yield to the gentleman.

Mr. HALL. The gentleman mentioned the pharmaceutical industry being heard and their testimony being made a part of the hearings. I did not notice where they were heard to any extent or whether any part of the pharmaceutical associations were heard, yet I notice that there were the HEW experts testifying as to what the pharmacists thought. Were they ever given a chance to rebut it?

Mr. CURTIS. No; they were not. As a matter of fact, the committee sat there throughout all of these executive sessions with the officials of the Department of Health, Education, and Welfare constantly present. The usual occurrence was for the HEW officials to state what the various industries—the pharmaceutical industry or the hospitals or the nursing homes or visiting nurses associations thought. Many is the time, and I think the record will show it, I said I am interested in interrogating these people myself and I chided the chairman of the committee on occasions when he said, "Here is what they told me." And I said, "But, Mr. Chairman, what I want to do is to interrogate them myself."

Mr. MILLS. Mr. Chairman, will the gentleman yield?

Mr. CURTIS. I yield to the gentleman.

Mr. MILLS. The gentleman from Missouri [Mr. HALL] raised a question about whether the pharmaceutical people appeared before the committee.

Mr. CURTIS. That is right.

Mr. MILLS. They did appear before the committee in connection with the hearings on the bill we had under consideration in 1963-64.

Mr. CURTIS. Yes.

Mr. MILLS. They did not appear in 1965.

I believe my friend from Missouri who is in the well of the House should call the attention of the gentleman from Missouri to the fact that the quarrel with the Pharmaceutical Association was over the fact that we had limited available drugs under this program to those drugs listed as being all right by the publications used in the professions or those that are passed on by medical staffs of hospitals. This is spelled out on page 24 of the report. They wanted to go

beyond that, and we did not believe it appropriate to do so.

Mr. CURTIS. I might say to the chairman that there were many points they made. I read from a letter in the committee one of the points they did make which was ignored.

The chairman is verifying, in essence, the manner in which we proceeded. That is the very area as to which we have a quarrel and disagreement on procedures.

What I am trying to bring out for the benefit of the House, but also to make a record here in the CONGRESSIONAL RECORD, at any rate, is the procedures we did follow and why I am suggesting that this matter is not ready for debate on the floor of the House. We lack the information we should have acquired in public hearings if these knowledgeable people had been permitted to testify not on a general subject but on the specific proposals. There was H.R. 1, which was a new bill, 139 pages long, and the confidential print which the chairman had made up for the committee, of some 250 pages, which many of us had not seen until it came in. Under the orders of the chairman, this print was not to be taken out of the committee room. I told the chairman that I certainly intended to take it out, and to at least allow some of the people who had knowledge in this field an opportunity to comment on some of the language.

This is the procedure we did follow. I submit we are not in a position under these kinds of circumstances, for a measure of this importance, to move forward to debate it with intelligence.

Mr. JONES of Missouri. Mr. Chairman, will the gentleman yield for a question?

Mr. CURTIS. I yield to the gentleman from Missouri.

Mr. JONES of Missouri. Can the gentleman tell me upon whom we must rely for the estimates of the increase in the hospital patient load under either one of these plans?

Mr. CURTIS. Yes. It is essentially on the testimony of Mr. Myers and his associates. He is the chief actuary of HEW. In addition, the colloquys and conversations he in turn has had with some of the top actuaries of the health insurance organizations, all of this I might add was behind closed doors.

Mr. JONES of Missouri. My apprehension has been that I know, in the locality in which I live, our hospitals are filled to capacity all of the time. Observing the hospital insurance plans which are in effect, are we in danger of creating an obligation which cannot be met by the physical hospital facilities, under this plan?

The CHAIRMAN. The time of the gentleman has expired.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield 5 additional minutes to the gentleman from Missouri.

Mr. CURTIS. The answer to that question is, I believe there is a real danger. There is a real concern not so much over the facilities as over the skills; the available nurses and doctors.

Mr. JONES of Missouri. The nurses and technicians, but even the physical plant. I know that in my area we do

not have sufficient hospitals to take care of any additional load at all.

Mr. CURTIS. That is a real concern of the limited facilities and one of the factors we need to go into.

I offered a bill which has been law for some time, to provide FHA guarantee for private nursing homes, which did produce about 100,000 beds and we are now building about 80,000 new beds capacity a year.

Mr. MILLS. Mr. Chairman, will the gentleman yield on that point?

Mr. CURTIS. I wanted to finish two or three points, but I will yield. The point is that we are not in a position to talk with intelligence, Mr. Chairman, because we did not call in the people who know the answers.

Mr. MILLS. My friend from Missouri and I can always talk with intelligence.

Mr. CURTIS. Not always. I cannot talk with intelligence without studying these things first. I try to, but what constitutes study?

Mr. MILLS. The work both you and I do.

Mr. CURTIS. We try to get knowledge from people in the particular fields of their excellence by interrogating them.

Mr. MILLS. On the point made by the gentleman from Missouri, I thought my friend believed as I have believed over the years, that most of the people who need hospitalization and who need the care of a doctor, in your country and in my country and in the country that the gentleman from Missouri (Mr. Jones) serves, get it, whether they are in a position to pay for it or not.

Mr. CURTIS. That is correct.

Mr. MILLS. If they get it, then how does this bill which provides the means of making payment for these services bring about this undue overutilization which the gentleman is talking about?

Mr. CURTIS. The gentleman is fully aware of why, because we devoted a lot of time to this problem of hospital overutilization. The emphasis in this bill on hospital utilization boards and the concern many people express when we go to this kind of a program there will be this overutilization. However, let me go on to finish my points.

Mr. MILLS. All right.

Mr. CURTIS. All I am making a point about is this: I am not trying to engage in a debate on the substantive issues of this bill because we are not in a position as a committee to advise this House with any intelligence. We have failed to obtain the information and what information we obtained in the past we have not kept up to date. We do not know what we are talking about in this area. However, let me go on to the three other points that I want to make.

What concerns me so deeply about moving forward in this important area in ignorance is that we do not know; but this we do know: the payroll tax has a limitation, just as we have now found that the Federal income tax has a limitation, and we all recognize the economic damage it is creating.

Senator RUSKOV, when he was the Secretary of Health, Education, and

Welfare, advised this committee in one of our public hearings under cross examination that he was concerned with the limitation of the King-Anderson bill, which was to give benefits that were less than 25 percent of the cost to the older people. I said, "Why did you limit it?" and he said, "Even to pay for these we have to get the payroll tax to where it is 10 percent of the payroll, and when it reaches that it creates real danger for the social security system itself."

Now, this bill has 11.2 percent ultimately with a base of \$6,600. I tried to engage and I did engage in a limited colloquy with the Director of the Budget, Mr. Gordon, and I put in the RECORD, excerpts from the hearings, a colloquy on the economic consequences involved if we load too much on the payroll tax. The unemployment insurance system is based on that tax, too. In effect, so is workmen's compensation. We are moving ahead here without the benefits of the wisdom and the knowledge that experts in this field might have given us. Just because there is a popular label on this bill it will be passed. This is the kind of a climate that has been created, and in which we cannot conduct an intelligent debate.

The second point is the compulsion and the comprehensiveness of medicare. If you look at the bill, right at the very beginning there is a great big label on page 9. It says "Prohibition Against Any Federal Interference." It says there will be no Federal interference, and that free choice by the patient is guaranteed. Then the next 70 pages tell you how the Federal interference will be carried out. Let us not kid ourselves about it. It has to be. I am not arguing against that. If we use Federal funds, we have to have Federal regulations. The provisions are that the Department of Health, Education, and Welfare must enter into contracts or agreements with hospitals and nursing homes, and if your nursing home or your hospital which you want to go to does not agree with the officials in Washington on their charges and what they can charge for, then the older person cannot go to that hospital or nursing home.

The CHAIRMAN. The time of the gentleman has expired.

Mr. BYRNES of Wisconsin. I yield to the gentleman 5 additional minutes.

Mr. CURTIS. Then the older person cannot go to that hospital. Where is the ultimate decision in the event of a controversy between the hospital board or the nursing home and the great Department of Health, Education, and Welfare? The ultimate decision is in Washington. There is a lot of machinery in between provided, of course, but in the event of a difference of opinion, the ultimate decision is vested, as it has to be, in the Department of Health, Education, and Welfare. I am happy that I was able to improve this bill to some degree by getting judicial review. So that there could be at least an appeal to the courts from the arbitrary decisions of the Department of Health, Education, and Welfare. So we have the basis for what many of us believe will lead to socialized medicine, moving into a socialization in this area.

My concluding remarks are these: In our society we have always taken care of those in need. The Kerr-Mills Act took this approach.

The American Medical Association has not been falsely propagandizing eldercare by saying it will provide up to 100 percent of medical cost. Eldercare is really only a modest improvement of Kerr-Mills. In my judgment it probably would only cost about \$100 to \$200 million in addition to what we are doing under Kerr-Mills. Kerr-Mills, which has been so badly misrepresented by the officials of the Department of Health, Education, and Welfare actually was saying this: We know the people on relief now are being cared for. However, there are some people who are not on relief. They own their own little home, have their pension, but if they get hit with a major medical cost, they could be thrown on relief.

Kerr-Mills in effect says to the States: You tell those people to bring in their medical bills and we can take care of them up to 100 percent if that is what they need, so they stay off relief.

Right, Mr. Chairman? Is not that the thrust of Kerr-Mills, so people would not go on relief? It is not the other way around, and so what eldercare says is this: Let us not wait until these people get hit with a major medical. Let us cover them with health insurance, and if they have difficulty in meeting the premium cost then we can help them to pay the premium. This is the approach, and why eldercare and Kerr-Mills is really not very costly. It is taking care of up to 100 percent of all the medical costs. But it only relates to 15 or 20 percent of the older people in our society. But this compulsory program in the bill before us is to cover 100 percent of our older people—the rich, the medium income, as well as the poor, whether they can afford it or not, and cover about 25 percent of their average health costs.

As the chairman of our committee has often pointed out—and I agree with him—we should not use general revenues for welfare matters unless we have a means test; because, if we ever went to that there would be no end to it. That is why I am pleased that in the Byrnes bill, in a limited way—not the way I would like to, because it is too lush a means test—but at least we do say that in using general revenues as to people over \$5,000 of income there shall be a recoupment.

My concluding remarks are those that I began with, that this matter is not ready for debate. It is obvious that this House is not in a mood to debate and deliberate. The decision which was made outside of the wall of the House, outside the deliberative process, is going to prevail. Members have already made up their minds. They are voting on a label.

What the chairman of the committee might say—and he is eloquent and is a student and I have great respect for him; and what Congressman Byrnes might say, and I have a similar respect for him, or what I in a small way might say, or the author of the King-Anderson bill, Mr. Kline, might say, makes no difference.

Is it not obvious, Mr. Chairman, what has happened? The Congress of the United States has become a rubber-stamp.

Mr. Chairman, under permission to extend my remarks, I am including a discussion of another point in the bill, namely the amendment to the disability program.

AMENDMENT OF DISABILITY PROGRAM

During the committee discussion of the medicare legislation the processes for procedural and substantive action, namely the hearings and public discussions of the proposals contained in the legislation, were so lacking that many important changes were made without proper consideration.

To illustrate, Mr. Chairman, I refer to the committee action in changing the definition of disability in the Social Security Disability Act system. The definition under the present law declares a person eligible for benefits if he has an impairment "which can be expected to result in death or to be of long continued and indefinite duration." The amendment in the bill would make a person eligible for benefits if he suffered a total disability for a period of 6 months.

This change would affect thousands of persons and cost additional millions of dollars. In fact, the Social Security Administration estimates that 155,000 persons—other sources estimate a much higher figure—will be added to the disability rolls immediately upon enactment of this amendment. The important national effect and import of this amendment apparently was unimportant to the sponsors because no public notice nor any public hearings at any time have been made upon this subject.

The additional cost of this disability definition change was never considered in the financing of the medicare legislation although a great amount of time and thought was given to the matter of adequate financing of other aspects of the bill. This change made in the last several days of committee meetings with its additional millions of dollars of cost will serve only to make the original finance figures more unreliable.

Furthermore, such a change in adding thousands of persons to the disability rolls will compound the injury already being done in the State workmen's compensation programs by the lack of coordination in Social Security Disability Act. Since 1958 disabled persons under the Federal and State programs have been receiving dual benefits as a result of the repeal of the offset provision in the act that year. Prior to repeal the Federal disability benefits were reduced by amounts received under the State workmen's compensation programs. These dual benefits generally exceed the take-home pay of the worker which he received as an able-bodied workman on the job. It is a simple deduction then that by changing the disability definition and bringing more persons into the category of receiving dual benefits, the Federal program reduces the effectiveness of the State programs. Already some States have acted upon the suggestion of those in the Federal Government to reduce the benefits under the

State programs by the amounts received from the Federal Disability Act. I do not believe that the Congress in its creation of the Social Security Disability Act ever intended it to water down or replace the State programs—yet, this is the actual happening.

The area of most serious concern is the rehabilitation of the disabled persons. Those most experienced in the field of rehabilitation point out that motivation is the key factor in bringing about rehabilitation. There is no question that cash benefits greatly motivate a person's desire to be or not to be rehabilitated. Commonsense dictates that a person receiving more income while disabled than when on the job will minimize, if not eliminate, the incentive to be rehabilitated. Opening up the disability rolls to thousands of additional persons without careful study and control will increase the difficult problems inherent in the rehabilitation programs.

An argument has been made by the proponents of social security replacing the State programs that the cost is on a 50-50 basis. Once the benefits become high enough, this method of sharing does not hold true. Witness the Italian program where 52 percent of payroll goes for social benefits and the employer pays 42 percent and the employee pays 6 percent of the costs.

Also in some countries, notably England, where the workmen's compensation program has been nationalized, the right to sue at common law by the employee against the employer has been made available again. Under the State compensation programs the employee gives up his common law rights to sue the employer for any injury received on the job in exchange of a definite amount of compensation. Should the State programs in this country be superseded by the Federal program, there is every reason to believe that we will return to the chaos, confusion, and suffering that existed under the common law operation. I believe that such a development will have both labor and management up in arms all over the Nation against the possibility of such a happening.

There have been some statements that under the present definition, doctors cannot easily determine a total and permanent disability of long duration. However, doctors under the State programs have been able to make such determinations medically, conveniently, and wisely for 50 years.

It is also argued that the present definition creates hardship cases. Informed persons in this field tell me that proper administration and the courts in their rulings take care of any hardship cases which may arise and whenever we draw a line there will be argument, and properly so, as to just where the line should be. This is inherent in all legislation.

The report of the committee calls for the Health, Education, and Welfare Department to make a study of this problem and report no later than December 31, 1966. The Social Security Advisory Council made a recommendation for a study of this problem area in its report

last year. It is amazing in the light of these two recommendations that the committee would legislate prior to the findings of the study rather than afterward. It is inconceivable that action would be taken prior to the fact rather than after the fact.

Mr. SCHNEEBELI. Mr. Chairman, I ask unanimous consent to extend my remarks at this point in the Record.

The CHAIRMAN. Is there objection to the request of the gentleman from Pennsylvania?

There was no objection.

Mr. SCHNEEBELI. Mr. Chairman, I join my Republican colleagues in supporting many of the provisions in the social security bill. Like them, I have felt that many of these amendments are long overdue.

I am in full accord with the amendments in the bill that would increase benefits by 7 percent across the board with a \$4 minimum increase for a worker, continue benefits to age 22 for certain children in school, provide tax exemption of certain religious groups, provide actuarially reduced benefits for widows at age 60, and pay benefits, on a transitional basis, to certain persons currently 72 or over now ineligible; liberalize the definition for disability insurance benefits; and, increase the amount an individual is permitted to earn without suffering full deductions from benefits. These social security amendments were agreed upon by the conference committee in the 88th Congress. A bill containing these amendments could have been enacted long ago, and with unanimous support on the part of the Republican members of the committee.

During the consideration of the so-called King-Anderson bill—H.R. 1—in the 88th Congress, the Way and Means Committee also tentatively agreed upon amendments to improve and enlarge the Kerr-Mills Act. I am glad to find these amendments in the bill. I am certain that the committee would have reported out similar amendments last year, except for the fact that the proponents of medicare—lacking support for their program—asked that the committee pass over all amendments dealing with medical care for the aged. These Kerr-Mills amendments would be in the law today, with the full support of the Republicans, were it not for that fact. I know that these amendments will enable my State—the Commonwealth of Pennsylvania—to improve its already extensive Kerr-Mills program.

There are other fine amendments in the bill providing for medical aid to dependent children, the blind, and the disabled; services for maternal and child health, crippled children, and the mentally retarded; and a 5-year program of special grants for health services for children. I fully support these amendments.

I also have no objection to the voluntary program of supplemental insurance added to the original medicare proposal. The Republicans have consistently pointed out that the original hospitalization program proposed by the administration was wholly inadequate. This inadequacy would have resulted in de-

ception and confusion for some 18 million of our elder citizens—the overwhelming majority of whom had been led to believe that the so-called medicare bill, H.R. 1, provided what that term implied; namely, complete medical care.

Not only do I find nothing wrong in the voluntary approach to insure the elderly for doctors' charges and other medical services, I believe that the bill would be immeasurably better if that concept had been applied to the entire hospitalization program.

Our committee should take pride in the fact that with the exception of the compulsory payroll deduction aspect, the bill has broad support among Democrats and Republicans alike. Why should we have this one large negative feature in the bill—and by this I refer to the hospitalization program—financed by a payroll tax automatically and compulsorily extended to everyone over age 65 regardless of need. In using the term "need," I do not refer to a "needs test" or "means test." I refer to the fact that there are many of our elder citizens who are already being covered in increasing number at no cost to themselves under adequate programs of group health insurance, provided for by their employers, their unions, or by other organizations. Those people have no need for a Government program; for them, it is superfluous.

In opposing the financing of the hospitalization program, I am not unmindful of the increased cost of health insurance for those over age 65. On the contrary, I believe that the comprehensive health insurance program embodied in a bill which I introduced—H.R. 4354—and in similar bills introduced by other Republicans, will provide more adequate health insurance for the aged, at a lower cost, and without imposing a regressive payroll tax upon tomorrow's workers.

The payroll tax is one of the most unfair and regressive taxes in the entire Federal tax system. It applies to the first dollar of earnings. There are no exemptions, no deductions, no exclusions, and no tax credits. The president of a large corporation pays the same tax as his workers earning as little as \$5,600 per year.

Under the committee bill, a worker earning a mere \$3,600 wage, with a wife and two children to support, will be taxed on his first dollar of earnings—not for his future benefit—but to pay current hospital benefits for a retired couple with the same or more income, who pay no Federal taxes at all. I just do not think that this is fair and proper.

Under the tax rates in the committee bill, a 21-year-old worker and his employer will pay the equivalent of \$8,590—during the employee's working years—and those rates may be inadequate.

Under the Republican program a participating individual will pay only when he reaches age 65—not for 44 years in advance—and under present assumptions he can expect to pay \$874.50 in premiums during his retired years. Although this figure is only about 10 percent of the amount that must be paid on behalf of an individual worker, under the commit-

tee bill the benefits greatly exceed those financed by the committee's compulsory social security program.

Not only does the Republican proposal avoid this regressive payroll tax, but on the other hand its voluntary aspects and broad coverage provide additional advantages over the committee bill.

The basic hospitalization program in the committee bill is extended to all eligible persons over age 65 automatically and compulsorily.

The Republican program would be wholly voluntary. When coupled with the payment of a premium contribution, this reduces the duplication of coverage for those already covered under private programs. It preserves the insurance concept.

The Republican program requires the participants, including those presently over age 65, to make a contribution toward the cost of their insurance. This reduces the cost which is passed on to taxpayers under age 65. It also acts as a deterrent to excessive utilization of benefits on the part of those enrolled.

The hospitalization program in the committee bill is, in fact, a part of the social security tax system. An additional liability of \$133 billion is imposed on the social security tax structure by the adoption of that program.

The Republican program is financed wholly apart from the social security system. It does not jeopardize future increases in cash benefits.

In financing the hospitalization program through the payroll tax, as a part of the social security system, the committee bill gives rise to the concept of "entitlement." It creates the erroneous impression that the wage earner is "pre-paying" for a specific hospital benefit. This precludes any revision of benefits in the future, except to increase the scope of the program.

The Republican program preserves a high degree of flexibility. When the insured is required to pay a premium for the benefits, both premiums and benefits can be modified as the need arises. Pressures for increased benefits will be minimized if such increases are charged against the insured through higher premiums.

The committee bill does not meet the problem of catastrophic illness. Benefits of the combined hospitalization program and medical services program in the committee bill fall short of the benefits provided for in the Republican program.

The Republican program covers the catastrophic illness up to a lifetime maximum of \$40,000 in benefits. The Republican bill also covers prescribed drugs, while the committee bill excludes this item.

By eliminating duplication of coverage and combining all medical benefits in a single comprehensive insurance program, the Republican program will provide more protection for less dollars.

The Republican proposal provides for premium contributions related to cash benefits under social security, coupled with a tax recoupment of the subsidy attributable to individuals with incomes of over \$5,000 and married couples with incomes of over \$10,000. This eliminates

"need" as a basis for qualification without extending benefits to those who are, in fact, able to pay the full cost of their own insurance.

The Republican proposal also incorporates the amendments to the social security laws proposed in the eldercare bills, thus making more specific the right of the States to enter into private contracts of insurance to cover the State-administered OAA and MAA programs.

I am also critical of the committee bill in another respect—not for what the bill does—but for what it fails to do with regard to the overcharge on the self-employed.

On several occasions, I proposed that the committee amend the social security tax schedules in order to remove an obvious inequity with respect to the self-employed. Under existing law—and under the schedules in the bill—the self-employed will be paying $1\frac{1}{2}$ times the tax paid by the employee for the same benefits. I have not been able to get a reasonable explanation for this difference.

Time and time again, we have been told by the Department of Health, Education, and Welfare that the tax paid by the employer should not be credited to or attributed to any individual employee. The Department takes the position that the employer's tax should be treated as a part of the general fund to finance benefits for those who have only paid a nominal social security tax. If we accept that proposition, there is even less basis for taxing the self-employed any differently than we tax the employee. The self-employed is the "forgotten man" in our payroll tax structure.

This extra tax on the self-employed becomes particularly onerous as the tax rates increase. Under this bill, a self-employed person whose earnings equal the tax base will over his productive years—age 21 to 65—have paid total social security—OASDI—taxes of \$19,712 as compared with taxes of \$13,467 paid on the same wage base by an employee. When compounded at $3\frac{1}{2}$ percent interest—the rate used by the Department—the self-employed OASDI tax comes to \$45,032 compared with \$30,679 for the employee. Forty-five thousand dollars is a lot of money to a small farmer, a small shopkeeper, a member of the clergy, a barber, and the many millions of self-employed in our service industries.

This additional tax on the self-employed cannot be justified either by the benefits they receive or by their ability to pay. Benefits are the same both for the self-employed and the employee. In the payroll tax, ability to pay is completely disregarded. The president of a large corporation pays only two-thirds the tax of the self-employed barber—and we can be certain that there are more barbers, small shopkeepers, filling station operators, and the like, than there are affluent professional people among the self-employed.

Of the approximately 7 million taxpayers who file returns as self-employed, more than one-half report adjusted gross income of less than \$5,000 per year. This is the group which pays 80 percent more

in social security taxes than do the executives of our large corporations. They are the farmers, ministers, barbers, taxi owners, filling station operators, small grocers, newsstand operators, and the like. Many have no employees at all, other than occasional family or part-time help.

A minister in my district wrote:

So far this year I have paid or owe \$587 in taxes on my 1964 income (which is slightly over \$4,800). This total figure for taxes includes \$139 in local taxes, \$189 in Federal income tax, and \$259 in social security tax. The figure, of course, does not include the Pennsylvania sales tax and the various bid-den taxes.

There are three children in our family (the youngest is 5 years of age and the oldest, 12 years of age). I find it extremely difficult at the present time to set aside one-eighth of my income to cover these various taxes. If the social security tax is increased, the payment of the increase will not only be extremely difficult, but it will become virtually impossible without depriving the five members of the family of adequate food, clothing, and dental and medical care. Doubtless many other clergymen and other persons classified as self-employed find themselves in this same predicament.

In rejecting my proposal that we take action in this bill to remove the penalty on the self-employed, I was told that it would cost too much. I am not impressed with the answer. Actually, the initial cost to adjust this tax would amount to 0.05 percent of payroll at a \$5,600 base. With the projected increases in both the tax and wage base, which are provided in the bill, I am confident that the shifting of this extra burden—now paid by the self-employed—to all wage earners and employers, including the same self-employed, would not have a significant impact on the social security trust fund. And this impact could well be spread over a period of years, just as the committee bill spreads the cost of increased cash benefits and the cost of the hospitalization program.

The additional tax to finance the health insurance program provides the same rate for the employer, the employee, and the self-employed alike. If the principle of this new tax is right, there is no justification for continuing to tax the self-employed at a much higher rate to finance cash benefits.

I earnestly hope that the other body, on passage of the bill, will face up to this problem. The self-employed need help; and all I ask is that they be given the same consideration as everyone else.

Mr. MILLS. Mr. Chairman, I yield 10 minutes to the gentleman from Missouri (Mr. KARSTEN).

Mr. KARSTEN. Mr. Chairman, my colleague from Missouri complains that the decision on the medical care bill was made outside of this House. The gentleman from Missouri and I do not often agree, but I am inclined to agree with him to a certain extent in this instance.

Under our system of government it is the people themselves every election who determine the kind of government we shall have and how much government we shall have. By the largest majority in history the people last November elected a President who campaigned on a pro-

gram of medical care for the aged. And, the Committee on Ways and Means in reporting this bill is carrying out the wishes of a great majority of the American people.

Now, Mr. Chairman, insofar as hearings are concerned it has been my privilege to serve on the Committee on Ways and Means for over 10 years. To my personal knowledge medical care for the aged has been the subject of public hearings at almost every session during that period of time. In the current session there are two volumes of hearings consisting of 898 pages of testimony. If there is one matter that has been thoroughly discussed by the Committee on Ways and Means, it has been the subject of medical care for the aged.

Mr. MILLS. Mr. Chairman, will the gentleman yield?

Mr. KARSTEN. I yield to the gentleman from Arkansas.

Mr. MILLS. Is the gentleman from Missouri making it clear that those two volumes of hearings consisting of 898 pages occurred at this session?

Mr. KARSTEN. I made that statement, Mr. Chairman, and we have had a similar record for almost every session of Congress since I have been a member of the committee.

I am glad that the moment is at hand when the House of Representatives will have an opportunity to vote on legislation to provide medical care for the aged.

