SOCIAL SECURITY AMENDMENTS OF 1970

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-FIRST CONGRESS

SECOND SESSION

ON

H.R. 17550

AN ACT TO AMEND THE SOCIAL SECURITY ACT TO PROVIDE INCREASES IN BENEFITS, TO IMPROVE COMPUTATION METHODS, AND TO RAISE THE EARNINGS BASE UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, TO MAKE IMPROVEMENTS IN THE MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS WITH EMPHASIS UPON IMPROVEMENTS IN THE OPERATING EFFECTIVENESS OF SUCH PROGRAMS, AND FOR OTHER PURPOSES

PART 1

JUNE 17, AND JULY 14, AND 15, 1970

ADMINISTRATION WITNESSES

Printed for the use of the Committee on Finance

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SOCIAL SECURITY AMENDMENTS OF 1970

WEDNESDAY, JUNE 17, 1970

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to notice, at 10:05 a.m., in room 2221, New Senate Office Building, Senator Russell B. Long (chairman) presiding.

Present: Senators Long, Anderson, Gore, Talmadge, Ribicoff, Williams of Delaware, Bennett, Curtis, Miller, Jordan of Idaho, and Hansen.

The CHAIRMAN. This hearing will come to order.

The Committee on Finance today begins hearings on H.R. 17550, the Social Security Amendments of 1970.

We will include in the record a copy of the bill, H.R. 17550, and our press release announcing these hearings.

(The press release appears on page 2. The bill appears as appendix A of this volume.)

PRESS RELEASE

FOR IMMEDIATE RELEASE
June 5, 1970

COMMITTEE ON FINANCE
UNITED STATES SENATE
2227 New Senate Office Bldg.

FINANCE COMMITTEE ANNOUNCES HEARINGS ON THE SOCIAL SECURITY - MEDICARE BILL

The Honorable Russell B. Long (D., La.), Chairman of the Committee on Finance, announced today that on Wednesday, June 17, 1970 the Committee would begin public hearings on H.R. 17550, the bill to increase social security benefits and to revise and reform the Medicare and Medicaid programs. This bill passed the House on May 21, 1970, by a vote of 343 to 32.

The Honorable Robert H. Finch, Secretary of the Department of Health, Education and Welfare, will be the lead-off witness and will state the Administration's case for the bill.

The hearing will be held in room 2221 New Senate Office Building, and will begin at 10:00 A.M., Wednesday, June 17, 1970.

The Chairman noted that the Administration has not yet submitted its welfare reform proposal to the Committee, and that the Committee felt that it should begin its work on social security and Medicare by hearing Administration witnesses. The Chairman emphasized that the Committee was not fixing a schedule at this time for receipt of testimony from non-government witnesses. He indicated that the Committee's plan would make the Secretary's testimony available for study by witnesses scheduled to testify later. He stated that a further announcement would be made by the Committee fixing the time for public witnesses to testify.

Requests to Testify. -- Senator Long also urged those persons desiring to present testimony on H.R. 17550 should make their request to Tom Vail, Chief Counsel of the Finance Committee, 2227 New Senate Office Building, no later than Friday, June 26, 1970.

The Chairman noted that because of the breadth of the bill's contents, a large number of witnesses are expected at the hearing. For this reason, he stated that it would be necessary to very carefully control the time allotted for oral presentations before the Committee.

Legislative Reorganization Act. -- In this respect, the Chairman observed that the Legislative Reorganization Act of 1946, as amended, requires all witnesses appearing before the Committees of Congress --

> "... to file in advance written statements of their proposed testimony, and to limit their oral presentations to brief summaries of their argument."

The statute also directs the staff of each Committee to prepare digests of all testimony for the use of Committee members.

Senator Long stated that in light of this statute and in view of the large number of witnesses who desire to appear before the Committee in the limited time available for the hearing, all witnesses who are scheduled to testify must comply with the following rules:

(1) All statements must be filed with the Committee at least two days in advance of the day on which the witness is to appear. If a witness is scheduled to testify on a Monday or a Tuesday, he must file his written statement with the Committee by the Friday preceding his appearance.

(2) All witnesses must include with their written statement a summary of the principal points included in the statement.

(3) The written statements must be typed on letter-size paper (not legal size) and at least 50 copies must be submitted to the Committee.

(4) Witnesses are not to read their written statements to the Committee, but are to confine their oral presentation to a summary of the points included in the statement. The oral presentation should not exceed ten minutes.

Witnesses who fail to comply with these rules will forfeit their privilege to testify.

Consolidated Testimony. -- The Chairman also stated that the Committee urges all witnesses who have a common interest and a common position in a provision in the social security bill to consolidate their testimony and designate a single spokesman to present their common viewpoint orally to the Committee. He stated that this procedure would enable the Committee to receive a wider expression of views on the total bill than it might otherwise obtain. He praised witnesses who in the past have combined their statements in order to conserve the time of the Committee, and he urged very strongly that all witnesses exert a maximum effort to consolidate and coordinate their statements, not only to conserve the time of the Committee, but also to avoid repetitious testimony.

Staff Digests. -- The Chairman emphasized that the Committee staffs had been instructed to fully digest all statements submitted to the Committee so that every important point made by any witness would be called to the Committee's attention. He stated that these digests would be made available to the Committee members each morning before the witness involved actually appears before the Committee.

Written Submissions. -- The Chairman observed that the Committee would be pleased to receive written statements in lieu of a request for oral presentation. He also invited persons whom the Committee would be unable to schedule for oral testimony to submit a written statement of their views on the bill.

OPENING STATEMENT OF THE CHAIRMAN

The CHAIRMAN. This bill provides a 5-percent social security benefit increase effective January 1971, and it includes other provisions modifying the cash benefit social security programs. A major provision of the House bill authorizes the Secretary of Health, Education, and Welfare to increase social security benefits when he determines that the cost of living has increased by 3 percent. A companion provision authorizes him to increase the amount of wages taxed every 2 years--and thus the amount of the social security tax—based on his determination of the extent to which average taxable wages have risen since 1971. The committee will want to look at this provision most carefully since it involves a delegation of the taxing power vested in Congress under the Constitution.

The House bill also increases medicare taxes by a staggering 77 percent over the next 25 years in order to raise the $200-plus billion needed to make up the projected 25-year deficit in the program. A deficit of this magnitude should not have occurred, and would not have occurred, if medicare had been operated on an aggressive, hard-headed, business-like basis, and if Congress had been asked to close the gaps in that program which now loom so large.

The committee has held a series of legislative oversight hearings over the last year to examine the problems in the medicare and medicaid programs, and we have published a detailed report including recommendations for strengthening the program. Some of these recommendations have already been incorporated by the House in the bill before us today, and that is good. We will be looking for other ways to control excessive costs under medicare and medicaid, and if we are successful, then hopefully we may not need to raise medicare taxes as sharply as the House bill proposes.

Because of the urgency of our work on the extension of the public debt limitation, the committee plans to suspend hearings on the Social Security Amendments of 1970 at the end of today's session and to hold public hearings tomorrow and Friday on H.R. 17802, the bill

to raise the public debt limit. Administration witnesses on this social security bill will be scheduled to continue testimony next week.

At a later time, the committee will schedule hearings by non-Government witnesses who wish to testify on the social security amendments. By having hearings on the social security amendments in two stages, it will be possible to make administration testimony available to those witnesses who will be scheduled to appear later, and they may wish to comment upon it.

This morning we are pleased to have with us as our first witness the Honorable Creed C. Black, the Assistant Secretary of Health, Education, and Welfare for Legislation. I see, Mr. Black that you are accompanied by the old veteran in this field, Mr. Bob Ball who, I think even preceded me to Washington which, I must say, really makes him an oldtimer.

STATEMENT OF HON. CREED C. BLACK, ASSISTANT SECRETARY OF HEALTH, EDUCATION, AND WELFARE FOR LEGISLATION; ACCOMPANIED BY ROBERT M. BALL, COMMISSIONER OF SOCIAL SECURITY; AND HOWARD A. COHEN, DEPUTY ASSISTANT SECRETARY OF HEALTH, EDUCATION, AND WELFARE FOR LEGISLATION

Mr. BLACK. Well thank you, Mr. Chairman. I can assure you that as a relative newcomer to Washington I am delighted to have Mr. Ball on one side and, on the other, Mr. Howard Cohen, Deputy Assistant Secretary for Legislation.

I want to start by expressing our gratitude for the committee's very prompt and favorable action on the nomination of our new Secretary, Mr. Elliot L. Richardson. He has, as you know, now been confirmed and expects to be sworn in early next week and fully aboard then.

Meanwhile, Mr. Veneman is Acting Secretary and he had hoped to be here to lead off this presentation today. However, he is at the University of California at Davis, delivering a commencement speech at his daughter's graduation. I am sure you can understand his absence.

The CHAIRMAN. That is right. We can understand that. I think it is fortunate for a man to have a daughter but it brings certain burdens with it.

Mr. BLACK. Well, he will be back next week, when you resume hearings on this bill, to make our principal presentation.

Meanwhile, today I want to just hit the highlights of this bill for you.

