

Social Security Amendments of 1972: Summary and Legislative History

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PRESIDENT NIXON'S SIGNATURE on H.R. 1, the Social Security Amendments of 1972, brought to a close 3 years of consideration of and deliberations on proposals to improve the social security program. What the President called "landmark legislation" became Public Law 92-603 on October 30, 1972. Among its most significant and far-reaching provisions are:

—Higher benefits for most people eligible for benefits as aged widows and widowers

—For men reaching age 62 in the future, repeal of the provisions under which a man the same age and with the same earnings as a woman generally got a lower benefit than the woman worker and under which men needed more social security credits to qualify for retirement benefits than women did (the change will be accomplished over a 3-year period beginning with 1973)

—Changes in the retirement test to assure that the more a beneficiary works and earns, the more spendable income (social security benefits plus earnings after taxes) he will have, and to raise from \$1,680 to \$2,100 the annual exempt amount of earnings with future automatic adjustment to keep pace with increases in earnings levels

—A special minimum benefit for those who have worked in covered employment for many years, but at low earnings

—Higher benefits for workers who do not get social security retirement benefits before age 65 but continue to work past that age

—Improvements in disability insurance protection (including a reduction in the waiting period for benefits and extension of childhood disability benefits to persons disabled between ages 18 and 22) as well as improved protection for a worker's dependents and survivors

—Extension of Medicare protection to disability insurance beneficiaries who have been on the social security disability benefit rolls for at least 2 years

—Extension of Medicare protection to persons under age 65 (those getting monthly social security benefits, those not getting benefits who have worked in covered employment long enough to be insured, and the wives or husbands and children of such persons) if they need hemodialysis treatment for chronic kidney disease or require a kidney transplant

—Changes in the Medicare program to improve its operating effectiveness.

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The amendments also created a new Federal supplemental security income program, effective January 1974, for the needy aged, blind, and disabled. Administered by the Social Security Administration but financed out of general revenues of the Federal Government, this program will replace the present Federal-State programs of old-age assistance, aid to the blind, and aid to the permanently and totally disabled. Federal payments under this program will assure minimum income levels; States may supplement the Federal payments to maintain existing payment levels where these are higher.

Other major social security legislation was enacted in July 1972. Those amendments (1) provided a 20-percent across-the-board increase in social security benefits effective for September 1972; (2) included provisions for keeping social security benefit amounts up to date automatically in the future as the cost of living rises; and (3) increased from \$9,000 in 1972 to \$10,800 in 1973 and to \$12,000 in 1974 the maximum amount of a worker's annual earnings that may be counted in figuring his and his family's social security benefits (and on which he pays social security contributions) and provided in addition for keeping the amount up to date automatically in the future as average wages rise; and a revised contribution rate schedule, which included increases in the hospital insurance rates to restore the financial soundness of that part of the program.

A detailed summary of all major provisions enacted in 1972 is given later in this article.

Background and Legislative History

ACTION IN 1969

On September 25, 1969, the President sent to the Congress his recommendations for social security legislation. They included:

- (1) A 10-percent across-the-board increase in social security cash benefits;
- (2) automatic adjustment of social security benefits to future increases in the cost of living;
- (3) an increase in the annual exempt amount of earnings under the retirement test from \$1,680 to \$1,800, with a corresponding increase in the monthly measure of retirement, and a provision for \$1-for-\$2 withholding of benefits for all earnings in excess of \$1,800 (instead of withholding \$1 for each \$2 earned above \$1,680 through \$2,880 and for each \$1 of earnings above \$2,880), and a provision for automatic adjustment of the test to future earnings levels;
- (4) an increase in the social security contribution and benefit base from \$7,800 to \$9,000 for 1972 and 1973, with provision for subsequent automatic increases to take account of future increases in earnings levels;
- (5) an increase from 82½ percent to 100 percent of the spouse's benefit for a widow or widower who begins receiving benefits at age 65 or later, with the benefit amount graded down to 82½ percent for a widow or widower who takes benefits at age 62;
- (6) noncontributory earnings credits (in addition to credit for contributory coverage of basic pay) of \$100 a month for military service from January 1957 through December 1967, similar to the credits previously provided for service after 1967;
- (7) extension of childhood disability benefits to people who become disabled after age 18 and prior to age 22;
- (8) determination of benefit amounts and insured status for men on the same basis as that for women in the existing law—that is, over a period equal to the number of years up to age 62 rather than up to age 65; and
- (9) changes in the contribution rate schedules for both cash benefits and for hospital insurance.

On September 30, 1969, the minority leader of the House of Representatives, Gerald R. Ford, introduced H.R. 14080, a bill containing the President's recommendations for social security legislation. The bill was referred to the Committee on Ways and Means of the House of Representatives for consideration.

On October 15, the Ways and Means Committee began public hearings on H.R. 14080 and H.R. 14173, which contained President Nixon's proposals for reforming the Federal-State programs of public assistance. Secretary of Health, Education, and Welfare Robert H. Finch appeared as the Administration's first witness. In his testimony, Secretary Finch announced that the Administration was forwarding to the Committee that day for its consideration (along with the Medicare provisions of H.R. 14080) a proposed bill, the "Health Cost Effectiveness Amendments

of 1969," containing several provisions intended to strengthen administrative controls over program payments, coordinating health facility reimbursement with community planning efforts, and experimenting with alternative methods of reimbursement that it was hoped would be considered for inclusion in the social security bill. The public hearings continued until November 13 and the Committee went into executive sessions on November 19.

15-percent benefit increase enacted.—Early in December it became clear that the Senate would attach several amendments to the Social Security Act to a tax bill that seemed certain of enactment. The Committee on Ways and Means unanimously ordered reported to the House a bill, H.R. 15095, which had been introduced on December 4 by Committee Chairman Wilbur D. Mills and the ranking minority member of the Committee, Representative John D. Byrnes. As reported, the bill provided for a 15-percent increase in social security benefits, effective for January 1970, removing the \$105 limitation on wife's and husband's insurance benefits which had been enacted by the previous Congress, and increasing the allocation of contribution income to the disability insurance trust fund. Because the old-age, survivors, and disability insurance (OASDI) program had a substantial favorable actuarial balance (1.16 percent of taxable payroll), the benefit increases that were provided did not necessitate increases in either the contribution rates or the contribution and benefit base. The House passed the bill on December 15, 1969, by a vote of 398 to 0.

In the meantime H.R. 13270, the proposed Tax Reform Act of 1969, was being debated and amended on the floor of the Senate. The amendments that related to the social security program were to provide:

- (1) A 15-percent across-the-board general increase in social security benefits effective for January 1970;
- (2) a minimum benefit of \$100;
- (3) an increase in the contribution and benefit base to \$12,000 beginning in 1973;
- (4) elimination of the \$105 limitation on wife's and husband's benefits;
- (5) actuarially reduced benefits payable at age 60 for workers, wives, husbands, widowers, and parents;

(6) a disregard of social security benefit increases for January and February 1970 in determining eligibility for, and amount of, public assistance; and

(7) a guarantee that all those receiving both aid to the aged, blind, or disabled and social security benefits would receive a net increase in income of at least \$7.50 for months after March 1970.

The Tax Reform Act, with these amendments, was passed by the Senate by a vote of 69 to 22. It was sent to a House-Senate conference committee on December 11 to settle the differences between the two versions of the bill. The conferees agreed upon:

(1) A 15-percent across-the-board general increase in social security benefits effective for January 1970;

(2) elimination of the \$105 limitation on wife's and husband's benefits;

(3) an increase in the allocation of contribution income to the disability insurance trust fund;

(4) a disregard of social security benefit increases for January and February 1970 in determining eligibility for, and amount of, public assistance; and

(5) a guarantee that all people receiving aid to the aged, blind, or disabled and also social security benefits for any month after March 1970 and before July 1970 would receive a net increase in income of at least \$4 or, if less, the actual amount of the increase in their social security benefits.

The report of the conference committee was agreed to by both the House and the Senate on December 22. On December 30, the President signed the Tax Reform Act of 1969 into law. It became Public Law 91-172.

ACTION IN 1970

In January the Ways and Means Committee resumed consideration of the President's proposals. On May 11, a new bill H.R. 17550, reflecting the Committee's decisions, was introduced in the House by Chairman Mills and Representative Byrnes.

The major social security proposals made by the President were included in H.R. 17550 with several significant exceptions. In September 1969, the President had recommended a 10-percent increase in cash benefits effective for March 1970 and automatic adjustment of benefits in the future. The Congress had subsequently enacted a 15-percent increase in benefits effective for January 1970, and the Committee's bill provided

for an additional 5-percent increase in benefits to be effective for January 1971. The bill did not include the President's proposal for automatic adjustments of benefits (and of the contribution and benefit base), though these proposals were later included in the bill before it was passed by the House.

Under the Committee bill, the annual amount of earnings to be exempted under the retirement test would have been increased from \$1,680 to \$2,000, with \$1 in benefits withheld for each \$2 of earnings between \$2,000 and \$3,200 and for each \$1 of earnings above \$3,200. The President had recommended an annual exempt amount of \$1,800, with \$1 in benefits to be withheld for each \$2 of *all* annual earnings above \$1,800 and automatic adjustment of the exempt amount to keep pace with increases in earnings levels.

The contribution rates approved by the Committee were in accord with those recommended by the President but differed in detail from his. The Committee also provided for significant changes in the financing of the hospital insurance program, intended to restore it to a state of acceptable actuarial balance.

H.R. 17550 included further changes in the cash benefits program, in addition to those recommended by the President. Among these were provisions for the payment of reduced benefits to dependent widowers at age 60, elimination of the support requirement as a condition for benefits for divorced wives and widows, continuing child's benefits beyond age 22 for certain full-time students, changes in the disability insured status requirements for the blind, and a change in the workmen's compensation offset for disability beneficiaries.