The struggle for a program of this kind began about 20 years ago. There have been outstanding advocates like the late John Dingell, our former colleague, Amie Forand, and more recently, our distinguished colleague, the gentleman from California, CECIL KING. On the other side of the question we have also had humane and considerate men but their views and their approach to this problem set them far apart from the advocates. This resulted in a stalemate on legislation to provide medical care for the aged, with the votes on the Committee on Ways and Means pretty evenly divided between those for and those against.

Stalemates have to await the arrival of a peacemaker. So it has been in this case. The distinguished chairman of the Committee on Ways and Means, the gentleman from Arkansas, has been the peacemaker. He has brought together the divergent viewpoints of the present as well as the past, and the bill before us is a tribute to his ingenuity, skill, and dedication to a task which seemed almost insurmountable.

Perhaps there are still imperfections in the legislation but I believe it is far better than any single bill heretofore introduced in the House. This measure is a consolidation of the best of all that has gone before. While the many provisions in its 296 pages are complex and technical, basically the legislation establishes the principle of providing a way for our elder citizens to take care of their major health needs.

The bill is divided into four principal parts. First, it provides a basic insurance program of hospital care based on H.R. 1, the King-Anderson bill. This will be financed in a manner similar to the regular social security program, by

a tax on employees and employers. This program will provide 60 days of hospitalization and related nursing home service for all persons when they attain the age of 65.

The second part is voluntary and it covers doctor's fees in and out of the hospital. Aged persons who elect this coverage will pay a \$3 monthly premium which can be deducted from their social security cash benefits and this will be matched by a similar contribution from the Government. Hospital and medical benefits under these programs will be available beginning July 1, 1966.

The third major provision of the bill includes a 7-percent increase in social security monthly cash benefits. Under this provision, no primary beneficiary will receive less than a \$4-a-month increase so all of the aged may purchase the optional medical program with no loss of income.

Finally, the bill makes many substantial improvements in the Kerr-Mills program and also includes more liberal financing of health care services to needy children, the blind, and the disabled. It also strengthens and expands the maternal and child health and crippled children's programs.

As good as this bill is there are still some who oppose it. I have read the Republican minority report and to me the conclusions are not surprising. The minority report declares that the health care plan for the aged is too costly, inadequate, illusory and some kind of a terrible threat.

The reason I am not surprised at the minority report is that these are the same charges the Republican Party has been making since the inception of the original cash benefit social security program in 1935. It was my privilege to serve as a House committee employee at that time and I well remember the dire predictions of the Republican spokesman on social security both in and out of Congress.

There was the late Allen T. Treadway, of Massachusetts, the then ranking minority member of the Committee on Ways and Means. Here is what he had to say on February 2, 1935, on the general subject of social security:

The greatest single threat to recovery . . . many businesses . . . probably will be unable to continue in operation.

Then there was the late Harold Knutson, who later became chairman of the Committee on Ways and Means. Here is the gloomy prediction he made in the well of the House on April 12, 1935:

The passage of this proposed legislation will further and definitely increase unemployment.

Mr. Knutson felt so strongly against social security that in the minority report he amplified his views with this condemnation of the social security program:

There are certain provisions of this bill so objectionable to me that I cannot support it. . . . The measure is wholly inadequate . . . The two payroll taxes which the bill imposes will greatly retard business recovery by driving many industries, now operating at a loss, into bankruptcy.

The late Republican minority member, Daniel A. Reed, of New York, who like

Mr. Knutson before him, also became chairman of the Committee on Ways and Means, described social security this way:

The lash of the dictator will be felt. And 35 million free American citizens will for the first time submit themselves to a fingerprint test and have their fingerprints filed down here with those of Al Capone and every jailbird and racketeer in the country.

Our former colleague, John Taber, of New York, made a stirring speech on the floor on April 19, 1935, and here are his kind words about the social security program:

Never in the history of the world has any measure been brought in here so insidiously as to prevent business recovery, to enslave workers, and to prevent any possibility of employers providing work for the people.

Republican opposition to the principle of compulsory social security was not confined to the Congress. There were many otherwise responsible Republican leaders going about the country making speeches condemning the entire social security program.

Here is a copy of the New York Times, for November 1, 1936, and listen to what the Republican National Committee chairman, John D. M. Hamilton, had to say about social security:

HAMILTON PREDICTS TACS FOR WORKERS—REPUBLICAN CHAIRMAN WARNS THAT NEW DEAL WOULD RECRUIT 27 MILLION

If the Roosevelt administration is returned to power . . . 27 million men and women . . . will be forced to report to a politically appointed clerk. . . . In European countries, people carry police cards and are subject to police surveillance. So far, American citizens have not been subject to these indignities.

If Chairman Hamilton was not speaking for his party, perhaps the Republican candidate for President, Alfred Landon, was on September 27, 1936, when he had this to say. Here is a copy of the front page of the St. Louis Post-Dispatch for that date. Let me read the major headline: "Landon Calls Social Security Act Cruel Hoax on the Worker—Urges Repeal of Compulsory Old-Age Section of New Deal Program as Unjust and Stupidly Drafted."

A few weeks later, he came to St. Louis, and told us more of what he thought about social security. Here are the choice remarks he made in St. Louis which were reported in the Post-Dispatch for November 1, 1936:

How could any administration keep track of these 36 million of our fellow citizens? Imagine the vast army of clerks that would be necessary. Imagine the boost for bureaucracy. Imagine the field open for Federal snooping. Are these 36 million going to be fingerprinted . . . or are they going to have identification tags put around their necks? . . . We must repeal the present tax on pay envelopes.

But let us return to the present. The minority report indicates our Republican friends today are trying to make the same mistakes as our late and former Republican colleagues of the 74th Congress. The real basis of Republican opposition today is the role of the Government in collecting a compulsory tax and serving as trustee for the aged. That is the same principle the Republicans op-

posed 30 years ago. I hope my friends on the left of the aisle will profit by the mistakes of their predecessors and I urge them to vote for the bill.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield 10 minutes to the gentleman from Virginia [Mr. BROYHILL].

Mr. BROYHILL of Virginia. Mr. Chairman, I want to repeat what has already been said in abundance on many occasions this afternoon, and will be said repeatedly before we conclude debate on this bill, and that is I, as well as most Members, support many of the provisions contained in this bill we have before us for consideration. In fact, I advocate the passage of many of these provisions as being not only desirable but necessary. I will go further and say that I support all of the broad objectives of this legislation if those objectives are to liberalize and broaden the Social Security Act. We approved a similar bill last year with a number of these same provisions in it. I also support any effort to correct some of the inequities that exist in the Social Security Act and that always exist in a law such as this that is so far reaching.

I support the objectives of this bill if it means we are trying to provide adequate—the best possible—health and medical treatment to all people over 65 who cannot afford adequate medical treatment. I am for providing this medical help without any embarrassment or humiliation to them; in other words, to eliminate all suffering, among all people, for that matter, and certainly for those over 65 which is the age group covered by this bill.

I support those objectives. All of us do. And we should support it. I think most of the people think that these are the objectives of this legislation. That is the reason why it has such broad support among the American people. But I feel that this legislation we have before us falls to meet those objectives.

This brings up a very interesting thing about our political system. It may be a good thing. That is, that all of us may see a problem which exists. Some see it a little earlier, some a little later than others. Some see the problem from their own point of view. But all of us can agree that a problem exists and that something should be done about it, that a solution is desirable. In fact we can agree that a solution is necessary. But we can disagree and honestly disagree as to what is the best method of solution or the best plan of solution.

Yet, under our political system we often shout and charge that the fellow that does not agree with our own method of solution, or has another plan or method, is not sympathetic to the problem or is not aware that the problem exists. Of course, some of us are often too anxious to claim the political credit for coming up first with an answer to the problem rather than finding the best answer.

I believe that is the situation that may cause some of the difficulty in the consideration of this bill. It has been said and agreed to before by both the chairman of the committee and the ranking minority member that a problem does

exist in this area and that the people over 65 need help in arriving at a better solution of this problem. We all agree, therefore, a problem exists in this area, but we do disagree as to the method of approach. I disagree and seriously disagree with the approach for a solution contained in this bill, but I do not question the honesty and sincerity of any of the supporters of the bill. I commend the Committee on Ways and Means for the work they have done, the detailed and thorough manner in which all parts of the bill were considered. This thorough procedure was discussed by the gentleman from New York [Mr. Kroch] earlier in the day.

I was impressed by the amount of time taken by the committee in discussing every detail of the bill. I found it difficult to be at all the committee hearings because they met so often. They met morning and afternoon, day after day. I will admit that many alternatives were discussed in the committee deliberations even though public hearings were not held this year as some of us felt should have been. All alternatives were considered, all amendments were considered but most of them, particularly those offered by the minority side, were voted down. My objection or criticism is not against the Committee on Ways and Means or the way it considered the legislation but against the plan contained in the bill.

I hope that my criticism will be considered as constructive criticism, because we are concerned, seriously concerned, that this bill does not contain the best solution to this problem. We feel that it will not solve the problem as we would like to have it solved. We feel it would injure the medical services and conditions we enjoy here today. There is no finer medical system anywhere in the world.

It was said earlier that the old-age, survivors, and disability insurance provisions in the bill are noncontroversial. There was a little give and take in the committee's consideration of that part of the bill. It did not go so far as some of us wanted it to go. It went a little further than others wanted it to go in other parts of the program, such as bringing doctors under the program, and tips. By and large however, it was a package all of us could support. The provisions of the bill which are amendments to the old-age, survivors, and disability insurance program, are listed on pages 2 and 3 of the report. Therefore, a detailed discussion of these provisions is not really necessary.

But I would like to discuss the treatment of the Federal employees in this bill—or maybe the mistreatment of the Federal employees. We have for many years in the Congress, and I understand in the Committee on Ways and Means, been discussing the relationship between the social security system and the civil service system. The question we have been asked repeatedly is: Are Federal employees being treated fairly by not being brought under the social security system? The question has been asked if they were brought under the social security system, would it impair the civil service retirement system, and because

of the fear that it might impair the civil service retirement system, Federal employees by and large have not pushed and insisted on being brought under it.

Many of us feel they should be permitted to come under it voluntarily and therefore have the same additional benefits as other employees in private industry, and I have actually introduced legislation in order to have this matter formally brought up before the committee. But I will confess this is a most complicated problem and needs a great deal of study. In fact, on page 103 of the committee report, it makes reference to the fact that in 1960 when the Committee on Ways and Means was considering the social security amendments, they discussed the problems of the relationship between social security and civil service and directed the executive branch to make a study of this particular problem and report back to the committee. Interestingly enough, that report came back to the committee just before we took final action and final consideration of this bill—actually, too late to have the benefits of that study that took 5 long years.

In the meantime we are told that the executive branch wants to make a complete study of the civil service retirement system before any further action is taken by the committee in this area and a report is due from them on December 1, 1965.

But the committee did recognize that there was a gap in the relationship between social security and civil service that did need immediate action. That was the group of Federal employees who have less than five years of service. Under the present civil service system, an employee does not have and is not entitled to civil service benefits during the first 5 years nor does his survivor in the event of death become entitled to any survivorship benefit. Yet, during those 5 years he is having withheld for retirement, whether he likes it or not, $6\frac{1}{2}$ percent from his pay. We feel, and the committee felt, that these people during the first five years should be brought under social security automatically in the event they left, resigned or retired from the Federal service or died within the first 5 years. The funds are there. The funds can easily be shifted from the civil service retirement system to the social security system and it would cost the Federal Government no extra money. So we would then treat Federal employees equal with employees in private industry.

As I said, the committee did discuss this proposal and the committee favorably considered it. It would be in the bill at this time except that there was a technical problem of drafting the language of the amendment. We had been on the bill for many months and we were coming to the conclusion of our deliberation. The technical language of the bill had to be drafted and the report had to be written. It was feared the additional time required to draft the technical aspects of this amendment might delay the bill being brought to the floor. So for that reason this provision was not included in the bill. I regret this

action and this decision was not discussed in detail in the report. But the minutes of our executive session, I am certain, will show that. I am bringing it up here now to make abundantly clear in the Record the intention and the desire of the committee on this subject. I therefore can assure the membership of the House that the committee would be willing to take action on it in the very near future.

If I have stated the situation incorrectly, I would be very happy for any member of the Committee on Ways and Means to stand up and correct me at this time. But that is the impression I have and I want the record to show that was the action taken by the committee. In fact, this afternoon the gentleman from New York [Mr. Kroch] and I introduced a bill that would accomplish just the objective that I have been discussing here for the past few minutes.

We did include in the bill a similar provision to bring the substitute schoolteachers of the District of Columbia school system under social security. Up to this time they have been excluded.

We have heard a great deal about the Federal employees who retired after 1960 not being included in this legislation. On top of page 23 of the report, in the paragraph near the top of the page, Members will notice that the only people excluded from the basic medical benefits of this bill are aliens who have not resided in the United States for 10 years, some subversives, and Federal employees who retired subsequent to July 1, 1960. That is a grouping which I am sure the Federal employees will not like.

We did, however, include the Federal employees who retired prior to July 1, 1960. That was not proposed in the original bill. That was included as a result of an amendment in the committee.

Why did we bring those who retired prior to July 1, 1960, under the act? When we passed the Health Insurance Benefits Act of 1959, which became effective July 1, 1960, this was after years and years of study and deliberation. We included in that bill all active Federal employees as of that time and those who would retire in the future. We did not include those who had retired in the past, because that would have made the cost of the health insurance program excessive.

We did come back with a separate action a year later, and in a separate bill we brought in those employees retired prior to July 1, 1960. It was a great deal more costly, because they were people of the average age of 67 or 68. Obviously the cost of insurance was going to be a great deal higher. The Federal Government was not going to put any more into the program, basically, than for active employees. In fact, the entire insurance program for this group of people is inadequate. It provides only about \$15 a day for hospital benefits and a proportional amount for medical benefits. That type of program, basic and major, cost the employee \$29 for the family group plan and the Federal Government's contribution is only \$7. Therefore, it cost the former

employee, who retired prior to July 1, 1960, approximately \$23 a month for something that is not adequate. He needs help in meeting the cost of his present plan as well as supplemental benefits.

There were about 400,000 retired employees at that time who were not brought under the original act, and only \$35,000, or roughly 59 percent, of those actually chose to come under the system which was provided for them. This proved a defect in the program provided and therefore we felt that certainly this group did deserve some further consideration in this bill (H.R. 6675).

What were the reasons why the committee did not include the Federal employees who retired after July 1, 1960? I said a moment ago that we did enact a fairly good plan for the Federal employees in 1959. In fact we gave them a choice of 40 plans. The employee had an option of 40 plans—major medical or basic medical, a service-type plan or an indemnity-type plan. Ninety-five percent of the employees did take advantage of that, and, as I understand it, 95 percent of them actually kept the program into the years of retirement. I also understand that the vast majority of them came under the high-option plan, which did give reasonably full coverage. In fact, there were 2.2 million employees who came under the system, with 4.5 million dependents, making a total of 6.7 million people under this voluntary health and hospitalization system, which made it really the biggest health insurance system in the world.

The committee felt, since the Federal employee had an adequate plan, which was true, that they should not be brought under this particular bill and this particular program. But what about the private industry employees who had a similar health insurance plan? If the voluntary plan for Federal employees, being a sound and reasonable one, is a reason for exclusion from this bill, then do we not actually admit that we do not need to blanket the employees in private industry who have similar systems? This actually proves the point, I feel, that many of us have been trying to make, namely, we should not have a payroll tax or any tax system for those who do not actually need health insurance benefits.

No one who has been retired prior to the enactment of this bill will have paid one quarter into this basic health insurance program being provided in this bill whether he is a former Federal employee or not. Yet the former Federal employee is the only one excluded from the bill, and to that extent I think it is unfair. Yet I have recognized, as have many Federal employees, that we do run a risk by insisting that we be brought under the plan, because we might also get trapped into the compulsory payroll deductions which will come later on.

There is another inequity which exists or which could exist in this particular proposal affecting Federal employees, which I believe can easily be corrected. Everyone will get the supplemental health insurance benefits under this bill,

including Federal employees, whether they are under social security or not. Everyone can get this supplemental plan at a cost of \$3 for each individual, which will be matched dollar for dollar by the Federal Government, and that will come from the general revenues of the Treasury and not the payroll tax. It will be matched by the Government as a Federal Government and not an employer. It will not be a prepaid insurance plan where people are paying into it prior to the years of retirement and will benefit all citizens alike. Here is how the supplemental plan could be unfair to the Federal employees.

I mentioned a moment ago that we have a reasonably good plan for the Federal employees now which they can take into the years of retirement. It is not free, but it is just a reasonable, good, sound employer-employee voluntary health insurance plan. The Government actually pays one-half of the minimum basic medical cost for each employee, individual or family. In other words, the Federal Government will pay \$2.82 a month for an individual in the basic plan or \$6.76 for a family plan. As I said a moment ago, also, most employees have a supplemental plan or a comprehensive plan which can run as high as \$35.51 a month, but the average plan and the cost of the average plan for most Federal employees runs from \$23.51 to \$23.83 a month. That is the family type comprehensive health insurance plan to which the Federal Government makes a contribution of \$6.76 or roughly 28 percent. As I say, he could carry that program into retirement.

Now let us look at the Federal employee's neighbor who might have a similar plan during his years of employment.

The CHAIRMAN. The time of the gentleman from Virginia has expired.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield the gentleman 5 additional minutes.

Mr. BROYHILL of Virginia. Now, the non-Federal employee at the time of retirement will, of course, come under the basic payroll tax plan that is contained in this bill, and if he retires prior to the enactment of the bill, he will have it free of charge and also have the supplemental plan I have been discussing at a cost of \$3 per person. He will probably have a private plan which he will be able to blend into the medicare plan and into the supplemental plan, but if the Federal employee takes the supplemental plan—and it is there for him and it is there for his neighbor as well as the Federal employee—he may find he will really be duplicating the payments for the same benefits he has under his voluntary plan. Or he would have a lot of complications in going back to the insurance carrier and saying they should recast his health plan at the age of 65, which will undoubtedly run into some actuarial problems, because the cost of health insurance at the age of 65 is a great deal greater than it is prior to that.

Here is my plan or my suggestion of how we might prevent this inequity from occurring. I am also introducing a bill to try to do this immediately. In fact, it is being prepared right now.

That is to take the Federal employee when he reaches the age of 65, and have the Federal Government as the Federal Government and not as an employer make this \$3 supplemental contribution into the voluntary health plan that the Federal employee already has and which the Federal Government already has approved of; just add that to the Government's share. This would not cost the Federal Government 1 additional penny. Since the Federal employee has his own health insurance plan, it would avoid the necessity of complicating, or changing his insurance plan or of the Federal employee having two insurance programs.

We already recognize the Federal employee as being in a different category because he is the only individual—it is the only group of individuals—other than some of these subversives and aliens, not included in the basic medical provisions of the act. So we are not being inconsistent to recognize that even further and provide a separate way, another way for him to get the same benefits under the supplemental program. Why should we not make the system a little more convenient to the Federal employee at no extra cost to the Federal Government?

I have a couple more comments about the social security provisions of this bill. I know that many Members will be asked the question as I have already: why did we not increase the benefits by more than 7 percent? that the \$4 minimum is not sufficient, that we must help many people who need a great deal more money to live on. There has always been a great deal of criticism about the \$1,200 maximum that a person may earn from other sources without having his social security benefits reduced. We discussed that in the committee. In fact, the gentleman from Massachusetts (Mr. BYRNE) offered an amendment to increase that limitation to \$1,500.

These are good questions that will be asked of you by your constituents and the committee is mindful of the fact that these are not overliberal increases of benefits. But there is a problem of financing the cost of these benefits. Every increase in benefits has got to be related to an increase in the payroll tax. So the committee had to weigh the problem of increasing the payroll tax, the ability of the wage earner to pay the additional money, the additional hardship that this would impose on the wage earner and the possible shock to the economy.

As has been pointed out here several times before, we have caused a substantial increase in payroll taxes in this bill for these limited benefits that we have provided, including medical care benefits. Right now the total payroll tax under social security is \$348 a year on \$4,800 of income. That is for the employers and employees. But under this bill that total payroll tax will go up to \$739.20 per year on an income of \$6,600, increasing the percentage of the payroll tax up to 11.2 percent of the payroll.

Are we reaching the limit that we can afford to add to the cost of the payroll tax? How can we be sure? Some of us feel that we may already have reached

the danger point when this rate does get to 11.2 percent—and it is going to get that high—whether we increase benefits later on or whether the cost of this medical care program goes up or not.

I will agree that there is going to be some increase in the payroll taxes for the social security program whether we pass the bill before us or not. It is going to go up in 1968 to \$444 per person in the total payroll. I think we can consider this as a tax increase bill because it does increase taxes as well as provide benefits.

It is not an insignificant tax increase bill, either. In fact the cost of the present social security program is not insignificant. It is not insignificant even though the rate seems rather small, 3½ percent of the payroll of each employee and employer. But this year of 1965 that system will bring in \$17.2 billion in taxes and under the bill, starting next year, 1966, with these increases in this bill it will bring in a total of \$21.9 billion. In other words, a tax increase of \$4.7 billion and by 1972—this is only 7 years from now—without any action taken on the part of our committee, the total tax take under this bill will be \$33.2 billion a year or \$14 billion a year more than is being taken in right now.

The medical costs, of course, or the cost of the medicare program are included in these figures I have given you. We are adding \$1.6 billion to the payroll tax next year for medicare, and by 1990, without any increase in costs, we will have a total intake each year of \$9 billion for the cost of medicare.

Mr. Chairman, I submit—and this has been mentioned before by a couple of the previous speakers—that this cost of medicare, this \$1.6 billion next year and which goes up to \$9 billion a year in 1990, will prevent further liberalization of these old-age, survivors, and disability benefits now and is going to prevent more liberal increases in the future.

Mr. Chairman, this is one of the major objections that we have to this plan of providing the cost through payroll taxes for this medicare program. It will place a ceiling on the cash benefits or additional cash benefits that the recipients of old-age and survivors insurance will receive in the future.

Mr. MILLS. Mr. Chairman, I yield 10 minutes to the gentleman from Oregon (Mr. ULLMAN).

Mr. ULLMAN. Mr. Chairman, I want to take this occasion to commend the chairman of our committee, the gentleman from Arkansas (Mr. Mills), for the dedicated work that he has performed with reference to this issue for the past many years, and for the masterful manner in which he has handled the committee during the writing of this most important piece of legislation.

I also would like to pay my respects to the gentleman who was in Congress before my time, the late Honorable John Dingell, who was the father of the gentleman who now occupies the chair, and who was one of the pioneers in this field and who long ago saw the need for this kind of legislation.

Mr. Chairman, I also want to pay my respects to another gentleman, Aime

Forand, who is not in this House now but who was dedicated to the purposes of this bill for many years and who led the fight in this House for it. Also, I want to commend the gentleman from California (Mr. King) who spoke earlier this afternoon for his dedicated efforts in behalf of this legislation.

Mr. Chairman, the program that we bring to you today is a uniquely American approach to this complicated and difficult problem of providing adequate medical care for our older citizens. It is America's answer to that problem. There is no prototype anywhere in the world to the kind of program we bring you here.

Mr. Chairman, this program is the assurance that we will not have socialized medicine in America, because we have over the years studied this problem and analyzed it and we have had hearing after hearing before our committee. I know of no comparable piece of legislation since I have been in Congress that has been studied more and that has received wider consideration by any committee than the legislation that we bring you here today.

The package that we have put together makes sense. It makes sense from the point of view of the administration; it makes sense from the point of view of financing; it makes sense to the older citizens of America, and to every citizen of America from the point of view of a benefit which fills a need, a demonstrated need in our society.

Let us look at a few specifics. I can understand some confusion about this legislation because of the expensive campaign of opposition to it that has been conducted, not just in recent months, but over the course of many years. Much of this campaign has been dedicated to stirring up confusion in the minds of American citizens.

First, why do we single out the hospital benefit portion of the bill to be financed under the social security program? Was this just a willy-nilly decision, or does it have some real substantive basis?

I want to tell you it does have a real basis, and it does make sense.

What we have done is separate the institutional benefits in this bill from the physician service-type benefits. There is a real distinction between these benefits, and that distinction merits different consideration. We have said here that the institutional services that are so important in health care—basically hospital care outpatient diagnostic services, posthospital skilled nursing home care, and home health care—are admirably adapted to the social security type of financing, the payroll type of financing that we have provided in this bill.

At the same time we have very rigidly kept out of the "basic" package, which is supported by the payroll tax, any benefits with respect to physicians' services because it is not easy to fit the latter into reasonable or precise actuarial estimates.

We have, however, in this legislation, built a voluntary supplemental package providing for payments for physicians' services. This makes sense. And I want to pay tribute to the gentleman

from Wisconsin who originally proposed the legislation that took this approach to the problem. Most of us on the committee, and people generally, recognized that the need of our older citizens will not be met until you take into consideration physicians' services as well as institutional care.

What are the weaknesses of the so-called Byrnes package which will be presented to this committee in the form of a motion to recommit? It has very basic weaknesses. One of the weaknesses is this matter of a needs test. The gentleman said there was no "needs" test, but there actually is. May I say this problem of a needs test has been the greatest stumbling block in this whole area of legislation.

It was the problem which was almost insurmountable in the Kerr-Mills approach to the problem, where every State imposed a different kind of "means" test, so that you wound up with totally uneven and inadequate care for our older citizens. But the Byrnes' package provides that your individual amount of contribution depends on your status in the social security system.

I say this is inadequate and a totally unjustifiable form of a "means" test, because who is to say that because someone is receiving a minimum social security benefit he has any greater need than anyone else? What about the doctor who has enough wage earnings in his lifetime to establish a minimum social security contribution? He is going to get the maximum amount of benefit under the program at the minimum contribution.

This is only one of the weaknesses in the substitute proposal you have before you. A second weakness in this proposal is that the total governmental cost is borne by the general Treasury.

If you are going to hold down the program, hold down this cost, a far better way of doing it is to establish an actuarially sound social insurance system. That is what we do in the committee bill by establishing a fund, a separate fund, an isolated fund, and getting actuarial estimates that are accurate. You cannot afford to do otherwise. Since the social security system has been established, these actuarial estimates have been good and the estimates we have in this bill are also based on conservative assumptions. The best way to hold down a program is to tailor it to finance a particular benefit package, knowing all the time that when you put in a benefit you have to match it with the increased payroll deduction.

Mr. Chairman, on the other hand, when you take a program such as you find in the substitute proposal and finance it from the general Treasury, you have no such assurance that the cost will be limited in any manner, shape, or form. All of us know from our legislative experience that the best way to build a program is to put it on an open-ended basis, financed by the general Treasury. Then each time you get pressure for increased benefits, that pressure is going to build up on the Congress to provide those benefits irrespective of the costs.