The CHAIRMAN, Any answer that you give to one of our questions which is not satisfactory you may be sure we will try to get it from Mr. Veneman if we can, and if we still are not satisfied, why we will try to get it from the Secretary.

One way or the other we will try to find out what we need to know.

Mr. BLACK. I thank you.

The CHAIRMAN. But I am not complaining. I think your Department has been very cooperative with us.

Mr. BLACK. Thank you. We will keep producing witnesses until you get the answer, Mr. Chairman. [Laughter.]

Following this brief presentation of mine, which, as I say, is just to sketch the highlights of the bill, Commissioner Ball will give you a chart presentation that will give you the broad outline of the proposals. When Mr. Veneman comes, he will go into additional subjects, and following that we have more witnesses on the bill.

As you know, President Nixon has endorsed the broad provisions of this bill which is before you, and has urged you to act favorably upon it. Our Department strongly advocates such action.

AUTOMATIC COST-OF-LIVING ADJUSTMENTS

In our opinion, the most significant reform included in this bill is the provision for automatic cost-of-living adjustments of future benefits and for automatic adjustment to earnings levels of the maximum earnings on which social security taxes are levied and on which benefits are figured.

With these two changes taken together, the cost of the social security program, as a percent of covered payroll, will not be increased, and the automatic adjustment of benefits will not require any increase in contribution rates. The automatic provisions will also have significant and permanent effects on the entire social security system.

Of primary importance is the substitution of economic determinants for biennial politics. The automatic provisions will greatly reduce the hardships beneficiaries face because of inflation and the general trend of rising prices. As present beneficiaries know all too well, the time which elapses between congressional increases in the levels of benefits is often marked by rising prices. Many beneficiaries consequently suffer a severe financial squeeze while waiting for Congress to act.

This bill provides for automatic increases in benefits in every year in which the cost of living goes up by more than 3 percent. The first such increase could be effective in January 1973. Any increases that may occur in the cost of living before 1972 are anticipated by the 5-percent across-the-board increase included in this bill, an increase which this administration has endorsed.

The automatic increases in the taxable base will become effective at the same time as benefit increases; the base will be immediately raised by this bill to $9,000 in 1971 from the present $7,800. The automatic provision is needed in this section to keep the taxable wage base—those wages on which social security taxes are paid and on which benefit credits are based—up to date with current earning levels.

These two provisions, together with changes in the retirement test and other less sweeping proposals, will make a significant impact on

the lives of the more than 26 million beneficiaries of social security, and on all covered workers and their families. The administration believes these reforms should be enacted into law.

MEDICARE AND MEDICAID CHANGES

Also included in this bill, H.R. 17956, are several important vehicles for change in medicare and medicaid. Of major importance, of course, is the Health Maintenance Organization option under medicare.

We believe this innovation can stimulate a much needed change in the health care delivery system of this country. This provision allows HMO's to be reimbursed on an annual per capita basis when they contract to provide all the medical and hospital services currently provided under parts A and B of medicare.

I want to emphasize specifically the word "services" and the idea of a fixed annual rate, because these two concepts are the keys to this new and exciting alternative to the traditional ways of delivering health care in the United States. Because the HMO must provide all needed services during the year for a single fixed per capita payment, the HMO has a strong economic incentive to keep the medicare patient healthy, treat his illnesses early, and use efficient, economical, and high quality techniques.

The market theory thinking behind the HMO option is also reflected in the administration's proposals for prospective reimbursement to providers of services. We will be able to use this provision to set target rates and negotiated rates for institutional providers under medicare and create incentives to keep the provider's charges below these rates. This bill encompasses several other important changes in the medicare program, many of which were first announced as part of the health cost effectiveness amendments sent to the Ways and Means Committee on March 23, 1970 and several of which reflect recommendations suggested by the staff of this committee. These will be covered more fully later in the Department's presentation.

Before concluding, I would like to discuss briefly a few of the medicaid provisions. We are all aware of the serious shortcomings which the medicaid program has suffered in the past, and I am sure all of us want to see an improved medicaid program. The most important change in medicaid is still being developed. I refer, of course, to the proposal which is being developed in response to questions raised by this committee during its initial consideration of the family assistance plan—the establishment of a family health insurance plan. This plan, to be forwarded to the Congress by February 1971, will be designed to replace and expand the medicaid program as it applies to the current AFDC category and the working-poor families under the President's welfare reform. The Congress should not wait for that reform package before legislating a more effective medicaid program for all categories. We should begin immediately to reform the existing system, both because the present program needs reform and because the family

health insurance plan would not replace medicaid as it applies to recipients of adult-category assistance.

The reforms which we are recommending and which are found in the House-passed bill include uniform standards as they apply to institutional providers under medicare, medicaid, and title V programs; financing for the development of information retrieval systems for claims and utilization review; and coverage under medicaid for those eligible at the time they receive services.

Finally, I wish to call your attention to a critically important proposal in this bill. We are seeking authority that will enable us to use the Federal reimbursement formula under medicaid to stimulate the States to move toward more rational health care delivery systems. Our proposal includes financial incentives to encourage the States to use appropriate outpatient and institutional facilities for appropriate periods of time, thereby enhancing the quality of patient care and lessening inefficiency and an ineffective use of taxpayers' funds.

Thank you very much, Mr. Chairman. Now, if the committee will agree, I will ask Commissioner Ball to proceed with the chart presentation.

Mr. BALL. Mr. Chairman, the large charts, I believe, will be visible to all the members of the committee, and the people in the audience have books of small charts before them, as do the members of the committee.

There are many detailed provisions in this bill, and I will be hitting only the major and important ones. I will confine my presentation to the part of the bill that is administered by social security: that is, the cash benefits in the social security program and the medicare changes.

The CHAIRMAN. I would think, Mr. Ball, if your assistant would turn that stand around a little bit more the people over the entire room could see it, the audience and the press could see it, as well as the committee members. That ought to do it.

Senator BENNETT. You are going to have to move this chart out of the way because this one blocks that one.

Mr. BALL. I really think, Mr. Chairman, that, with your permission, the small charts can be followed quite well in the audience.

The CHAIRMAN. Is this it?

Mr. BALL. Yes, the books are in the same order as the large charts.

The CHAIRMAN. Good. Then we can follow it here then.

Mr. BALL. The group of charts in the back are just going to be standing charts giving an outline of various parts of the presentation, with the actual presentation occurring on these two easels in front.

The CHAIRMAN. Right.

Mr. BALL. The first point I want to make, Mr. Chairman, is that the presentation will be in three parts, the cash-benefit proposals, the medicare proposals, and then the financing proposals that relate to both cash benefits and medicare.

CASH BENEFIT PROPOSALS

1. 5% BENEFIT INCREASE
2. AUTOMATIC ADJUSTMENT OF BENEFITS TO PRICES
3. INCREASE IN EARNINGS BASE TO $9,000 IN 1971
4. AUTOMATIC ADJUSTMENT OF EARNINGS BASE TO WAGES
5. ELIMINATION OF WORK DISINCENTIVES IN THE RETIREMENT TEST
6. INCREASE IN WIDOW'S BENEFITS
7. AGE-62 COMPUTATION POINT FOR MEN
8. DISABILITY PROTECTION
9. OTHER IMPROVEMENTS

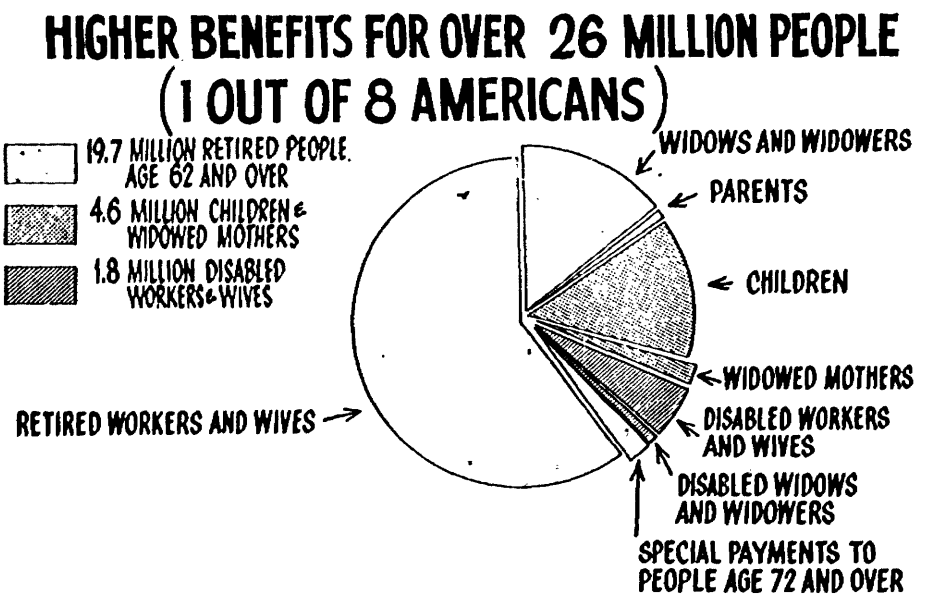
Mr. BALL. As Secretary Black mentioned, the major features of the cash-benefit proposals are the 5-percent benefit increase, automatic adjustment of benefits, the increase in the earnings base with the future automatic adjustment of the base, elimination of work disincentives in the retirement test, an increase in widow's benefits, age 62 computation point for men, improvements in disability protection, and then some other minor and miscellaneous points that I will mention.