The provisions in the Committee bill dealing with the Medicare and Medicaid programs reflected, for the most part, changes recommended by the Department. In testimony before the Senate Finance Committee in February, concerning that Committee's Staff Report on Medicare and Medicaid, Under Secretary John G. Veneman recommended a change in the method of reimbursing institutional providers under Medicare and the introduction of additional limitations on the recognition of physicians' fee increases. These recommendations were embodied in the Committee on Ways and Means version of H.R. 17550, under which (1) the Secretary was

directed to develop large-scale experiments and demonstration projects to test various methods of making payments to providers of services on a prospective, rather than retroactive, cost basis and (2) recognition of increases in physician fee levels were to be related to indexes reflecting changes in costs of practice for physicians and in earnings levels.

As part of the Administration's proposals to stimulate the development of health maintenance organizations, announced by Secretary Finch in March 1970, an HMO option for Medicare beneficiaries was added to the bill. Under the option, Medicare beneficiaries could choose to receive their covered services only through an HMO. The organization would be paid on a capitation basis instead of being reimbursed for individual physician visits or hospital stays. The Committee's bill also included a number of other changes designed to improve the operating effectiveness of the Medicare program (as well as changes to improve the operations of the Medicaid and maternal and child health programs).

On May 21, the House passed H.R. 17550 by a vote of 344 to 32, after recommitment to the Committee for amendments to provide for the automatic adjustment of benefits, the contribution and benefit base, and the retirement test exempt amount. These provisions had been included in the Administration's proposals for improving the program but were not included in the bill reported out by the Ways and Means Committee. In adding the provision for automatic adjustment of the retirement test, the House also extended the \$1-for-\$2 deduction provision so that it would apply to all earnings above the \$2,000 annual exempt amount.

Following House passage, the bill was sent to the Senate for consideration and was referred to the Senate Committee on Finance, which began public hearings on June 17. During the summer of 1970, the Committee continued to hold hearings on H.R. 17550 and it also held hearings on H.R. 16311, the proposed Family Assistance Act of 1970, which had superseded H.R. 14173. In September the Committee began consideration of the two bills in executive sessions.

These sessions lasted from September 29 to December 9, when the Committee completed its deliberations and reported a revised version of H.R. 17550 to the Senate. Many of the provisions

of the House-passed bill were approved by the Committee on Finance, but a number of changes were made and new provisions were added. In the cash benefits area, the major modifications included:

(1) A 10-percent increase in social security benefits instead of the 5-percent increase in the House-passed bill;

(2) a \$100 regular minimum benefit rather than the \$67.20 minimum resulting from the 5-percent increase in the House-passed bill;

(3) a limitation on the increase in widow's and widower's benefits so that benefits would not exceed the amount the deceased spouse would be receiving if he were still alive (as could have occurred under the House-passed provision);

(4) automatic increases in contribution rates and in the contribution and benefit base, with the stipulation (not included in the House bill) that automatic increases would only go into effect in the absence of Congressional action changing social security benefit levels, contribution rates, or the contribution and benefit base. Also, half of the cost of each automatic benefit increase would be financed by an increase in the contribution rates and the other half by an increase in the contribution and benefit base. (Under the House bill rising wages with automatic adjustment of the contribution and benefit base would have provided adequate financing, without increases in the contribution rates.);

(5) basing benefits for men on earnings up to age 62, rather than on earnings up to age 65, only for those coming on the rolls in the future, to be accomplished over a 3-year transition period (instead of immediately, as in the House-passed provision and for those already on the rolls as well as future beneficiaries);

(6) in place of the House-passed provision which eliminated the recency-of-work requirement for disability insurance benefits to the blind, a much more far-reaching provision, under which insurance benefits were provided for a blind person with 6 quarters of coverage earned at any time, regardless of his ability to work;

(7) extension of the House-passed provision improving childhood disability benefits, by providing that a person who was entitled to childhood disability benefits could become reentitled if he becomes disabled within 7 years after his prior entitlement was terminated;

(8) reduction of the waiting period for disability benefits from 6 months to 4 months (not included in the House-passed bill); and

(9) a revised contribution rate schedule for cash benefits.

The Committee deleted provisions under which (1) election to receive actuarially reduced benefits in one category would not be applicable to certain benefits in other categories; (2) the support

requirements for benefits for divorced women would be eliminated; and (3) the ceiling on income from combined workmen's compensation and social security disability benefits would be raised from 80 percent to 100 percent of the worker's average earnings.

Medicare provisions that were added by the Committee included:

(1) Establishment of a peer review system through the use of organizations representing a substantial number of practicing physicians in local areas to be called Professional Standards Review Organizations (PSRO's) (these organizations would assume responsibility for comprehensive and ongoing review of services provided under Medicare and Medicaid);

(2) establishment of an Office of Inspector General for Health Administration within the Department of Health, Education, and Welfare having the responsibility to review and audit Medicare and other health programs on a continuing and comprehensive basis and the authority to suspend any regulation, practice, or procedure employed in the administration of such programs if he determines that the suspension will promote efficiency and economy of administration or that the regulation, practice, or procedure involved is contrary to or does not carry out the objectives and purposes of applicable provisions of law;

(3) provisions for conforming requirements for participation under Medicare and Medicaid of extended care facilities and skilled nursing homes;

(4) broadening of penalty provisions relating to the making of a false statement of representation of a material fact in any application for Medicare payments to include the soliciting, offering, or acceptance of kickbacks or bribes by providers of health care services;

(5) establishment of a Provider Reimbursement Appeals Board to resolve disputes between providers and fiscal intermediaries concerning the amount of reasonable cost reimbursement;

(6) coverage of services involving the manipulation of the spine by licensed chiropractors under Medicare if the chiropractor meets certain minimum standards established by the Secretary;

(7) requirement that the Secretary of HEW make reports of a provider's significant deficiencies (such as staffing, fire, safety, and sanitation) a matter of public record readily available at social security offices if, after a reasonable lapse of time (not to exceed 90 days), such deficiencies are not corrected;

(8) requirement that the Secretary of HEW develop and employ proficiency examinations to determine whether health care personnel, not otherwise meeting specific formal criteria included in Medicare regulations, have sufficient professional competence to be considered qualified personnel for Medicare purposes; and

(9) a revised contribution schedule for hospital insurance.

In addition, the Finance Committee added a provision which would have established a program of catastrophic health insurance under the Social Security Act for all persons under age 65 who are insured under social security, their spouses and dependent children, as well as all persons under age 65 who are entitled to retirement, survivors, or disability benefits. The health services covered under the provision would have been those covered under the Medicare program, and coverage would have been available after family health care expenses exceeded certain defined limits. The program would have been administered through regular Medicare administrative procedures and subject to all utilization, cost, quality, and administrative controls applicable to that program. Coverage under the program would have been effective beginning January 1972.

Committee modifications of the House-passed bill included:

(1) Expansion of the authority for the Secretary to engage in prospective reimbursement experiments and to conduct experiments with methods of payment or reimbursement designed to increase efficiency and economy, to include experiments with various types of outpatient treatment centers, including mental health centers;

(2) a liberalization in the definition of extended care and a provision for deemed coverage of extended care or home health services if required medical certification and plan of treatment are submitted promptly; and

(3) elimination of provision for part B coverage of up to \$100 per calendar year of physical therapy services furnished by a licensed physical therapist in his office or in the patient's home under a physician's plan.

H.R. 17550 as modified by the Senate Finance Committee also included certain changes in the welfare programs for families and for adults. Changes in the welfare programs had been passed by the House in H.R. 16311, which contained the Administration's proposals. That bill was not acted on separately by the Finance Committee but was, essentially, incorporated in its consideration of H.R. 17550. With respect to the aged, blind, and disabled, H.R. 16311 provided a substantially new Federal-State program under a new title XVI, combining the three categories into one adult assistance program. The minimum monthly income level was to have been the higher of \$110 or the State's standard on the date of

enactment. Uniform definitions of blindness and disability were to be applied, and for the blind and disabled there would have been a mandatory disregard of \$85 of earned income plus one-half of the remainder; there would have been an optional earnings exclusion for the aged of \$60 per month plus one-half of additional earnings. The resource limitations for all would have been \$1,500, plus home, personal effects, and income-producing property essential to support. This new program would have prevented the States from imposing any duration of residency requirement, and they could not have citizenship requirements affecting United States citizens or aliens lawfully admitted for permanent residence and residing continuously for 5 years, nor could there be relative responsibility provisions other than for spouses or parents.

Under the House bill, the Federal Government was to share the administrative costs on a dollar-for-dollar basis and pay 90 percent of the first \$65 of average payments to recipients and 25 percent of the remainder, up to a maximum to be set by the Secretary. Any State could have agreed to have the Federal Government administer all or part of the program and thereby have the administrative costs paid by the Federal Government.

The Senate Finance Committee version of H.R. 17550 provided for retaining the separate programs of aid to the aged, blind, and disabled, but with national minimum income standards of \$130 for an individual and \$200 for a couple (with States required to increase their standards by \$10 for an individual and \$15 for a couple so that in States already having standards above \$120 and \$190 for an individual and a couple, respectively, recipients would realize an increase in income in connection with the social security benefit increase), uniform definitions of blindness and disability, similar to the social security definitions, a prohibition of liens against the property of the blind as a condition of eligibility for aid to the blind, and a provision to assure that all additional expenditures required by the bill with respect to aid for the aged, blind, and disabled would be met without increasing State costs.

The bill was reported to the Senate on December 11. During the final 2 weeks of the 91st Congress the Senate debated the bill. Floor

amendments were added to increase the annual exempt amount of earnings under the retirement test from \$2,000 (in the Committee bill) to \$2,400, to provide benefits for dependent grandchildren, and to raise the ceiling on income from combined social security disability benefits and workmen's compensation benefits from 80 percent to 100 percent of a worker's average earnings prior to becoming disabled (the provision had been deleted by the Committee). The Senate voted to recommit the bill to delete title IV (the catastrophic health insurance program) and title III (the Trade Act of 1970), as well as other provisions of the bill. The bill was passed by a vote of 81 to 0 on December 29.