The Byrnes' package will put a burden on the Treasury of the United States, ac-

according to the best actuarial estimates, of \$2.8 billion in the initial year. This \$2.8 billion increase in general revenues is being recommended by the very people who year after year have come before this body and have argued against increasing the ceiling on the public debt.

The committee bill we have before you is more conservative, more soundly financed by far, than the substitute proposal that is being presented.

Then I want to say that there is a third basic weakness in this substitute motion that is going to come before you. The amount of the individual contribution that the gentleman from Wisconsin would impose on our older citizens would have the effect of increasing the incentive for them to drop out of the program and cause them to fall back on the welfare rolls for their benefits in their later years. We want to accomplish exactly the opposite. We want to decrease their dependency on welfare payments, but by putting all of our older citizens under a basic hospital benefits program and financing it sensibly under a payroll tax. And then putting it alongside the supplementary program for physicians' services, financed part out of the Treasury and partly by the individual, we are encouraging the maximum participation of our older citizens. With these coordinated programs we would rely to a minimum on our welfare program to carry our older citizens through their later years.

Again the "needs" test has been the stumbling block. In the committee package that we bring before you in the first two layers, we have no "needs" test whatsoever. It is the great strength of this program—you can waste all kinds of funds and all kinds of administrative effort in trying to administer a "needs" test. We do not have that test in the basic or supplementary program. In the case of the voluntary program, what we have said is this—we are going to reestablish for our older citizens the 3-percent floor on medical deductions. We are putting all the taxpayers in this regard on the same basis. We are eliminating a complication in our internal revenue structure and we are also eliminating a needs test, thus providing for a maximum of efficient operation of this total overall program.

Now there has been some talk about the long-range cost of the social security system. I am not going to go into it at any great length because it is a complicated picture. But I want to tell you this, as the chairman has told you, that the social security system is sound and that the tables that you have in your report have been prepared by the best actuary in the business. I urge all of you to take the time to look at the study by Robert Myers, the Social Security Administration actuary, who presented to us a complete set of actuarial tables that are available to you. I hope you will take the time to examine them because he is, in my opinion, the finest actuary in the whole insurance field. Time after time after time, we had him before our committee with the best actuaries in the private insurance field, and I have never

seen an instance where he has not come out on top.

What we have done in the long range estimates is to have gone up to a point in time—1971—and established a wage base ceiling of \$6,600 and have assumed that wage base will not go up any further. When you look ahead and make actuarial estimates of what the fund is going to be in the future, you have several variables to work with. One is a wage base, the maximum amount of taxable earnings, which is \$4,800 today. In this bill it will be \$5,600 next year and then we increase it to \$6,600 after 1970. Then we assume that it remains at that figure. Well, if you keep that a fixed figure, then you are going to a tax rate for the hospital program which appears in the committee bill. But the sound way to finance a social insurance program in the long run is to keep that wage base increasing with the wage level over the years. I predict the Congress will do that and by doing that you will exactly be able to reduce the hospital tax rate that appears in the bill. So do not let them make a bugaboo about this 10 percent limit or 11 percent limit or any limit because it is going to be up to the Congress in the future as to how to keep this system balanced. In my opinion the fair way of doing it is to spread the cost throughout the wage earners of this country on an equitable basis by keeping the same ratio between the wage level and the wage base that we have established in this bill now before us. I think the Congress will do it in the future and by doing it, we will hold down the tax rate that you see in the tax schedules in the report.

I want to speak for just a second about the self-employed and the separate fund. A lot has been said about the fact that this is not a separate fund. It is a separate fund and I want to point out one very distinct difference in this separate fund that involves the self-employed.

We are treating the self-employed exactly the same way as we are treating the employee under the hospital insurance program. In other words, the amount of the contribution by the self-employed will be exactly the same as that by the employee. All Members know that under the social security system, the contribution paid by the self-employed is 150 percent of that paid by the employee. So this is a very important distinction in the way that these funds will operate, and I believe it is an important principle.

One of the reasons why we established this principle of separation is because of the basic differences between this program and the social security cash benefit program as a whole.

We have heard a lot of nit picking on the part of the opposition. I wish to conclude by saying that this is a sound program. This program has been studied by the committee for many years. Last year we spent month after month after month on it. We have held public hearing after public hearing. There have been independent studies by Presidential committees for years. There is no proposed legislation that has been studied more than this one.

The formula which we have arrived at is uniquely sound. It is uniquely American. It is a milestone in legislation in this area. All of us will find, as the years go by, this is going to be considered landmark legislation, as much so as the legislation originally passed when we established the social security system.

I urge all Members to vote against the motion to recommit because it is not a sound proposal, and to vote for the committee bill, which is sound, which is creative, and which is uniquely American.

Mr. MILLS. Mr. Chairman, will the gentleman yield?

Mr. ULLMAN. I yield to the gentleman.

Mr. MILLS. The gentleman mentioned some of the points he believes are weaknesses in the suggested substitute. I wonder whether the gentleman feels that the development of any plan for the benefit of our older people must take into consideration the feasibility of compliance and the economic situation of these people in connection with it.

What I am thinking about is this: does the gentleman find any weakness in the proposed motion to recommit, in that there is no contribution to be made either on a voluntary basis or otherwise by an individual until that person is living in retirement or on retirement income? Is it not more fair to these people to spread the cost of their hospital benefits, as we propose to do in the committee bill, over the time when they are working and before the time when they are in retirement?

Mr. ULLMAN. This certainly should be one of the points of weakness, because it is a basic weakness. What the gentleman suggests, and what we do in the bill, is much more fair, much more equitable, and will provide a much stronger program for our older citizens than trying to finance it all after the citizen gets to be 65.

I am sure, however, that if we wished to extend this business of finding weaknesses in the motion to recommit of the gentleman from Wisconsin, we could carry this on for a long time. I believe we have pointed out the basic weaknesses which exist in the motion to recommit.

Mr. JOELSON. Mr. Chairman, I ask unanimous consent to extend my remarks at this point in the Record.

The CHAIRMAN. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

Mr. JOELSON. Mr. Chairman, it is with a sense of being a participant in a great event in the social and economic history of the United States that I rise in support of H.R. 8675.

It is a humane measure whereby Americans will be able to show our concern for our senior citizens and our respect for individual dignity. Far from being a socialistic measure as its opponents charge, it will in the best American tradition provide the machinery to allow millions of Americans to help themselves.

It has been said that a civilization is to be judged by the way it treats its elderly citizens. Up until now, we have failed this test but I am thankful that

at long last we are facing up to our responsibility. No society can be truly great which coldly turns its back on the plight of its aging members.

Not only is H.R. 6675 a humane measure, it is also a practical one. It will furnish a workable plan whereby the bills of our senior citizens for hospital and medical care can be met with self-respect.

We must not overlook the fact that this measure also attends to the much-needed increase in social security benefits other than hospital and medical care. In view of the cost of living, those people in retirement have experienced great difficulty in making ends meet and the bill we are considering will be helpful in this respect.

Mr. Chairman, I will have a deep sense of gratification all my life to have been a Member of the 89th Congress which is apparently about to write into law one of the great social measures of our century.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield myself 3 minutes.

I simply cannot refrain from getting into this colloquy on the matter of whether there is a prepayment by the current workers, so that they really will have paid for the benefits they will receive upon retirement. That is the implication of the statement of the chairman of the committee and of the gentleman from Oregon.

Mr. MILLS. No, I disagree with the gentleman.

Mr. BYRNES of Wisconsin. Is it not better to have people start paying during their lifetime, rather than when they get to retirement?

Mr. MILLS. Mr. Chairman, will the gentleman yield at that point?

Mr. BYRNES of Wisconsin. If the gentleman will correct this picture, I will appreciate it very much.

Mr. MILLS. I would not want the gentleman to think I was referring to those in retirement. The gentleman remembers the committee majority part of the report clearly says that with respect to those people presently retired who would receive this benefit there is no prepayment.

Mr. BYRNES of Wisconsin. I am glad at least that we admit somebody will get the benefit tomorrow without having prepaid anything.

Mr. MILLS. I am sure the gentleman remembers that in the report. We very honestly admitted that for them there is no prepayment as such.

Mr. BYRNES of Wisconsin. At least in that area you have no alternative.

Mr. MILLS. That is right.

Mr. BYRNES of Wisconsin. Because you could not by any stretch of the imagination suggest that anybody who was getting a benefit for which they would make no additional payments of any kind had made a prepayment. However, my point here is this: if you will look at your table—and you have the table there—showing the revenues that will be produced by the payroll tax that is assessed in each year, and then you show the total you anticipate will be paid out for those hospital benefits in that year, you will find throughout that they are pretty much in balance. I will agree that

there is some slight surplus that exists as far as the income to the fund is concerned, but that certainly the chairman would not contend is a funding.

Mr. MILLS. Oh, no.

Mr. BYRNES of Wisconsin. That reserve, as I understand it, is to take care of any contingencies which might occur as a result of a miscalculation of what the benefits will be or what the revenue return will be from the payroll tax. Am I correct?

Mr. MILLS. Mr. Chairman, will the gentleman yield?

Mr. BYRNES of Wisconsin. Yes. I yield to the chairman.

Mr. MILLS. I will certainly admit, just as I would admit about the OASDI trust funds that they will not—and they have not—operate on a funding basis; but they do operate on a prepayment basis. There is a difference between prepayment and funding.

The CHAIRMAN. The time of the gentleman from Wisconsin has again expired.

Mr. BYRNES of Wisconsin. I yield myself 1 additional minute.

Mr. MILLS. If the gentleman will yield further, if we operated the system on a funding basis, as my friend from Wisconsin knows, we would have to maintain several hundred billions of dollars in the funds.

Mr. BYRNES of Wisconsin. I must confess, Mr. Chairman, that I get considerably confused at some of the mental gymnastics going on where now we can rationalize that the hospitalization program is not under social security and it is separate from the OASDI insurance system and now we have the mental gymnastics that you prepaid for something even though what you are doing is simply paying a tax which is used in order to pay a benefit to someone else. That is the way the system works. To me, if I pay such a tax, I am not prepaying for any benefit that I am going to get in the future, but I am simply hoping, because I paid a tax during my lifetime for the benefit of today's retired, that tomorrow when I am retired those people who are then working and their employers will pay for the cost of my benefits. But I am not able to rationalize as to how that becomes a prepayment.

Mr. Chairman, I yield 10 minutes to the gentleman from Ohio (Mr. BETTS).

Mr. BETTS. Mr. Chairman, throughout this debate speakers on both sides have ably presented arguments for and against the bill now before us. While I want to voice briefly some of my own thoughts on the issue, I would first like to pay tribute to two friends of mine.

These two men, Amy Forand and Cecil Krue, with whom I have served on the Ways and Means Committee, have made a great contribution to the welfare of persons over 65. Although I disagree with the program they have advanced, they have alerted the country to the need for health care for the aged. As a result of their persistence, there has been action in many areas. Insurance companies have brought forth new plans. States have legislated to permit State 65 programs. Medical associations and hospitals have concentrated attention in

the area. In Congress we have acted with new programs such as Kerr-Mills. As a result, the protection of persons over 65 against the financial drain of sickness has expanded fantastically. If no more legislation were ever passed in this field, this age group is in a much-improved position mainly because of these two men, and I think a word of commendation is due them regardless of our positions on this bill.

I also want to pay my compliments to my colleague from Ohio (Mr. Bow). A long time ago he saw the need of exploring the possibility of medical care with a different method of financing. He deserves much credit for keeping alive the idea of finding an alternative to the payroll tax approach, an effort which has finally resulted in the Byrnes bill.

In a measure consisting of 300 pages, naturally there are parts which are acceptable and some that are objectionable. It is for that reason that I object to so-called omnibus bills. This is true not only with H.R. 6675, but the same complaint can be directed to foreign aid bills, agriculture bills, and tax bills, to mention only a few. With only one single vote, the Member must accept proposals with which he disagrees in order to express his approval of provisions in which he is in agreement. Conversely, if he votes no to voice his objection to certain portions of the bill, he is forced to reject those provisions which he favors. This situation is especially true in this measure.

Probably the most outstanding example in this bill of a provision which has always had my support is the proposed increase in social security benefits to bring them in line with the cost of living. Last year I voted for such increases in a bill which unfortunately never became law. Benefits were thereby delayed for at least a year to persons who were justly entitled to them. I would support a bill now which dealt only with this subject. As a matter of fact, I will support it now in the motion to recommit which will be offered together with the Byrnes bill as a substitute for the compulsory payroll tax approach in part A.

Many objections have been raised to this part of the bill which is the hospital benefits provision. Among them is that it is compulsory, and therefore incompatible with the traditional free enterprise concept of the American economy. Another is that it benefits the rich as well as the poor—a feature which burdens its administration and removes it from the classification of a welfare measure. Americans have always taken care of the needy but a Government program to care for millionaires is illogical to say the least. Also impressive is the argument that the payroll tax method is retrogressive and that it creates situations where persons receive help who have not contributed to the program and where many contribute who will not be benefited.

In the Washington Post of February 11, 1965, Columnist John Chamberlain commented on this as follows:

The principle of regressive taxation that is embodied in the administration's current

medicare proposal is an affront to every young couple in the lower middle income brackets. Why, in terms of their incomes, should they be called upon to pay a wildly disproportionate share of the cost of taking care of the old? Do we start the Great Society by grabbing the same amount of medical insurance money from the \$5,600-a-year kids that we take from people named Harriman, Kennedy, or Rockefeller? Why not be decent about it and pay for medicare out of the general tax funds?

But the one objection which has seemed overriding is the increasing burden on the payroll tax. In 1967 this will rise to 11.2 percent on a base of \$6,600. The Republican members of the Ways and Means Committee have stressed their concern about this in their separate views in the committee report. We say there:

We believe that the reliance on a payroll tax to finance a hospitalization program jeopardizes the cash benefit program under the social security system by imposing upon that system a liability to finance undetermined future service benefits. The magnitude of that liability should cause concern to anyone dedicated to the preservation of social security cash benefits.

A payroll tax is one of the most unfair and regressive taxes in our entire tax system. It applies to the first dollar of earnings. There are no exemptions, no deduction, no exclusions and no tax credits. No consideration is given to the taxpayer's ability to pay. The president of a large corporation pays the same tax as his worker. The justification for this type of tax rests upon the basic premise of the social security system that the benefits, for which the tax is levied, are wage related. The financing of a hospital service benefit by a payroll tax represents a basic departure from that principle.

I simply state that I concur in these objections. They are reasons for opposing this bill. And, to further substantiate this position, I would point out that on at least two occasions, in 1962 and 1964, after weeks of exhaustive and painstaking consideration, the Ways and Means Committee rejected the concept of health and hospital care through payroll financing. These objections should not be obscured by the fact that politically attractive amendments now have been added and that the bill is labeled "Social Security Amendments of 1965." The plain fact is that the hospital insurance program in this bill, at an estimated initial cost of \$2.6 billion annually, is basically the same proposal which the Ways and Means Committee has repeatedly rejected and it is my purpose to maintain the same position which the great committee of which I am a member has consistently maintained until now.

Aside from the merits or objections to the bill, many think of its passage in political overtones. For example, the Johnson election has been interpreted as a "mandate" to pass the health and hospital programs. I think this was effectively answered by an editorial in the Toledo, Ohio, Times of November 19, 1964, which said in part:

It would be a great mistake if President Johnson interprets his landslide victory as, in part, a mandate to resurrect the by now discredited medicare scheme. There were many reasons for his lopsided election, but as far as we have been able to determine medicare was never one of the issues and,

for that matter, was scarcely mentioned by either candidate. One would think that medicare as a political issue or a social panacea had been effectively disposed of by the three congressional sessions in a row which refused to enact it.

As a matter of fact, the mail coming to my office on this subject is overwhelmingly against medicare—the name by which the payroll tax plan is known to the public. It is interesting to note that much of the mail is from older folks, the very people whom proponents of the bill seek to help. Most of the mail is from individuals, but groups are also represented. For example, the Eighth District of Ohio is predominantly rural and one of the most important farm organizations, The Farm Bureau, has always been against this type of financing health insurance.

In my opinion, if Congress had been left alone to work its way in the normal course of events, this bill would never be here today. But obviously the pressure of the administration and the political realignment of the Ways and Means Committee have brought this about. Until now this committee has been a bulwark which millions of people have relied on to stem the tide against oppressive increases of payroll taxes. Now that is over, and most of my constituents are fearful of the future. They understand, more than many politicians realize, that along with talk of reducing income taxes, the bite grows bigger and bigger out of payrolls.

What will be the amendments to this bill in 2 years—or 5 years after it becomes law? Anyone who has followed Federal legislation knows the answer. There will be amendments expanding the law. And how will it be expanded? There is only one way I see, and that is by extending the payroll tax provisions to include both hospital and medical care, and thus the whole program compulsory. That was the original intention, and commonsense would conclude it is the end purpose.

Mr. GROSS. Mr. Chairman, will the gentleman yield?

Mr. BETTS. Yes, I yield to the gentleman from Iowa.

Mr. GROSS. Would the gentleman like an audience to hear him, instead of the few Members who are now present?

Mr. BETTS. I am practically completed. I would like to have just 1 further minute and I shall be finished. I do not wish to take advantage of some of the other Members who have not had audiences.

Mr. CURTIS. Mr. Chairman, will the gentleman yield?

Mr. BETTS. I yield to the gentleman from Missouri.

Mr. CURTIS. I would like to advise the gentleman from Iowa that the audience we have here is the usual attendance throughout the day. I tried to point out during debate that it is obvious this is a farce. The decision has been made and whatever the chairman of the committee might say and the gentleman from Ohio who is making a very fine statement might have to say, or any of us, will make little difference.

This is not a deliberative body on this important issue.

Mr. GROSS. Mr. Chairman, will the gentleman yield?

Mr. BETTS. I yield to the gentleman from Iowa.

Mr. GROSS. Does the gentleman have any estimate of how many there are on the House floor at this time?

Mr. BETTS. I would not care to make an estimate. I am not a good counter. I think the gentleman, who has been here a long time, is much better at that.

Mr. GROSS. Would the gentleman say 40 or 50, perhaps?

Mr. BETTS. I think so.

Mr. GROSS. Will the gentleman yield to me for a question or two when he completes his statement?

Mr. BETTS. Yes.

Mr. Chairman, I want to conclude my remarks by saying that I have great concern, and I call attention to the plight of the small businessman. I have never been at a hearing of this committee or any other committee, or even on the floor of the House, but what it seems the plight of the small businessman is mentioned.

As a matter of equal concern, I want to call attention to the plight of the small businessman. How can he continue to meet the employer's share of increasing social security taxes? It is a situation which is spelling doom to many of these great figures in our economy. They have been fighters in the frontlines for our free enterprise system and I, for one, do not want to be a party to their economic extinction.

These, then, are some of the reasons why I cannot support this bill. Each Member, of course, must himself weigh the good against the bad in it. I only hope that before he casts his vote, he will give serious thought to the possible consequences of this legislation—the damage it could do to our social security system, our national economy, and to that basic right of every American—individual freedom.

Mr. GROSS. Mr. Chairman, will the gentleman yield?

Mr. BETTS. I yield to the gentleman from Iowa.

Mr. GROSS. Can the gentleman give us any idea of what this bill will cost?

Mr. BETTS. The report of the committee fixes it at about \$6 billion.

Mr. GROSS. Six billion dollars?

Mr. BETTS. That includes all four parts of the bill that the chairman mentioned this morning.

Mr. GROSS. I thought it was \$5.5 billion, but the gentleman says it is \$6 billion?

Mr. BETTS. I am quoting the committee's report.

Mr. MILLS. That is approximately correct for the first full year. That is \$4.2 billion out of trust funds, \$1.4 billion from general funds, and about \$500 million in contributions from individuals for the voluntary supplemental insurance.

Mr. BETTS. That includes the social security amendments?

Mr. MILLS. Yes, everything.

Mr. BETTS. In addition to hospital and medical care.

Mr. MILLS. And cash benefits.

Mr. BETTS. And cash benefits; also the increases.

Mr. GROSS. Is all this coming from taxes?

Mr. BETTS. About \$2.6 billion or \$2.8 billion comes from a payroll tax.

Mr. MILLS. Would the gentleman yield?

Mr. BETTS. I yield to the gentleman from Arkansas.

Mr. MILLS. About \$4.25 billion would come from the payroll tax supported trust fund, and \$1.366 billion would come from the General Fund of the Treasury under the committee proposal. The rest comes from persons enrolling in the supplemental plan.

Mr. GROSS. It would all have to come out of the pockets of the taxpayers?

Mr. BETTS. It has to be met by a payroll or income tax and from subscribers to the voluntary supplemental plan.

Mr. GROSS. Will the gentleman yield for me to read a brief statement?

Mr. BETTS. Yes.

Mr. GROSS. Going back to February 24, 1964, dealing with the implications of the Revenue Act of 1964, and the fiscal policy of the United States, a Member of the House of Representatives, made this statement:

In enacting this revenue bill . . . we are choosing tax reduction as the road toward a larger, more prosperous economy and we are rejecting the road of expenditure increases. We do not intend to try to go along both roads at the same time. If we fail to limit the growth of Federal expenditures, we will be leaving the tax reduction road. Even a 3-year detour may make it extremely difficult to get back on it.

Does the gentleman recognize the author of that statement?

Mr. MILLS. Mr. Chairman, will the gentleman yield so that I can plead guilty as the author of that statement?

Mr. BETTS. I will be glad to yield to my chairman.

Mr. MILLS. I said that, and we are still trying to follow that in the committee bill. That is why I had to oppose the substitute coming from the gentleman's side, and I hope the gentleman joins me in doing it.

Mr. GROSS. Any time a bill costs \$6 billion, we are not exactly following the road to tax reduction and economy. Would the gentleman agree with that?

Mr. BETTS. I would agree that any Federal program costs money and somebody has to pay for it. This represents an increase in taxes.

Mr. GROSS. This is not the road to economy, is it?

Mr. BETTS. I do not think you can call it the road to economy, no.

Mr. GROSS. Last year, Congress reduced taxes by \$11.8 billion, and now it proposes to turn around and increase taxes by \$6 billion.

Mr. MILLS. The gentleman from Iowa, the great student of legislation that he is, is aware of the fact that this bill includes the expenditure of approximately \$6 billion but provides for an increase in taxes to offset this \$6 billion and more we are spending out of the trust fund.

The gentleman is not accusing me of being for tax reduction one year and raising taxes in another year.

Mr. GROSS. The revenue has to come from somewhere. I do not know how else I could figure the gentleman's position today as compared with his position in cutting taxes last year.

Can the gentleman give me any idea as to how many people will be put on the payroll to administer this program?

Mr. MILLS. I am not certain whether it will be in a 12- or 24-month period, but undoubtedly in assuming the initial responsibilities which are imposed upon the Social Security Administration under the bill, as I recall there would have to be somewhere in the neighborhood of 2,500 to 3,000 additional employees for the basic plan and about the same number for the supplemental plan scattered throughout the United States to carry out this program.

Mr. HARVEY of Indiana. Mr. Chairman, I ask unanimous consent to extend my remarks at this point in the Record and include extraneous matter.

The CHAIRMAN. Is there objection to the request of the gentleman from Indiana?

There was no objection.

Mr. HARVEY of Indiana. Mr. Chairman, I recently received a letter from Dr. Frank Green, of Rushville, Ind., a general practitioner.

The questions he raises are worthy of Members' consideration.

The letter referred to is as follows:

RUSHVILLE, IND.,
April 2, 1965.

CONGRESSMAN RALPH HARVEY,
Capitol Hill, Washington, D.C.

DEAR CONGRESSMAN HARVEY: There are several conditions which will be created with the passage of H.R. 6675 that I would like to bring to your attention.

1. How and in what manner of precedence will available beds be assigned to those in need of hospital care?

2. Once an unoccupied bed in the hospital is assigned in the approved way, who will have the responsibility of dismissal?

At the present time, the average stay in our Rush County Hospital is 7 days. Under bill H.R. 6675, what is to prevent this occupancy in the hospital from going up a number of days to the limit of 60 days as provided in H.R. 6675?

It is now a fact that by only using beds the minimum number of days we are still unable to accommodate our paying needy sick. What will happen when they have it guaranteed by Government finance?

Who will have to say that the bed should be vacated when not really needed? Who will say this or that patient must get up and go home, short of the full utilization as guaranteed by law?

There cannot be a nonmedical committee in control of dismissals for here may be a very touchy area. There is no hospital committee of doctors, or hospital personnel, or management able to do this job. Only a physician who knows the patient's condition and who is willing to assume this responsibility is really able to say when a patient may be sent home against their wishes.

But reprisal or fear of reprisal is a reason why the committee idea of usage of beds cannot be depended upon. Dismissal of any patient who wants to stay might lead to a suit against the physician or hospital for abandonment or neglect.

In my opinion there is here an upset of reasonable humane and orderly procedures

that will be bad for all concerned. It could destroy the present fine patient-doctor relationship.

To disrupt this fine doctor-patient relationship or use it to bail out a bad arrangement would be imprudent when it could be avoided or controlled before the contract for service is entered into and guaranteed by national law.

A contract for service between a patient and a hospital and physician should arrange for the control of overstaying the time needed for the necessary care of the patient. Overuse of a bed by a patient beyond the time needed for necessary care should place this excessive cost on the patient. This would then give bargaining power to the institution to control and better use available bed space for others who need hospitalization.

Any body politic when attempting to do good must surely be aware of the obvious rebound from joy to resentment when the offered becomes impossible only because of ill-laid plans.

Sincerely,

FRANK H. GREEN, M.D.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield 5 minutes to the gentleman from Iowa [Mr. Gross].

Mr. GROSS. Mr. Chairman, I have in my hand a newspaper clipping dated Washington, D.C., which says, speaking of the proposed erection of a social security building in Minneapolis, Minn., that it will cost \$722,400. Apparently preparations are already being made for this bill.

Mr. MILLS. This group of employees would not all be located in Minnesota or Washington. They would be in the gentleman's State of Iowa as well.

Mr. GROSS. That leads me to ask how many employees will be added as a result of this bill?

Mr. MILLS. Between 2,500 and 2,700 additional, I think.

Mr. GROSS. Of course, they would not all be located in Minneapolis. Continuing this news story, we are told that there will be a 20-percent increase in the social security payroll. What is the reason, and is that under the committee bill if enacted?

Mr. MILLS. It would not amount to a 20-percent increase. There are over 25,000 employees already.

Mr. GROSS. As of last February there were 34,783 persons on the payroll of the social security setup.

Mr. MILLS. I think that is right.

Mr. GROSS. A 20-percent increase would add about 7,000.