First, Mr. Chairman, I should like to show, using this chart, the people to whom this 5-percent benefit increase is going to apply. You will all remember that there was a 15-percent benefit increase applicable to the entire social security rolls and for all those coming on the rolls later, effective last January. The payments were actually made on April 3rd and then there was a catch-up payment made in the third week of April.

Well, the Ways and Means Committee felt, and the House felt, that another 5-percent increase should be effective next January, which would take into account an anticipated increase in the cost of living during 1970.

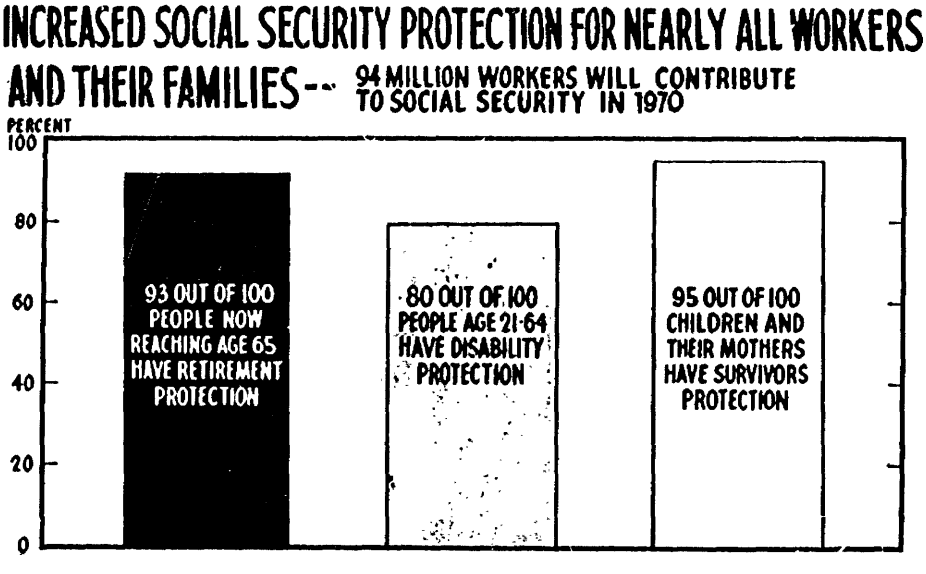
These figures on the number of people getting social security benefits change so rapidly that I did want to remind the committee of who it is who gets these payments.

We are now paying one out of every eight Americans. Over 26 million people by next January will be getting a check every month through social security. This number, of course, is made up of not only retired people, but of widows and orphans and disabled people and their families as well.



Mr. BALL. On this pie chart, the purple area represents older people. The largest group, of course, is retired workers and their wives, and then represented in this cut are widows and widowers, and then a small group of parents, and then those who receive the special payment that is paid at age 72 for individuals who aren't insured for regular social security benefits.

Taking it all together, by January, when the benefit increase becomes effective, there will be almost 20 million people age 62 and older who are receiving social security benefits. The fact that social security pays most older people is very well known. Perhaps less well known is the fact that there are more than 4½ million children and younger women—widowed mothers of those children—who will be receiving benefits. And then finally, under the latest part of the cash benefit program, 1.8 million disabled workers and their wives will be getting benefits in January.



Mr. BALL. This bill not only increases benefits for those currently receiving benefits, but increases protection for all the people who are now paying into the program. During 1970, 94 million people—workers and self-employed persons—will make contributions to social security.

This program is very rapidly becoming, and has largely become, quite a mature program in terms of the protection it now gives. Looking at the measures of the people who will benefit from the changes in the bill, shown in the next chart: Right today, 93 out of every 100 of the people who are reaching 65 are eligible for social security benefits. They don't all get benefits right away, because of the retirement test—those who continue to work full-time at high earnings don't—but 93 out of 100 are eligible. If you look at the whole group of aged—everybody over 65, and not just those becoming 65 this year—about 90 out of 100 are eligible.

The disability protection covers a somewhat smaller proportion. About 80 out of 100 between the ages of 21 and 64 have this protection. The reason the percentage is smaller is that the requirements on the amount of covered work under social security needed to be eligible for disability benefits are stricter than the requirements for retirement benefits. Fewer people have been able to meet the test of recency of work that is required for disability benefits, as well as being fully insured. As shown here, 95 out of 100 of young children and their mothers in the country would be eligible for monthly benefits in the event of the death of the breadwinner in the family.

For all these people, this bill improves protection on into the future.

AUTOMATIC ADJUSTMENT OF BENEFITS TO PRICES

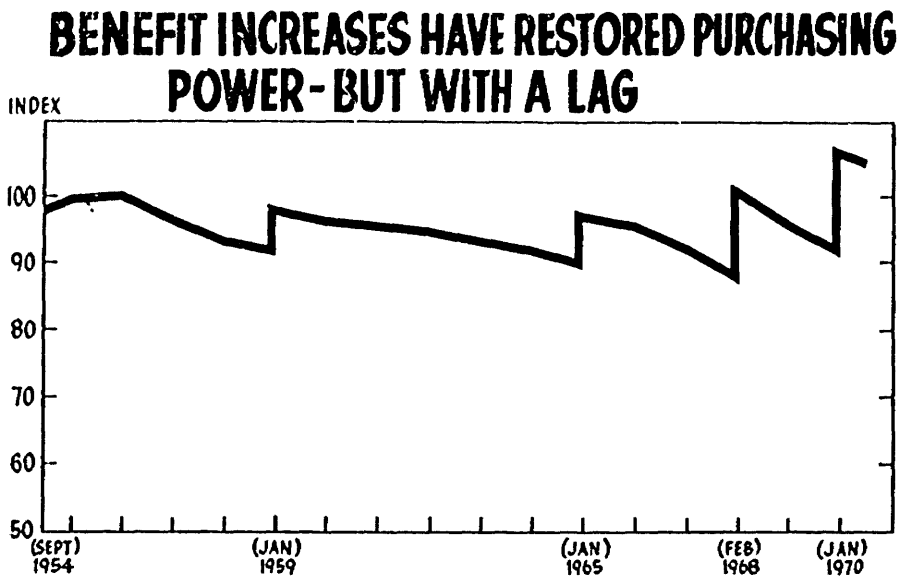
1. WHEN THE CPI INCREASES AT LEAST 3 PERCENT

2. BUT NO MORE OFTEN THAN ONCE A YEAR

Mr. BALL. Mr. Chairman, as Secretary Black indicated, we believe the automatic adjustment of benefits to prices to be the most important cash-benefit proposal in the bill.

The provision—as shown on this chart—is that whenever the Consumer Price Index increases at least 3 percent from the last benefit increase, the benefits would be automatically increased by the amount of the increase in the CPI. This would occur no oftener than once a year and the increase would be for the following January. This is not a matter of discretion, of course, with the Secretary; this is an automatic provision; he has to do it. The increase flows entirely from the provisions of the law.

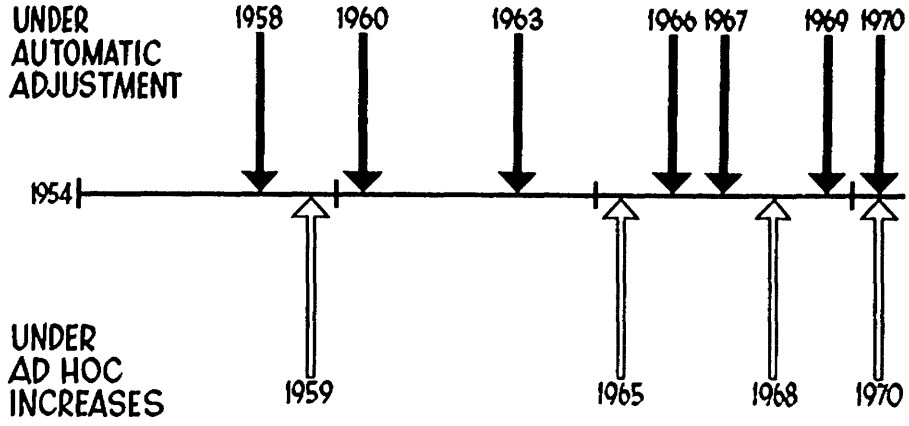
We feel this gives very important additional protection, Mr. Chairman, without really being a change from the fundamental policy the Congress has been following. This next chart indicates how from 1954—over the last 15 years and up until the present time—the Congress has been restoring the purchasing power of benefits through periodic changes in the benefit level.



Mr. BALL. This chart is based on an index of 100 for the benefit level established in 1954. What happens, as the chart shows, is that the cost of living goes up for a while and the value of the benefits drops, and then the Congress increases the benefits, bringing them back approximately to where they were before. Then there is another period where the value of the benefits declines, and then Congress brings it back again, and then another decline, and then you bring it back, as shown here. This last increase of 15 percent, as you see, went above the index of a hundred somewhat. It is true that if I had on the chart the period 1950 to 1954 we would see for that period, too, some increase in the absolute benefit level. But from 1954 to 1969 benefits were just about kept up to date, with a lag. There is no quarrel with the fact that the Congress has acted. I think it is really a settled policy by now that the benefits will at least be kept up to date with changes in the purchasing power of the dollar. The problem is, though, that this is accomplished with a time lag. As you see on this chart, there was quite a substantial period, 1959 to 1965, where there was no change in the benefit level.