The Senate requested a conference and appointed conferees. However, there was no conference and the bill died with adjournment, January 2, 1971. Chairman Mills indicated he would make social security legislation the Ways and Means Committee's first order of business in the 92d Congress.

In 1970, an amendment to the act to continue the suspension of duties on manganese ore (P.L. 91-306) extended the pass-along of \$4 of the 1970 social security benefit increase for recipients of aid to the aged, blind, and disabled. As enacted in the Tax Reform Act of 1969, the pass-along was effective only for the period April-June 1970. P.L. 91-306 extended the provision through October 1970. In the closing days of the 91st Congress, another bill was passed which further extended the \$4 pass-along provision. As passed by the House, the pass-along provision would have become permanent, but a Senate amendment made the extension effective only through December 1971. This bill was enacted in January 1971 as P.L. 91-669.

ACTION IN 1971

When the 92d Congress convened, Chairman Mills and Representative Byrnes jointly introduced H.R. 1, the social security provisions of which were, for the most part, the same as those passed by the House in H.R. 17550 in 1970. (In a few cases the provisions of H.R. 1 incorporated changes made by the Senate in the House-passed version of H.R. 17550.) H.R. 1 also included welfare reform provisions passed by the House

in a separate bill in 1970. The Ways and Means Committee held executive sessions on H.R. 1 from February through May. No public hearings were held since they had previously been held on essentially the same proposals.

10-percent benefit increase enacted.—In February and March of 1971, the Congress was also considering H.R. 4690, a bill to increase the public debt limit. During the debate the Senate added several social security amendments to the bill. The House-Senate conference committee, which met to resolve the differences, deleted two social security provisions—those calling for a \$100 minimum benefit and for a \$2,400 annual exempt amount under the retirement test—but accepted the other social security changes which had been added by the Senate. The President signed the bill into law on March 17. It became Public Law 92-5.

The new law provided a 10-percent across-the-board increase in social security benefits, including future maximum family benefits—the maximum amount payable to a family based on one worker's earnings. Under earlier benefit increases, maximum family benefits were increased only for families whose benefits were limited to the maximum on the effective date of the increase. In its report, the conference committee explained that this new method of increasing maximum family benefits was intended to "change the basic nature of the family maximum by making it a percentage of the primary insurance amount rather than a percentage of the worker's average monthly wage."

Under the change, families coming on the rolls after an increase in benefits has been enacted will get the same benefits as those already on the rolls.

The special monthly payments made to certain individuals aged 72 and over who are not insured for regular social security cash benefits were increased by only 5 percent. Both the 10-percent across-the-board increase and the 5-percent increase in special age 72 payments were effective retroactively to January 1971.

The social security contribution and benefit base was increased from \$7,800 to \$9,000, beginning in 1972. In addition, the contribution rate for the social security cash benefits program for 1976 and after was increased from 5.0 percent

each for employees and employers to 5.15 percent. There was no change in the contribution rate for the self-employed.

1971 Advisory Council on Social Security.—In March, the Advisory Council on Social Security—a group composed, by law, of representatives of organizations of employers and employees in equal numbers, and representatives of the self-employed and the public, and including many distinguished leaders in insurance, labor, business, and other fields—issued its reports. The Council had been appointed by Secretary Finch in 1969 and had conducted a comprehensive study of all aspects of the social security program. Its recommendations for changes in the social security cash benefits program included most of the major changes relating to cash benefits that were contained in H.R. 1 and major changes in financing policy, which will be described.

Further action on H.R. 1.—In May, the Committee on Ways and Means completed its consideration of H.R. 1 and sent the bill, as amended by the Committee, to the House for its consideration.

As approved by the Committee, H.R. 1 called for a 5-percent across-the-board benefit increase, effective for June 1972, and an increase in the contribution and benefit base to \$10,200, beginning in 1972. It also contained the major cash benefits and Medicare provisions that were in H.R. 17550 in 1970—some as they were passed by the House, others that were passed by the House but modified by the Senate, and still others that were added to the House-passed version by the Senate. The bill included compromise provisions for automatically adjusting benefits to increases in prices and for automatically adjusting the contribution and benefit base and the retirement test exempt amount to increases in earnings levels; increased benefits for widows and widowers, with benefits limited to the amount the worker would be getting if he were alive; an age-62 computation point for men effective over a 3-year transitional period; liberalization of the retirement test; and the several health cost effectiveness amendments to the Medicare program.

Several major provisions affecting cash benefits that were not in the 1970 House-passed bill (H.R. 17550) were added by the Committee. These

included a special minimum benefit for people who work for 15 or more years under social security; additional dropout years for long-term workers; increased benefits for workers who delay retirement beyond age 65; computation of benefits for certain married couples based on their combined earnings; and a reduction in the waiting period for disability benefits from 6 months to 5 months.

The Committee's bill also included a number of new provisions in the Medicare area. The most significant of these was the extension of Medicare protection to the disabled. Other provisions, not in the House-passed bill in 1970, included: a restriction on increases in the amount of the supplementary medical insurance premium so that each increase would be limited to the percentage by which benefits had been increased across-the-board since the premium was last increased; automatic enrollment (subject to individual opting out) for supplementary insurance for people entitled to hospital insurance; an increase in the supplementary medical insurance deductible from \$50 to \$60 per year; an increase in the lifetime reserve under hospital insurance from 60 to 120 days; and coinsurance equal to one-eighth of the inpatient hospital deductible for each day of inpatient hospital coverage during a benefit period beginning with the 31st day and through the 60th day.

In order to pay the additional cost of the changes made by the Committee in the cash benefits and hospital insurance programs and to restore the actuarial soundness of the hospital insurance program, a new schedule of contribution rates was provided and the contribution and benefit base was raised.

H.R. 1 also contained provisions for far-reaching reforms in the Nation's public assistance programs. Three new Federal welfare programs incorporating the President's plans for welfare reform were included. In line with Administration recommendations, one was to be a Federal adult assistance program to replace the existing Federal-State programs of aid to the aged, blind, and permanently and totally disabled. Two new Federal programs were to replace the program of aid to families with dependent children to provide assistance for the working poor.

The provisions for a Federal adult assistance program differed significantly from the adult

assistance provisions of H.R. 16311 (passed by the House in 1970) and H.R. 1 as it was introduced. Under the Committee's bill, a new title XX of the Social Security Act would establish a totally Federal program to replace the Federal-State programs of old-age assistance, aid to the blind, and aid to the permanently and totally disabled, beginning July 1, 1972; provisions were included, however, for States to supplement the Federal payments with the objective of continuing higher payment levels where they existed. The Federal program and the State supplement, if the State so elected, would be administered by the Social Security Administration.

The Committee bill provided for full monthly payments (assuming no other income) of \$130 for an individual for fiscal year 1973, \$140 for fiscal year 1974, and \$150 thereafter; for a couple, \$195 for fiscal year 1973, and \$200 thereafter. Aged, blind, and disabled persons would be eligible if their income (except for certain exclusions) did not exceed the full benefit amount, and their resources did not exceed \$1,500. A home, household goods, personal effects, and property essential to self-support generally would not be counted as resources. The principal exclusion of income from consideration in determining eligibility and payment amounts applied to earnings: the first \$85 of earnings per month and one-half above \$85 for the blind and disabled (plus work expenses for the blind), and the first \$60 of earnings per month and one-third above \$60 for the aged.

Definitions of disability and blindness under the adult assistance provisions were generally the same as under the social security (title II) provisions. Disabled and blind recipients would be referred to State agencies for consideration for vocational rehabilitation services; refusal, without good cause, to accept offered vocational rehabilitation services would mean ineligibility for assistance payments.

States choosing to provide their own supplements to the Federal payments could have the Federal Government administer the supplements, with the Federal Government paying full administrative costs. States also were provided with a guarantee that if they supplemented the Federal payments, to the extent that the Federal payments and a State's supplementary payments to recipients did not exceed the payment levels

in effect under public assistance programs in the State in January 1971, their costs for the payments would not exceed their total expenditures for all public assistance payments in calendar 1971; the Federal Government would assume the additional cost.

Following the Ways and Means Committee's action on H.R. 1, President Nixon endorsed the bill, calling it "the single most significant piece of social legislation to be considered by the Congress in decades." In his statement, the President said:

The House Ways and Means Committee has taken a momentous step in approving H.R. 1. This bill, with its important symbolic designation as the first order of business of the 92d Congress represents an important landmark in the history of both social security and public welfare reform. As reported by the Committee, under the responsible leadership of Chairman Wilbur Mills and Congressman John Byrnes, this bill represents the finest kind of cooperation between this administration and the Congress.

The President also said, however, that there were areas in the bill that could be improved. In particular, he continued to urge inclusion of his proposal to eliminate the supplementary medical insurance premium and to finance the supplementary medical insurance program (as hospital insurance is financed) through employer-employee contributions made during the working years, rather than from reduced retirement incomes.

On June 22, H.R. 1 was passed by a House vote of 288 to 132 and sent to the Senate for consideration. The Senate Committee on Finance held public hearings in July and August, but no further action was taken until 1972.

Late in 1971, the Congress passed and the President signed into law H.R. 10604, which contained a minor social security amendment. It permitted the payment of the social security lump-sum death payment in cases where the body of an insured worker is not available for burial and the worker had no spouse who was living with him at the time of his death. (The law already provided that the spouse of a worker who was living with him before his death could get the lump-sum death payment whether or not the body was available for burial.)

Under the change, where no body is available for burial, the provisions previously applicable

where a body was available will apply; that is, the lump-sum death benefit is paid to any equitably entitled person, or persons, to the extent and in proportion to the expenses each person incurred in connection with the death of the insured worker. The expenses can include a memorial service, a memorial marker, a site for the marker, or other expenses customarily incurred in connection with a death. The amendment was effective for deaths occurring after 1970.