Mr. MILLS. It is my understanding it will not amount to that increase.

Mr. GROSS. I wonder where the newsmen get this information.

Mr. MILLS. I would like to know sometime where all the information that is written is produced.

I raised the question in the committee with the Social Security Administration as to what employees would be involved if we proceeded as we did. Under the committee bill, in reporting responsibility on the Social Security Administration, he told me it would be a maximum of around 2,700 employees for the basic program.

Now had we gone the other way, I would call to my friend's attention, and set up an entirely different agency to administer it, it prob-

ably would have taken 2,500 to 3,000 employees.

Mr. GROSS. I hope the gentleman has the right estimate of the increased number of employees.

Mr. MILLS. If the gentleman will yield, I do believe I may be unintentionally misleading the gentleman and, of course, I would not do that for anything.

Mr. GROSS. I yield to the gentleman.

Mr. MILLS. Let me get the facts straight. This may be nearer what the gentleman is talking about. With respect to the basic plan, anywhere between 2,500 to 3,000 employees would be needed. That is what I was talking about. I was overlooking the fact that there would be an additional administrative problem with respect to this program that we wrote in, taken from the idea of "voluntary" of our colleague, the gentleman from Wisconsin (Mr. BYRNES). There would be additional employees involved in that and they might run anywhere from 2,500 to 3,000.

Mr. GROSS. So that would bring it pretty close to a 7,000 increase?

Mr. MILLS. It would not bring it up to quite 7,000—no.

Mr. GROSS. Well, it would not be very far from that. I will say to the gentleman.

Mr. MILLS. The point is this—If I can get the gentleman to see my point—by using the Social Security Administration, undoubtedly, we bring about the creation of fewer jobs than if we gave it to an entirely different and newly established bureaucracy.

Mr. GROSS. I have one other question since the gentleman is on his feet. How much longer do you anticipate going on this evening in order to get the T. & T. Club, the out-on-Thursday, back-on-Tuesday Club on the road this week?

Mr. MILLS. It is not for that purpose at all that we are here this evening. I want to get the gentleman straight on that. We are simply trying to give as many Members as possible an opportunity to speak today.

Mr. GROSS. I might say to the gentleman that there might be something going on this evening—I do not know. Perhaps there is a repeat performance at the Ebony Table.

Mr. MILLS. I am not certain of anything going on this afternoon. I have not been invited. Now if there is, I wish the gentleman would advise me.

Mr. Chairman, I yield 10 minutes to the gentleman from Massachusetts (Mr. BURKE).

Mr. BURKE. Mr. Chairman, I take particular pleasure in supporting the provision of H.R. 6675 under which benefits will be paid to children age 18 to 22 who are in full-time school attendance. This is an especially fine and forward-looking provision. It will extend the survivorship protection of the social security program and enhance the educational opportunities we offer our young people.

A child who has lost parental support through the retirement, disability or death of his mother or father is considered dependent under the present social security program if he is under age 18 or if he has a disability which

began before he reached age 18. I strongly concur in the committee's view that a child who is in full-time school attendance after reaching age 18 is similarly dependent. It is simply not realistic today to stop a child's benefits on his 18th birthday and tell him that he is now presumed to be able to go to work and to support himself. While some children can and do become economically independent by the time they are 18, most children cannot be financially independent at 18 because they have not finished high school, and they must look for a living to an economy that has little use for the untrained, unskilled, and uneducated worker. It is time we recognize that this is the situation, that this situation will continue, and that a child who has reached age 18 and is still continuing his education is as dependent on social security benefits to replace lost parental support as he was when he was younger.

Under the bill about 295,000 children age 18 to 22 would get benefits this September, when the school year begins. In a full year these benefits will add up to \$195 million. Many of these youngsters would not be able to continue their education without the benefits this bill will provide. It will mean a great deal to them and to their parents, so many of whom have written to us asking that the benefits be continued.

THE ECONOMIC IMPACT OF H.R. 6675

When we consider social security we tend to focus on its effect on people as individuals—the needs of the individual retired worker, disabled worker, widow, and orphan—and this is as it should be. For the social security program is first and foremost a program that affects almost every American family in a very personal way and under changed circumstances—when the worker retires because of age or disability or when the family loses him in death.

But there is another side to social security. In providing an assured and regular income currently to 20 million of the most economically vulnerable people in the Nation, it provides a steady source of consumer demand that helps prevent deflation. Let us consider the bill before us today from this standpoint.

The provisions of the bill affecting cash benefit payments will become effective this year; the across-the-board benefit increase and benefits for children in school up to age 22 will be effective from the start of the year, and most of the other changes will be effective in the second month after enactment. It is estimated that these changes will increase benefit disbursements under the program by \$1.5 billion over the amount that would be paid out in 1965 under present law. In 1966, when all of the provisions of the bill affecting the cash benefits will be in operation for the full year, an estimated \$2.1 billion will be paid out in benefits over the amount that would be paid out under present law. In addition, an estimated \$1 billion will be paid out under the basic hospital insurance plan, and \$200 to \$300 million under the voluntary supplementary health insurance plan, in the last 6 months of 1966. In 1967, the first full year in which all of

these benefit provisions will be in effect for a full year, an estimated \$2.4 billion will be paid out in benefits under the cash benefits program over the amount that would be paid out under present law, an estimated \$2.2 billion will be paid out under the new hospital insurance program, and \$700 million to \$1.2 billion will be paid out under the voluntary supplementary health insurance plan. All of these funds will be paid either for health care services or as income to beneficiaries, who, for the most part, will use it to meet their day-to-day living expenses. Thus the bill will not only increase the effect of the social security program as a source of assured purchasing over the long run, but will provide an immediate boost in consumer purchasing power to stimulate the economy in the next several years.

This economic stimulus will, of course, be offset to some extent by the additional social security taxes that will be collected under the bill. However, this counterbalancing effect is limited by two factors. First, the new social security tax rate schedules in the bill have been designed to avoid the excessive build-up of trust fund assets that would take place in the next several years under present law by providing for a more gradual attainment of the full rates needed to support the program over the long-range future.

In 1965 the amount paid in cash benefits will increase by an estimated \$1.5 billion without any increase in social security tax payments over the amount that would be paid under present law. In 1966 the estimated increase in benefit payments over the amount estimated under present law, including the benefits paid under the new hospital insurance program, will be about \$3.1 billion, while the additional amount collected in social security taxes is estimated to be about \$2.2 billion. In 1967 the increase in benefit payments is estimated to be about \$4.6 billion over the amount expected under present law, while the additional amount to be collected in social security taxes is estimated to be about \$3.7 billion.

The other factor limiting the effect of the higher social security taxes in counterbalancing the economic stimulus of the increase in benefits is the fact that while the beneficiaries who would receive the additional income generally must use all of their disposable income to meet their day-to-day living expenses, the workers and employers who would pay the additional taxes use only part of their disposable income for immediate consumption. As a result, even that part of the additional benefits paid out under the bill that is offset by higher social security taxes will tend to increase consumer demand.

While our main concern in enacting this bill then, is the welfare of the millions of American families who look to the social security program for protection against dependency and want when the worker's earnings are cut off by retirement, disability, or death, a side effect of its enactment will be to strengthen the American economy. The bill will not only add to the social security program's

long-range effect of providing a regular flow of consumer demand among the aged, the disabled, the widowed, and orphaned of the Nation, but will also provide an immediate stimulus to the economy that will help us sustain our economic growth in the next several years.

It is important to stress these facts, because this is not an entire drain on the Treasury of the United States. This money is going into the economy. The Government will reach back and get part of the money and keep the money in circulation, which will keep our economy going, while taking care of the needs of our aged.

Mr. MILLS. Mr. Chairman, I yield such time as he may require to the distinguished gentleman from Ohio (Mr. SECREST).

Mr. SECREST. Mr. Chairman, I believe this bill, H.R. 6675, which has replaced the old so-called medicare bill, is one of the greatest pieces of legislation to come before the Congress in this century.

I am confident that this bill, designed to benefit millions of our citizens 65 years of age and over, will also benefit doctors, hospitals, and insurance companies. In my opinion, this bill will greatly accelerate the sale of additional hospital and medical insurance just as record sales of retirement insurance followed enactment of the original social security law.

I was in Congress and supported the original social security legislation in 1935. I supported and voted in 1950 for the proposal to place independent businessmen under social security. I was a leader in the fight in 1954 to get farmers the same benefits under social security that had for years been enjoyed by factory workers and others.

With such a longtime interest in this legislation, I am anxious that Congress do nothing that will endanger the soundness of the social security system. I want to be sure that a young man 20 years of age today will find the system as solid as the Rock of Gibraltar when he is ready to retire many years from now.

The Ways and Means Committee made a wonderful decision when it let the regular social security system alone and set up a separate tax and trust fund for the hospital insurance provided under this bill. Hospital insurance stands on its own two feet wholly apart from the regular retirement provisions of the long-existing Social Security Act. This is the way it should be. Neither program can weaken the other. Both will be sound and dependable.

Under this bill, a new title is added to the Social Security Act providing for basic hospital care to be financed by a comparatively moderate contribution by employers and employees. For persons 65 and above, 60 days of inpatient services will be provided for each spell of illness. The patient pays the first \$40 of his hospital bill.

In addition to the regular hospital service, drugs and biologicals will be provided. Under this title of the bill, private duty nurses and the first 3 pints of blood are not furnished. For each

spell of illness, from 20 to 100 days of posthospital care in a nonhospital facility will be provided.

Outpatient hospital diagnostic services will be provided for a 20-day period. The patient will pay \$20 for each diagnostic study and the remainder will be paid under the basic hospital plan. After the patient returns home, the basic plan will pay for 100 visits to provide him posthospital care, home health services, including intermittent nursing care, therapy, and part-time services of a home health aid. This will include speech therapy for those whose illness results in impairment of speech. The cost of services under the basic hospital plan for people not under social security will be financed from general revenues.

In addition to hospital care, the bill establishes a voluntary supplemental plan to provide payment to physicians for services rendered in the hospital, the office, or the home. Such payments will include diagnostic X-ray and laboratory tests, electrocardiograms, basal metabolism readings, and X-ray, radium, and radioactive isotope therapy. Prescriptions are not covered but drugs furnished by the doctor are provided.

When used in the patient's home, this section of the bill will pay rental for iron lungs, oxygen tents, hospital beds, and wheelchairs. It will also provide for artificial legs, arms, eyes, and so forth. Under this plan, 80 percent of medical costs will be paid for each calendar year after payment by the patient of the first \$50 of his total yearly medical bills. The cost of this voluntary supplemental plan will be \$3 per month for each individual who enrolls. For those under social security or railroad retirement, this amount will be deducted from his regular check. A person 65 or over will be able to deduct all medical and hospital expenses in excess of 3 percent of his gross income. This will result in limited recovery of the Government's premium contributions.

The bill provides for a 7-percent increase in all social security payments, and in every case will be sufficient to pay the individual's cost for his insurance. The Federal Government, from the general treasury, will pay an additional \$3 premium on each person who signs up for the insurance. It is expected that insurance under this voluntary plan will be furnished by Blue Cross and private insurance companies. Persons not covered by social security could make periodic payments of their half of the premium. The whole package is somewhat similar to that now provided by law for employees of the Federal Government.

In addition to furnishing hospital care and providing substantial payment toward medical bills, this legislation contains many other excellent features.

For instance, under the Kerr-Mills Act, expanded medical assistance is provided for aged persons who are indigent and help is extended to needy dependent children, blind persons, and totally and permanently disabled persons who qualify for assistance under the Act.

Each indigent old person will be judged by his own resources. The income of his children will no longer bar him from benefits. Ohio is not now under the Kerr-Mills Act, but each State is given until June 30, 1967, to qualify for this vastly expanded program which includes in-patient hospital services, out-patient hospital services, laboratory and X-ray services, skilled nursing home services, and physicians services either in a physician's office, the patient's home, or a skilled nursing home.

The whole Kerr-Mills program is vastly expanded by increasing the Federal Government's contribution by some \$200 million each year. The bill also expands the program for maternal and child health, crippled children and health care for needy children. It also includes grants for mental retardation planning.

In this bill many excellent amendments are made to the existing Social Security Act. In addition to the 7-percent increase in social security payments, the maximum family benefits under social security will be gradually raised from the present \$254 limit to \$368 effective in 1971.

Under present law, payment for children's insurance ceases at age 18. This bill raises the age to 22 providing the child is attending public or accredited schools, including a vocational school or a college, as a full-time student. The new age limit of 22 also applies to children of deceased retired or disabled workers. It is estimated that 295,000 children will benefit under this provision in 1965.

Another amendment will permit widows to receive retirement benefits at age 60 at slightly reduced rates. It is estimated that 185,000 widows will take advantage of this provision in 1966.

Another excellent amendment applies to the disability program. Under present law, a worker cannot retire unless his disability is expected to result in death or to be of long, continued and indefinite duration. This new bill would make an insured worker eligible for disability benefits if he has been totally disabled throughout a continuous period of 6 calendar months. Benefits will be payable for the last month of the 6 months' waiting period and for subsequent months until recovery from the disability. It is estimated that 155,000 workers and individuals will benefit from this amendment.

Also, under present law, no worker can retire under social security without a minimum of six quarters of coverage. The new law will permit a person 72 years of age or over to qualify for social security with three quarters of coverage acquired at any time since the beginning of the program in 1937.

This bill also provides that a widow who will be 72 or over in 1966 will be eligible for social security payments if her husband died or reached the age of 65 in 1954 or earlier. This liberalization will benefit many widows.

The bill also liberalizes the social security earned income limitation. For example, a person retired under social security will be permitted to earn \$2,400

per year and lose only \$600 annually in his social security pay. This is far more liberal than the present law.

Another provision deals with divorced women. Too often a divorcee will leave a wife of long standing without social security retirement. This bill will provide retirement to a divorced wife at the age of 62 if she was married to the husband at least 20 years before the date of the divorce. It also provides that a wife's benefits will not terminate when a woman and her husband are divorced if the marriage has been in effect for 30 years.

The bill has another good provision for the benefit of small farmers with relatively low incomes. If a farmer has a gross income of \$2,400 or less, he can pay his social security tax on two-thirds of his gross earnings rather than his net earnings. This will enable the small farmer to retire with a larger social security pension.

The bill also exempts self-employed members of the Amish and other religious sects from payment of social security taxes upon application and by signing a waiver of benefit rights.

Self-employed physicians and interns are brought under coverage of the social security act for the first time.

Long ago I stated that I could not support a bill that would place doctors on the Federal payroll or take from a patient the right to pick his own doctor and his own hospital. This bill in no way violates these principles. The insurance from which doctors will receive their customary fee is voluntary and the traditional practice of medicine is not interfered with in any way. This is an excellent bill, and I have attempted to discuss the major provisions in it.

We have come a long way since the days when the old and sick, who could not keep pace with the wandering tribe, were given a 3 days' supply of food and left on the trail to die. Never in the history of mankind has a generation heard so clearly and responded so magnificently to the commandment to "Honor thy father and thy mother, as the Lord thy God hath commanded thee; that thy days may be prolonged, and that it may go well with thee, in the land which the Lord thy God giveth thee."

For the older people of this Nation and many, many others this bill is a sonic boom of decency, hope, and respect. Never have I voted for any legislation with more pride and satisfaction.

Mr. MILLS. Mr. Chairman, I move that the Committee do now rise.

The motion was agreed to.

Accordingly, the Committee rose; and the Speaker having resumed the chair, Mr. DICKIN, Chairman of the Committee of the Whole House on the State of the Union, reported that that Committee having had under consideration the bill (H.R. 6675) "to provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the old-age, survivors, and disability insurance

system, to improve the Federal-State public assistance programs, and for other purposes," had come to no resolution thereon.

ADJOURNMENT TO 11 A.M. ON THURSDAY, APRIL 8

Mr. ALBERT. Mr. Speaker, I ask unanimous consent that when the House adjourns today it adjourn to meet at 11 o'clock tomorrow.

The SPEAKER. Is there objection to the request of the gentleman from Oklahoma?

There was no objection.

FURTHER MESSAGE FROM THE SENATE

A further message from the Senate by Mr. Arrington, one of its clerks, announced that the Senate insists upon its amendments to the bill (H.R. 5721) entitled "An act to amend the Agricultural Adjustment Act of 1938, as amended, to provide for acreage-poundage marketing quotas for tobacco, to amend the tobacco price support provisions of the Agricultural Act of 1949, as amended, and for other purposes, disagreed to by the House; agrees to the conference asked by the House on the disagreeing votes of the two Houses thereon, and appoints Mr. ELLENDER, Mr. HOLLAND, Mr. TALMADGE, Mr. JORDAN of North Carolina, Mr. YOUNG of North Dakota, and Mr. COOPER to be the conferees on the part of the Senate.

APPRECIATION TO AMBASSADOR FROM JAPAN FOR OFFER TO PRE- SENT NATION'S CAPITAL WITH 4,000 CHERRY TREES

Mr. PICKLE. Mr. Speaker, I ask unanimous consent to address the House for 1 minute and to revise and extend my remarks.

The SPEAKER. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. PICKLE. Mr. Speaker, my purpose in rising is to extend a warm thanks and appreciation to the Ambassador from Japan for his kind offer to present our Nation's Capital with another beautiful forest of some 4,000 cherry trees to border the Washington Monument.

I know that we speak the sentiments of all Americans in expressing our deepest gratitude to Ambassador Ryuji Takeuchi for this friendly gesture he has made in behalf of Premier Eisaku Sato and all the people of Japan.

Through the years the beautiful blossoms of the cherry trees that bloom so magnificently at this time of the year have greatly enhanced the beauty of our Nation's grand Mall. No shrine about us so beautifully symbolizes the ever-growing friendship of Japan and the United States.

It is most fitting and appropriate, too, that we take this opportunity to extend a special thanks and commendation to our First Lady, Mrs. Lyndon Johnson,

for the personal efforts she has undertaken in this project to magnify the magnificent beauty of the Mall.

The proposed planting of these additional cherry trees will most certainly serve to cement further the friendly relations between all Americans and the people of the Rising Sun.

I know that every Member of the House joins me in this sincere expression of heartfelt gratitude.

And, Mr. Speaker, may I also state that it has been a personal privilege for me to visit with Ambassador Takeuchi and his lovely wife, and I have been enriched and impressed with their dedication and support of ideals so common to those democratic principles that made our two countries great.

LAUNCHING OF COMSAT'S EARLY BIRD

Mr. HARRIS. Mr. Speaker, I ask unanimous consent to address the House for 1 minute and to revise and extend my remarks.

The SPEAKER. Is there objection to the request of the gentleman from Arkansas?

There was no objection.

Mr. HARRIS. Mr. Speaker, yesterday afternoon I was privileged to witness by closed-circuit television at the headquarters of the Communications Satellite Corp. here in Washington, the launching of Comsat's Early Bird. The launching of this communications satellite constitutes a milestone in the development of a worldwide satellite communications system contemplated by the Communications Satellite Act of 1962.

Many of the Members of this House will remember the policy battle which preceded the enactment of this legislation. You may recall that this battle was fought so heatedly in the other body that a prolonged discussion—sometimes referred to as filibuster—ensued with regard to the policies to be adopted by the Congress.

President Kennedy approved this legislation on August 31, 1962. It provides for a very unusual private corporation created by the Congress, owned 50-50 by communications common carriers and public stockholders. Under this legislation, the President of the United States nominates three directors to sit with the other directors elected by the stockholders. In other words, the legislation provides for unusual teamwork between the private and public sector in this country.

In order to make a worldwide satellite communications system a reality, teamwork, however, is required not only here at home but also among all nations interested in participating in this worldwide communications system. In order to achieve this objective first of all, it was necessary to secure the allocation of radio frequencies to be used for communications satellite purposes. This was achieved by the Space Radio Communications Conference held in Geneva in the fall of 1963 and I had the great honor of serving as a member of the U.S. delegation to that Conference.

Addendum 14

B. Income Maintenance Provisions

Aid to Families With Dependent Children (AFDC) Provisions

1. Parents and Siblings of Dependent Child Included in Filing Unit (sec. 197 of the bill)

Present Law

There is no requirement in present law that parents and all siblings be included in the AFDC filing unit. Families applying for assistance may exclude from the filing unit certain family members who have income which might reduce the family benefit. For example, a family might choose to exclude a child who is receiving social security or child support payments, if the payments would reduce the family's benefits by an amount greater than the amount payable on behalf of the child. In addition, a mother who is a minor is excluded if she is supported by her parents. However, if she has no income of her own which may be attributed to her child, the child may qualify for assistance as a one-person unit, and receive proportionately more in assistance than it would receive as part of a two-person unit. The income of the minor parent's parents is not considered in determining the eligibility of the child.

Explanation of Provision

The amendment approved by the committee would require States to include in the filing unit the parents and all dependent minor siblings (except SSI recipients and any stepbrothers and stepsisters) living with a child who applies for or receives AFDC. In addition, if a minor who is living in the same home as his parents applies for aid as the parent of a needy child, the income of the minor's parents would be counted as available to the filing unit. The rules that would be used in determining the amount of available income would be the same as are currently used in counting the income of stepparents.

This change will end the present practice whereby families exclude members with income in order to maximize family benefits, and will ensure that the income of family members who live together and share expenses is recognized and counted as available to the family as a whole. A similar provision was approved by the committee last year, but was dropped in conference with the House.

Effective Date

October 1, 1983.

Addendum 15

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Social Security Administration

45 CFR Parts 205, 206, 232, 233, 234, 235, 236 and 238

Aid to Families With Dependent Children

Agency: Social Security Administration, HHS.

Action: Final rule.

SUMMARY: These final regulations implement changes made in the Aid to Families With Dependent Children (AFDC) program by the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97-35). The statutory changes are generally effective October 1, 1981. The key provisions fall within four basic areas, as follows:

(1) Enable families to move from welfare dependency to job-based self-sufficiency by providing States flexibility to develop work alternatives, including community work experience, provision of jobs instead of welfare, and by letting each State agency, if it so requests, demonstrate its own work incentive (WIN) program.

(2) Target assistance to the neediest by:

- Setting a total income limit of 180 percent of the State's need standard; and
- Standardizing and changing the sequence of the earned income disregards by allowing a standard \$75 disregard, actual child care costs up to \$160 per child, then \$30, then one-third of the remainder. The \$30 and one-third disregards will be applied only to the first 4 consecutive months in which they occur.

(3) In calculating need, count existing sources of income which are available to families but which were previously excluded by:

- Counting the income of a stepparent, after appropriate disregards, to determine the need of stepchild(ren) with whom he or she is living;
- Allowing States to count the value of Food Stamps and housing subsidies an AFDC family receives to the extent this value is duplicated by money for food and housing in the AFDC payment;
- Assuming on an ongoing basis receipt of the advance earned income credit (EIC) for those eligible to receive it;
- Counting nonrecurring income in excess of the State's need standard as available to meet future needs; and
- Treating resources (excluding the home and a reasonably valued car,

and at State option certain basic items essential to day-to-day living) in excess of \$1,000 equity value (or a lower State-set limit) as available to meet needs, thereby making the family ineligible.

(4) Improve program administration through requiring:

- Retrospective accounting and monthly recipient reporting;
- Recovery of all overpayments and payment of underpayments to current recipients; and
- Elimination of payments to those eligible for amounts less than \$10.

Changes made by these final regulations are limited to the AFDC program and do not affect the adult financial assistance programs in the territories.

EFFECTIVE DATE: These final regulations interpret the statutory changes required by Pub. L. 97-35 and were effective on October 1, 1981, except § 233.20 which contains information collection requirements subject to OMB approval.

FOR FURTHER INFORMATION CONTACT: Mr. Dave Siegel, Transpoint Building, 2100 Second Street, SW, Washington, D.C. 20201, (202) 245-2141. 7697

SUPPLEMENTARY INFORMATION

Timing and Form of Regulations

On September 21, 1981, we published interim final regulations for the Aid to Families with Dependent Children Program. (See Volume 46 of the Federal Register, pages 46750-46773.) In accordance with section 2321 of Pub. L. 97-35, these interim final regulations were effective on October 1, 1981, except where the State welfare agency satisfactorily demonstrated to the Secretary that legal barriers under State law prevented its compliance on that date. In such case, the Secretary, after review, could waive the effective date for one or more provisions with legal impediments until no later than the first month beginning after the close of the next session (of any sort) of the State legislature.

Regulatory Burden

Regulatory Impact Analysis

These regulations may have an annual effect on the economy of more than \$100 million. They may, therefore, be "major rules" as defined in Executive Order 12291, and require a regulatory impact analysis. Such analysis must contain a description of potential benefits and costs and net benefits of the rule (including those that cannot be put into monetary terms) and a description of alternative approaches and their potential costs and benefits. For the

reasons stated below, we have not written a separate analysis but instead have incorporated it into the preamble on a section-by-section basis.

The statutory changes which these regulations implement are projected to save the Federal government more than \$6 billion, and State and local governments more than \$5 billion, over the next five years. These savings arise primarily from retargeting scarce resources on those most in need and restricting eligibility to the truly needy.

These reforms will have effects both on AFDC recipients and on the economy as a whole. Their aim is fair allocation of scarce resources among the most needy; cost savings through more efficient program administration, and increased opportunities for work that will be of value both to the recipients and their communities. These statutory changes represent, in the best judgment of the legislative and executive branches of the Federal government, the kinds of reductions of cost and retargeting of benefits that will be the most productive for both recipients and taxpayers.

To effect these savings, the statute contains numerous provisions affecting the AFDC program. The provisions with the greatest fiscal effects on Federal and State budgets and on recipients leave little regulatory latitude. For example, receipt of the \$30 and one-third disregard is statutorily limited to four consecutive months, work expense deductions are standardized at \$75 for full-time employment.

For the most part, therefore, the economic effects of these changes are not created or caused by these regulations. There are, however, several provisions of these regulations which result in substantial costs. Although these costs may not meet the criteria for a major rule, we have voluntarily prepared a regulatory impact analysis.

Because of the above considerations, this regulatory impact analysis is limited in scope. For purposes of the regulatory impact analysis, there were two areas in the legislation in which there are both regulatory latitude and the effects of adopting different options could significantly impact on costs and benefits—Determination of Resources and the Community Work Experience Program. We have focused the regulatory impact analysis on the major decisions which were made in these two areas of the regulation. Overall economic effects of adopting different alternatives are small in comparison to the projected economic effects of the statutory changes as a whole. Furthermore, the available information

Addendum 16

Mr. BAKER Madam President, I yield the floor.

Mr. DOLE Let me assure the Senate if things go as we hope they will, there will not be any need for cloture. I do not have any desire to file cloture. I do not think we have in any past tax bill that I have managed on the Senate floor. What we are concerned about is that last year, on the debt ceiling bill, we had amendments on Jordanian arms sales, on Lebanon, and perhaps a total of eight or nine foreign policy amendments. I know there are others floating around.