What we have shown on this next chart, below the line here, is the actual time at which congressional action resulted in benefit increases. From 1954, when there was a new absolute benefit level established, up to the present time, there have been four changes. During periods when there are rising prices but the Congress has not yet acted, there is a decline in the purchasing power of the benefits, and for the people who live during that time the loss can never be made up.

AUTOMATIC ADJUSTMENT REDUCES LAG BETWEEN BENEFIT INCREASES



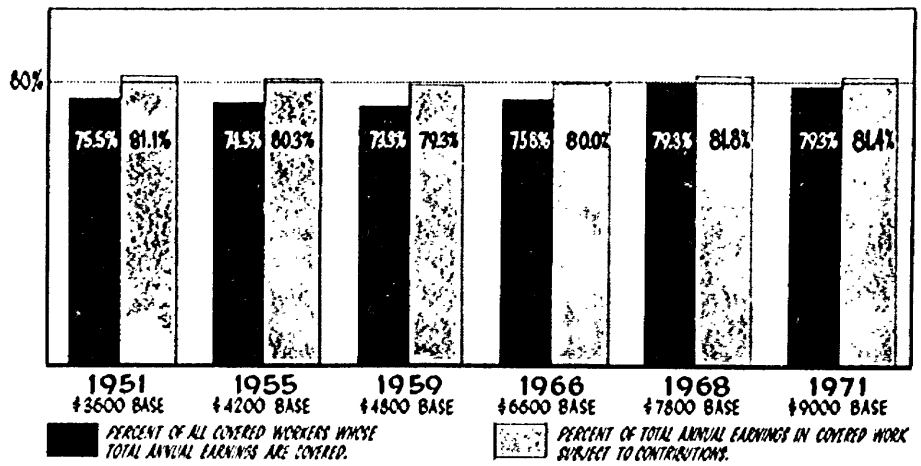
Mr. BALL. An older person who has had his purchasing power reduced does not have that hardship made up for by a later action restoring the purchasing power of the benefit.

The main point of this automatic provision is to put what I believe is settled congressional policy of keeping the benefits up to date right in the law so that there would be automatic action keeping the benefits up to date. In the chart, above the line, we have indicated what would have happened under such a provision by taking the price situations of the past and showing when the automatic provisions would have resulted in a benefit increase. Instead of the four changes that we actually have had, with these lags, we would have had seven changes during this period. People would then not have had the long years in which they had declining purchasing power.

Even an automatic provision doesn't keep the purchasing power all the way up to date—there is always some lag even in an automatic provision—but it comes much closer to maintaining purchasing power than relying on ad hoc legislative action.

Mr. Chairman, accompanying the benefit changes we have proposed, and the House has adopted, an increase in the earnings base from the present $7,800 a year to $9,000, effective in 1971. This next chart indicates what I believe has come to be a settled policy of the Congress, reaching back to 1951, of keeping the earnings base up to date. Periodically the maximum amount of earnings covered under Social Security has been raised as earnings have risen so as to cover approximately the same proportion of covered wages that the previous earnings base covered. Thus the financial base of the social security program has been maintained, and also, as a result, the benefit protection that people are earning is related to approximately the same portion of their earnings as was contemplated in 1951 even though earnings levels have greatly increased.

$9000 CONTRIBUTION AND BENEFIT BASE IN 1971 MAINTAINS RELATIONSHIP OF BASE TO EARNINGS LEVELS



Mr. BALL. We have two measures here on this chart. The darker one indicates the percent of all covered workers whose total annual earnings were covered by the earnings base that was in effect at a particular time, and the lighter one indicates the percent of covered payrolls that was covered by the base. You see that starting in 1951 roughly a little over 75 percent of all workers under the program had their total earnings covered, and a little over 80 percent of total payrolls in covered industry were included.

What has happened is that as wages rise, these percentages decline, and then are restored by an action of the Congress. In 1955 you come approximately back to the 1951 relationships. By 1968 we were just slightly ahead by these tests, and the 1971 recommendation for a $9,000 base in 1971 retains the 1968 situation. But, by and large, the point is that the Congress has maintained the same relationship by ad hoc action since 1951.

The proposal in this bill, in addition to going to $9,000 next year—which restores the previous situation immediately—is that as a companion piece to the automatic adjustment of benefits to prices, the Congress would write into the law a specific formula—without any discretion allowed on the part of the administrator—that will continue automatically what I believe, from this history, is shown to be a settled policy of the Congress, a policy of keeping the base up to date.

Under the proposal, as shown in this next chart, maximum earnings base would rise, in rounded amounts of $600, no oftener than every 2 years on the basis of comparing the level of average wages reported under Social Security in future years with the level base year of 1971. Any change in the base would be an automatic result without any discretion whatsoever on the part of the Administrator. The reports, of course, are employer reports. The wages are recorded and the average is compared with that for the base year. The result is nondiscretionary.

AUTOMATIC ADJUSTMENT OF MAXIMUM EARNINGS BASE

1. MAXIMUM INCREASED BY PERCENTAGE INCREASE IN AVERAGE WAGES, ROUNDED TO NEAREST $600

2. INCREASE LIMITED TO EVERY TWO YEARS, BEGINNING WITH 1973

Mr. BALL. Mr. Chairman, a very important proposal of the President's that was adopted by the House is in the area of the so-called retirement test.

ELIMINATING WORK DISINCENTIVES IN THE RETIREMENT TEST

	PRESENT	PROPOSAL
ANNUAL EXEMPT AMOUNT	$1680	$2000
$1-for-$2 ADJUSTMENT	$1680-$2880	Above $2000
$1-for-$1 ADJUSTMENT	Above $2880	—
MONTHLY MEASURE	$140	$166 AUTOMATICALLY ADJUSTED

Mr. BALL. This is the provision that limits the amount of social security benefits that a beneficiary gets if he continues at work and earns above specified amounts.

The major problem that we have been grappling with in this test is to reduce the disincentives to work that are inherent in taking away part of people's benefits when they earn more than a specific amount. The present provision is particularly bad in that respect in relation to earnings above the $2,880 level.

Let me just take time to remind you of how this test works today.

As shown here on the chart, under present law an individual gets his full benefits for a year if in that year he earns $1,680 or less. Then

there is a band between $1,680 and $2,880 where his benefits are reduced by $1 for each $2 earned, and that is fine. But above $2,880 his benefits are reduced by a dollar for every dollar that he earned, with the result, of course, that with the expenses of working, and with the fact that he pays income tax on earnings and not on social security, he actually is worse off by earning somewhat over $2,880 than if he had confined his earnings to $2,880 or less.

Let me remind the committee that notwithstanding these annual tests, an employee gets his full benefits for any month in which his wages are $140 or below.

Among the changes proposed, the most important one in principle is to eliminate the dollar-for-dollar area, and instead have the $1-for-$2 rule apply to all earnings above the exempt amount.

The proposal is for a $2,000 exempt amount instead of $1,680. The shift from $1,680 to a $2,000 exempt amount just about recognizes the increase in wages that nas taken place since the $1,680 was established.

The CHAIRMAN. Would you mind being a bit more explicit so someone who is not familiar with it can understand precisely what you mean by that. Give us an illustration of how it works now and how it would work under your proposal.

Mr. BALL. Well, Mr. Chairman, suppose a man earned at the present time $1,780 in the course of a year. His first $1,680 is exempt entirely, but he has $100 over that, and there is a one-for-two ad-adjustment on that $100. We take $50 away from his annual total of social security benefits under present law.

Under the proposal, because of raising the exempt amount to $2,000, the entire amount of $1,780 would be exempt, and we would pay him his full social security benefits.

Then, under present law, if the individual earned over $2,880, we start taking away from his social security one dollar for every dollar that he earns. Our proposal is not to do that, but to continue a one-for-two deduction all the way up, until all the social security benefits are eliminated.

The CHAIRMAN. While you are rounding figures off why didn't you just make that $3,000 or $2,800 rather than $2,880.

Mr. BALL. The $2,880 is a figure $1,200 above the $1,680 exempt amount, Before the present test was enacted the exempt amount was $1,500 and the $1-for-$2 reduction applied in a $1,200 span from $1,500 up to $2,700. When the exempt amount was raised from $1,500 to $1,680, the $1,200 span was continued.

Raising the exempt amount is of course another matter—really. That is really a matter of both cost and principle to an extent, I would say, Mr. Chairman. If you went as high as $3,000 for the annual exempt amount, a fairly significant number of people would be eligible at age 65 to draw social security even though they continued to earn just as they had before. They wouldn't really be retired people; they would just be people who suddenly reached a given age. You would be paying them on an annuity basis. We have always taken the view—although I know there are many Members of the Congress who have disagreed with this—that the funds of the program really ought to be conserved for people who have suffered a loss of income by having to retire or partially retire.