The bill extended until the end of 1972 the \$4 pass-along provision that was first enacted in 1969 to guarantee recipients of aid to the aged, blind, and disabled, who also receive social security benefits, an increase in income as a result of the social security benefit increase effective for January 1970. Had the amendment not been passed, the pass-along provision would have expired at the end of 1971.

ACTION IN 1972

Further public hearings on H.R. 1 were held by the Senate Finance Committee in January and February of 1972, and the bill was then considered by the Committee in executive sessions through June. While these sessions were going on, interest in providing another substantial benefit increase was growing. On February 23, 1972, Chairman Mills introduced a bill, H.R. 13320, calling for a 20-percent increase in social security benefits, an increase in the contribution and benefit base to \$10,200 in 1972 and to \$12,000 in 1973, and automatic increases in benefits and the contribution and benefit base.

The contribution rate schedule in H.R. 13320 was based on financing recommendations that had been made by the 1971 Advisory Council on Social Security in its reports that year and that had subsequently been endorsed by the boards of trustees of the social security trust funds and by the Nixon administration. Under the practice usually followed in the past, when a schedule of social security contribution rates was enacted, it was generally designed to provide income slightly in excess of expenditures for the first few years after enactment and sufficient income to build up large trust funds in later years. Interest earned by investing these accumulated funds would pro-

vide a significant amount of income that would help to support the program in future years. The Advisory Council's recommendation reflected in H.R. 13320 was that the law should include contribution rates sufficient to finance all benefit costs (assuming that benefits are increased as the cost of living increases) and administrative expenses of the program but that would keep the trust funds at a contingency-reserve level—a level approximately equal to one year's expenditures.

In this regard the Council's recommendation was in basic accord with the practice followed in financing social security for many years. Over the years, when Congress has provided for changes in the social security program, it has generally postponed the effective date of the high contribution rates under which the large trust funds would accumulate and provided new current rates at levels necessary to meet program costs and allow for relatively small annual increases in the trust funds. The Council's recommendation, then, reflected the way the program had, in fact, been financed over the past 20 years.

The Council also recommended, and H.R. 13320 reflected, a change in the assumptions used in making the cost estimates on which contribution rates are based. In the past, cost estimates were based on the assumption that wages and benefits would remain level. When wages did in fact rise, the actual income to the program was greater than the income shown in the estimates. As a result, the program was overfinanced; the contribution rates in the law were higher than were necessary to meet the cost of the benefits payable under the program. The Council recommended that the cost estimates used to determine contribution rates should be based on the assumption that wages and benefits will continue to rise in the future as they have in the past. Thus, the financing recommendations of the Advisory Council made it possible to finance the existing social security benefits with lower contribution rates for the next 40 years than were then in the law.

On June 30, 1972, during its consideration of H.R. 15390, a bill which provided for an extension of the public debt limitation, the Senate added an amendment, introduced on June 28 by Senator Frank Church, which was substantially the same as the Mills bill. (The 20-percent benefit increase was to be effective for September 1972, instead of June, as under the Mills bill,

and the contribution and benefit base was to be increased to \$10,800 in 1973, and to \$12,000 in 1974, with automatic adjustments thereafter.) Both the Church amendment and the Mills bill provided for financing the cost of automatic benefit increases from increases in the contribution and benefit base, rather than financing half the cost from increases in the contribution rates and the other half from increases in the base as the Senate Committee on Finance had recommended earlier.

The amendment also provided for a new contribution rate schedule based on the financing recommendations of the Advisory Council, as had the Mills bill. In addition, it corrected, through revised hospital insurance contribution rates, the underfinancing of the hospital insurance program and put that program on a financially sound basis.

H.R. 15390, with these social security amendments was passed by both the Senate and the House on June 30, and on July 1 President Nixon signed the bill into law. It became Public Law 92-336.

In September, the Senate Finance Committee again turned its attention to H.R. 1 and on September 26 completed its deliberations and reported the bill to the Senate. A number of changes in the House-passed bill were made by the Committee. Major changes in the social security cash benefits program included:

- (1) Provision for a special minimum benefit of as much as \$200 a month for a person who had been in covered employment for 30 years, instead of \$150 a month;
- (2) making the delayed retirement increment effective retrospectively;
- (3) providing a \$2,400 annual exempt amount under the retirement test; and
- (4) reducing the waiting period for disability benefits from 6 months to 4 months (instead of 5 months as in the House provision).

The Committee added a number of new provisions, including one which would have provided for the payment of benefits for certain aged dependent sisters and disabled dependent brothers and sisters. It deleted the provisions relating to actuarially reduced benefits in cases where the beneficiary is eligible for benefits in more than one category, computation of benefits on the basis of combined earnings of a married

couple, and dropping of additional years of low earnings from the computation of benefits. In view of the fact that a 20-percent benefit increase had just been enacted, the bill reported by the Committee did not contain a general benefit increase.

With respect to Medicare, the Committee made substantial changes and additions to the House-passed bill. Again included were the amendments, added earlier by the Senate to H.R. 17550, that related to Professional Standards Review Organizations, an Inspector General for Health Administration, disclosure of information concerning provider deficiencies, and coverage of services of chiropractors. Substantive changes in the House-passed version:

(1) Expanded the Secretary's experimental authority to include experiments with payment for various forms of care (not currently covered under Medicare) as alternatives to covered care, particularly the services of physicians' assistants and additional types of institutional and home care;

(2) eliminated provisions which would have (a) raised the part B annual deductible from \$50 to \$60 and (b) covered services of independently practicing physical therapists;

(3) eliminated the addition of coinsurance for the 31st through the 60th day of an inpatient hospital stay and an increased lifetime reserve and substituted a provision reducing the lifetime reserve coinsurance from one-half to one-fourth of the inpatient hospital deductible; and

(4) changed the method of reimbursement of health maintenance organizations to provide for sharing between the Government and an established HMO of any savings achieved under the costs of non-HMO beneficiaries, and recognized a second category of "newly established" HMO's which would have prospective reimbursement payments retroactively adjusted to reflect actual cost (the House bill authorized payment on a capitation basis not to exceed 95 percent of the cost of Medicare benefits had beneficiaries not been enrolled with an HMO).

Additions made by the Finance Committee included:

(1) Coverage of certain maintenance prescription drugs used in treatment of most common chronic diseases of the elderly, with \$1 copayment per prescription;

(2) extension of Medicare protection, on an optional basis, at cost (\$33 monthly for part A and \$11.60 monthly for part B) to spouses, aged 60-64, of Medicare beneficiaries; to others aged 60-64 who are entitled to retirement, dependents, or survivors benefits under the social security or railroad retirement programs; and to disability beneficiaries aged 60-64 not otherwise eligible for Medicare because

they have not been entitled to cash disability benefits for 24 months (the House bill extended Medicare to uninsured persons 65 and over on a voluntary, premium-financed basis);

(3) termination of the Medical Assistance Advisory Council and consolidation of its functions with that of the Health Insurance Benefits Advisory Council, as advisory body to the Secretary on matters of general Medicare and Medicaid policy;

(4) provisions which would conform Medicare and Medicaid requirements and procedures with respect to skilled nursing facilities (formerly called ECF's under Medicare) and level of care requirements for reimbursement of care received in such facilities (including a broadening of Medicare's extended care definition to include certain rehabilitation care);

(5) requirement that the Secretary disclose certain information concerning performance of State agencies, fiscal intermediaries, and carriers;

(6) program for validating, for Medicare purposes, accreditations by the Joint Commission on Accreditations of Hospitals; and

(7) waiver of Medicare's 14-day transfer requirement for extended care benefits in certain situations involving nonavailability of beds or unavoidable delay in start of a skilled care regimen.

The Senate Committee also made a number of substantial changes in the welfare reform provisions of the bill.

After previously (in June of 1972) having made a tentative decision to abandon federalization of adult assistance in favor of continuing State and local administration of the existing programs of aid to the aged, blind, and disabled, modified to set a Federal guaranteed minimum income level, the Senate Finance Committee decided to include in its bill a Federal program structured like that provided for by the House. Details of the Federal program differed in certain significant respects from those in the House bill. The Finance Committee provided for a new title XVI Federal program of supplemental security income assuring aged, blind, and disabled people of income of at least \$180 a month for an individual and \$195 a month for a couple. The limit on assets of an eligible individual or couple was set at \$2,500, compared with \$1,500 under the House bill. It also called for an exclusion of \$50 of any income, which in the majority of cases would mean that \$50 of social security benefits would not count as income. The earned-income exclusions were set at \$85 per month plus one-half of the rest for all three categories—that is, aged, blind, and disabled. Those disabled under age 18 would not have been eligible as

Major Provisions of 1972 Social Security Legislation

they would have been under the House bill. Disabled persons who were drug addicts or alcoholics were excluded from eligibility for supplemental security income, but the bill established a new program (title XV) to provide treatment and, if necessary, maintenance payments for addicts and alcoholics who qualified under the new title XV provisions.

The supplemental security income provisions were not made applicable to Puerto Rico, Guam, and the Virgin Islands; the present Federal-State programs were to remain in effect in those areas.

Debate on the bill began in the Senate on September 26 and continued until October 6. A number of amendments were offered from the floor and several were adopted. These included reduced benefits at age 60 for workers, wives, husbands, and parents, and at age 55 for widows; an increase to \$3,000 in the annual exempt amount of earnings under the retirement test, with a corresponding change in the monthly measure; Medicare coverage for most persons under age 65 suffering from chronic kidney disease; elimination of the part B coinsurance payment for home health services under Medicare; and coverage under Medicare for coal miners entitled to black lung benefits.