As long as we are presented with germane amendments and we have an opportunity to dispose of them by adoption or tabling or whatever, then we are not going to be in favor of filing cloture. But I do hope we understand we have some responsibility to take some deficit reduction action.

I know this is a large bill, \$48 billion in revenue changes, \$23 billion in spending changes. There are areas like IDB's and others that will need considerable time to discuss. I am willing to assure both leaders that we are not going to file cloture today or tomorrow. If things go along well on Wednesday and we are making progress, there is not much need to do it then, either. If, in fact, we are getting a lot of nongermane amendments coming out of the woodwork, perhaps then the leaders on both sides would help us and file a cloture motion.

Mr. BYRD. Mr. President, will the distinguished Senator yield?

Mr. DOLE Yes, I yield.

Mr. BYRD. Mr. President, I do not support the kind of amendments to which the distinguished Senator from Kansas has alluded. I certainly have no interest in the calling up of amendments that deal with the foreign policy of this country or any other subject area that is clearly out of the direct or indirect line of germaneness as it relates to this amendment. It might be that a Senator would want to call up some amendment that would, otherwise than by taxes, affect the budget or affect appropriations or whatever, I do not know.

But as to amendments that would be so far out, such as foreign policy amendments, I have no desire to see those amendments called up. And if the situation were to get to that point, I would be constrained to support cloture. I simply want Senators on both sides of the aisle to have adequate opportunity with their staffs to study this amendment and to know what is in it as best they can. I dare say that I will be one of the Senators who, in the final analysis, will be voting on this amendment and will not know exactly what is in it. I would like for any Senator other than a Senator on the Finance Committee who knows what is in this massive tax amendment to stand and say so now or later this afternoon; I may be seeking the advice of such Senator on the amendment. I would like to know for example, what

happens to medicare, what happens to health services by virtue of this tax amendment.

So I am assured by what the distinguished Senator from Kansas has said, and I believe I understood him to say that as long as he clearly sees that amendments called up are legitimate, reasonable, germane or even nongermane, if they directly or indirectly affect this subject area, he will not rush to offer cloture. I believe him when he says that. I have only raised the issue today because, as Senator STENNIS has indicated, I heard some of the same rumors around. I am satisfied with the statement by the distinguished Senator and therefore, will not offer any objection to dispensing with the reading of the finance committee amendment at this time.

Mr. DOLE. I thank the minority leader, and again let me indicate that we are pleased we are this far along in the process. We would like to complete this bill this week, if not next week, but that is something to be determined by the leadership, not the managers of the bill. Obviously, if we are making progress, this Senator has no intention of filing cloture for the sake of filing cloture. I urge my colleagues to offer germane amendments and avoid the nongermane amendments, though there may be some who do not feel compelled to do that.

AMENDMENT NO. 2903

Mr. DOLE. If there is no objection—at the close of business on Thursday, the amendment was sent to the desk and ordered printed in the Record—I would not call up that amendment.

The PRESIDING OFFICER. The amendment will be stated.

The legislative clerk read as follows:

The Senator from Kansas (Mr. Dole), for himself and Mr. Lora, proposes an amendment numbered 2902.

Mr. DOLE. Madam President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The text of the amendment is printed in the Record of April 8, 1984, at page S3921.

Mr. DOLE. As the distinguished minority leader indicated, this amendment is some 1,300 pages long. It would take the better part of 2 days to read. Copies are available. The explanation of the amendment has been available since last Tuesday.

Madam President, we have before us the amendment from the Finance Committee. As indicated, it is a very lengthy amendment. It is a very important amendment, and I think it really indicates that we are now ready to go to work on the deficit. Maybe it is not as much as some would like, but it is part of the so-called down payment that many Members on both sides have talked about.

It may not be the perfect way to proceed. It may not be large enough in the eyes of some, but it is a substantial

amount. Seventy-three billion dollars from the Finance Committee would indicate that at least, if we can adopt this first installment on the downpayment, that we will have made some progress. We would then move on to another part of the procedure, so that we would have an entire package in the neighborhood of \$145 to \$150 billion in deficit reduction over the next 3 years.

I do not know of any Member of this body who is for big deficits. I do not know of any Member of the other body who is for big deficits. It seems to me that we have had enough speech-making about deficits, so I am pleased that we are starting on the legislative process, which is taking place, finally, at this very moment.

I have watched with interest the House proceedings as they voted up and down seven or eight budget resolutions. I remind my colleagues that the House budget resolutions have no impact on the deficit at all. Anybody can offer a budget resolution, and whether it succeeds or fails makes very little difference. We need legislative action which has an impact on the deficit. Resolutions do not force the kinds of tough decisions needed to cut spending and raise revenue.

I will not recite the familiar reasons why we must control the budget: first, because it would take too long; and, second, I have a bad cold.

I read in the morning paper that car loans are now being impacted by the increase in the interest rates, that home mortgage loan rates are going to be increased by the increase in the prime interest rates, and this may have an adverse impact on the housing industry by midsummer.

I have been in my State for the last 3 days, talking with farmers and others who indicated that cattle operating loans are going up a bit. They reiterated their position that they believe that the best farm bill we could pass would be one to lower the interest rates. That is the view of some farmers.

So I think it is fairly obvious that the most threatening cloud over this recovery—and we are in a recovery—is the big deficit.

I assume that, during the debate, some Members will assign blame to different administrations or whatever, but the reality is that Congress has some responsibility—some responsibility in creating the deficit, and certainly some responsibility in reducing the deficit.

I wish to indicate what happened in the Senate Finance Committee. I am not boasting about our committee, but we spent more than 30 days working at this big bill; and I thank the distinguished minority leader for suggesting that some of us may understand it all. I would not want to bet the store on that proposition. We understand a little about each provision. Senator

Long may understand it all, but the chairman does not.

When we completed action, even though we had some differences on the various parts, the vote on the final product was 20 to 0, and we have only 20 members on the committee—11 Republicans and 9 Democrats. Every member of the Finance Committee voted for the product. It is my hope that the members of the Finance Committee will form a nucleus for support of the bill to help us retain this package.

That does not suggest that there might be good amendments lurking out there that should not be adopted; but if they lose revenue, it is going to be difficult for us to accept those amendments, unless there is some offset. Then, perhaps we can work out an accommodation.

I am told that there may be 30 amendments floating around, which is not too many for a tax bill. The Senator from Ohio advised me that he has about that many but that he is willing to move with some dispatch on his amendments.

So the point I wish to make is that we understand that the stakes are high. We believe that if we put together something that finally passes Congress and reaches the President's desk—something in the neighborhood of \$140 billion to \$160 billion or \$170 billion over a 3-year period—it will have a positive impact on the markets, and we hope it will have an impact on interest rates. I am not an expert, but at least it should have some impact on interest rates, and it will be an indication to the American people—Democrats and Republicans or independents or whatever—that we are not suffering from total paralysis in Congress.

I have said on this floor before that I hope the administration would be a little more aggressive in their efforts for deficit reduction. I am very pleased to say now—not because of anything I have said—that the President is fully on board, that virtually every provision in the tax bill, as I understand it, has the blessing of the administration; that everything done in the Finance Committee, so far as spending reduction is concerned, has the blessing of the administration.

In fact, we were asked that question by different members as we went through the bill: "Is this provision supported by the President or supported by the administration?" I think I can safely say—there may be a few exceptions—that nearly every provision is supported by the administration.

We did make changes in some of the health programs. We considered spending reductions in our committee before we considered revenue changes, because many members indicated that they would not vote for revenue changes unless they were certain we would do something on the spending side. So we did something on the spending side—not as much as some would like, maybe a little more than

others would like. But we had a unanimous vote on most of these provisions.

Madam President, we continue to hear a lot of rhetoric in this body, and on the campaign trail, about the problem of the deficit. It is easy to get agreement that we need a serious effort to begin closing the budget gap. But, as the members of the Finance Committee have found over the past few months, it is not so easy when you get down to specific policies and programs. Speeches lamenting our budget problem may be fashionable, but they do not take one dime of the deficit.

The fact is that it is easy to vote for resolutions and issue press releases. But neither of those things force the kind of tough decisions needed to cut spending and raise revenue. But with the legislation now before us, we finally find ourselves in a position to do something about those deficits we regularly decry.

I will not recite the familiar reasons why we must get control of the budget. Senators are by now painfully aware of the damage that yearly \$200 billion deficits would inflict on our recovering economy. Instead, I pose just one question: Is there a Senator, Congressman, business, or labor leader, economist, or President who would not feel better about our economic future if the deficit was lower?

The answer is obvious. The most threatening cloud on the economic horizon is the deficit. Enacting a significant deficit-reduction package would cause consumer and business confidence to soar. I offer as proof the tremendous response to the passage of TEFRA in 1982. This display of congressional responsibility caused interest rates to tumble and set off a stock market rally that pushed up equity nearly 60 percent in a year. TEFRA helped set the stage for a vigorous economic expansion that has brought the unemployment rate down by 2.9 percentage points: The strongest labor market recovery since 1948.

The stakes this year are different, but no less important. TEFRA helped to kick the economy off dead center; this year our goal is to remove the major impediment to a prolonged, balanced, noninflationary recovery.

No one in this Chamber needs convincing: We all are for lower deficits. The question is how to get there. To bring it off will require courage, skill, and compromise.

We now have a chance to enact a package that is balanced and fair. The goal—alicing \$150 billion off the cumulative deficit of \$500 to \$600 billion we anticipate over the next 3 years—may in fact be too modest. But it is a goal we can reach, and it is far more than many believed we would do just a few months ago. Even if we do not touch off a ticker-tape parade down Wall Street, at least we can dispel some of the gloom that has been plaguing the financial markets.

Make no mistake, this is only a downpayment on future deficit reduc-

tion. By enacting this package in an election year, Congress and the administration will be making a good faith commitment that we will do whatever is necessary to cut deficits and keep the recovery alive in 1985.

We all wish this package were larger. But we have to be realistic. Any amendment to increase revenues significantly above the level that the Finance and Ways and Means Committees have reported likely would attract a veto. And while I would favor deeper spending cuts, the votes just are not there in this election year.

So this is a balanced, but fragile package. The Finance Committee provisions would share \$72.5 billion from deficits through fiscal year 1987, including \$24.5 billion in outlay savings and \$48 billion in revenue gains. In addition, the work of other committees contained in this bill would reduce outlays by another \$9.8 billion.

It seems to this Senator that is worth the effort. And once this bill is enacted, I am willing to support any responsible effort to do more to lower deficits.

HEALTH PROGRAMS

Madam President, the spending reductions proposed by the committee include measures already pending in S. 2062, with some modifications agreed to this year, plus some new proposals. For the most part, they affect medicare, the largest health program under the jurisdiction of the committee. In considering spending reductions the committee was concerned with the rate of growth in the medicare program.

The administration estimates that current law benefit and administrative outlays under medicare will be \$76.8 billion in fiscal year 1985.

I might add that that is a program we started out, I think, at \$4.7 billion in 1967.

Of this amount, benefit payments will account for \$74.8 billion. This represents an increase of 15.9 percent over fiscal year 1984 benefit payments of \$64.6 billion.

Both in terms of total outlays and total benefits per enrollee receiving reimbursement, the rate of growth for part B of medicare, the "supplementary medical insurance program," continues to exceed that for part A, the hospital insurance program. The increase in part A benefits per enrollee receiving care are 88 percent higher than the projected fiscal year 1985 medical care component of the CPI, but the increase in part B benefits are 100 percent higher.

In medicare the spending provisions primarily address part B, the supplementary medical insurance (SMI) program. In fiscal year 1984, the general fund of the U.S. Treasury will have to contribute an estimated \$16.8 billion to the SMI trust fund in order to keep it solvent. That general fund obligation is expected to grow by 13.3 percent to \$19 billion in fiscal year 1985.

The major provision affecting SMI would hold reasonable charges of all physicians to prior year levels for a 12-month period, followed by a limited fee freeze imposed on those physicians who do not accept assignment over the next 12 months.

Along with the freeze, a voluntary participating system would be established for medicare. By agreeing to accepting assignment in advance for all services for all medicare patients, participating physicians would agree to accept the medicare determined allowance as payment in full except for cost-sharing amounts. Nonparticipating physicians could continue to accept or reject assignment on a claim-by-claim basis.

This limit on physician payments under part B is designed to moderate the double digit growth that has occurred in physician fees.

They have gone up, as I recall, an average of about 11 percent per year.

We have worked on this, I might suggest, with the American Medical Association, and with other physician groups. They have committed themselves to helping us work out some way to dissuade physicians from passing on the costs to beneficiaries which would not be a very happy result.

I might say there is a feature piece in this week's National Journal, which came to our office this morning, discussing physicians' fees and how we are going to control these in the out-years.

Madam President, we would like to know that our actions effectively limit any shifting of cost savings intended for physicians onto beneficiaries. While this Senator understands that it is not feasible to monitor each individual physician's response, we do expect the Secretary to very closely monitor any fees. While some physicians may want to accept fewer medicare assignments as a result of this proposal, the committee has included provisions to offer incentives for physicians to take assignment and better inform beneficiaries as to which physicians do so.

For example, the Secretary would establish electronic billing transmission lines and simplified billing procedures for beneficiaries with approved medigap or group health insurance coverage. In addition, the Secretary would be required to publish lists indicating the assignment experience for each physician and establish toll-free hot lines for the same purpose. This should help beneficiaries to better select physicians who take assignment.

The committee proposals to increase the financial stake of beneficiaries should help bring cost sharing more in line with the cost of the benefits provided under part B. In fiscal year 1984 each premium dollar being paid by beneficiaries is being matched by \$3.40 from the U.S. Treasury to keep the SMI program solvent. Without the committee's premium provision, by fiscal year 1990 the U.S. Treasury will have to match each beneficiary dollar

with \$4.60 to maintain the trust fund solvency of SMI.

Madam President, we are aware of the pending insolvency in the hospital insurance trust fund, part A of medicare. Congress has acted to restrain growth of hospital costs, the largest single component of part A's cost, but that will not be enough. To bring the part A trust fund into actuarial balance will require a great deal more effort by the committee. Our proposals cannot restore the part A trust fund to solvency, but they are a necessary first step.

Hospital insurance, part A, benefits for fiscal year 1985 are projected to be \$50.7 billion, \$6.6 billion or 15 percent higher than fiscal year 1984. Inpatient hospital services will account for 95 percent of part A benefit payments.

The major provision in our bill which reduces spending, limits the rate of increase in payment to hospitals. We recognize the tremendous improvement that has been made in the health status of the elderly by medicare, and in considering spending reductions we sought to protect one of the most important programs the Nation offers its citizens.

Our bill also makes a few changes in the medicaid program. The administration project total Federal-State medicaid costs for fiscal year 1985 at a \$41.4 billion. The Federal share is \$23.2 billion. This is a 14.5-percent increase over fiscal year 1984, attributable in part to the discontinuation of the current 4.5-percent reduction in Federal payments.

The principal medicaid change is to extend the current reduction in Federal matching payments to the States for 3 more years. The reduction would be set at 3 rather than 4.5 percent, but offsets which allow the States to decrease the Federal reduction would be permitted as under current law. The committee also recommends outlay increases for children and pregnant women through the medicaid program and maternal and child health block grant, as well as increased medicaid spending ceilings for Puerto Rico and the territories.

Madam President, given the size of the Federal deficit, the health program proposals recommended by the committee do make sensible spending reductions but they also reflect the committee's concern for directing spending to where it is most needed, including modest increases where appropriate.

So I suggest that the things that we did do in this health care field were minimal indeed.

And I also suggest that we had good bipartisan support for all of those proposals.

INCOME MAINTENANCE PROGRAMS

The Finance Committee carefully reviewed the entitlement programs which fall within the income maintenance area. A limited number of provisions were adopted by the committee dealing with the aid to families with

dependent children (AFDC) program and the supplemental security income (SSI) program. The provisions approved generally deal with overlapping benefits and administrative simplification and efficiency.

The two AFDC provisions with the greatest budget impact are the requirement for a standard AFDC assistance filing unity and the requirement that a minor AFDC parent must live with her own parents when possible. Both of these provisions were adopted by the Finance Committee and the Senate last year, but were dropped in conference with the House. The changes are supported by the American Public Welfare Association and were adopted by the committee without disagreement.

The other AFDC provisions and the single SSI provision are basically technical in nature, clarifying provisions in the law dealing with the earned income disregards the use of community work experience programs by Federal agencies and, in the SSI program, a clarification of the procedures to be used to recoup overpayments under that program. An amendment was adopted by the committee which would provide that the earnings of a full-time student would be excluded from consideration when determining a family's eligibility for AFDC benefits. This amendment has a negligible cost and conforms the treatment of student earnings with that established for earnings under the Job Training Partnership Act of 1982.

Madam President, the proposals approved by the Finance Committee in the income maintenance area were approved basically because they represented good policy. Some have deficit reduction impact, others have no impact or a negligible impact. We believe they represent worthwhile reforms in these important social welfare programs.

SOCIAL SECURITY PROVISIONS

The committee bill includes several changes in social security, most of which are of a technical nature. The one important exception is a provision which modifies the coverage of certain religious organizations under social security. As my colleagues will recall, the 1983 Social Security Amendments extended mandatory social security coverage to the employees of all non-profit organizations—including churches and other religious organizations. Rather than allowing voluntary participation, as under prior law, such organizations are now required to withhold the social security (FICA) tax from each employee and also pay the employer share of the tax. This provision has created a great deal of confusion and concern among members of the religious community, who saw this as a serious violation of the separation of church and state.

At the urging of Senator JENSEN, the Finance Committee held a public hearing on this issue in December. As

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House bill

Repeals the time limitations on these provisions and makes them a permanent part of the law. Effective October 1, 1984.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill but would extend the provisions until October 1, 1987.

24. Parents and Siblings of Dependent Child Included in Filing Unit

Present law

There is no requirement in present law that parents and all siblings be included in the AFDC filing unit. Families applying for assistance may exclude from the filing unit certain family members who have income which might reduce the family benefit. In addition, a mother who is a minor may be excluded if she is supported by her parents. However, if she has no income of her own which may be attributed to her child, the child may qualify for assistance as a one-person unit. The income of the minor parent's parents is not considered in determining the eligibility of the child.

House bill

No provision.

Senate amendment

Requires States to include in the filing unit the parents and all minor siblings living with a dependent child who applies for or receives AFDC. SSI recipients and stepbrothers and stepsisters are excluded from this requirement. In addition, if a minor who is living in the same home as his parents applies for aid as the parent of a needy child, the income of the minor's parents would be counted as available to the filing unit. The rules that would be used in determining the amount of available income would be the same as are currently used in counting the income of stepparents. Effective April 1, 1984.

Conference agreement

The conference agreement follows the Senate amendment with the following modification: a monthly disregard of \$50 of child support received by a family is established. The disregard is applied at eligibility determination and benefit calculation. The provision is effective October 1, 1984.

25. Households Headed by Minor Parents

Present law

A minor parent who has a child, and who leaves home, may apply for AFDC as a separate family unit. The income of the parents of the minor parent is not presumed to be available to the minor parent, because they are not sharing the household.

Addendum 18

Senate Print 98-169, Data and Materials for the Fiscal Year 1985
Finance Committee Report Under the Congressional Budget Act,
1007-1009 (March, 1984).

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8. Estimated cost to the Federal Government: The estimated costs to the federal government are shown in Table 1.

TABLE 1 — ESTIMATED COST TO THE FEDERAL GOVERNMENT

(In thousands of dollars)

| | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 |
|------------------------|-------|-------|-------|--------|--------|--------|
| BUDGET SPENDING | | | | | | |
| Section | | | | | | |
| Part 1 program | | | | | | |
| Budget authority | 0 | 0 | -204 | -204 | -1,507 | -2,249 |
| Outlays | 0 | 0 | -204 | -204 | -1,507 | -2,249 |
| Budget authority | | | | | | |
| Budget authority | 0 | -30 | 1 | 30 | 34 | 64 |
| Outlays | 0 | -345 | -230 | -255 | -200 | -205 |
| Budget authority | | | | | | |
| Budget authority | 0 | -30 | -17 | 12 | 30 | 30 |
| Outlays | 0 | -260 | -200 | -415 | -455 | -405 |
| Budget authority | | | | | | |
| Budget authority | -277 | -281 | -264 | -1,177 | -1,391 | -1,483 |
| Outlays | -40 | -750 | -910 | -1,970 | -1,730 | -1,410 |
| Budget authority | | | | | | |
| Budget authority | 0 | 30 | 30 | 30 | 135 | 170 |
| Outlays | 0 | -300 | -430 | -460 | -200 | -430 |
| Budget authority | | | | | | |
| Budget authority | -110 | -274 | -204 | -201 | 0 | 0 |
| Outlays | -70 | -255 | -270 | -400 | 0 | 0 |
| Budget authority | | | | | | |
| Budget authority | 0 | 5 | 30 | 30 | 65 | 75 |
| Outlays | 0 | -30 | -130 | -170 | -270 | -200 |
| Budget authority | | | | | | |
| Budget authority | -1 | -4 | -8 | -12 | -17 | -23 |
| Outlays | 20 | 20 | 20 | 40 | 60 | 80 |
| Budget authority | | | | | | |
| Budget authority | -27 | -37 | -77 | -70 | -30 | -30 |
| Outlays | -15 | -35 | -70 | -75 | -30 | -30 |
| Budget authority | | | | | | |
| Budget authority | 0 | -34 | -30 | -27 | -20 | -30 |
| Outlays | 0 | -35 | -35 | -30 | -30 | -30 |
| Budget authority | | | | | | |
| Budget authority | 0 | 0 | 35 | 25 | 30 | 30 |
| Outlays | 0 | -30 | -77 | -200 | -150 | -140 |
| Budget authority | | | | | | |
| Budget authority | (1) | (1) | (1) | 1 | 1 | 1 |
| Outlays | (1) | (1) | (1) | 1 | 1 | 1 |
| Budget authority | | | | | | |
| Budget authority | -11 | -11 | -11 | -12 | -13 | -14 |
| Outlays | -11 | -11 | -11 | -12 | -13 | -14 |
| Budget authority | | | | | | |
| Budget authority | -10 | -10 | -10 | -10 | -11 | -12 |
| Outlays | -10 | -10 | -10 | -10 | -11 | -12 |
| Budget authority | | | | | | |
| Budget authority | -10 | -10 | -10 | -10 | -11 | -12 |
| Outlays | -10 | -10 | -10 | -10 | -11 | -12 |
| Budget authority | | | | | | |
| Budget authority | 1,000 | 1,000 | 1,000 | 1,000 | 1,000 | 1,000 |
| Outlays | 1,000 | 1,000 | 1,000 | 1,000 | 1,000 | 1,000 |
| Budget authority | | | | | | |
| Budget authority | -100 | -100 | -100 | -100 | -100 | -100 |
| Outlays | -100 | -100 | -100 | -100 | -100 | -100 |
| Budget authority | | | | | | |
| Budget authority | -10 | -10 | -10 | -10 | -10 | -10 |
| Outlays | -10 | -10 | -10 | -10 | -10 | -10 |

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TABLE 1—ESTIMATED COST TO THE FEDERAL GOVERNMENT—Continued

(In kind per million of dollars)

| | 1954 | 1955 | 1956 | 1957 | 1958 | 1959 |
|---|------|------|------|------|------|------|
| Interest under contract to Puerto Rico | | | | | | |
| Budget authority | 20 | 20 | 20 | 20 | 20 | 20 |
| Outlays | 20 | 20 | 20 | 20 | 20 | 20 |
| Program costs | | | | | | |
| Budget authority | 0 | 11 | 12 | 13 | 14 | 16 |
| Outlays | 0 | 11 | 12 | 13 | 14 | 16 |
| Reimbursement of 50¢ and 67¢ | | | | | | |
| Budget authority | -3 | -6 | 0 | 1 | 1 | 1 |
| Outlays | -3 | -6 | 0 | 1 | 1 | 1 |
| Psychiatric hospital | | | | | | |
| Budget authority | 0 | 10 | 0 | 3 | 0 | 0 |
| Outlays | 0 | 10 | 0 | 3 | 0 | 0 |
| Other | | | | | | |
| Budget authority | -30 | -34 | -37 | -39 | 65 | 134 |
| Outlays | -30 | -34 | -37 | -39 | 65 | 134 |
| Block 1 effect on production | | | | | | |
| Budget authority | 0 | 223 | 310 | 235 | 241 | 274 |
| Outlays | 0 | 223 | 340 | 235 | 241 | 274 |
| Block 2 effect on production | | | | | | |
| Budget authority | 1 | 3 | 0 | 10 | 13 | 17 |
| Outlays | -13 | -17 | -20 | -24 | -25 | -26 |
| AFSC | | | | | | |
| Support living unit | | | | | | |
| AFSC | | | | | | |
| Budget authority | -20 | -136 | -140 | -145 | -150 | -156 |
| Outlays | -20 | -136 | -140 | -145 | -150 | -156 |
| Other—medical | | | | | | |
| Budget authority | 0 | 0 | 0 | 100 | 150 | 150 |
| Outlays | 0 | 0 | 0 | 100 | 150 | 150 |
| Heavy metal permit to use with parents | | | | | | |
| AFSC | | | | | | |
| Budget authority | -5 | -20 | -20 | -20 | -20 | -20 |
| Outlays | -5 | -20 | -20 | -20 | -20 | -20 |
| Other—medical | | | | | | |
| Budget authority | (1) | -5 | -5 | -5 | -5 | -5 |
| Outlays | (1) | -5 | -5 | -5 | -5 | -5 |
| Early closure of school meals | | | | | | |
| Budget authority | -5 | -20 | -20 | -20 | -20 | -20 |
| Outlays | -5 | -20 | -20 | -20 | -20 | -20 |
| Formal CWP work to Federal agencies | | | | | | |
| Budget authority | (1) | (1) | (1) | (1) | (1) | (1) |
| Outlays | (1) | (1) | (1) | (1) | (1) | (1) |
| Include school meals of children who are full-time | | | | | | |
| Students | | | | | | |
| Budget authority | (1) | (1) | (1) | (1) | (1) | (1) |
| Outlays | (1) | (1) | (1) | (1) | (1) | (1) |
| Other | | | | | | |
| Budget authority | (1) | -17 | -17 | -10 | -10 | -10 |
| Outlays | (1) | -17 | -17 | -10 | -10 | -10 |
| Other | | | | | | |
| Budget authority | -24 | -17 | -16 | -11 | -14 | -11 |
| Outlays | 0 | 0 | 0 | 0 | 0 | 0 |
| Other | | | | | | |
| Budget authority | 0 | 0 | -240 | -200 | -200 | -200 |
| Outlays | 0 | 0 | -240 | -200 | -200 | -200 |
| Other data—AFSC | | | | | | |
| Budget authority | 0 | 0 | -200 | -200 | -200 | -200 |

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TABLE 1—ESTIMATED COST TO THE FEDERAL GOVERNMENT—Continued

(In thousands of dollars)

| | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 |
|---|------|--------|--------|--------|--------|--------|
| Outlays | 0 | 0 | -200 | -200 | -700 | -900 |
| Revenue Treasury—Cash management | | | | | | |
| Outlays | 0 | 0 | -200 | -200 | 0 | 0 |
| Outlays | 0 | 0 | -200 | -200 | 0 | 0 |
| Public Health Service fee | | | | | | |
| Outlays | 0 | -205 | -222 | -267 | -267 | -264 |
| Outlays | 0 | -205 | -222 | -267 | -267 | -264 |
| Local income tax | | | | | | |
| Outlays | 0 | 0 | 170 | 170 | 110 | 100 |
| Outlays | 0 | 0 | 170 | 170 | 110 | 100 |
| Total direct spending | -437 | -1,045 | -2,020 | -2,064 | -710 | -1,017 |
| Outlays | -151 | -2,547 | -4,080 | -6,126 | -5,291 | -6,700 |
| Authorizations | | | | | | |
| Outlays and other health benefit programs | | | | | | |
| Outlays | 22 | 25 | 1 | -20 | -61 | -96 |
| Outlays | 22 | 25 | 1 | -20 | -61 | -96 |
| Outlays for education program | | | | | | |
| Outlays | 0 | 20 | 20 | 20 | 20 | 21 |
| Outlays | 0 | 7 | 15 | 21 | 25 | 20 |
| Food stamps | | | | | | |
| Outlays | 15 | 57 | 64 | 60 | 60 | 62 |
| Outlays | 15 | 57 | 64 | 60 | 60 | 62 |
| Total authorization | | | | | | |
| Outlays | 60 | 105 | 94 | 61 | 20 | -3 |
| Outlays | 60 | 80 | 81 | 66 | 40 | 13 |
| Total | | | | | | |
| Outlays and Treasury authority | -264 | -939 | -1,924 | -2,003 | -770 | -1,015 |
| Outlays | -163 | -2,547 | -4,170 | -6,070 | -5,251 | -6,707 |

* See the 1983.00

Basis of estimate

We have assumed an enactment date of May 1984 for the purpose of estimating provisions that would become effective upon enactment.