More important than that, though, is the fact that if you raised the exempt amount as high as $3,000, instead of a relatively modest cost for the proposal to go to $2,000, you would have a very expensive proposal.

Senator TALMADGE. What is the cost of the present proposal?

Mr. BALL. The present proposal costs 0.13 percent of payroll, I am informed. You might be interested——

The CHAIRMAN. In dollars how much is that?

Mr. BALL. This is the average cost over a 75-year period.

The CHAIRMAN. Yes, but how much next year?

Mr. BALL. For the first full year, the cost is estimated at $570 million.

Senator CURTIS. Mr. Chairman, may I ask how do you apply the monthly test, on earnings test, for retirement?

Mr. BALL. Yes; the monthly test, Senator Curtis, is an overriding test. You really say that regardless of how much the individual has earned during the year—you might take a person who earned as much as $5,000—you say that nevertheless, in any month in which he has earned wages of $140 or less, he nevertheless gets a benefit for that 1 month regardless of his annual earnings.

Senator CURTIS. So if an individual is in a business or profession where he can crowd certain employment into 1 month there is no limit except for that month?

Mr. BALL. That is correct. For the self-employed, because you can't determine a self-employed person's income by the month, the test is whether he has rendered substantial services in his business during a month. If he didn't work in his business during a particular month, then he would be eligible for benefits for that month even though the earnings for the year might exceed the annual exempt amount.

I might remind the committee why the law is set up that way. It is particularly significant as people move in and out of employment.

Take the first year of retirement. If you stuck solely to an annual test, an individual who had relatively high earnings in the first 5 or 6 months might be put in a position where you wouldn't pay him any benefits for the rest of that year. Yet he is retired when he stops work.

In order to start paying him benefits right away, you use the monthly test, and say, well, he isn't earning anything after he retired in May, and therefore you can pay him for the rest of the year, even though early in the year he had quite high earnings.

The same applies if he goes back to work after he has retired and then retires again. There is a lot of movement in and out of employment.

Senator CURTIS. I am not critical of it.

Mr. BALL. No; I know.

Senator CURTIS. I think it has to be that way but I wondered how it would apply to the self-employed. For instance, a lawyer might go back for the month of tax returns and make himself four or five thousand dollars, and still he could draw his benefits for 11 months.

Mr. BALL. If he does nothing else during the rest of that year he draws benefits for 11 months. It seems to me he really is a retired person in the case you have cited.

Senator GORE. Mr. Chairman, may I ask a question.

Mr. Ball, isn't there some unfairness involved in applying this test to earned income alone leaving no ceiling, no adjustment, no reduction whatsoever applicable to people with income from investment.

Mr. BALL. It doesn't seem so to me, Senator Gore, for this reason. I think the principles on which this system is built are really very sound from the standpoint of the question you raised. People get their social security benefits without regard to any income, other than work income, that they may have, with the idea that social security benefits are relatively low and we hope that people will have private pension plans that supplement the benefits, and that they will have private savings that will supplement the benefits. Unless you let people have their private savings, their private pensions, and also social security, then you can't encourage that voluntary saving activity, and you can't build on social security.

As soon as you write in what amounts to an income test or a means test, and say, "We are going to reduce your social security because you have dividends or interest earnings or a private pension"—as soon as you do that I think you have moved over toward a welfare-type program, and also you have discouraged individual savings throughout life.

Senator GORE. Well you have explained it very well but I don't think you have answered the question of the inherent unfairness involved. True we hope that people will have other sources of income, but the present policy which you are recommending to continue, discriminates against those who are not so fortunate.

Mr. BALL. I really don't believe it does, Senator Gore. Thinking of this as a retirement system where your benefits are based on the earnings that you had in the past, you must test whether you have retired or partially retired. This is the reason for looking at your earnings. It is just a test of whether you have retired or not.

We don't look at other income, because that has nothing to do with the question of whether you have retired, any more than you would look at savings in paying benefits under a private retirement system. In a private system you would test whether the individual has left his employer, or whether he left his industry under an industrywide plan, or whether he has left the Government under the Civil Service system. Then you pay him his retirement benefits and you don't look at any other income or resources he may have.

Senator GORE. Of course, this is based on the goal which I really wished to question, of requiring people to quit work before they are entitled to benefits. I think with the improvement in medical care, the advances we have made in longevity, and in the elongation of health and capabilities into the later years of life, that we may need to re-examine this whole question of placing a premium upon retirement. A man 62 or 65 years of age can contribute a great deal to his country.

You are not a boy yourself, and you seem to be in your prime here this morning.

Mr. BALL. I hope I stay that way this morning, Senator.

[Laughter.]

Senator, we very much agree with the importance of having a situation in which people are not seriously penalized for taking jobs, and I think the present test does that, above this line of $2,880.

Senator GORE. This I would disagree with you on. I think with the present high cost of living that this figure is too low.

Mr. BALL. What I am saying is that we are proposing, and the House has approved, the dropping entirely of this idea of taking away dollar for dollar from your social security benefits when you earn above the exempt amount. Instead the bill provides that for earnings above $2,000, we will reduce social security benefits by only one dollar for each two you earn. This is a major step in the direction of what you are seeking, which is to have no barriers to the employment of older people. Now there would be an even stronger incentive to work if you abolished the retirement test altogether, I agree----

Senator GORE. Well, I will close with this.

Mr. BALL. Abolishing the test is very expensive.

Senator GORE. If this theory is to be continued then I think we must have some ratio that applies with respect to unearned income as well as earned income.

Mr. BALL. I would hate very much to see the Congress do that, Senator, for the reasons I have explained. It really is introducing an income test into the program. Instead of basing benefits on earnings and contributions. You wouldn't get the benefits if you are one of the people who have saved. That would be a very big departure in this program. Instead of being a base which you will hope people will add to, you would be saying, in effect, "If you are one of those who save on your own you are not going to get your social security." I think that would be a bad change in the program.

Senator GORE. Well, you are persuasive in that regard but not very persuasive to me with respect to this low limit on earned income.

Mr. BALL. I will settle for 50-50.

Senator GORE. Thank you. [Laughter.]

That is the best deal I have had in a long time.

Senator WILLIAMS. What would be the cost of the program to make that $2,400 rather than $2,000?

Mr. BALL. That would be 0.08 percent more, Senator. This provision in the bill for $2,000 would cost 0.13 percent. It would add 0.08 percent more to go to $2,400 and then have a $1 for $2 adjustment for all earnings over $2,400.

Senator HANSEN. Mr. Chairman.

The CHAIRMAN. As Chairman of the Committee, I started it so I should accord everyone else the same courtesy that I insist upon myself and I will. But after we have this round of questions at this pause, I am going to suggest that we merely make notes and save our questions until our turn comes. But I am not going to deny other Senators the same advantage I insisted upon and accord myself. I suggest that after this break we let Mr. Ball finish his presentation in chief and then I will call upon the Senators.

I am planning to recognize the junior Senators first this time and you will be the first one, Senator Hansen.

Mr. BALL. Did Senator Williams get the answer to his question?

The CHAIRMAN. Did you get it?

Senator WILLIAMS. I didn't hear it.

Mr. BALL. It was 0.08 percent, in addition to the 0.13 percent for the $2,000 in the bill. It would cost 0.08 percent more to raise that $2,000 to $2,400. It starts to get very expensive as you raise it to where you hit a lot of full-time workers.

Senator MILLER. Mr. Ball, I would like to ask a follow-on question of what Senator Gore asked and also one that Senator Curtis asked. Senator Gore suggested the earnings test which you discount. I would like to refine that a little bit by suggesting an earnings and contributions test. Suppose in the example that he gave you had someone who had a very large amount of income from dividends or interest. That person had only contributed, let's say, $3,000 to the social security system, and after a few years he received back $3,000 in benefits. Now if he continues to get benefits which he quite obviously doesn't need because of all of his other outside income, why should the system continue to pay him some benefits? That is going to come out of the hide of the younger worker in the system, and that does not seem equitable to me.

Mr. BALL. Well, Senator Miller, my feeling is very much the same in relation to that proposal, in that you would be treating differently under social security one individual as compared with another depending upon whether or not he had accumulated savings of his own, even though——

Senator MILLER. And depending upon whether or not he had contributed, and——

Mr. BALL. Right.

Senator MILLER (continuing). How much he contributed so that he was getting a windfall out of the system.

Mr. BALL. But what I mean is that nevertheless, if two individuals had both contributed the same, each $3,000, you would apply this deduction of social security benefits only to the one who had accumulated savings; you would not apply it to the other.

Senator MILLER. Well, I think that the reason would be obvious. I think you have a social hardship situation there in the case of the one who doesn't have any income, and you do not have a social hardship in the case of the one who has plenty of income.

Mr. BALL. My fundamental belief is that it has been an important point of strength in the program to base the benefits objectively upon wages that people have earned, not taking into account in any way what their own savings and resources are. Once you start in that direction, the program turns more and more in the welfare direction and away from contributory insurance approach. We have got a welfare system, although we need to improve it a lot. If it is a question of dealing with these means test questions I would rather that they be handled under the welfare system.