On October 6, the bill passed the Senate by a vote of 68 to 5. The Senate requested a conference with the House, and a committee was appointed. The conferees met on October 10, and by October 14 they had completed their work and submitted a report. Most of the welfare provisions of the bill, except those relating to the new Federal adult assistance program, as well as most of the changes in the bill that were added on the floor of the Senate, were dropped.

In the Medicare area, the conferees dropped the provisions relating to the coverage of drugs, the creation of an Office of Inspector General, coverage of miners on entitlement to black lung benefits, and coverage for the uninsured aged 60-64. They agreed not to change the part A coinsurance provisions or to increase the lifetime reserve days. The conference committee compromises were agreed to by the House on October 17 by a vote of 305 to 1, and on the same day by the Senate by a vote of 61 to 0. On October 30, 1972, H.R. 1 was signed into law by the President and became Public Law 92-603.

PUBLIC LAW 92-336

On July 1, 1972, President Nixon signed Public Law 92-336, a bill to extend the public debt limit. The legislation also contained amendments to the Social Security Act, raising the amounts of monthly cash benefits and revising several financing provisions.

Increase in Benefits

A 20-percent increase across the board was provided for monthly cash benefits, including the special monthly payments to certain individuals aged 72 and over who are not insured for regular monthly benefits. The amendments also provided for automatic increases in benefits as prices rise in the future. The first automatic increase will be possible in 1975. The procedure in the law for such increases is as follows:

In 1974 and every calendar year thereafter (except in a calendar year in which a general benefit increase is enacted or becomes effective), it will be determined if a "cost-of-living" increase in cash benefits shall be established. For the first determination, the arithmetical mean of the Consumer Price Index (CPI) prepared by the Department of Labor for April, May, and June of 1974 will be divided by the arithmetical mean of the CPI for July, August, and September 1972. If such quotient (rounded to the nearest $\frac{1}{10}$ of 1 percent) is greater than or equal to 3 percent, then a "cost-of-living" increase in benefits will be established in 1974 and the level of benefits will be increased by the same percentage, effective January 1, 1975. If the contribution and benefit base is raised at the same time (see below), the benefit formula will provide an additional 20 percent on average monthly earnings above the previous monthly contribution and benefit base.

In subsequent years, the same procedure will be followed except that the arithmetical mean of the CPI for April, May, and June in the year of the computation will be divided by the latest of (a) the arithmetical mean of the CPI for April, May, and June of the year in which the last effective "cost-of-living" increase was established or (b) the mean of the 3 months of the quarter in which the effective month of the last general benefit increase occurred (July-September 1972, if that is the latest such quarter). When a "cost-of-living" increase is established, the new benefits become effective on January 1 of the following year.

The bill also included a revised tax rate schedule that included increases in the hospital insurance rates to restore the financial soundness of that part of the program.

Financing

A revised contribution rate schedule was enacted (and later superseded by the schedule in the October amendments), with rates as shown in the table on page 23 under the heading "old law." The earnings base for contribution and benefit purposes was also revised—from \$9,000 in 1972 to \$10,800 in 1973 and to \$12,000 in 1974. The base is to be raised automatically in the future as wages rise, under the following procedure:

Whenever an automatic adjustment in monthly cash benefits is made, a determination will also be made as to whether an adjustment in the maximum amount of annual earnings that will be taxed and credited toward benefits is required. The determination is made by multiplying the contribution and benefit base in effect in the year of determination by the ratio of the average taxable wages (under the social security program) of all employees, as reported in the first calendar quarter of the year of determination, to the average taxable wages of all employees as reported for the latest of (a) the first calendar quarter of 1973 or (b) the first calendar quarter of the year in which the last automatic determination resulted in a base increase or of the year in which a legislative increase in the base was enacted. The product, rounded to the nearest multiple of \$300, will be the amount of the contribution and benefit base, effective with respect to remuneration paid after the year of determination. In no case, however, will the base be reduced to an amount lower than the base in the year of determination.

PUBLIC LAW 92-603

Cash Benefits

Increase in widow's and widower's benefits.—A widow (or widower) who first becomes entitled to benefits at or after age 65 receives a benefit equal to 100 percent of her deceased husband's primary insurance amount if he did not receive reduced benefits before his death. If he did receive reduced benefits, the widow's benefit can be no more than the amount her husband would

be receiving if he were still alive. (A widow who becomes entitled to benefits at or after age 62 receives no less than 82.5 percent of her husband's primary insurance amount.) Benefits for widows (or widowers) who become entitled between ages 62 and 65 are reduced to take account of the longer period over which they are paid, just as widow's benefits are reduced, under the previous law, between ages 60 and 62.

Age-62 computation point for men.—For men who reach age 62 in the future, benefits will be based on average monthly earnings figured up to age 62, as is now the case for women. The change is to be accomplished in three steps: A man who reaches age 62 in 1973 will have his average earnings figured over a period 1 year shorter than under the old law; a man who reaches age 62 in 1974 will have his earnings figured over a period 2 years shorter than under previous law. For men reaching age 62 in 1975 or later, the computation period will end at age 62 (3 years less than previously). Similar changes are made in the insured-status requirements.

Liberalization and automatic adjustment of the earnings test.—The annual exempt amount of earnings is increased from \$1,680 to \$2,100. The amount of wages an individual may earn in a month and still receive full benefits for the month is raised from \$140 to \$175. Benefits are reduced by \$1 for each \$2 of all earnings above \$2,100. At no point is \$1 in benefits withheld for each \$1 of earnings, as had been the case for earnings above \$2,880. The annual exempt amount in the retirement test and the monthly test will be adjusted automatically in the future to reflect rises in the general earnings levels, according to the following procedure in the law:

A determination as to whether an adjustment of the earnings test is required will be made in the year a "cost-of-living" increase is established. The determination is made by multiplying the exempt monthly amount that is effective with respect to months in the year of determination by the ratio of the average taxable wages of all employees, as reported in the first calendar quarter of the year of determination, to the average taxable wages of all employees as reported for the latest of (a) the first calendar quarter of 1973 or (b) the first calendar quarter of the year in which the last automatic determination resulted in an increase in the base or of the year in which a legislative increase in the base was enacted.

The product, rounded to the nearest multiple of \$10, will be the new exempt monthly amount effective for the taxable year beginning after the year of determination (unless Congress has enacted an increase in the exempt amount in the year of determination). In no case, however, will the new exempt amount be reduced to an amount lower than the exempt amount in the year of determination.

In the year in which a person attains age 72, his earnings in and after the month of attainment of age 72 will not be included in determining his total earnings for the year. (Before the amendment, they were included.) These provisions are effective for taxable years ending after 1972.

Delayed retirement credit.—The average benefit of a worker who does not take a reduced benefit is increased by 1 percent for each year ($\frac{1}{12}$ of 1 percent for each month) after 1970 for which the worker between ages 65 and 72 did not receive benefits because of earnings from work. No increased benefit will be paid under this provision to the worker's dependents or survivors.

Special minimum primary insurance amount.—A special minimum benefit equal to \$8.50 multiplied by a worker's years of coverage in excess of 10 years, up to a maximum of 30 years, is provided. The highest minimum benefit under this provision is \$170 a month for an individual (\$255 for a couple) with 30 or more years of coverage. A special minimum is thus payable to those who worked for many years at low earnings under the social security program. The special minimum will be paid as an alternative to the regular benefit when a higher benefit results. If an increase is provided under the automatic benefit increase provision in the law, this special minimum will not, however, be raised.

Reduced benefits for widowers at age 60.—Nondisabled widowers, like widows, may elect to receive reduced benefits at age 60.

Changes in disability provisions.—Several changes have been made that relate to the disability program:

1. The waiting period throughout which a person must be disabled before disability benefits can begin is reduced from 6 months to 5 months.

The first benefit is payable for the sixth month of disability.

2. A blind person will be insured for disability insurance benefits if he is fully insured—that is, if he has as many quarters of coverage as the number of calendar years elapsing after the year he reached age 21 (or 1950, if later) and up to the year in which he became disabled. He no longer has to meet the requirement of recent covered work (generally 20 quarters of coverage in the period of 40 calendar quarters preceding disablement).

3. Childhood disability benefits are extended to the disabled adult son or daughter of an insured deceased parent or a parent eligible for old-age or disability insurance benefits if the son or daughter became totally disabled after age 18 but before age 22. Previously, benefits were limited to those disabled before age 18. In addition, a person can now become reentitled to childhood disability benefits if he again becomes disabled within 7 years after his earlier entitlement to such benefits was terminated.

4. The amendments modify the provisions under which social security disability benefits are reduced where workmen's compensation is also payable. Previously, social security disability benefits had been reduced if the combined payments from both programs exceeded 80 percent of the worker's average current earnings before disablement; average current earnings for this purpose were computed on two different bases and the larger amount was used. The new provision adds a third alternative base under which a worker's average current earnings can be based on a single year of his highest earnings in a period consisting of the year of disablement and the 5 preceding years.

5. The application requirement for disability insurance benefits (and dependents' benefits based on the worker's entitlement to disability benefits) will be met if the application is filed within 3 months after the disabled worker's death or within 3 months after enactment of the provision. (Previously, an application had to be filed while the disabled worker was alive, either by the disabled worker or, if he was unable to file it, by another person on his behalf.) This new provision applies with respect to deaths occurring after 1969.

6. The amendments authorize an increase in

the amount of social security trust fund money that can be used to pay the costs of rehabilitation services for social security disability beneficiaries. The amount is increased from 1 percent of the previous year's disability benefits under the old law to 1.25 percent for fiscal year 1973 and to 1.5 percent for fiscal year 1974 and thereafter.

Changes in eligibility requirements.—The amendments include the following revisions relating to eligibility:

1. The law no longer requires that to qualify for benefits as a divorced wife, divorced widow, or surviving divorced mother, a woman must show that a court order in effect provided for substantial contributions to the woman's support by the former husband, that she received substantial contributions from her former husband, pursuant to a written agreement, or that she received half her support from her former husband.