The authorization estimates are shown as changes from the CBO baseline. The estimates assume corresponding appropriation action.

The estimates are based on preliminary draft language and on Committee descriptions of the proposals. Since final language was not available, the estimates should be considered preliminary.

The estimates include the provisions in the spending title. Also included are spending estimates for provisions included in the tax title that have spending implications.

6 Estimated cost to State and local governments: The estimated change to State and local budgets result from several major provisions. The income verification proposal would result in state savings in AFDC, BSI, and Medicaid. Changing the AFDC filing unit would result in state savings in AFDC and state costs in Medicaid. Additional state Medicaid costs would also result from the extension of the Medicaid penalties. The net estimated cost to state and local budgets is shown below.

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Addendum 19

9. Eliminate mandatory utilization review.—The Administration budget proposes to eliminate the requirement for utilization review in hospitals and skilled nursing facilities. The Administration estimates that this proposal will reduce outlays for fiscal year 1984 by \$58 million.

10. Reduce reimbursement to home health agencies for durable medical equipment.—The Administration budget proposes to reimburse home health agencies for durable medical equipment at 80 percent (rather than 100 percent) of reasonable cost. The agencies would be permitted to bill beneficiaries for the remaining 20 percent. The Administration estimates that this proposal will reduce outlays for fiscal year 1984 by \$15 million.

11. Competitive procurement of laboratory services, durable medical equipment and other medical supplies.—The Administration budget proposes to employ competitive purchasing procedures for the procurement of laboratory services, durable medical equipment, and other medical supplies. The Administration estimates the proposal will reduce outlays for fiscal year 1984 by \$9 million.

12. Eliminate waiver of provider liability for uncovered services.—The Administration budget proposes to eliminate the waiver of liability provision under which payment is made for certain uncovered or medically unnecessary care if the institution could not have known payment would be disallowed. The Administration estimates that this provision will reduce outlays for fiscal year 1984 by \$10 million.

13. Program management.—The Administration budget proposes several initiatives including changing the basis for processing Medicare hospital claims, eliminate the end-stage renal disease (ESRD) program networks and eliminate a separate Part B contract carrier for the railroad retirement board. The Administration estimates that the claims processing provision will reduce outlays for fiscal year 1984 by \$3 million; the elimination of ESRD networks will reduce outlays for fiscal year 1984 by \$4.5 million; and the provision relating to the railroad retirement board will reduce outlays by \$1.5 million.

14. Increased revenues for hospital insurance.—The Administration budget proposes a number of tax law changes which will result in increased social security tax revenues into the Health Insurance trust fund. These include taxing employee health benefits, applying social security tax to nonprofit organizations, and prohibiting State and local government agencies from dropping out of the Social Security system. The Administration estimates that these proposals will increase revenues to the Hospital Insurance Trust Fund by \$322 million in fiscal year 1984.

MEDICAID

The Administration's fiscal year 1984 budget contains several legislative and one regulatory initiative designed to achieve a reduction of \$7 million in fiscal year 1983 and \$293 million in fiscal year 1984.

Legislative Initiatives

1. Required Cost-Sharing by Medicaid Recipients.—The Administration budget would mandate the imposition of the following co-payment amounts:

- For the categorically needy, \$1 per visit for physician, clinic, and hospital outpatient department services;
- For the medically needy, \$1.50 per visit for physician, clinic, and outpatient department services;
- For the categorically needy, \$1 per day for inpatient hospital services;
- For the medically needy, \$2 per day for inpatient hospital services.

The Administration estimates that this proposal will reduce Federal outlays by \$249 million in fiscal year 1984.

2. Improve third-party collections.—The Administration budget proposes to require, as a condition of medicaid eligibility, that an applicant assign his or her health insurance rights to the State medicaid agency. The Administration estimates that this proposal will reduce outlays in fiscal year 1984 by \$6 million.

3. Simplified handling of cross-over claims.—The Administration budget proposes to require that medicare/medicaid claims on behalf of individuals dually eligible for medicare and medicaid, be processed a single time by the medicare carrier. The carrier would make the payment to the provider; the State medicaid agency would make the appropriate payment to the medicare carrier. The Administration estimates that this proposal will reduce outlays for fiscal year 1984 by \$1 million.

4. Extend reduction in Federal payments.—The Administration budget proposes to extend indefinitely the existing provisions relating to reductions and offsets in Federal matching payments over the fiscal year 1982-1984 period. The reduction would be 3 percent for fiscal year 1985 and beyond. The Administration estimates that the proposal will have no cost impact in fiscal year 1984; it will reduce outlays in fiscal year 1985 by \$525 million.

5. Impact of changes in other program.—The Administration budget is proposing a number of changes in AFDC which will reduce AFDC caseloads. Since medicaid eligibility is linked to eligibility for AFDC, medicaid savings are also anticipated. The Administration budget is also proposing a number of modifications in medicare (primarily increases in required beneficiary cost-sharing charges), which will result in increased medicaid costs on behalf of dual recipients. The Administration estimates reductions in outlays for fiscal year 1984 of \$93 million due to AFDC changes. It estimates increases in outlays for fiscal year 1984 of \$56 million due to medicare changes.

Regulatory Initiative

1. Third party liability collections.—The Administration budget proposes to require State Child Support Enforcement (CSE) agencies to petition the court to include medical support as part of the child support order whenever health care coverage is available to the absent parent at a reasonable cost. In addition improved information exchange would be required between the CSE and medicaid agencies on the availability of health insurance coverage. The Ad-

Addendum 20

should be made, and the Managing Trustee, through the Division of Disbursement of the Treasury Department, and prior to any action thereon by the General Accounting Office, shall make payment in accordance with the certification of the Secretary (except that in the case of (A) an individual who will have completed ten years of service creditable under the Railroad Retirement Act of 1937 [45 U.S.C. 228a et seq.] or the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.], (B) the wife or husband of such an individual, (C) any survivor of such an individual if such survivor is entitled, or could upon application become entitled, to an annuity under section 2 of the Railroad Retirement Act of 1974 [45 U.S.C. 231a], and (D) any other person entitled to benefits under section 202 of this Act [42 U.S.C. 402] on the basis of the wages and self-employment income of such an individual (except a survivor of such an individual where such individual did not have a current connection with the railroad industry, as defined in the Railroad Retirement Act of 1974, at the time of his death), such certification shall be made to the Railroad Retirement Board which shall provide for such payment or payments to such person on behalf of the Managing Trustee in accordance with the provisions of the Railroad Retirement Act of 1974: *Provided*, That where a review of the Secretary's decision is or may be sought under subsection (g) of this section the Secretary may withhold certification of payment pending such review. The Managing Trustee shall not be held personally liable for any payment or payments made in accordance with a certification by the Secretary.

(j) Direct or indirect certification

When it appears to the Secretary that the interest of an applicant entitled to a payment would be served thereby, certification of payment may be made, regardless of the legal competency or incompetency of the individual entitled thereto, either for direct payment to such applicant, or for his use and benefit to a relative or some other person.

(k) Payments to incompetents

Any payment made after December 31, 1939, under conditions set forth in subsection (j) of this section, any payment made before January 1, 1940, to, or on behalf of, a legally incompetent individual, and any payment made after December 31, 1939, to a legally incompetent individual without knowledge by the Secretary of incompetency prior to certification of payment, if otherwise valid under this subchapter, shall be a complete settlement and satisfaction of any claim, right, or interest in and to such payment.

(l) Delegation of powers and duties by Secretary

The Secretary is authorized to delegate to any member, officer, or employee of the Department of Health, Education, and Welfare designated by him any of the powers conferred upon him by this section, and is authorized to be represented by his own attorneys in any court in any case or proceeding arising under the provisions of subsection (e) of this section.

(m) Repealed. Aug. 28, 1950, ch. 809, title 1, § 101(b)(2), 64 Stat. 488

(n) Joint payments

The Secretary may, in his discretion, certify to the Managing Trustee any two or more individuals of the same family for joint payment of the total benefits payable to such individuals for any month, and if one of such individuals dies before a check representing such joint payment is negotiated, payment of the amount of such unnegotiated check to the surviving individual or individuals may be authorized in accordance with regulations of the Secretary of the Treasury; except that appropriate adjustment or recovery shall be made under section 404(a) of this title with respect to so much of the amount of such check as exceeds the amount to which such surviving individual or individuals are entitled under this subchapter for such month.

(o) Crediting of compensation under Railroad Retirement Act

If there is no person who would be entitled, upon application therefor, to an annuity under section 5 of the Railroad Retirement Act of 1974 [45 U.S.C. 231a] or to a lump-sum payment under section 6(b) of such Act [45 U.S.C. 231e(b)], with respect to the death of an employee (as defined in such Act), then, notwithstanding section 410(a)(10) of this title, compensation (as defined in such Railroad Retirement Act, but excluding compensation attributable as having been paid during any month on account of military service creditable under section 3(i) of such Act [45 U.S.C. 231b(i)]) if wages are deemed to have been paid to such employee during such month under subsection (a) or (e) of section 417 of this title) of such employee shall constitute remuneration for employment for purposes of determining (A) entitlement to and the amount of any lump-sum death payment under this subchapter on the basis of such employee's wages and self-employment income and (B) entitlement to and the amount of any monthly benefit under this subchapter, for the month in which such employee died or for any month thereafter, on the basis of such wages and self-employment income. For such purposes, compensation (as so defined) paid in a calendar year shall, in the absence of evidence to the contrary, be presumed to have been paid in equal proportions with respect to all months in the year in which the employee rendered services for such compensation.

(p) Special rules in case of federal service

(1) With respect to service included as employment under section 410 of this title which is performed in the employ of the United States or in the employ of any instrumentality which is wholly owned by the United States, including service, performed as a member of a uniformed service to which the provisions of subsection (ix)(1) of such section are applicable, and including service, performed as a volunteer or volunteer leader within the meaning of the Peace Corps Act [22 U.S.C. 2501 et seq.], to which the provisions of section 410(o) of this title are applicable, the Secretary shall not make determinations as to whether an individual has performed such service, the periods of such service,

(5) After the expiration of the time limitation following any year in which wages were paid or alleged to have been paid to, or self-employment income was derived or alleged to have been derived by, an individual, the Secretary may change or delete any entry with respect to wages or self-employment income in his records of such year for such individual or include in his records of such year for such individual any omitted item of wages or self-employment income but only—

[See main edition for text of (A) to (C)]

(D) to transfer items to records of the Railroad Retirement Board if such items were credited under this subchapter when they should have been credited under the Railroad Retirement Act of 1937 or 1974 [45 U.S.C. 228a et seq., 231 et seq.], or to enter items transferred by the Railroad Retirement Board which have been credited under the Railroad Retirement Act of 1937 or 1974 when they should have been credited under this subchapter;

[See main edition for text of (E) to (H)]

(I) to enter items which constitute remuneration for employment under subsection (o) of this section, such entries to be in accordance with certified reports of records made by the Railroad Retirement Board pursuant to section 5(k)(3) of the Railroad Retirement Act of 1937 [45 U.S.C. 228e(k)(3)] or section 7(b)(7) of the Railroad Retirement Act of 1974 [45 U.S.C. 231f(b)(7)]; or

[See main edition for text of (J), (6) to (8); (d)]

(e) Judicial enforcement of subpoenas; contempt

In case of contumacy by, or refusal to obey a subpoena duly served upon, any person, any district court of the United States for the judicial district in which said person charged with contumacy or refusal to obey is found or resides or transacts business, upon application by the Secretary, shall have jurisdiction to issue an order requiring such person to appear and give testimony, or to appear and produce evidence, or both; any failure to obey such order of the court may be punished by said court as contempt thereof.

[See main edition for text of (f) and (g)]

(h) Finality of Secretary's decision

The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.

(i) Certification for payment

Upon final decision of the Secretary, or upon final judgment of any court of competent jurisdiction, that any person is entitled to any pay-

ment or payments under this subchapter, the Secretary shall certify to the Managing Trustee the name and address of the person so entitled to receive such payment or payments, the amount of such payment or payments, and the time at which such payment or payments should be made, and the Managing Trustee, through the Fiscal Service of the Department of the Treasury, and prior to any action thereon by the General Accounting Office, shall make payment in accordance with the certification of the Secretary (except that in the case of (A) an individual who will have completed ten years of service creditable under the Railroad Retirement Act of 1937 [45 U.S.C. 228a et seq.] or the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.], (B) the wife or husband of such an individual, (C) any survivor of such an individual if such survivor is entitled, or could upon application become entitled, to an annuity under section 2 of the Railroad Retirement Act of 1974 [45 U.S.C. 231a], and (D) any other person entitled to benefits under section 402 of this title on the basis of the wages and self-employment income of such an individual (except a survivor of such an individual where such individual did not have a current connection with the railroad industry, as defined in the Railroad Retirement Act of 1974, at the time of his death), such certification shall be made to the Railroad Retirement Board which shall provide for such payment or payments to such person on behalf of the Managing Trustee in accordance with the provisions of the Railroad Retirement Act of 1974): *Provided*, That where a review of the Secretary's decision is or may be sought under subsection (g) of this section the Secretary may withhold certification of payment pending such review. The Managing Trustee shall not be held personally liable for any payment or payments made in accordance with a certification by the Secretary.

(j) Certification for direct or indirect payment; investigation; accountability monitoring; exceptions; reports to Congress

(1) When it appears to the Secretary that the interest of an applicant entitled to a payment would be served thereby, certification of payment may be made, regardless of the legal competency or incompetency of the individual entitled thereto, either for direct payment to such applicant, or for his use and benefit to a relative or some other person.

(2) Any certification made under paragraph (1) for payment to a person other than the individual entitled to such payment must be made on the basis of an investigation, carried out either prior to such certification or within forty-five days after such certification, and on the basis of adequate evidence that such certification is in the interest of the individual entitled to such payment (as determined by the Secretary in regulations). The Secretary shall ensure that such certifications are adequately reviewed.

(3)(A) In any case where payment under this subchapter is made to a person other than the individual entitled to such payment, the Secretary shall establish a system of accountability

monitoring whereby such person shall report not less often than annually with respect to the use of such payments. The Secretary shall establish and implement statistically valid procedures for reviewing such reports in order to identify instances in which such persons are not properly using such payments.

(B) Subparagraph (A) shall not apply in any case where the other person to whom such payment is made is a parent or spouse of the individual entitled to such payment who lives in the same household as such individual. The Secretary shall require such parent or spouse to verify on a periodic basis that such parent or spouse continues to live in the same household as such individual.

(C) Subparagraph (A) shall not apply in any case where the other person to whom such payment is made is a State institution. In such cases, the Secretary shall establish a system of accountability monitoring for institutions in each State.

(D) Subparagraph (A) shall not apply in any case where the individual entitled to such payment is a resident of a Federal institution and the other person to whom such payment is made is the institution.

(E) Notwithstanding subparagraphs (A), (B), (C), and (D), the Secretary may require a report at any time from any person receiving payments on behalf of another, if the Secretary has reason to believe that the person receiving such payments is misusing such payments.

(4)(A) The Secretary shall make an initial report to each House of the Congress on the implementation of paragraphs (2) and (3) within 270 days after October 9, 1984.

(B) The Secretary shall include as a part of the annual report required under section 904 of this title, information with respect to the implementation of paragraphs (2) and (3), including the number of cases in which the payee was changed, the number of cases discovered where there has been a misuse of funds, how any such cases were dealt with by the Secretary, the final disposition of such cases, including any criminal penalties imposed, and such other information as the Secretary determines to be appropriate.

[See main edition for text of (k)]

(l) Delegation of powers and duties by Secretary

The Secretary is authorized to delegate to any member, officer, or employee of the Department of Health and Human Services designated by him any of the powers conferred upon him by this section, and is authorized to be represented by his own attorneys in any court in any case or proceeding arising under the provisions of subsection (e) of this section.

[See main edition for text of (m) to (o)]

(p) Special rules in case of Federal service

(1) With respect to service included as employment under section 410 of this title which is performed in the employ of the United States or in the employ of any instrumentality which is wholly owned by the United States, including service, performed as a member of a uniformed service to which the provisions of subsection

(1)(1) of such section are applicable, and including service, performed as a volunteer or volunteer leader within the meaning of the Peace Corps Act (22 U.S.C. 2501 et seq.), to which the provisions of section 410(o) of this title are applicable, the Secretary shall not make determinations as to whether an individual has performed such service, the periods of such service, the amounts of remuneration for such service which constitute wages under the provisions of section 409 of this title, or the periods in which or for which such wages were paid, but shall accept the determinations with respect thereto of the head of the appropriate Federal agency or instrumentality, and of such agents as such head may designate, as evidenced by returns filed in accordance with the provisions of section 3122 of the Internal Revenue Code of 1954 and certifications made pursuant to this subsection. Such determinations shall be final and conclusive.

[See main edition for text of (2) and (3); (q)]

(r) Use of death certificates to correct program information

(1) The Secretary shall undertake to establish a program under which—

(A) States (or political subdivisions thereof) voluntarily contract with the Secretary to furnish the Secretary periodically with information (in a form established by the Secretary in consultation with the States) concerning individuals with respect to whom death certificates (or equivalent documents maintained by the States or subdivisions) have been officially filed with them; and

(B) there will be (i) a comparison of such information on such individuals with information on such individuals in the records being used in the administration of this chapter, (ii) validation of the results of such comparisons, and (iii) corrections in such records to accurately reflect the status of such individuals.

(2) Each State (or political subdivision thereof) which furnishes the Secretary with information on records of deaths in the State or subdivision under this subsection may be paid by the Secretary from amounts available for administration of this chapter the reasonable costs (established by the Secretary in consultations with the States) for transcribing and transmitting such information to the Secretary.

(3) In the case of individuals with respect to whom federally funded benefits are provided by (or through) a Federal or State agency other than under this chapter, the Secretary shall to the extent feasible provide such information through a cooperative arrangement with such agency, for ensuring proper payment of those benefits with respect to such individuals if—

(A) under such arrangement the agency provides reimbursement to the Secretary for the reasonable cost of carrying out such arrangement, and

(B) such arrangement does not conflict with the duties of the Secretary under paragraph (1).

(4) The Secretary may enter into similar agreements with States to provide information

(i) Certification for payment

Upon final decision of the Secretary, or upon final judgment of any court of competent jurisdiction, that any person is entitled to any payment or payments under this subchapter, the Secretary shall certify to the Managing Trustee the name and address of the person so entitled to receive such payment or payments, the amount of such payment or payments, and the time at which such payment or payments should be made, and the Managing Trustee, through the Fiscal Service of the Department of the Treasury, and prior to any action thereon by the General Accounting Office, shall make payment in accordance with the certification of the Secretary (except that in the case of (A) an individual who will have completed ten years of service creditable under the Railroad Retirement Act of 1937 [45 U.S.C. 228a et seq.] or the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.], (B) the wife or husband of such an individual, (C) any survivor of such an individual if such survivor is entitled, or could upon application become entitled, to an annuity under section 2 of the Railroad Retirement Act of 1974 [45 U.S.C. 231a], and (D) any other person entitled to benefits under section 402 of this title on the basis of the wages and self-employment income of such an individual (except a survivor of such an individual where such individual did not have a current connection with the railroad industry, as defined in the Railroad Retirement Act of 1974, at the time of his death), such certification shall be made to the Railroad Retirement Board which shall provide for such payment or payments to such person on behalf of the Managing Trustee in accordance with the provisions of the Railroad Retirement Act of 1974): *Provided*, That where a review of the Secretary's decision is or may be sought under subsection (g) of this section the Secretary may withhold certification of payment pending such review. The Managing Trustee shall not be held personally liable for any payment or payments made in accordance with a certification by the Secretary.

(j) Certification for direct or indirect payment; investigation; accountability monitoring; exceptions; reports to Congress

(1) When it appears to the Secretary that the interest of an applicant entitled to a payment would be served thereby, certification of payment may be made, regardless of the legal competency or incompetency of the individual entitled thereto, either for direct payment to such applicant, or for his use and benefit to a relative or some other person.

(2) Any certification made under paragraph (1) for payment to a person other than the individual entitled to such payment must be made on the basis of an investigation, carried out either prior to such certification or within forty-five days after such certification, and on the basis of adequate evidence that such certification is in the interest of the individual entitled to such payment (as determined by the Secretary in regulations). The Secretary shall ensure that such certifications are adequately reviewed.

(3)(A) In any case where payment under this subchapter is made to a person other than the

individual entitled to such payment, the Secretary shall establish a system of accountability monitoring whereby such person shall report not less often than annually with respect to the use of such payments. The Secretary shall establish and implement statistically valid procedures for reviewing such reports in order to identify instances in which such persons are not properly using such payments.

(B) Subparagraph (A) shall not apply in any case where the other person to whom such payment is made is a parent or spouse of the individual entitled to such payment who lives in the same household as such individual. The Secretary shall require such parent or spouse to verify on a periodic basis that such parent or spouse continues to live in the same household as such individual.

(C) Subparagraph (A) shall not apply in any case where the other person to whom such payment is made is a State institution. In such cases, the Secretary shall establish a system of accountability monitoring for institutions in each State.

(D) Subparagraph (A) shall not apply in any case where the individual entitled to such payment is a resident of a Federal institution and the other person to whom such payment is made is the institution.

(E) Notwithstanding subparagraphs (A), (B), (C), and (D), the Secretary may require a report at any time from any person receiving payments on behalf of another, if the Secretary has reason to believe that the person receiving such payments is misusing such payments.

(4)(A) The Secretary shall make an initial report to each House of the Congress on the implementation of paragraphs (2) and (3) within 270 days after October 9, 1984.

(B) The Secretary shall include as a part of the annual report required under section 904 of this title, information with respect to the implementation of paragraphs (2) and (3), including the number of cases in which the payee was changed, the number of cases discovered where there has been a misuse of funds, how any such cases were dealt with by the Secretary, the final disposition of such cases, including any criminal penalties imposed, and such other information as the Secretary determines to be appropriate.

[See main edition for text of (k)]

(l) Delegation of powers and duties by Secretary

The Secretary is authorized to delegate to any member, officer, or employee of the Department of Health and Human Services designated by him any of the powers conferred upon him by this section, and is authorized to be represented by his own attorneys in any court in any case or proceeding arising under the provisions of subsection (e) of this section.

[See main edition for text of (m) to (o)]

(p) Special rules in case of Federal service

(1) With respect to service included as employment under section 410 of this title which is performed in the employ of the United States or in the employ of any instrumentality which

Addendum 21

Social Security Amendments of 1965: Summary and Legislative History

BY WILBUR J. COHEN AND ROBERT M. BALL*

WITH THE SIGNING on July 30, 1965, of H.R. 6675, the Social Security Amendments of 1965 became law. The historic legislation, Public Law 89-97, establishes two coordinated health insurance programs for the aged and makes a number of substantial improvements in the existing old-age, survivors, and disability insurance (OASDI) program and other programs under the Social Security Act.

The most significant changes in the social security system are the following:

1. Establishment of two related national health insurance programs for the aged—(a) a basic plan affording protection against the costs of hospital and related care, and (b) a voluntary supplementary plan covering payments for physicians' services and other medical and health services.
2. A 7-percent increase in OASDI benefits.
3. Liberalization of the definition of disability.
4. Liberalization of the retirement test.
5. Payment of benefits to eligible children aged 18-21 who are attending school.
6. Payment of benefits to widows at age 60 on an actuarially reduced basis.
7. Coverage of self-employed physicians.
8. Coverage of tips as wages.
9. Liberalization of insured-status requirements for persons already aged 72 or over.
10. Increase to \$6,600 in the contribution and benefit base.
11. Increase in the contribution rate schedule.

The amendments include the following important changes in the public assistance titles of the Social Security Act.¹

* Mr. Cohen is Under Secretary of Health, Education, and Welfare and Mr. Ball is the Commissioner of Social Security.

¹ For a brief summary of the amendments affecting public assistance and the maternal and child health and child welfare programs, see pages 16-19. *Welfare in Action* (Welfare Administration), August 1965, carries a legislative history and a fuller description of the welfare provisions of P. L. 89-97.

1. Establishment, under a new title, of a program to provide medical assistance for needy or medically needy aged, blind, or disabled persons and dependent children.

2. Increased Federal sharing in assistance payments to the aged, the blind, the disabled, and dependent children.

3. Removal of limitations on Federal participation in assistance payments with respect to aged persons in tuberculosis and mental disease hospitals under certain conditions.