Senator MILLER. Mr. Ball, I just want you to know that this social security system is becoming more refined all the time. We are in a computer age now, and I think that we are capable of making a differentiation between someone who is getting a windfall at the expense of the younger worker, and I have talked to some of these younger workers who are having a hard time maintaining themselves and their little growing families, and they are quite concerned when they pick up the newspaper and they read that somebody has made a contribution of $2,000 into the social security system, has received $10,000 in benefits, and is also getting $25,000 to $50,000 in earnings from dividends and interest. Now they don't like that, and I don't blame them. It seems to me we are in a position in our capacity to do something about it.

I subscribe to Senator Gore's basic theory here, with the modification that I want to eliminate windfalls.

Now one other question on that response to Senator Curtis. Do I understand that if you have two individuals who are retired, and one earns $140 every month, the other earns nothing except for 2 months, and during those 2 months he earns $5,000 as a lawyer coming in and working on income tax returns, that for the other 10 months they both are treated alike. The one during the course of the years has a total income of $1,680 and the other has a total income of $5,000, and yet they are going to be treated alike for 10 months and each receive their monthly benefits.

Mr. BALL. That is correct. The individual who worked for only 2 months is considered retired the rest of the year, and he is paid for 10 months.

Senator MILLER. And yet during the whole year he has $5,000 of income and the other fellow only has $1,680.

Mr. BALL. That is correct.

Senator MILLER. They are treated alike for those 10 months?

Mr. BALL. That is correct.

Senator MILLER. Do you think that is fair?

Mr. BALL. I think it is, Senator, because I think what you are testing is not how much income they have. What we are trying to get at in this rough way—and it is the only way that we and Congress have ever been able to think up—we are trying to get at who are the retired people or partially retired people who should get these benefits. A man who doesn't work for 10 months out of the year would seem to me to be a retired person.

Senator MILLER. And the fellow who works for every month during the year——

Mr. BALL. Is working.

Senator MILLER. Is not fully retired because he is exempt on that.

Mr. BALL. I misunderstood you. I thought you asked me would he be getting benefits during those months.

Senator MILLER. The monthly amount was $140.

Mr. BALL. Yes, and if he earned $1,680 in the whole year, if that is all he earned, he would get benefits for every month, all 12 months.

Senator MILLER. That is right, although he is working every month.

Mr. BALL. That is right.

Senator MILLER. Here is another fellow who is not working except for 2 months but he has $5,000 of income, looking at it from a years standpoint, and the other fellow only has $1,680 and you are going to treat them both alike.

Mr. BALL. Well, the theory of it is—I am not sure whether you will agree with it, but the theory of it is that this individual who worked the 2 months is retired during the other 10, so you pay him for those 10. This individual who worked every month but worked at so low a level as $140 a month—$166 a month under the bill—can be assumed to be a partially retired individual throughout the year, because the theory of these exempt amounts is that they are so low that people who earn less can be considered retired.

Senator MILLER. I wouldn't have a problem if we looked at this from an annual standpoint rather than a monthly standpoint, would I?

Mr. BALL. Well, there is another problem when people move in and out of employment. You take the case of a man who earns a substantial amount in January, February, March, and April and then retires. If you go solely on an annual basis he may have earned an amount in those first 4 months high enough that you couldn't pay him at all during that year. You have to wait until next year to pay him.

Senator MILLER. What is wrong with that.

Mr. BALL. He is a retired individual, and he may have been living very close to what he is earning. These amounts are not so high as to make that unlikely. A retirement system, I think, ought to pay people when they retire and not make them wait 8 or 10 months before they can get benefits.

Senator MILLER. Mr. Ball, I suggest to you we are getting into semantics on this, and I am afraid that because we do we find the cost of this system getting higher and higher all the time. I get back to my proposition. With our computers and our capability I think we can refine this more so we don't have to worry about these in-and-outers. But I do appreciate your responsive answers.

Mr. BALL. Thank you, Senator.

I am not sure I made the point on this chart, Mr. Chairman and members of the committee, that these dollar provisions in the retirement test under the bill and under the President's proposal would also be automatically adjusted as wages rise in the future to keep these amounts up to date. There are lags, too, in making those changes.

The next important proposal in the cash benefit area is——

The CHAIRMAN. Just one moment. Senator Hansen, did you want to ask a question at this time?

Senator HANSEN. I did. The cost of—these programs, the cost is 0.13, what are you talking about 0.13 billion?

Mr. BALL. No; 0.13 percent of covered payroll. This is the long-range cost figured over a 75-year period.

Senator HANSEN. Thank you, that is all I have.

Senator BENNETT. Mr. Chairman, I understand you have some charts and I think they should be in the record. I also think the charts should show the dollar cost per year as well as the cost in terms of percent of payroll because we have to worry about dollars, and I ask that those be included in the record.

The CHAIRMAN. Can you provide that for us?

Mr. BALL. We'll be very glad to do that, Senator Bennett.

The CHAIRMAN. You do have a chart further back in here that I believe tried to demonstrate that?

Mr. BALL. Yes.

Senator BENNETT. I am talking about his basic charts to which he referred and we would like to have them in the record.

Mr. BALL. I will be glad to do it.[1]

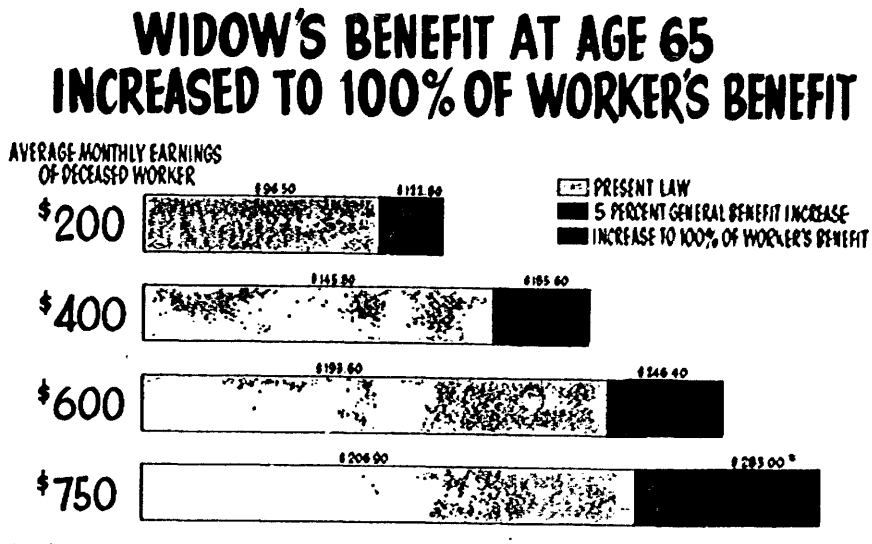
The CHAIRMAN. Gentlemen, everyone has had a chance and if he hasn't I will recognize him now to ask his questions, and aside from that I am going to urge all members and try to restrict myself also, to permit Mr. Ball to finish his presentation in chief before we interrogate him further.

[1] The charts were therefore printed in this volume at the point at which they are referred to in Mr. Ball's prepared statement.

Thank you very much.

Mr. BALL. All right, Mr. Chairman.

The next cash-benefit change proposed in this bill is the President's proposal to increase the benefits for widows to 100 percent of the retired worker's benefit when she seeks the benefit at age 65.



Mr. BALL. The present formula is that the widow gets 82½ percent of the worker's benefit—called the primary insurance amount. The proposal is that she get the same as a retired worker would get. There is no reason to think that a single widow living alone needs less than the worker himself living alone.

This chart shows the effect of this proposal. Down the left hand side of this chart we have indicated various examples of the average monthly earnings, which, as you know, determine the benefit amount under social security.

The light portion of the bars shows the dollars that are paid to widows under present law—82½ percent of the primary insurance amounts derived from average wages.

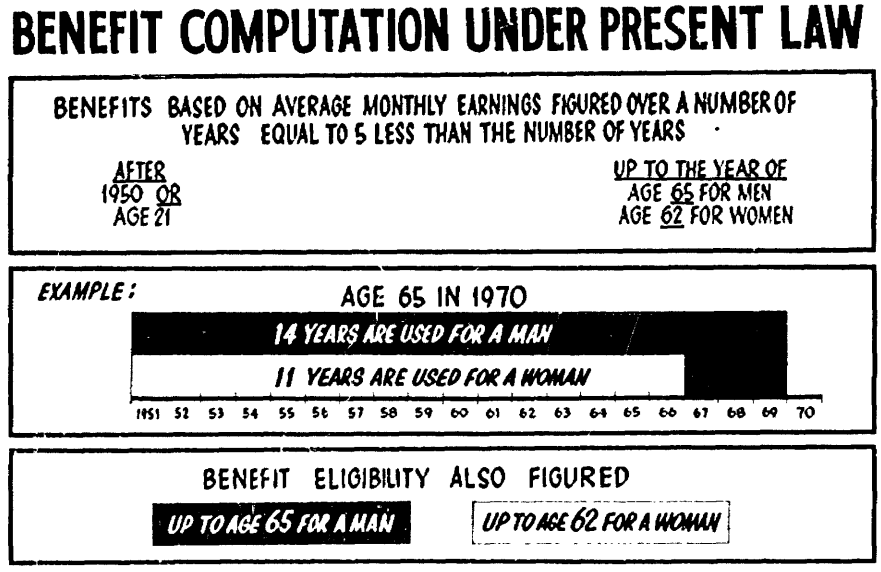
Then there is a somewhat darker smaller portion which indicates the increase that they get from the 5-percent provision that I previously described. Then the still darker amount shows the increase that results for widows who are 65 or older because of the increased percentage of the primary insurance amount that they will get.