2. For a child who is attending school full time when he reaches age 22, benefit payments will continue through the end of the semester or quarter in which he reaches that age if he has not received or completed the requirements for a bachelor's degree from a college or university. If the educational institution in which he is enrolled is not operated on a semester or quarter system, benefits continue until the month following the completion of the course in which he is enrolled or 2 calendar months have elapsed after the month in which he reaches age 22, whichever occurs first.

3. For children adopted by old-age and disability insurance beneficiaries, the differences in eligibility requirements for entitlement to child's benefits are repealed and new uniform requirements for both cases are provided. Now, a child who is adopted by a worker getting retirement or disability benefits, regardless of when the adoption occurs, may get benefits if (1) the adoption was decreed by a court of competent jurisdiction within the United States; (2) the child was living with and receiving at least half his support from the worker for at least 1 year before the worker became entitled to retirement or disability benefits; and (3) the child was under age 18 when he began to live with the worker. (A child born in the 1-year period during which he would otherwise be required to have been living with and receiving at least half his support

from the retired or disabled beneficiary is deemed to meet the living-with and support requirements if he was living with the beneficiary in the United States and receiving at least half his support from the beneficiary for substantially all of the period occurring after his birth.)

This provision is effective with respect to benefits payable for January 1968 and thereafter if an application for benefits is filed within 6 months after the month of enactment; otherwise, it is effective with respect to benefits payable for the month of enactment and after.

4. Child's insurance benefits are provided for a grandchild of a worker or of his spouse if (1) the child was living with and receiving at least half his support from the worker for the year immediately before the worker became disabled or entitled to old-age or disability benefits or died; (2) the child began living with the worker before he attained age 18; and (3) at the time the worker became disabled or entitled or died (a) the child's natural or adopting parents or stepparents were disabled or were not alive or (b) the child was adopted by the worker or by the worker's surviving spouse after the worker's death and the child's natural or adopting parent or stepparent was not living in the worker's household and making regular contributions toward the child's support at the time the worker died. (A child born in the 1-year period during which he would otherwise be required to have been living with and receiving at least half his support from the grandparent is deemed to meet the requirement if he was living with the grandparent in the United States and receiving at least half his support from the grandparent for substantially all of the period occurring after his birth.)

5. Effective on enactment, the amendments repeal the provisions that required the termination of child's insurance benefits if the child was adopted by someone other than (1) his natural parent, (2) his natural parent's spouse jointly with the natural parent, (3) the worker—a stepparent, for example—on whose earnings the child was getting benefits, or (4) a stepparent, grandparent, aunt, uncle, brother, or sister after the death of the worker on whose earnings the child is getting benefits. A child whose entitlement to benefits was terminated because of the earlier provision and who would otherwise still be en-

titled may, on filing an application, become re-entitled to benefits effective with the month of enactment of the amendments.

6. The 3-month duration-of-relationship requirement in the old law is repealed for cases of accidental death or death in the line of duty as a member of a uniformed service on active duty. Retained, however, is the prohibition against the payment of benefits in cases where the relationship does not last 9 months because of such deaths, if the Secretary of Health, Education, and Welfare determines that at the time of the marriage of the deceased individual he could not have reasonably been expected to live for 9 months. Also waived is the duration-of-relationship requirement for entitlement to benefits as a worker's widow, widower, or stepchild when the worker and his spouse were previously married, divorced, and then remarried, the relationship existed at the time of the worker's death, and the duration-of-relationship requirement would have been met if the worker had died on the date he was divorced from his spouse.

Wage credits for members of the uniformed services.—Noncontributory wage credits are provided, in addition to contributory credits for basic pay, for military service during the period January 1957 (when military service was first covered) through December 1967. (Previously, such credits had been provided for military service beginning January 1968.) Wage credits will uniformly be \$300 for each quarter in which the serviceman receives military pay—rather than \$100, \$200, or \$300, depending on the amount of covered military pay in the quarter, under the old provision. The new provision is effective for monthly benefits after December 1972.

Members of religious orders taking a vow of poverty.—Effective on enactment, the amendments extend coverage to members of a religious order who have taken a vow of poverty (with respect to services performed in the exercise of duties required by the order) as employees of the order, if the order makes an irrevocable election of coverage for its entire active membership and for its lay employees. Wages for social security purposes will be the fair market value of any board, lodging, clothing, and other perquisites furnished to the member (but not less

than \$100 a month). Each order can elect up to 5 years of retroactive coverage for persons who were active members on the day coverage took effect.

Social security numbers.—Effective on enactment, the amendments make it a misdemeanor (1) to willfully, knowingly, and with intent to deceive the Secretary of Health, Education, and Welfare as to someone's identity, furnish false information to the Secretary in connection with the establishment and maintenance of social security records and (2) to use a social security number obtained on the basis of false information, to falsely represent a number to be a social security number, or to use someone else's social security number, for the purpose of increasing a payment under social security or any other federally funded program, or for the purpose of obtaining such payment.

The provision directs the Secretary to issue social security numbers to (1) aliens at the time of their admission for permanent residence and aliens at the time they are admitted temporarily with permission to work or at the time their status is changed to permit them to work; (2) any individual who applies for or receives benefits under any Federal or federally subsidized program; and (3) any individual who could have been but was not assigned a number under the categories listed above.

The Secretary is authorized, but not directed, to issue social security numbers to schoolchildren and to preschool children upon request by their parents or guardians. In addition, the Secretary is required to establish the age, citizenship, alien status, and identity of all applicants for social security numbers.

Medicare

Medicare for the disabled.—Medicare protection is extended to persons entitled for not less than 24 consecutive months to cash benefits under the social security and railroad retirement programs because they are disabled. Coverage includes disabled workers at any age, disabled widows, and disabled dependent widowers between ages 50 and 65; women aged 50 or older who are entitled to mother's benefits and, for 24

months before the first month they would have been entitled to Medicare protection, met all the requirements for disability benefits except for actual filing of a disability claim; those aged 18 and over who receive social security benefits because they became disabled before reaching age 22; and disabled qualified railroad retirement annuitants.

Medicare protection under this provision will begin with the later of (a) July 1973 and (b) the 25th consecutive month of an individual's entitlement to social security disability benefits and will terminate the month following the month notice of termination of disability benefits is mailed.

Chronic kidney disease deemed to constitute a disability for purposes of Medicare.—Effective July 1, 1973, Medicare coverage is extended to individuals under age 65 who are currently or fully insured or entitled to monthly social security benefits, and to the spouses and dependent children of such individuals, who require hemodialysis or renal transplantation for chronic renal disease. Such individuals are deemed to be disabled for purposes of coverage under both parts of Medicare. Eligibility for coverage begins with the third month after the month in which a course of renal hemodialysis begins through the twelfth month after the month in which an individual had a transplant or dialysis terminates. Benefits include those of both parts of Medicare, with the usual deductibles and coinsurance. The Secretary is authorized to limit reimbursement for treatment to kidney disease treatment centers that meet regulatory requirements. These requirements include a minimal utilization rate for covered procedures and a medical review board to screen patients for medical suitability for treatment.

Health Maintenance Organization option.—Individuals eligible for both parts of Medicare, or for SMI only, may choose to have their covered health care provided through a health maintenance organization (HMO)—a prepaid group health or other capitation plan that meets prescribed standards. Two methods of reimbursement for HMO's are to be established. Under the first, an HMO will be "at risk" and payments will be made on an incentive capitation basis. This method, which can be used only by substantial, established HMO's, will permit the HMO and the Government to share, according to a prescribed

formula, in any savings the HMO achieves in relation to adjusted average per capita costs of covered health services for persons outside the HMO. The second method, which must be used by newly established HMO's and may be used by any other HMO, provides for interim monthly capitation payments subject to year-end adjustment that reflects the HMO's actual reasonable costs of providing Medicare-covered services.

A beneficiary enrolled with an established HMO that uses the risk-sharing method of reimbursement will receive covered services only through the HMO, except for emergency services and urgently needed services received when he is temporarily outside the HMO's service area. A beneficiary enrolled in an HMO receiving cost reimbursement will not be required to use the HMO as his single source of health care. Payment will be made by Medicare in the usual manner for services he receives outside the HMO.

The provision is effective with respect to services provided on or after July 1, 1973.

Professional Standards Review Organizations.—By January 1, 1974, the Secretary must establish areas throughout the United States with respect to which Professional Standards Review Organizations (PSRO's) may be designated. They are to consist of substantial numbers of practicing physicians (usually 300 or more) in a local area and will be responsible for comprehensive and ongoing review of services covered under the Medicare, Medicaid, and maternal and child health care programs. They are to assure that services are (1) medically necessary and (2) provided in accordance with professional standards. The PSRO's are not required to review services other than institutional care and services unless they so choose and the Secretary agrees. They will not be involved with reasonable charge determinations; they are required to recognize and use utilization review committees in hospitals and other medical organizations to the extent these are deemed effective by the PSRO. Safeguards, designed to protect the public interest and to prevent *pro forma* carrying out of review responsibilities, include appeals procedures.

Until January 1, 1976, the Secretary will be able to make an agreement only with a qualified organization representing a substantial proportion of the physicians in the designated geo-

graphical area. Until January 1, 1976, the Secretary is also required to poll the practicing physicians in the area—at the request of 10 percent or more of such physicians—to determine whether or not an organization of physicians that has requested an agreement with the Secretary to establish a PSRO substantially represents the area's practicing physicians. If more than 50 percent of the practicing physicians responding to the poll indicate that the organization does not substantially represent them, the Secretary cannot enter into an agreement with that organization.

Level-of-care requirements in skilled nursing facilities.—The Medicare definition of covered extended-care services is broadened somewhat, and the same definition applies to skilled nursing facility services under Medicaid. Services covered are those provided directly by or requiring the supervision of skilled nursing personnel, or skilled rehabilitation services needed by the patient on a daily basis that, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis. Medicare coverage will also continue during short periods when no skilled services were actually provided but when discharge from a skilled facility for such brief period is neither desirable nor practical. This provision is applicable to services furnished after December 31, 1972.