4. New or increased amounts of income received by assistance recipients that may be disregarded in determining need.

The major changes in the maternal and child health and child welfare services are the following:

1. Increase in the annual authorizations of Federal funds for the three programs.
2. Authorization of special project grants to provide comprehensive health care for children of low-income families.

Background and Legislative History of the Insurance Provisions

The Social Security Amendments of 1965 embody the most far-reaching social security legislation to be enacted since the original Social Security Act was passed 30 years earlier. The law closes one of the major gaps in the economic security of the elderly by providing protection against the high costs of hospital and medical care, and it brings the existing OASDI program more in line with current economic and social conditions.

Bills to provide hospital insurance and related health benefits as part of the social security system have been introduced in every Congress since 1952. The proposals did not receive active congressional consideration, however, until 1958,

when Representative Forand (D., R.I.) introduced a bill that became the subject of testimony in public hearings before the Committee on Ways and Means of the House of Representatives on the Social Security Amendments of 1958. The Committee concluded that more information was needed before legislation could be recommended, and no further action was taken on the proposal at that time.

In 1959 and 1960 the Committee on Ways and Means held public hearings on several proposals to amend the Social Security Act, including another bill (H.R. 4700) introduced by Representative Forand to provide "insurance against the costs of hospital, nursing-home, and surgical services for persons eligible for old-age and survivors insurance benefits." The Committee, after careful review of the many proposed solutions to the problem of meeting health costs in old age, concluded that Federal action was necessary but did not recommend adoption of the proposal for hospital insurance under the social security system. Instead, the Committee recommended additional medical assistance for the needy aged through liberalizations in the Federal-State public assistance programs. This proposed medical assistance legislation was later modified by the Senate Finance Committee, and the result was a new program of medical assistance for the aged. Before its passage, Senator Clinton P. Anderson (D., N. Mex.), Senator John F. Kennedy (D., Mass.) and eight other Senators proposed adding a program of hospital insurance for persons aged 68 and over who were eligible for OASDI benefits. The amendment was defeated by a vote of 51 to 44.

The medical assistance legislation — often referred to as the "Kerr-Mills" program—won bipartisan support and was enacted on September 13, 1960, as part of H.R. 12580 (P. L. 86-778). These amendments made Federal matching grants available to the States to help finance programs of medical assistance for older persons who do not receive old-age assistance payments but who cannot afford necessary medical care. The legislation also provided increased Federal grants to help the States furnish more nearly adequate medical aid to old-age assistance recipients.

With the election of President Kennedy in 1960, the proposal for hospital insurance for the

aged under the Social Security Act became part of the Administration's legislative program. In 1961 the Administration-sponsored hospital insurance proposal was contained in bills introduced by Representative King (D., Calif.) and by Senator Anderson (D., N. Mex.) and Senator Javits (R., N.Y.).

In 1962, Senator Anderson proposed, as an amendment to the public welfare bill, hospital insurance as part of the social security system. The Senate voted 52 to 48 to table the amendments, and no further action was taken on the proposal by the Eighty-seventh Congress.

ACTION IN THE EIGHTY-EIGHTH CONGRESS

In his State of the Union Message of January 14, 1963, President Kennedy urged the new Congress to enact a program of health insurance for the aged under the Social Security Act. He elaborated on this theme in both his special Message on a Health Program, submitted to Congress on February 7, and in his special Message on Elderly Citizens of Our Nation, submitted on February 21. In the latter message, the President recommended not only the enactment of a program of hospital insurance for the elderly but also numerous improvements in the OASDI program, such as increases in benefit amounts and in the contribution and benefit base. Representative King and Senator Anderson again introduced the proposed hospital insurance legislation on behalf of the Administration; the two companion bills were introduced on February 21, 1963.

On July 7, 1964, the House Committee on Ways and Means reported out H.R. 11865, which provided for a number of major improvements in the social security program, including a 5-percent increase in cash benefits and extension of coverage to additional groups. Although proposals for a hospital insurance program for the aged were considered by the Committee, the proponents did not request that the Committee vote either on the hospital insurance measure or on any changes in medical assistance for the aged. H.R. 11865 was passed by the House by a vote of 388 to 8.

The Senate Finance Committee rejected proposals to add to H.R. 11865 hospital insurance for the aged within the framework of the social

security program. During the Senate debate on H.R. 11865, however, an amendment to provide such a program was adopted by a vote of 49 to 44, and the Senate subsequently passed the bill by a vote of 80 to 28. The Conference Committee failed to reach agreement on the hospital insurance part of the bill as passed by the Senate, and H.R. 11865 died in the Conference Committee when the Eighty-eighth Congress came to an end on October 3, 1964.

CONGRESSIONAL ACTION IN 1965

As the Eighty-ninth Congress convened on January 3, 1965, there was every indication that major social security legislation related to both health insurance and increased cash benefits would be on its agenda for early consideration. The improvements in OASDI that had failed to be enacted 3 months earlier because the Conference Committee did not agree on the hospital insurance provisions of H.R. 11865 were considered to be noncontroversial. It was also generally conceded that the November elections had ensured passage by the House of any hospital insurance legislation that the Committee on Ways and Means might report out. Finally, the House, in an unusual action, changed the composition of the Ways and Means Committee—shortly after Congress convened—to reflect the large majority that the Democrats held in the House of Representatives.

On January 4, 1965, Representative King introduced H.R. 1—the Administration's proposals for hospital insurance and improvements in the OASDI program as well as in the public assistance programs. Senator Anderson introduced the companion bill, S. 1. The King-Anderson bills contained a number of the provisions that had been considered by Congress in 1964.

The major provisions of H.R. 1 were:

1. Hospital insurance for the aged.
2. A general increase of 7 percent in cash benefits.
3. An increase to \$5,800 in the contribution and benefit base.
4. An increase in the contribution schedule.
5. Coverage of self-employed doctors.
6. Coverage of tips.
7. Extension of the period for filing proof of

support and filing application for lump-sum death payments.

A. Automatic recomputation of benefits.

Action of Ways and Means Committee

On January 27 the Committee on Ways and Means began executive sessions on the King-Anderson bill and other bills, particularly H.R. 288, which was introduced by Representative Byrnes (R., Wis.)—the ranking minority member of the Committee. The OASDI provisions of H.R. 288 were similar to those in H.R. 11865, but there was no provision for hospital insurance.

Two other bills, which would have provided health insurance benefits for the aged under a system not related to social security, also received the Committee's attention. The "Eldercare" proposal—identical bills, H.R. 3727 and H.R. 3728—was made by Representative Herlong (D., Fla.) and Representative Curtis (R., Mo.). This proposal would have modified the provisions of the Kerr-Mills program to encourage the States to provide medical assistance for the aged, the blind, and the disabled in the form of private health insurance coverage.

The second proposal, H.R. 4351, was introduced by Representative Byrnes and was supported by five of the eight Republican Committee members. It would have established a Federal health insurance program for the aged, financed from Federal general revenues and from premiums paid by participants. Enrollment would have been voluntary, and premium amounts would have been scaled to the amount of the participant's OASDI benefits.

After 2 months of deliberations, Chairman Mills introduced H.R. 6675, embodying the decisions made during the executive sessions of the Committee. The new bill provided for two related health insurance programs. The first was a basic program, under the social security system, of protection against hospital and related health costs, similar to the program proposed by the King-Anderson bill. Unlike that bill, however, the Committee's bill called for financing by an earnings tax identified separately from the present social security taxes.

The second health program for the aged proposed in the Committee's bill was a voluntary

program of protection against the cost of physicians' and certain other medical and health services not covered under the basic program. The supplementary program was to be financed by premiums from enrollees and a matching amount paid by the Federal Government from Federal tax revenues.

The Committee's reasons for recommending the health insurance programs were stated in its report² as follows:

Although your committee believes that the Kerr-Mills legislation as a whole has been very beneficial to the needy aged in our country, it has now concluded that the overall national problem of adequate medical care for the aged has not been met to the extent desired under existing legislation because of the failure of some States to implement to the extent anticipated and thus the existing program is inadequate to solve the problem. Your committee, therefore, has concluded that a more comprehensive Federal program as to both persons who can qualify and protection afforded is required.

Therefore, a threefold approach to meet this national problem has been developed. First, since your committee believes that Government action should not be limited to measures that assist the aged only after they have become needy, your committee recommends more adequate and feasible health insurance protection under two separate but complementary programs which would contribute toward making economic security in old age more realistic, a more nearly attainable goal for most Americans. In addition, your committee recommends . . . a strengthening of the medical assistance provisions of the Social Security Act so that adequate medical aid may be provided for needy people.

In addition to the OASDI provisions of H.R. 1, the Committee adopted the following provisions of H.R. 288:

1. Payment of actuarially reduced benefits to widows at age 60.

2. Payment of child's insurance benefits after attainment of age 18 and up to the age of 22 for a full-time student.

3. Payment of benefits to certain uninsured persons already aged 72 and over who have fewer than 6 quarters of coverage under transitional provisions that would permit benefits to be paid on the basis of 2, 4, or 5 quarters of coverage.

4. Provision for members of certain religious sects to be exempt from social security self-employment taxes upon application accompanied by a waiver of all benefits and other payments under the Social Security Act.

5. An increase from \$1,800 to \$2,400 in the maximum amount of gross farm income that farmers may use in computing covered farm self-employment income under the optional method of reporting such income.

6. An increase from \$1,700 to \$2,400 in the span of earnings over which \$.1 in benefits is withheld for each \$2 in earnings.

The Committee also adopted the following provisions:

1. Payment of wife's or widow's benefits to a divorced wife aged 62 or over if she had been married to the worker for at least 20 years and if her divorced husband was making a substantial contribution to her support when he became entitled to benefits or died, and restoration of benefit rights that were terminated by remarriage if the marriage ended in divorce after 20 years.

2. Exclusion from gross income of a self-employed person who has attained age 65, for retirement test purposes, of royalties received in or after the year of attaining age 65 from a copyright or patent obtained before that year.

3. Elimination of the requirement that a worker's disability must be expected to result in death or to be of long-continued and indefinite duration, and provision instead for an insured worker to be eligible for disability benefits if totally disabled throughout a continuous period of at least 6 calendar months.

4. Payment of disability benefits beginning with the last month of the 6-month waiting period rather than after the 6-month waiting period.

H.R. 6675 was reported to the House of Representatives on March 29. On April 8, after 2 days of debate on H.R. 6675 under a closed rule, the House passed the bill, without amendment, by a vote of 313 to 115.

Action of Senate Finance Committee

The Senate Finance Committee held 15 days of public hearings (April 29 through May 19) on H.R. 6675. In testifying for the Administration the Secretary of Health, Education, and Welfare, Anthony J. Celebrezze, endorsed the proposed health insurance programs for the aged and recommended adoption with only one major change.

² *Social Security Amendments of 1965: Report of the Committee on Ways and Means on H.R. 6675, (House Report No. 212, 86th Cong., 1st sess.), 1965, page 20.*

The Secretary recommended that physicians' services in the fields of radiology, anesthesiology, pathology, and physical medicine be covered under the hospital insurance program rather than the supplementary program, where the services are furnished through an arrangement under which the physician bills for his services through the hospital.

Throughout the public hearings of the Senate Finance Committee, testimony centered on the proposed health insurance programs. Opposition to the programs came largely from the American Medical Association and various State and local medical societies. The American Medical Association based its opposition on the belief that the programs would eventually lead to Government intervention into the practice of medicine. Some medical groups, however, testified in support of the health insurance provisions of the bill.

During executive sessions, the Senate Finance Committee adopted the Secretary's recommendation, as proposed in an amendment by Senator Douglas (D., Ill.). Under this proposal, the professional services of radiologists, anesthesiologists, pathologists, and physiatrists, when provided under arrangements with hospitals, would be covered under the hospital insurance plan rather than under the supplementary plan (as the House bill had provided). The Committee also increased the maximum duration of hospital benefits from 60 days to 120, with the last 60 days of benefits subject to coinsurance payments by the beneficiary, and adopted several changes that liberalized benefits under the two proposed health insurance programs.

In addition, the Committee adopted a number of changes in the cash benefits provisions of the bill, including the following:

1. Liberalization of the House-approved retirement test provision by increasing to \$1,800 the annual amount of earnings exempt from the test, by extending the \$1-for-\$2 adjustment span to \$3,000 with a \$1-for-\$1 adjustment on earnings above \$3,000, and by raising to \$150 the amount that a beneficiary may earn in a month and still get full benefits for that month.

2. Amendment of the definition of disability to require that a qualifying disability be one that has lasted or can be expected to last at least 12 months (instead of 6, as under the House bill).

3. Deletion of the House provision under which payment of disability benefits would have started with the sixth full month of disability rather than the seventh month, as under present law.

4. Addition of a provision under which disability benefits under the Social Security Act would be reduced to take account of workmen's compensation payments when the combined monthly benefits exceed 80 percent of the recipient's average monthly earnings before his disablement.

5. Coverage of tips as self-employment income rather than as wages.

6. Payment of benefits to a child based on his father's earnings, without regard to State law, if the father was supporting him or had a legal obligation to do so.

7. Continuation of benefit payments based on a former spouse's earnings record, at the rate of 80 percent of his or her primary insurance amount, to widows aged 60 or over and to widowers aged 62 or over who remarry.

8. Restoration of the benefit rights lost because of remarriage for divorced wives, widows, surviving divorced wives, and surviving divorced mothers who are not currently married.

9. Addition of a provision authorizing limited expenditures from social security trust funds to reimburse State agencies for vocational rehabilitation services furnished to selected disability insurance beneficiaries.

10. Addition of a provision for payment of disabled child's benefits to a child who is disabled before reaching age 22 (instead of age 18, as under present law).

11. Addition of a provision under which an affiliated group of corporations would be considered a single employer for purposes of determining the maximum amount of annual wages subject to the employer tax.

12. Addition of a provision authorizing the Secretary to make disability determinations in those cases that can be promptly adjudicated on the basis of readily available medical and other evidence.

13. Revision of the financing provisions of the House bill to provide a \$6,600 contribution and benefit base, effective for 1966, and a contribution rate schedule under which rates would be somewhat lower in the immediate future than under

the House-passed bill but higher over the long run.

The Finance Committee reported the bill on June 30.

Senate Floor Debate

A number of amendments were adopted during the Senate debate, including the following:

1. Removal of the 120-day limit on the payment of inpatient hospital benefits; benefits beyond the sixtieth day would be reduced by a coinsurance payment of \$10 a day.

2. Elimination of the requirement under the basic hospital insurance plan that a person must have been in a hospital or extended-care facility in order to be eligible for home health benefits.

3. Appointment, to be made by the Secretary, of an Advisory Council on Social Security to make a comprehensive study of nursing homes and other extended-care facilities.

4. Provision for the Secretary to study the feasibility of covering prescription drugs under the supplementary medical insurance plan.

5. Reduction in the age of eligibility for cash benefits to 60 for everyone, with the benefits reduced to take account of the longer period over which they will be paid.

6. Exclusion of the increase in benefits under the Social Security Act from income considered for purposes of determining a person's eligibility for, or the amount of, a veteran's pension.

7. Payment of disability insurance benefits to blind persons on the basis of 6 quarters of coverage, without respect to their capacity to work.

8. Requirement that the most recent addresses of husbands and parents who have deserted their families be disclosed to a State public welfare agency or a court.

9. Addition of a provision under which adoption by a brother or sister would not terminate a child's benefits.

10. Revision of the contribution schedule to provide for slightly higher rates to meet the cost of the changes made on the Senate floor.

The Senate rejected a number of amendments. They included proposals to (1) provide for an automatic 2-percent OASDI benefit increase whenever there is a 2-percent increase in the cost

of living, by a vote of 21 for and 64 against; (2) provide under the two health insurance programs for alternate variable deductible amounts related to a person's income-tax liability, by a vote of 40 for and 52 against; (3) delete the health insurance provisions, by a vote of 26 for and 64 against; (4) delete the provision for compulsory coverage of self-employed physicians and interns, by a vote of 41 for and 50 against; and (5) provide that a worker under age 31 may qualify for disability insurance benefits if he had been in covered work for at least half the period between the date he attained age 21 and the time he became disabled, by a voice vote. The Senate rejected, by a vote of 26 for and 63 against, a motion to recommit the bill to the Finance Committee, with instructions to report the bill back immediately after eliminating the health insurance provisions and report later a bill providing medical insurance for the aged patterned after the health insurance program now in effect for retired civil-service employees, with premiums paid by those covered except those unable to pay.

On July 9 the Senate passed H.R. 6675, with amendments, by a vote of 68 to 21.

CONFERENCE COMMITTEE ACTION AND ENACTMENT

On July 14 the House and Senate conferees met to settle the differences between the two versions of H.R. 6675. On July 26 the conferees filed their report.

The bill as reported by the conferees departed from the Senate version in the following significant respects:

1. Adoption of the House provisions for covering the professional services of certain hospital-based specialists under the supplementary medical insurance program rather than under the hospital insurance plan.

2. Adoption of a compromise provision under which inpatient hospital benefits can be paid for a maximum of 90 days in a spell of illness; benefits for the first 60 days would be reduced by a \$40 deductible amount, and benefits for each day beyond the sixtieth would be reduced by a coinsurance payment of \$10.

3. Adoption of the House provisions requiring

that a person must have been in a hospital or extended-care facility in order to be eligible for home health benefits under the hospital insurance program.

4. Rejection of the Senate provisions under which a study of nursing homes and other extended-care facilities would have been made by an Advisory Council on Social Security and under which the Secretary would have been required to make a study of the feasibility of covering the cost of drugs under the supplementary medical insurance plan.

5. Adoption of a compromise provision under which the amount that a beneficiary may earn in a year and get full benefits for the year is increased from \$1,200 to \$1,500, with an increase from \$100 to \$125 in the monthly measure; \$1 in benefits is withheld for each \$2 of earnings above \$1,500 and up to \$2,700 a year and for each \$1 of earnings thereafter.

6. Deletion of the Senate provision under which the eligibility age for cash benefits would have been reduced to age 60 for everyone. (The provision under which widows can elect to get benefits at age 60 was retained.)

7. Adoption of a compromise provision under which cash tips are covered as wages for social security and income-tax withholding purposes, except that employers are not required to pay the social security employer tax on tips.

8. Deletion of the Senate provision under which the increase in benefits under the Social Security Act would have been excluded from countable income in determining eligibility for and the amount of a veteran's pension.

9. Deletion of the Senate provision under which an affiliated group of corporations would have been considered a single employer in determining the maximum amount of annual wages subject to the employer tax.

10. Deletion of the Senate provision under which childhood disability benefits would have been payable to a child who became disabled before reaching age 22.

11. Deletion of the Senate provision under which the Secretary would have been authorized to make disability determinations in certain cases.

12. Adoption of a compromise providing for (a) the payment of benefits to blind workers aged 65-65 who are unable to engage in their usual occupation and who are not doing substantial

work; and (b) an alternative disability insured-status requirement, applicable to workers who become blind before reaching age 31, under which such workers are insured if they have quarters of coverage in half the quarters elapsing after age 21 up to the time of disablement or, for those becoming disabled before age 24, quarters of coverage in at least half the 12 quarters preceding the quarter in which they become disabled.

13. Adoption of a compromise provision under which the most recent address of a deserting parent would be disclosed to a State or local welfare agency if the children are applicants for or recipients of assistance, if there is a court order for the support of the children, if the agency has attempted to obtain the information from all other reasonable sources, and if the information is to be used-(by the agency or court) to obtain support for the children.

On July 27 the House adopted the conference report by a vote of 307 to 116. On July 29 the Senate approved the report by a vote of 70 to 24, and the bill was cleared for the President's signature.

On July 30, 1965, H.R. 6675 was signed by President Johnson and became Public Law 89-97.

Summary of Major Provisions

HEALTH INSURANCE FOR THE AGED

Public Law 89-97 adds to the Social Security Act a new title XVIII establishing two related health insurance programs for persons aged 65 and over: (1) a hospital insurance plan providing protection against the costs of hospital and related care, and (2) a medical insurance plan covering payments for physicians' services and other medical and health services to cover certain areas not covered by the hospital insurance plan.

The hospital insurance plan is financed through a separate earnings tax and a separate trust fund. Benefits for persons who are currently aged 65 and over who are not insured under the social security or the railroad retirement systems will be financed out of Federal general revenues.

Enrollment in the medical insurance plan is voluntary, and the plan is financed by a small

The District of Columbia Commissioners may arrange also for the coverage of temporary and intermittent employees to be shifted from the Federal civil-service retirement system to the social security system. Coverage begins after the calendar quarter in which the Secretary of the Treasury receives a certificate from the District of Columbia Commissioners expressing their desire to have coverage extended to the affected employees.

State and local coverage changes. — Another opportunity is provided, through 1966, for the election of coverage by members of State and local government retirement systems who originally did not choose coverage under the divided retirement system provision, under which current employees have a choice of coverage. Alaska is added to the list of States that may use the divided retirement system provision. These provisions are effective immediately.

Iowa and North Dakota are permitted to modify their coverage agreements with the Secretary of Health, Education, and Welfare to exclude from coverage services performed by students, including services already covered, in the employ of a school, college, or university in any calendar quarter if the remuneration for such services is less than \$50. The modification may specify the effective date of the exclusion, but it may not be earlier than July 30, 1965.

The past coverage under the social security system of employees of certain school districts in Alaska that have been included in error as separate political subdivisions under the Alaska social security coverage agreements is validated. (The employees of the school districts involved should properly have been covered as employees of the political subdivisions of which the school districts are integral parts.) The provision is effective for 1965 and earlier years; coverage for years after 1965 must be under the general provisions of the law.

California is permitted to modify its coverage agreement to extend coverage to certain hospital employees whose positions were removed from a State or local government retirement system. The State will have until the end of January 1966 to take action under this provision.

Maine is given until July 1, 1967 (rather than July 1, 1965), to treat teaching and nonteaching employees who are in the same retirement system

as though they were under separate retirement systems for social security coverage purposes.

Miscellaneous Changes

The law also includes a number of administrative and technical changes, including provisions relating to the length of time an application for benefits is effective, treatment of underpayments and of payments to two or more members of the same family, attorney's fees, and disclosure of the whereabouts of a beneficiary.

In addition to these changes, the legislation revises the provisions authorizing reimbursement of the social security trust funds out of general revenue for gratuitous wage credits for servicemen so that reimbursement will be spread over the next 50 years, rather than 10 years.

Financing Old-Age, Survivors, and Disability Insurance Amendments

The old-age, survivors, and disability insurance provisions of the law are financed by (1) an increase in the earnings base from \$4,800 to \$6,600, effective January 1, 1966, and (2) a revised tax rate schedule. The revised schedule is shown below:

| Year | Employer | Employer | Self-employed |
|---------------------|----------|----------|---------------|
| 1966..... | 3.85 | 3.85 | 6.8 |
| 1967-68..... | 3.9 | 3.9 | 6.9 |
| 1969-72..... | 4.1 | 4.1 | 7.1 |
| 1973 and after..... | 4.25 | 4.25 | 7.2 |

An additional 0.20 percent of taxable wages and 0.15 percent of taxable self-employment income will be allocated to the disability insurance trust fund, bringing the total allocation to 0.70 percent of wages and 0.525 percent of self-employment income beginning in 1966.

PUBLIC ASSISTANCE AMENDMENTS

Medical Assistance Program

To provide a more effective program of medical care for needy persons, the law establishes

a program of medical assistance under a new title of the Social Security Act—title XIX.

This title is intended to replace the Kerr-Mills law—medical assistance for the aged—and the provisions for direct payments to suppliers of medical care and services under old-age assistance, aid to the blind, aid to families with dependent children, aid to the permanently and totally disabled, and the consolidated program for the aged, the blind, and the disabled. The program may be administered by a State agency designated for the purpose, but eligibility is to be determined by the State agency responsible for administering old-age assistance.

The program is to include all persons now receiving assistance for basic maintenance under the public assistance titles and also may include persons who are able to provide their maintenance but whose income and resources are not sufficient to meet their medical care costs. Services offered the former group may be no less in amount or scope than those for the latter group. If the medically needy are included, comparable eligibility provisions are to apply so that all persons similarly situated among the aged, the blind, the disabled, and dependent children would be included in the program. Other medically needy children could be included. No age requirement may be imposed that would exclude any person over age 65 or, after July 1, 1967, under age 21. A flexible income test taking medical expenses into account would be used.

The old provisions in the various public assistance titles of the Act providing vendor medical assistance terminate upon the adoption of the new program by a State but no later than December 31, 1969.

Scope of medical assistance.—Under the old provisions, the State has had to provide "some institutional and noninstitutional care" under the program of medical assistance for the aged. There have been no minimum benefit requirements with respect to vendor medical payments under the other public assistance programs. For the new program a State must, by July 1, 1967, provide inpatient hospital services, outpatient hospital services, other laboratory and X-ray services, skilled nursing home services for individuals aged 21 and over, and physician's services (whether furnished in the office, the patient's home, a hospital, or a skilled nursing home) in

order to receive Federal participation in vendor medical payments. Other items of medical service are optional with the States.

Eligibility.—The law improves the program for the needy elderly by requiring that the States establish a flexible income test that takes into account medical expenses; it may not set up rigid income standards that arbitrarily deny assistance to persons with large medical bills. In the same spirit the law provides that no deductible, cost-sharing, or similar charge may be imposed by the State for hospitalization under its program and that such a charge on other medical services must be reasonably related to the recipient's income or resources. Elderly needy recipients under the State programs must be provided assistance to meet the deductibles imposed by the new basic program of hospital insurance. Where a portion of any deductible or cost-sharing under either program is met by a State program, it must be done in a manner reasonably related to the individual's income and resources. No income can be imputed to an individual unless it is actually available, and the financial responsibility of an individual for an applicant may be taken into account only if the applicant is the individual's spouse or child who is under age 21 or blind or disabled.

Increased Federal matching. — The Federal share of medical assistance expenditures under the new program is determined by a uniform formula, with no maximum on the amount of expenditures subject to participation—the procedure followed for medical assistance for the aged. The Federal share varies in relation to a State's per capita income; States with a national average income receive 55 percent (rather than the 50 percent formerly received for medical assistance for the aged), and States at the lowest level receive as much as 83 percent (in contrast to 80 percent).

To receive any additional Federal funds as a result of expenditures under the new program, the States must continue their own expenditures at their present rate. For a specified period, no State would receive less in Federal funds because of the new formula than it had in the past, and any State that did not reduce its own expenditures would be assured of at least a 5-percent increase in Federal participation in medical care expenditures. The Federal share in the

Addendum 22

Letter from Secretary of Health and Human Services
Margaret M. Heckler to President of the Senate George Bush
(May 25, 1983) (discussing proposed social welfare amend-
ments for 1983).