So taking everything together, a widow whose benefit was based, say, on a $400 average monthly wage of her husband would be getting $145.80 today. Under the combination of the 5-percent increase and this proposal, we would recompute her benefit to $185.60.

This category—benefits for aged widows—is the one that of all the social security benefit categories is the lowest, on the average, and these aged widows are also shown, from our surveys, to have the least in other resources.

About 33 million widows already on the rolls would have their benefits recomputed under this proposal, and then, of course, the provision would result in higher benefits for aged widows on into the future.

The next proposal, shown on this chart, is to compute benefits for men using a computation point of the year of attainment of age 62, the same as for women today.



Mr. Ball. For a variety of historical reasons, we now, in terms of benefit computation, treat a woman who has the same earnings record as a man better than we treat the man. The proposal is to treat them the same.

If I could remind the committee of how this is done now, the basic computation of the average wage, in most cases, is that you take all the earnings a person has after 1950 (or age 21, if that is later than 1950), and you count his earnings up to the year in which he attains age 65 if he is a man, but only to age 62 for a woman. You drop the earnings in the 5 years that are the lowest, and you also drop those years from the computation, and you figure the average wage over the resulting period. This average is what determines the amount of benefits that are paid.

If you take a person becoming age 65 in 1970, and you apply this formula, the result is that you average the earnings of a woman over her 11 best years, but for a man in the same situation you average his earnings over 14 years. That practically always means that a man in this situation is disadvantaged.

The proposal is to compute benefits in the same way for men and women. It would do the same for eligibility—that is, for determining insured status.

The computation applies to more people. The computation actually applies to over 10 million beneficiaries now on the rolls. These are not only retired men, but their dependents and survivors, whose

benefits are based on the average monthly earnings of the man. There are about 10 million people that we would recompute for, and there are around 60,000 people that we will pick up who are not now eligible but who become eligible for benefits when you apply the same test of eligibility to men that now applies to women. This is a matter of making the two equal.

The next chart in the cash-benefits area, Mr. Chairman, shows three things in the disability area. They are of less importance than these matters we have been talking about but that I believe are worth mentioning.

DISABILITY PROTECTION

- EXTENDS CHILDHOOD DISABILITY BENEFITS TO PEOPLE DISABLED AFTER REACHING AGE 18 AND BEFORE 22
- EXCEPTS THE BLIND FROM THE INSURED-STATUS REQUIREMENT OF RECENT ATTACHMENT TO COVERED WORK
- INCREASES CEILING ON TOTAL BENEFITS PAYABLE TO A SOCIAL SECURITY DISABILITY BENEFICIARY WHO RECEIVES WORKMEN'S COMPENSATION

Mr. BALL. First, as you know, today we pay benefits to an individual who was disabled in childhood and has had a continuous disability since childhood, when the parent who has been taking care of him retires or becomes disabled or dies. In other words, that individual, even though he may be 40 or 45, is treated as if he is a dependent child. The conditions are that he had to become disabled before age 18 and be continuously disabled thereafter.

The proposal here is that if the individual were disabled between 18 and 22, that same provision should apply. The provision that he must have been disabled before age 18 is really a carryover from the days when social security benefits were paid only to children below 18, whereas today, as you know, children attending school can get benefits up to age 22.

The next proposal embodies part of one of the very popular Senate bills. The proposal is to change the eligibility provisions for the blind under the disability program. There are a very large number of Senators who have co-sponsored a bill to do this.

What the House did was to drop the test of covered work for 5 out of the 10 years immediately before disability for the blind and pay them benefits if they meet the fully insured test, the same as we do for a retired worker.

Then there is a provision in the House bill which modifies the ceiling that applies under present law when an individual is getting both a disability benefit under social security and a workmen's compensation benefit. The present law says that we will reduce the social security benefit if the combined workmen's compensation and social security

disability benefit exceeds 80 percent of the worker's average current earnings. (The proposal does not change the definition of current earnings in the law, so that is a detail I don't think I need to get into.)

The House bill changes the provision from 80 percent to 100 percent.

The Administration did not propose that change. It is in the House bill.

Finally, the last chart on cash benefits, Mr. Chairman, shows only two other changes that are worth mentioning (there are other minor ones). Just to remind you, under present law, if you receive your benefits before 65, those benefits are reduced on an actuarial basis so that approximately you will get the same amount during the whole period of your life expectancy as you would have if you got a full benefit at age 65. You get a lower monthly benefit amount, but you get it for longer.

A person can of course be eligible for more than one type of benefit.

OTHER IMPROVEMENTS IN SOCIAL SECURITY PROTECTION

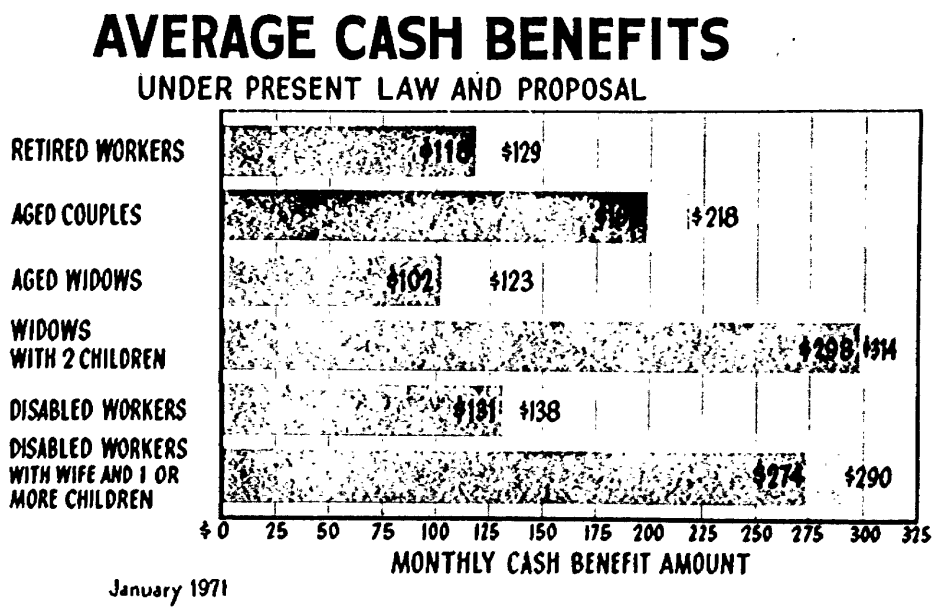
● ACTUARIAL REDUCTION IN ONE BENEFIT NO LONGER AFFECTS AMOUNT OF SECOND BENEFIT

● NONCONTRIBUTORY WAGE CREDITS FOR MILITARY SERVICE FOR THE PERIOD JAN. 1957 TO DEC. 1967

Mr. BALL. Under present law a working woman getting her own benefit on retirement may take it before 65 and get a reduced benefit. Then later on, or even at the same time, she may also be eligible for a reduced wife's benefit based on her husband's earnings—that is, for an additional amount based on her husband's earnings. Under present law, if she once has elected an actuarial reduction for any benefit, that reduction carries over to any other benefit she may qualify for. That carryover is eliminated: an actuarial reduction in one benefit would no longer affect the second benefit.

The next proposal, for noncontributory wage credits for military service, is designed to fill out a provision in present law. You will remember that the Armed Forces are covered under social security on a regular contributory basis beginning in 1957. The Congress, in the 1967 amendments, increased the protection that the Armed Forces had by adding $100 a month free credits to what they had previously been credited with—their basic pay. The Congress said $100 a month would roughly take the place of the wages-in-kind that the members of the armed forces get. But the additional credit started only in 1967. This new provision gives that $100 free credit from the time the contributory compulsory coverage was first established. This is a charge on the general revenues and not on social security.

Here we have a summary chart on the cash-benefit proposals, gentlemen. This chart compares the average benefit paid to various categories of beneficiaries today to what they would get next January under this bill. It reflects not only the 5-percent across-the-board increase, but the other provisions also.



Mr. BALL. For instance, male retired workers would have their benefits recomputed to take account of the new age-62 provision so the average benefit for all retired workers—men and women—is estimated to go from $118 to $129. Benefits for couples will go from $199 to $218 on the average, and for aged widows, who will have a very substantial increase because of the 100-percent provision, the average would go from $102 to $123. You see the comparable figures on the chart for other benefit categories.

MAJOR MEDICARE PROVISIONS H.R.17550

1. Contributions to the long-range solution of rising medical costs

2. Additional provisions for program control

3. Improvements in Medicare protection

Mr. BALL. If I could turn now to the proposals in the medicare area, the second part of the presentation. I have divided the proposals in the medicare area into three groups. The first group consists of rather long-range and fundamental proposals, which we think over time will contribute to a solution of the very, very serious problem of the long-range increase in medical costs.