Waiver of beneficiary liability in certain situations where Medicare claims are disallowed.—Medicare beneficiaries will be “held harmless” in certain situations where claims are disallowed but the beneficiary is without fault, including cases where the disallowance is based on determinations that the services were not medically necessary or did not meet level-of-care requirements. Where the beneficiary is “held harmless,” liability shifts either to Medicare or, where it is found that the provider has not acted with due care, to the provider. This provision is applicable to claims for services provided after the date of enactment.

Advance approval of extended-care and home health coverage.—The Secretary is authorized to establish, by medical condition, specified periods of time after hospitalization during which a patient will be presumed to require an extended-care level of services. Where a patient's physician

certifies to the need for such care and submits to the extended-care facility, in advance of admission, a plan for carrying out the services, the care furnished will be assumed to be the type of care covered as extended care. Comparable provisions applying to posthospital home health services are also included. The advance approval provisions can, however, be declared inapplicable to patients of any physician who is found to be unreliable in certifying patients' need for such care. In addition, an extended-care facility's utilization review committee can terminate payment to a patient during the approved period if it determines that further inpatient stay is no longer medically necessary. The provision specifically restricts the retroactive application of regulations pertinent to the provision. This provision is effective for admissions for extended-care services or the initiation of home health plans on or after January 1, 1973.

Hospital insurance for the uninsured.—Persons reaching age 65 who are ineligible for hospital insurance may enroll, on a voluntary basis, for such coverage under the same conditions as for supplementary medical insurance. Those who enroll will pay the full cost of the protection—\$33 a month at the beginning and more in later years as hospital costs rise; enrollment for supplementary medical insurance is also required. States and public organizations, through agreements with the Secretary, are permitted to purchase such protection on a group basis for their aged retired (or active) employees. Coverage under this provision will be effective on July 1, 1973.

Medicare services outside the United States.—Inpatient hospital services furnished a resident of the United States in a foreign hospital that is closer or substantially more accessible to his residence than the nearest suitable United States hospital will be covered. Payments under SMI for necessary physicians' and ambulance services furnished in connection with such hospitalization are also authorized, whether or not an emergency exists. Medicare payments are also authorized for emergency inpatient hospital services and related physicians' services needed by beneficiaries traveling in Canada between Alaska and another State. This provision applies to hospital admissions after December 31, 1972.

Elimination of provisions preventing enrollment under SMI more than 3 years after first opportunity.—Eligible persons may enroll under SMI during any prescribed enrollment period. Beneficiaries are no longer required to enroll within 3 years following first eligibility or a previous withdrawal from the program. The requirement that the SMI premium for late enrollees be increased 10 percent for each 12 months elapsing between the time they could have enrolled and actually do enroll is retained.

This provision is effective on enactment. It applies to all those ineligible to enroll because of the 3-year limit in effect under the old law.

Coordination between Medicare and Federal employees' plans.—Effective January 1, 1975, no payment will be made under Medicare for the same services covered under a Federal employees health benefits (FEHB) plan unless in the meantime the Secretary certifies that such plan or the FEHB program has been modified to make available coverage supplementary to Medicare benefits and that Federal employees and retirees will continue to have the benefit of a contribution toward their health insurance premiums from either the Government or the individual plan.

Uniform Medicare and Medicaid standards for nursing facilities.—A single "skilled nursing facility" definition is established, as well as a single set of health, safety, environmental, and staffing standards for institutions formerly identified as extended-care facilities under Medicare and skilled nursing homes under Medicaid. In the future, extended-care services covered under Medicare will be provided in institutions identified as "skilled nursing facilities" rather than as "extended-care facilities." Under both Medicare and Medicaid, a "skilled nursing facility" must meet the existing statutory conditions of participation for extended-care facilities plus certain additional requirements that skilled nursing homes must meet under existing Medicaid law. Where a skilled nursing facility desires to participate under both Medicare and Medicaid, the Secretary's determination that it meets Medicare standards would also serve for Medicaid. Uniformity of standards will be effective July 1, 1973.

Reimbursement rates for skilled nursing facili-

ties and intermediate-care facilities.—States will be required to develop methods for reimbursing skilled nursing facilities and intermediate-care facilities on a basis reasonably related to cost and to implement these methods under Medicaid (after approval by the Secretary) by July 1, 1976. These State payment rates for skilled nursing facilities can then be used under Medicare in reimbursing for extended-care services. The Medicaid rates can be adjusted upward, but not more than 10 percent, to account for specific factors related to Medicare not included by the State in computing Medicaid rates.

14-day-transfer requirement for posthospital extended-care benefits.—The Medicare extended-care benefit requirement that a patient's transfer to an extended-care facility take place within 14 days of his discharge from a hospital is modified to permit a longer interval for patients whose conditions do not permit provision of skilled services within 14 days (for example, a patient whose hip fracture has not mended to the point that physical therapy and restorative nursing can be utilized). An extension, not to exceed 2 weeks beyond the original 14 days, is authorized also in instances where admission to a facility providing extended-care services is prevented because of a shortage of appropriate bed-space in a geographic area.

Medical social services.—The Secretary may no longer require the provision of medical social services as a condition of participation for skilled nursing facilities under Medicare and Medicaid.

Waiver of registered-nurse requirement in skilled nursing facilities in rural areas.—The Secretary may waive the requirement that a skilled nursing facility must employ a registered nurse full time (to the extent that "full time" is deemed to mean more than 40 hours a week) for certain rural skilled nursing facilities unable to assure the presence of a full-time registered nurse 7 days a week. A facility of this type that has one full-time registered nurse and is making good-faith efforts to obtain another will be allowed a special waiver of the nursing requirement with respect to not more than two day shifts—over a weekend, for example. This special waiver will be authorized if the facility has only patients whose physi-

cians have indicated that the individual can be without a registered nurse's services for a 48-hour period. If the facility has any patients for whom physicians have indicated a need for daily skilled nursing services, it must make arrangements for a registered nurse or a physician to spend enough time at the facility to provide the skilled services needed.

Amount of supplementary medical insurance premium.—The Secretary will continue to determine and promulgate in December 1972 and each year thereafter a monthly enrollee premium (applicable for both the aged and the disabled) for the following fiscal year. The enrollee premium will, however, be increased only in the event of a general benefit increase—either an automatic increase or one resulting from future legislation. In any given year, the premium will rise by no more than the percentage by which cash benefits have been increased across the board since the premium was last increased. Federal general revenues will finance that part of program costs not met through enrollee premiums.

The change is effective for the fiscal year beginning July 1973. (Through June 1973, the premium amount is \$5.80, and it will be \$6.30 through July 1974.)

Change in SMI deductible.—The SMI deductible is increased from \$50 to \$60 as of January 1, 1973.

Elimination of coinsurance payment with respect to home health services under SMI.—Payments for home health services furnished under SMI are to be in amounts equal to 100 percent of the reasonable cost of services, rather than 80 percent as in the old law.

Automatic enrollment for SMI.—Aged and disabled beneficiaries, except for residents of Puerto Rico and foreign countries, will be automatically enrolled for SMI as they become entitled to hospital insurance. Persons eligible for automatic enrollment will, to the extent possible, be fully informed and given an opportunity to decline the coverage. This provision applies to any individual whose initial enrollment period begins after March 31, 1973, or who becomes entitled to hospital insurance after June 1973.

Coverage of chiropractors' services under SMI.—Coverage is provided for the services of licensed chiropractors who also meet uniform minimum standards, but only with respect to treatment by means of manual manipulation of the spine and only with respect to correction of subluxation of the spine demonstrated by X-ray. This provision will be effective July 1, 1973.

Limitation on Federal participation for capital expenditures.—The Secretary may withhold or reduce reimbursement amounts to providers of services under title XVIII for depreciation, interest, and, in the case of proprietary providers, a return on equity capital, or other expenses related to capital expenditures for plant and equipment in excess of \$100,000, which are determined to be inconsistent with State or local health facility plans. The Secretary will act on the basis of findings and recommendations submitted to him by various health facility planning agencies. If, after consultation with an appropriate national advisory council, the Secretary determines that a disallowance of expenses will discourage the operation or expansion of an organization that has demonstrated capability of economically providing comprehensive health care services or will otherwise be inconsistent with effective organization and delivery of health services or effective administration of titles V, XVIII, or XIX, he is authorized to allow such expenses. This provision is effective with respect to obligations for capital expenditures incurred after December 31, 1972, or earlier, if a State so requests.

Experiments and demonstration projects in prospective reimbursement and incentives for economy.—The Secretary is authorized to test various methods of making payment to providers of services on a prospective basis under the Medicare, Medicaid, and maternal and child health programs. In addition, he is authorized to conduct experiments with methods of payment or reimbursement designed to increase efficiency and economy (including payment for services furnished by organizations providing comprehensive, mental, or ambulatory health care services, as well as ambulatory surgical centers); with performance incentives for intermediaries and carriers; with reimbursement implications of paying for services rendered by physicians' assistants;

with the use of intermediate care and homemaker services by beneficiaries who either are ready for discharge from a hospital or are unable to maintain themselves at home without assistance; and with programs designed to improve the rehabilitation of patients in long-term health care facilities. The Secretary is also authorized to determine whether services of clinical psychologists might be made more generally available to persons eligible under Medicare and Medicaid.