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

The Honorable George Bush
President of the Senate
Washington, DC 20510

Dear Mr. President:

Enclosed for the consideration of the Congress is a draft bill "To amend the Social Security Act to make certain program and administrative improvements in the programs of aid to families with dependent children and supplemental security income, and for other purposes." When enacted, the bill may be cited as the "Social Welfare Amendments of 1983". Additionally, a section-by-section summary of the bill, and a table showing the budgetary effects of each section for fiscal years 1984 through 1987, are enclosed for your convenience.

The draft bill carries out recommendations in the President's budget for fiscal year 1984. These amendments will assure that limited Federal and State resources are spent as effectively as possible. To this end, several amendments to the program of aid to families with dependent children carry forward the thrust of improvements made by the Omnibus Budget Reconciliation Act of 1981 and the Tax Equity and Fiscal Responsibility Act of 1982. The WIN program would be repealed; in its place, the community work experience program is strengthened and made mandatory, and employment search must be required of applicants and recipients. Emphasis is placed on assisting applicants and recipients to become self-reliant as soon as possible and to move back into regular employment and avoid long-term welfare dependency.

Additionally, this bill contains a group of related amendments to establish uniform rules on the family members who must file together for AFDC, and the situations in which income must be counted. In general, the parents, sisters, and brothers living together with a dependent child must all be included; the option of excluding a sibling with income, for example, would no longer be available. Similarly, if a minor mother living with her own parents is receiving aid, her parents' income must also be taken into consideration. Improvements such as these are expected to result in payment of AFDC that much more realistically reflects the actual home situation.

Page 2 - The Honorable George Bush

The AFDC amendments made by title I of this bill are expected to reduce Federal costs by \$646 million in fiscal year 1984 and \$841 million in fiscal year 1985 (including savings attributable to repeal of the Work Incentive (WIN) program authorization). The ESI amendment made by section 202 would reduce Federal costs by \$14 million and \$15 million in fiscal years 1984 and 1985, respectively.

We urge that the Congress promptly enact this proposed legislation ensuring important fiscal and administrative improvements.

We are advised by the Office of Management and Budget that enactment of the enclosed draft legislation would be in accord with the program of the President.

Sincerely,

/s/ Margaret M. Heckler

Secretary

Enclosures

COST ESTIMATES FOR THE SOCIAL WELFARE AMENDMENTS OF 1983

(\$ in millions)

| | <u>1984</u> | <u>1985</u> | <u>1986</u> | <u>1987</u> |
|-------------------------------------|-------------------------------------|-------------|-------------|-------------|
| TITLE I--AFDC Provisions | | | | |
| Section 101 | -17 | -17 | -17 | -18 |
| Section 102 | -136 | -139 | -139 | -141 |
| Section 103 | -252 | -257 | -258 | -263 |
| Section 104 | -----negligible savings----- | | | |
| Section 105 | -217 | -404 | -384 | -369 |
| Section 106 | -19 | -19 | -19 | -19 |
| Section 107 | -----negligible savings----- | | | |
| Section 108 | -----negligible savings----- | | | |
| Section 109 | -5 | -5 | -5 | -5 |
| Section 110 | -----negligible savings----- | | | |
| Section 111 | -----negligible savings----- | | | |
| Section 112 | -----negligible savings----- | | | |
| Section 113 | -----negligible savings----- | | | |
| Section 114 | -----negligible savings----- | | | |
| Section 115 | -----negligible savings----- | | | |
| Section 116 | -----no effect----- | | | |
| TITLE II--SSI Provisions | | | | |
| Section 201 | -----negligible savings----- | | | |
| Section 202 | -14 | -15 | -16 | -17 |

**Section-by-Section Summary of
Social Welfare Amendments of 1983**

**Title I - Amendments to
the AFDC Program**

**Exclusion of Needs and Income of Caretaker
Relative of Dependent Child Age 16 or Over**

Section 101(a) of the draft bill would amend section 406(b) of the Social Security Act (the provision defining aid to families with dependent children). It would add, as a condition on the inclusion of the relative (or spouse of the relative) when the youngest dependent child has attained age 16, that the relative not be employable.

Subsection (b) would further amend section 406 to add a definition (appearing as subsection (d)) of the term "employable". It is defined there to include anyone required to register under section 402(a)(19)(A) and those excused from registration because they are remote from a WIN site or because they are already working 30 hours per week.

Subsection (c) amends section 402(a)(7) of the Act to make explicit in the statute the requirement that States consider the income of any parent or stepparent (regardless of whether his needs are included) who is living with the dependent child. If his needs are not included (for reasons other than his failure to participate in work and related activities, his participation in a strike, refusal to repay overpayments, or refusal to assign support), then the so-called "stepparent" disregards of paragraph (31), rather than the "recipient" disregards of paragraph (8), of section 402(a) will be applied. It also provides that if the caretaker relative is claiming aid, is a minor, and is living with his parent or stepparent, his parent's or stepparent's income will be treated as described in the preceding sentence.

These amendments will become effective October 1, 1983.

**Parents and Siblings of Dependent
Child Included in AFDC Family**

Section 102 of the draft bill would further amend the plan requirements contained in section 402(a) of the Social Security Act by adding a new requirement that the State include, as a member of the AFDC family (both the needs and the countable income of) the parents and the minor siblings of the dependent child for whom aid is claimed and who are living with the dependent child if the siblings are, themselves, deprived of parental support or care and under the age limit selected by the State.

The general inclusionary rule does not, however, include stepbrothers and stepsisters of the dependent child nor does it include, if the dependent child has attained age 16, the employable parent of the child. Once it has been determined that the parent or sibling must be included in the AFDC family unit, one consequence is, as would be made explicit within paragraph (37), that any income of the parent or sibling must be considered as part of the family's income for purposes of determining eligibility and benefit amount, notwithstanding section 205(j) of the Social Security Act, in the case of OASDI benefits. This amendment would become effective October 1, 1983.

Mandatory Adjustment of Shelter and Utilities Allowance

Section 103 of the draft bill would revise section 412 of the Social Security Act, pertaining to proration of the shelter allowance for an AFDC family living as part of a larger household. As amended, that section would require the State to make some adjustment to reflect the fact that others outside of the AFDC family are sharing the shelter and utilities. The State would have to pro rate (by the ratio of AFDC recipients to total household members) the shelter and utilities components of both the standard of need and the payment standard or develop an alternative adjustment method. The alternative would require the prior approval of the Secretary, and would have to result in average reductions (for the part of the caseload affected) comparable to those resulting from the (otherwise) prescribed prorating of the shelter and utilities components of the needs and payment standards. This amendment becomes effective October 1, 1983.

Treatment of Lump-Sum Payments to Individuals Outside the AFDC Family

Section 104 of the draft bill would clarify one of the AFDC amendments made by the 1981 Omnibus Budget Reconciliation Act. It dealt with the treatment by a member of an AFDC family of non-recurring income in an amount great enough to cause the family to be ineligible for the month of receipt. In short, that amendment required that the period of the family's ineligibility equal its income for that month divided by the applicable standard. The amendment to be made by the draft bill makes explicit that the same approach is applied to income received by someone who is not an AFDC recipient, in the technical sense, but whose income must be included in determining the family's eligibility and benefit amount, e.g. step-parents and sponsors of aliens. When the income is received by such a person, the "applicable standard" becomes the one that would apply to the family if that person and his dependents (for Federal income tax purposes) were included in the grant. These amendments would become effective October 1, 1983.

Work Requirements for Applicants for and Recipients of AFDC

Section 105 of the draft bill substantially revises the requirements for participation in employment related activities under the AFDC program. The amendments modify the description of the class of applicants and recipients who must participate in these activities, and, in place of the Work Incentive Program (WIN) under part C of title IV of the Social Security Act, which would be repealed by this section, adds requirements that the State operate employment search and community work experience programs (CWEP), as well as, at the State's option, the newly authorized subsidized employment program.

Subsection (a) repeals part C of title IV, the WIN program, including related authority for WIN demonstrations.

Subsection (b) amends section 402(a)(19)(A) of the Act to specify the applicants and recipients to whom the requirements apply. Exceptions are made only for (1) a child under 16 or in full-time attendance at an elementary, secondary, or vocational or technical school, (2) a person who is ill, incapacitated, or age 60 or above, (3) a person needed at home because of the illness or incapacity of another family member, (4) the caretaker relative personally providing care to a child under age 6 (but the State may require caretakers of younger children, but not younger than age 3, to participate if child care is available), and (5) a person working at least 30 hours per week in employment other than that supported under the AFDC program. Subparagraph (B), as amended, would state that, subject to the maximum discussed below, the number of hours that members of one family may be required to participate in CWEP in a month equals the amount of its AFDC benefit plus its food stamp allotment for such month, divided by the Federal minimum wage, (or the State minimum wage, if higher) but not more than 120 hours per month. (The Secretary is authorized to prescribe regulations for determining the amount of the family's allotment, for this purpose, when the food stamp household includes the AFDC family and others.) The maximum monthly number of hours that CWEP may be required is 120, reduced by hours spent in any other employment, and the maximum monthly number of hours in employment search is 160, reduced by hours spent in all other employment related activities.

Subparagraph (C) requires the State agency to refer all non-exempt applicants and recipients to the appropriate program. Each non-exempt parent in a family receiving benefits by reason of the unemployment of the principal earner must participate in a CWEP program, and in employment search, and all other recipients must take part in CWEP and employment

search or (if and to the extent the State finds it appropriate) in an approved subsidized employment program under section 414, as added below by this section of the draft bill, and employment search.

Subparagraph (D) maintains the same penalties for recipients, and extends them to applicants, for failing to comply with the requirements outlined above as are provided under current law by section 402(a)(19)(F) for failure to register for WIN. In addition, the penalties would be applied to an individual exempt from these participation requirements because he is already working at least 30 hours per week if he ceased working, or reduced the hours he worked, without good cause.

The remainder of the subsection repeals other WIN-related provisions in section 402(a).

Subsection (c) makes a series of amendments to the employment search program recently added to the AFDC law by the Tax Equity and Fiscal Responsibility Act of 1982. First, it would make mandatory the operation of such a program within each State. Further (in addition to various technical amendments to reflect the repeal of WIN), the paragraph is amended to require non-exempt applicants to participate until the application is acted upon, recipients who are participating in CWEP to engage in job search at intervals and for periods set by the State, but at least on a monthly basis, and other recipients to engage in job search on whatever basis the State finds appropriate.

The subsection would also add a direction parallel to the one existing in section 409 that provision will be made for meeting individuals' costs that are necessary and directly related to their employment search activities. The Secretary, as under section 409, will establish a ceiling on the monthly amount of an individual's costs to be provided by the State.

Section 403, providing for Federal financial participation in State costs would be amended by subsection (d). A new class of payments would be added to the definition of "erroneous excess payments" under subsection (i) (the general AFDC error rate provision). Payments (measured on the average) would be erroneous when made to cases subject to the participation requirements of section 402(a)(19)(A), in which the non-exempt member is nonetheless not participating in employment related activities, to the extent that such cases exceed 25% of all such cases. The percentage of participation will be measured over a period selected by the Secretary to correspond to the relevant quality control reviews. It also makes various technical and conforming amendments to section 403.

Subsection (e) would amend section 406(d) (added by section 101 of the bill) to conform the cross-references to the amended section 402(a)(19)(A).

Subsection (f) would make various technical amendments to section 407 of the Act, the section authorizing States to provide AFDC on the basis of the unemployment of a parent, reflecting the repeal of WIN and the participation requirements imposed by section 402(a)(19).

Subsection (g) would amend section 409, to require a State to establish a community work experience program and to make other necessary technical and conforming amendments.

Subsection (h) would substantially revise section 414 of the Act to authorize States to establish programs of subsidized employment. Section 414(a) would state the objectives of such a program -- to make jobs available to AFDC recipients under agreements between the State agency and the employer, in such a manner as will aid in moving people from welfare to unsubsidized employment and assist them in becoming financially self-sufficient.

Section 414(b) would be revised to require a State plan amendment to provide (1) that acceptance of a position is voluntary, but will only satisfy the section 402(a)(19) work requirement for hours when the individual is actually engaged in employment activities, (2) that the principal earner in an "unemployed parent" family will not be referred to subsidized employment (but would instead be required to participate in CWEP), (3) that recipients in subsidized employment will be treated the same as other employees in similar positions and State laws and regulations applicable to employment will be equally applicable to these program participants, (4) that the "30 + 1/3" disregard will not apply to wages earned in subsidized employment, but that participants will be considered to have been in recipient status so that the "30 + 1/3" will be immediately available in months after the subsidized employment ends (thus preserving the incentive to enter the regular work force), (5) that subsidized employment may be provided by any employer, either public or private, and (6) that the State agency may provide part, but not all, of the funding for the wages (and the employer must contribute to the wages).

Section 414(c) would state that wages earned from subsidized employment are to be considered earned income under any provision of law.

Section 414(d) would authorize the inclusion, for purposes of Federal matching as AFDC expenditures, of amounts provided to employers for payment as subsidized wages, up to the amount of AFDC such a family (with no other income) would have received for the first month of subsidized employment, reduced by the actual AFDC grant for that month, but for no more than six months.

Section 414(e) expressly waives Statewideness, but requires the State plan to specify the political subdivisions (or parts of subdivisions) in which the subsidized employment program will be in effect.

Section 414(f) addresses the relationship between an individual's status as an employee in subsidized employment and the child support enforcement program. For purposes of the requirements for assignment of support and cooperation, the individual is treated like a recipient, and for purposes of distributing collections of support, the amount that the State contributes to the wage subsidy, for which it may claim matching under section 403, increased by any AFDC paid, is considered to be aid paid under the plan.

Subsection (i) provides that these amendments would become effective October 1, 1983.

Households Headed by Minor Parents

Section 106 of the draft bill would add a new AFDC plan requirement to section 402 of the Social Security Act, addressing the situation in which a minor parent leaves home, establishes a household separate from that of her parent or guardian, and together with her child, she claims aid to families with dependent children. (In such case, her parents' income would not be counted since she is not living with them). Under the new requirement, an individual below the age selected by the State to define a dependent child, who has never been married, and is living apart from her parents or guardian, is eligible for AFDC (and the dependent child in her care is eligible) only if the State agency makes one of three specific findings: (1) the minor has no parent or guardian who is living and whose whereabouts are known; (2) the health and safety of the minor or the dependent child would be seriously jeopardized if they lived with the parent or guardian; or (3) the minor has lived apart from the parent or guardian for at least a year prior to the birth of the child or a year prior to claiming aid, whichever is later. If the minor caretaker is living with her parent or guardian, or if the State agency finds that one of these conditions exists, the (otherwise eligible) minor will be furnished aid, and the State agency may make protective payments under section 406(b)(2) of the Act until the minor attains the AFDC age limit. This amendment becomes effective October 1, 1983.

Repayment of AFDC from Retroactive Payment of Periodic Benefits

Section 107 of the draft bill would further amend the AFDC plan requirements to add a provision on repayment of AFDC from lump-sum retroactive payments of other public benefits, similar

to section 1127 of the Social Security Act pertaining to adjustments between OASDI and SSI. Under the new section 402(a)(39), the State agency would require repayment of AFDC (paid within such prior period as the Secretary may specify) from an individual who receives a retroactive payment of periodic benefits under a public program (other than SSI) if, had those other benefits been paid at the times regularly due, the AFDC would have been reduced as a result. The amount which must be repaid (which is to be treated like an AFDC overpayment for purposes of all other plan requirements) is equal to the amount by which the AFDC would have been reduced had the other benefits been paid when regularly due. Provision is also made for not counting so much of the retroactive payment as "caused" the excess payment under paragraph (7) (requirement for counting all income), (17) (treatment of lump-sum payments), (18) (150% of standard as an overall limit on eligibility), (31) ("step-parents" disregards), or section 415(b) (income of an alien's sponsor). Also, the State plan must specify the procedures that will be followed to notify recipients of this requirement and their obligations. This amendment would apply to AFDC and other benefits paid for months after September 1983.

Treatment of Amounts Withheld from Other Public Benefits as a Penalty

Section 108 of the draft bill would amend section 402(a)(7) of the Social Security Act, the statutory provision requiring the consideration of all income and resources (except to the extent the law otherwise provides). As amended, a new subparagraph (D) would require States to count as income amounts being withheld from public benefit payments because of the imposition of a penalty or other such sanction if such amounts would have otherwise been counted as income. Generally, only amounts actually available to the family are counted as income. Thus, the imposition of a penalty under another program would result in an equivalent increase in the AFDC benefit. This amendment would correct that perverse result. The amendment would become effective October 1, 1983.

Absence from Home Solely by Reason of Employment

Section 109 of the draft bill would amend the scope of "absence", as used in the definition of "dependent child" under section 406(a) of the Social Security Act. Section 153 of the Tax Equity and Fiscal Responsibility Act of 1982 recently amended that term so that absence of a parent, solely by reason of active duty in one of the uniformed services of the United States, will not qualify as absence of a parent in order that a child may be considered deprived of parental support or care

for purposes of AFDC. The amendment made here would recognize that active duty in a uniformed service is only one type of employment, and would therefore broaden the exclusion from "AFDC absence" to cover any absence for the sole reason of seeking or retaining employment. This amendment would become effective October 1, 1983.

Limitation on Individuals who may be Considered Essential Persons

Section 110 of the draft bill would amend section 402 of the Social Security Act to add a new subsection (f), providing conditions that must be met before the State may permit an individual to be treated as an essential person. The consequences of including a person within the State's definition of essential person are that, while he is not eligible to be an AFDC recipient, his needs are included together with those of the family members who are recipients, and his income and resources are also aggregated with the family's. As amended, a State could only permit the inclusion on this basis of an individual living in the home with the AFDC child and relative who is providing services to the relative or child which are made necessary because of the caretaker relative's physical or mental inability to care for himself or the dependent child or who is providing services (such as child care or care of an incapacitated family member) necessary to allow the caretaker relative to work on a full-time basis. This amendment would become effective October 1, 1983.

Effect of Participation in a Strike on Eligibility for AFDC

Section 111 of the draft bill would amend section 402(a)(21) of the Social Security Act, the plan requirement dealing with the eligibility of strikers. Current law, as added by the 1981 Reconciliation Act, precludes payment to a family receiving AFDC if the parent-caretaker relative is on strike on the last day of the month for which payment is being made. (The needs of any other person on strike at that time must be excluded when determining payment.) This section would change that benchmark day to the last day of the month covered by the recipient's report, either the month preceding the payment month or, in a State with two-month retrospective reporting, the second preceding month, in order to facilitate the administration and improve the accuracy of eligibility and payment determinations. The provision would also be amended to apply to the "employable" parent or other person -- the term "employable" being defined in a new section 406(d), previously added. In the case of an applicant the application must be denied if the employable parent is on strike on the day he files the application and the needs of any other employable person who is on strike at that time must be excluded. These amendments would become effective October 1, 1983.

Access to AFDC Information

Section 112 of the draft bill would amend section 402(a)(9) of the Social Security Act to broaden the permissible uses of AFDC information. Currently, information is available only for purposes directly connected with the administration of federal or federally-aided assistance programs. In addition to some purely editorial improvements, the amendment would allow disclosure to law enforcement officials of AFDC information to be used in connection with any criminal proceeding. This amendment would be effective upon enactment.

Eligibility of Alien for AFDC when Sponsor is an Agency or Organization

Section 113 of the draft bill would amend section 415 of the Social Security Act, the section requiring attribution of a sponsor's income and resources to an alien seeking AFDC. The amendment, which would appear as a new subsection (f), addresses the issue of application of the general attribution principle to the case where the alien's sponsor is an agency or organization. Instead of applying the other rules of section 415, the State AFDC agency would be required to find such an alien ineligible during the 3 years following his entry into the United States, unless it determines either that the sponsoring agency has gone out of existence or that the sponsor is unable to meet the alien's needs. The criteria for making either of these determinations, and the documentation that the State agency would require (including documentation to be furnished by the alien himself) are to be prescribed by the State, and set out in its approved AFDC plan. The amendments made by this section would apply to applications for benefits filed after September 30, 1983.

CWEP Work for Federal Agencies Permitted

Section 114 of the draft bill would amend section 409(a) of the Social Security Act, the Community Work Experience Program (CWEP). The amendment would provide an explicit statement of Congressional intent that CWEP participants might perform work, in the public interest, for Federal agencies, with the agencies' consent. However, these CWEP participants could not be considered to be Federal employees for any purpose and the State agency would be required to provide workers' compensation and tort claims protection. The amendment would be effective upon enactment.

Sanction for Refusal to Repay Overpayment of AFDC

Section 115 of the draft bill would amend section 402(a)(22) of the Social Security Act to direct the treatment

by the State agency of the caretaker relative in a family that continues to receive AFDC if the relative refuses to repay a previously made overpayment. The amendment would only apply where the family had income and liquid resources above 90 percent of the State's maximum payment standard for a family with no other income. In such a case, if the relative refused to use the excess over 90 percent to make repayment, the State agency would have to exclude the relative's needs. This amendment would become effective October 1, 1983.

Gross Amount of Earned Income

Section 116 of the draft bill would amend section 402(a)(8) of the Social Security Act, the paragraph prescribing the earned income disregards under the AFDC program. It makes explicit in the statute this long-standing understanding of this Department that the term "earned income" is meant by Congress to refer to the gross amount earned by an individual before deductions are taken for income taxes, insurance, FICA, support payments, or any other reason, regardless of whether the deduction is voluntary or involuntary. The income exclusions that the law requires the State agency to apply (i.e. \$75, child care expenses up to \$160, and \$30 plus one-third of the remainder) take into consideration, in the manner and the extent intended by Congress, amounts that must be applied from the individual's earnings to meet other obligations.

This amendment would become effective upon enactment.

Title II - Amendments to the Supplemental Security Income Program

Eligibility of Alien for SSI When Sponsor is an Agency or Organization

Section 201 of the draft bill would amend section 1621 of the Social Security Act, the section requiring attribution of a sponsor's income and resources to an alien seeking SSI. This section corresponds to the companion amendment to the AFDC program made by section 113 of this draft bill. These amendments, as under the AFDC title of the bill, would apply to applications for benefits filed after September 30, 1983.

Adjustments on Account of Retroactive Benefits under Title II

Section 202 of the draft bill would revise section 1127 of the Social Security Act in order to broaden its scope. Under current law, the Social Security Administration (SSA) is required to reduce Old-Age, Survivors' and Disability Insurance

(OASDI) benefits paid retroactively, following adjudication of initial eligibility, by the amount of supplemental security income (SSI) benefits that would not have been paid had the OASDI been received in the months when regularly payable. Since SSI benefits are generally computed based on income actually received in a month (rather than amounts subsequently received on a retroactive basis), the current provision mitigates what would otherwise be windfall benefits under title II. However, current law is not cast broadly enough to allow correction of certain related cases. The revised section is designed to cover the following additional situations.

In the case where retroactive OASDI benefits are paid before the SSI benefits for the same period, the retroactive SSI amount otherwise payable would be reduced by the amount of SSI that would not be paid had OASDI for months in the relevant period been paid when regularly due.

Second, the section would apply equally to retroactive OASDI benefits which result from an initial determination of eligibility under title II or a resumption of payment following a period of suspension of those benefits.

Finally, because SSI is, in general, determined on a two-month retrospective basis, the last two months of the retroactive OASDI payment would not have affected the amount of SSI benefits payable in the retroactive period had they been paid when regularly due. Rather, they would have affected the SSI benefits payable for the two months immediately following the retroactive period. Therefore, under current law, they are not subject to offset. As a result, a windfall can still occur. The revised section is intended to eliminate that potential windfall by requiring offset of the retroactive OASDI payment regardless of which months' SSI benefits it would have affected had it been paid when regularly due.

The amendment made by this section would apply to retroactive benefits (either OASDI or SSI) payable after September 3 1983.

Addendum 23

26-23-2. Administrative review of actions of department or director — Hearings — Procedure — Judicial review [Effective until January 1, 1988].

(1) Upon written request any person aggrieved by any action or inaction of the department or its executive director shall be given an informal hearing before the department. Minutes or a summary of the informal hearing shall be taken and filed in the department records. If the matter cannot be resolved at the informal hearing, the aggrieved person may then request a hearing before an impartial hearing officer appointed by the department, who shall have power and authority to conduct a hearing in the name of the department at any time and place, in accordance with rules and procedures for administrative hearings adopted by the department. Minutes or a summary of the proceeding of such hearing shall be taken and filed with the department records, together with recommended findings of fact and conclusions of law made by the hearing officer, from which the executive director shall make a final determination. In any such hearing, the hearing officer shall have authority to administer oaths, examine witnesses, and issue in the name of the department

notice of the hearings or subpoenas requiring the testimony of witnesses and the production of evidence relevant to any matter in the hearing. Hearings shall be conducted in a manner which guarantees the parties' due process rights. This includes, but is not limited to, the right to examine any evidence presented to the department or hearing officer, the right to cross-examine any witness, and a prohibition of ex parte communication between any party and a member of the committee or the hearing officer. Final rules incorporating these procedures shall be adopted by the committee on or before October 1, 1988.

(2) Judicial review of a final determination of the executive director may be secured by the aggrieved party by filing a petition in the district court within 30 days after receipt of notice of the executive director's final determination. The petition, which shall be served upon the executive director, shall state the grounds upon which review is sought. With his answer, the executive director shall certify and file with the court all documents and papers and a transcript of all testimony taken in the matter, together with the recommended findings of fact and conclusions of law of the hearing officer, and the final determination of the executive director.

(3) If the final determination of the executive director is consistent with the findings of fact and conclusions of law recommended by the hearing officer, the court shall review the record and may alter the final determination only upon a finding that the final determination is capricious, or not supported by the evidence.

(4) If the final determination of the executive director is not consistent with the findings of fact and conclusions of law recommended by the hearing officer, the executive director shall prepare and file with the court at the time of filing the answer to the petition, findings of fact and conclusions of law to support the final determination of the executive director. The petitioner shall have 15 days after receipt of the executive director's findings of fact and conclusions of law to amend the petition for review. The court may affirm or amend the final determination of the executive director, or require further or additional testimony necessary to be taken, and issue an order based on its own findings of fact and conclusions of law.

Administrative review of actions of department or director [Effective January 1, 1988].

Any person aggrieved by any action or inaction of the department or its executive director may request agency action and appropriate adjudicative proceedings. Hearings shall be conducted in a manner which guarantees the parties' due process rights. This includes, but is not limited to, the right to examine any evidence presented to the department or hearing officer, the right to cross-examine any witness, and a prohibition of ex parte communication between any party and a member of the committee or the hearing officer. Final rules incorporating these procedures shall be adopted by the committee on or before October 1, 1988.