Limitations on recognition of increase in prevailing charge levels for medical and other health services.—To determine the reasonableness of charges by physicians under Medicare, Medicaid, and maternal and child health programs: (a) after December 31, 1970, medical charge levels recognized as prevailing may not be increased beyond the 75th percentile of actual charges in a locality during the calendar year elapsing before the start of the fiscal year; (b) for fiscal year 1974 and thereafter, the prevailing charge levels recognized for a locality may be increased, in the aggregate, only to the extent justified by indexes reflecting changes in costs of practice of physicians and in earnings levels; and (c) for medical supplies, equipment, and services that, in the judgment of the Secretary, generally do not vary significantly in quality from one supplier to another, charges allowed as reasonable after December 1972 may not exceed the lowest levels at which such supplies, equipment, and services are widely and consistently available in a locality.

The existing Health Insurance Benefits Advisory Council, which has been engaged in a study of the methods of reimbursement of physicians' fees under Medicare, is to report its findings to the Congress.

Financing

Consistent with past policy of maintaining the social security program on a sound financial basis, provision is made for meeting the cost of the expanded program. The costs of the cash benefits program and the hospital insurance program are to be financed by revised contribution rate schedules. For 1973, the combined contribution rate for cash benefits and hospital insurance is increased from the previously scheduled 5.5 percent each

Contribution rate schedule under the Social Security Amendments of 1972 and under the previous law

Calendar year	Percent of covered earnings					
	OASDI		HI		Total	
	Old law	New law	Old law	New law	Old law	New law
	Employer and employee, each					
1972.....	4.60	4.60	0.60	0.60	5.20	5.20
1973-77.....	4.60	4.85	.90	1.00	5.50	5.85
1978-80.....	4.60	4.80	1.00	1.25	5.50	6.05
1981-85.....	4.60	4.80	1.00	1.35	5.60	6.15
1986-92.....	4.50	4.80	1.10	1.45	5.60	6.25
1993-97.....	4.50	4.80	1.20	1.45	5.70	6.25
1998-2010.....	4.50	4.80	(1.20)	(1.45)	(5.70)	(6.25)
2011 and thereafter.....	5.35	5.85	(1.20)	(1.45)	(6.55)	(7.30)
	Self-employed					
1972.....	6.90	6.90	0.60	0.60	7.50	7.50
1973-77.....	6.90	7.00	.90	1.00	7.80	8.00
1978-80.....	6.70	7.00	1.00	1.25	7.70	8.25
1981-85.....	6.70	7.00	1.00	1.35	7.70	8.35
1986-92.....	6.70	7.00	1.10	1.45	7.80	8.45
1993-97.....	6.70	7.00	1.20	1.45	7.90	8.45
1998-2010.....	6.70	7.00	(1.20)	(1.45)	(7.90)	(8.45)
2011 and thereafter.....	7.00	7.00	(1.20)	(1.45)	(8.20)	(8.45)

for employers and employees to 5.85 percent each. The provisions relating to the earnings base for tax and benefit purposes in the law (as amended in July 1972) are retained: the maximums of \$10,800 for 1973 and of \$12,000 for 1974, with automatic increases thereafter as wages rise. The cost estimates underlying the contribution rates were based on the new financing principles adopted earlier in 1972 under Public Law 92-336. The schedules for contribution rates under the provisions now in the law and under the previous provisions are shown in the accompanying table.

Supplemental Security Income for the Aged, Blind, and Disabled

The existing Federal-State programs of aid to the aged, blind, and permanently and totally disabled are repealed, effective January 1, 1974 (except in Puerto Rico, the Virgin Islands, and Guam), and a new, totally Federal supplemental security income program will become effective on that date. The new national program, designed to provide financial assistance to needy people who have reached age 65 or are blind or disabled is established by amendment of title XVI of the Social Security Act. The program is to be administered by the Social Security Administration.

Eligibility for and amount of benefits.—Individuals or couples may be eligible for assistance if their monthly income is less than the amount of the full monthly payment. Full monthly benefits are \$130 for an individual and \$195 for an individual with an eligible spouse. Benefits will not be paid for any full month the individual is outside the United States.

The Secretary will establish the circumstances under which gross income from a trade or business, including farming, is large enough to preclude eligibility (net income notwithstanding). People who are in hospitals or nursing homes getting Medicaid funds on their behalf are eligible for benefits of up to \$25 a month in lieu of their regular benefits. People who fail to apply for annuities, pensions, workmen's compensation, and other such payments to which they may be entitled will not be eligible.

Income as defined by the program.—In determining an individual's eligibility and the amount of his benefits, both his earned and unearned income are taken into consideration. The definition of earned income follows generally the definition of earnings used in applying the retirement test under the social security program. Unearned income means all other forms of income, including benefits from other public and private programs, prizes and awards, proceeds of life insurance not needed for expenses of last illness and burial (with a maximum of \$1,500), gifts, inheritances, rents, dividends, interest, and so forth. For people who live as members of another person's household, the value of their room and board will be deemed to be one-third of the full monthly payment.

These items are to be excluded from income:

- (1) \$20 of any income (earned or unearned) other than income paid on the basis of need;
- (2) \$65 of earnings a month and one-half above that (plus income necessary for fulfilling plans for self-support for the blind and disabled and work expenses for the blind);
- (3) within reasonable limits, earnings of a student regularly attending school;
- (4) an individual's irregular and infrequent earned income of \$30 or less in a quarter and irregular and infrequent unearned income of \$60 or less in a quarter;
- (5) any amount received from a public agency as a refund of taxes paid on real property or on food purchased;

- (6) the tuition and fees part of scholarships and fellowships;
- (7) home produce;
- (8) one-third of child-support payments from an absent parent;
- (9) foster care payments for a child placed in the household by a child-placement agency; and
- (10) supplementary benefits based on need and provided by a State or political subdivision.

Exclusions from resources.—Generally, individuals will not be eligible for payments if they have resources in excess of \$1,500 and couples will not be eligible if their resources are above \$2,250. Those who were receiving aid to the aged, blind, and disabled in December 1973 under an approved State plan, but whose resources were greater than those permitted under the Federal program, will be considered not to have exceeded this amount if the resources do not exceed the maximum amount permitted under the State plan in effect for October 1972. The following will be excluded from resources:

- (1) The home and appurtenant land to the extent that their value does not exceed a reasonable amount;
- (2) household goods, personal effects, and an automobile, not in excess of a reasonable amount;
- (3) other property essential to the individual's support (within reasonable value limitations);
- (4) life insurance policies, if their total face value is \$1,500 or less—otherwise, insurance policies would be counted only to the extent of their cash surrender value;
- (5) resources of a blind or disabled individual necessary for fulfilling an approved plan of self-support; and
- (6) shares of certain nonnegotiable stock held in a Regional or Village Corporation by Alaskan natives.

The Secretary will prescribe time limits and ways of disposing of excess property so that it will not be included as resources.

Definitions of terms.—The terms used in the SSI program in a particular sense are defined below.

An eligible individual: A resident of the United States and a citizen or an alien admitted for permanent residence or otherwise permanently residing in the United States under color of law, and aged, blind, or disabled.

Aged individual: One aged 65 or older.

Blind individual: An individual who has central

visual acuity of 20/200 or less in the better eye with the use of a correcting lens, or equivalent impairment in the fields of vision.

Disabled individual: An individual who is unable to engage in substantial gainful activity by reason of a medically determinable physical or mental impairment that is expected to last or has lasted for 12 months or can be expected to result in death. (This definition is the same as that used for social security disability benefits.) A child under age 18 who is not engaging in substantial gainful activity will be considered disabled if he suffers from any medically determinable physical or mental impairment of comparable severity. A disabled individual will be entitled to a 9-month trial work period unless he has had a prior trial work period during a period of eligibility based on the same disability. A disabled individual who is medically determined to be an alcoholic or drug addict will not be entitled to benefits under this program unless he undergoes appropriate available treatment in an approved facility.

(Those blind or disabled individuals who are on the benefit rolls in December 1973 under existing State programs will be considered blind or disabled for purposes of this program if they met the definition of disability or blindness which was in effect as of October 1972.)

Eligible spouse: An aged, blind, or disabled individual who is the husband or wife of an individual who is aged, blind, or disabled and who has not been living apart from such other spouse for more than 6 months.

Child: An unmarried person who is not the head of a household and who is either under the age of 18 or under the age of 22 and attending school regularly.

Determination of marital relationship: Appropriate State law will apply except that when two persons, for purposes of receiving social security benefits, are considered married and when two persons hold themselves out as married in the community in which they live, they will be considered married for purposes of this program.

The income and resources of a spouse living with an eligible individual will be taken into account in determining the benefit amount of the individual, whether or not the income and resources are available to him. Income and resources of a parent may count as income of a disabled or blind child.

Rehabilitation services.—Disabled and blind beneficiaries will be referred to State agencies for vocational rehabilitation services. A beneficiary who refuses without good cause any vocational

rehabilitation services offered will not be eligible for benefits.

Optional State supplementation.—A State may supplement the Federal benefits, and the supplementary payments will be excluded as income for purposes of the Federal supplemental security income program. In addition, the State will have the option of having the Federal Government make the supplementary payments and absorb the administrative costs. The Federal Government, in administering supplemental benefits on behalf of a State, will be required to recognize a residence requirement if the State decides to impose one.

No participation in food stamp and surplus commodity programs by SSI recipients.—Individuals who are eligible for benefits under the new program (or who would be if they filed an application) will be excluded from participation in food stamp and surplus commodity programs.

Determination of Medicaid eligibility.—The Secretary may enter into agreements with States under which he will determine eligibility for medical assistance for aged, blind, and disabled persons under title XIX. The State would pay half of the Secretary's additional administrative costs arising from carrying out the agreement.

Limitations on increases in State welfare expenditures.—States are guaranteed that, if they provide payments that supplement the Federal SSI program and that are administered by the Federal Government, it will cost them no more to do so than the amount of their total expenditures for cash public assistance payments to the aged, blind, or disabled during calendar year 1972—that is, to the extent that the Federal payments and the State supplementary payments do not exceed the payment levels in effect under the public assistance programs in the State for January 1972, plus the value of food stamps if the State pays in cash the value of food stamps.