Secondly, we have a grouping of additional provisions that are aimed at a variety of problems that we and you have discovered in reviewing the operation of the program. And then there are some improvements in medicare protection in the bill. Although not of a major kind, and, although without significant costs, they are nevertheless worth commenting on, I believe.

CONTRIBUTIONS TO THE SOLUTION OF RISING MEDICAL COSTS

1 Tie Federal participation in capital expenditures to health facility planning

2 Move from cost reimbursement to prospective rates

3 Limitations on recognition of physician fee increases

4 Health maintenance organization option

Mr. BALL. First then, the four major proposals in the bill that we believe will make a significant contribution over the long run to a solution of this problem of rising medical costs.

The four are: First, to have the medicare, medicaid, and maternal and child health programs back the efforts throughout the country that are being made in the area of planning.

The second proposal, as Secretary Black indicated, is to move from a cost reimbursement retroactively adjusted toward prospective rate setting. The bill also has in it some limitations on the recognition of future physician fee increases. And then finally, as Secretary Black mentioned, the very important option for beneficiaries to take their protection through a health maintenance organization.

I should like to go into each one of those now in somewhat more detail.

The first one relates to health facility planning.

HEALTH FACILITY PLANNING

1. In 1967 Senate adopted a provision to coordinate reimbursement with health facility planning (dropped in conference)

2. H.R. 17550 provides authority to withhold or reduce reimbursement to providers for capital expenditures inconsistent with State or local health plans

Mr. BALL. The significance of planning, as the committee so well knows, is that although in many parts of the country there are serious shortages of hospitals or nursing home facilities, in other places there is overbuilding. There is always the danger of duplication of facilities—of having large standby costs that everybody has to pay for—if there is unstructured growth of health care facilities.

It is not only additional beds that we are concerned about. Sometimes a major new service may be instituted in a hospital even though other hospitals in the community already provide enough of that kind of service.

The point has been made many times that if you build additional hospital beds they are almost bound to be filled in the future. One of the best ways to control costs, then, is to control facility building and the extension of services.

Now, against that general background, in 1967, the Senate Finance Committee recommended, and the Senate adopted, a proposal—I remember Senator Curtis and myself discussing this in executive session, for example—you adopted a proposal that would have gotten rid of one of the worst features of the medicare, medicaid and maternal and child health programs in relation to facility planning, but it was dropped in conference so it is not part of the law. At the present time, we are still required to pay depreciation, we are required to pay interest on loans, and we are required, in a profitmaking facility on which we are making payments may have been built in defiance of good planning and in defiance of the planning recommendations of a local or an areawide, or State-planning body.

So your proposal at that time was that we would not reimburse for depreciation, interest and so on in that kind of a situation.

Now, H.R. 17550 has put back in this same kind of provision, althought it is spelled out in considerably more detail. Also there is a way in which, if the Secretary finds after consultation with an advisory

group that, in spite of disapproval by a local or State agency, a particular addition is necessary for health care in that community, he can approve it. The general thrust of the proposal, however, is the same as the Senate amendment in 1967.

The next item, Mr. Chairman, is the proposal to move from retroactive cost reimbursement to a prospective rate.

ADVANTAGES OF PROSPECTIVE REIMBURSEMENT

COST REIMBURSEMENT	PROSPECTIVE REIMBURSEMENT
Provides no incentive to improve efficiency	Provides gains from improved efficiency
Provides no incentive to resist proposals for increased expenditures	Provider risks loss if costs not contained

Mr. BALL. We are talking now about institutions, of course, principally hospitals and extended care facilities. What we do now, as you know, is pay an interim rate through the year and then make an adjustment if actual costs turn out to be different from that ratio group operating the institution, unless they are completely out of line or do something that can be held to be truly unreasonable, really have from medicare and from medicaid, and in most States from Blue Cross, a blank check—an underwriting of costs that says pretty much, "Whatever you do, we will later make up for it on a cost basis."

So in the first place there is no incentive in our reimbursement method for people who operate the hospital or the extended care facility to resist throughout the year any increases in cost. They are told, in a bargaining situation—if the physician wants an expensive additional service, or if employees want a higher wage—"Well, Blue Cross pays on a cost basis (in most States), the Government reimburses on a cost basis (and between medicare and medicaid, that is half the cost in hospitals now), what do you care?"

And there is no serious resistance built into our formula to that kind of increase in expenditures.

On the other hand, supposing the operators of an institution do a really bang-up job in improving their operating efficiency. Under the present formula what do we do? We just reduce the amount of money we give them. If they get more efficient, their cost is lower and on a retroactive basis we just pay them the lower cost.

The proposal is to move toward setting up rates prospectively that one would stick with for a period of time. Any operator that can get under those agreed rates by operating more economically and efficiently would have that saving for the year. The next year the Government would benefit by working from a lower base in setting the new rate, and the operator would have an incentive, again, to do still better in the next period. On the other hand, the institution risks losing money if it goes along with a whole lot of increased costs. It has to pick up the bill ordinarily if it goes over the prospective rate.

We hope this change will be adopted. I believe that over time such a cange would get the managers of institutions and hospitals and extended care facilities themselves increasingly involved in cost control efforts. The managers of these 7,000 hospitals and four to five thousand extended care facilities would then have increased incentives to provide care more economically and efficiently. You can't improve operations primarily from a centralized place. You need to provide incentives so that it pays the local institution to start thinking in these terms.

PROVISIONS OF H.R. 17550 ON PROSPECTIVE REIMBURSEMENT

1. Endorses principle of prospective reimbursement

2. Directs Secretary to experiment with alternative methods for setting prospective rates

3. Requires report and recommendations for implementation by July 1, 1972

Mr. BALL. The provisions in the House bill are somewhat short of what our recommendation to you was earlier. The House has endorsed the approach in principle. They want to go in this direction, but they have said that we should experiment with different ways of arriving at a prospective rate and then report back to the Congress by July 1, 1972, so that the actual method of arriving at a prospective rate could be written into the law.

We had earlier asked for authority to put this into effect at a date in the future, with the Secretary deciding on what method to use in setting prospective rates. But the basic idea has been accepted in the House bill.

The third long-range proposal in this bill, Mr. Chairman, is designed to control medicare's recognition of increases in physicians' fees.

LIMITATIONS ON RECOGNITION OF PHYSICIAN FEE INCREASES

1. In FY 1971 increases in the prevailing charge cannot bring the charge above the 75th percentile of customary charges

2. For later years prevailing charge limit tied to indexes reflecting physicians costs and general earnings levels

Mr. BALL. At the present time, by and large, the way the program operates is that we reimburse for physicians' fees, subject to the coinsurance and the deductibles. We reimburse the customary fee that the physician charges, with a maximum set at what is called the prevailing fee. You take the customary charges of all the physicians in a particular area for the particular procedure in question, and then you cut off at a point where, under our present regulations, about the top 17 percent of charges are cut off as being too high for full reimbursement under medicare. These charges are reduced to the so-called prevailing level at the 83d percentile. That is the general approach.

Now we are proposing—the important part is in this second point on the chart here—that beginning with the fiscal year 1972, the prevailing level—applied not to a single procedure but to charges for all the procedures in the area taken as a whole—for purposes of medicare recognition would rise in accordance with an economic index. This index would be made up partly from a price index, and partly from general earnings levels. If physicians' fees generally do not rise faster than their cost of doing business and the earned income of other people, then this proposal would not have any effect. But if fees rise much more rapidly, then this proposal exercises a restraining influence on what medicare would pay for. We feel this would give us an important control in a market situation with which you are all very familiar.

The main difficulty we see ahead in the physician fee area is that the number of physicians is relatively stable. Even if you expanded medical schools very greatly the number of physicians would still increase very slowly over the next several years. The demand for physicians' services has tremendously increased and will increase further—partly because of medicare, partly because of medicaid, but even more importantly because of a general increase in the affluence of our whole

society. So you have a very large and growing demand for physicians' services, and a relatively slow increase in the number of physicians.

Under these circumstances, it is not surprising that there has been an increase in physician fees. The increase really hasn't been remarkably high in relation to the increase in prices generally or in wages generally. But we believe that limiting future medicare recognition of fee increases in the upper range of charges to these broad economic indices will guard against the possibility of the market situation I described being translated into increased medicare costs arising from possible skyrocketing increases in physicians' fees.

Finally, Mr. Chairman, there is the broad proposal that Secretary Black mentioned—the health maintenance organization option. This is a central point in the administration's proposals, and we plan, with your permission, when Secretary Veneman is here, to have three or four charts on this proposal and present it to you in some detail at that time. I would like merely, at this point, to say a few things in an introductory way. The prototype of the health maintenance organization is a group practice prepayment plan. There are two main points to be stressed: First, by having a per capita reimbursement of an organization, covering both the expense of hospitalization and various kinds of outpatient and physicians' services and by agreeing ahead of time that you are only going to pay them so much per person for the whole package, the organization has an incentive to keep down the cost of the care, and to give only the appropriate level of care.

On the other hand, if you pay everything on a fee-for-service basis and you consider only economic motivation (and I am not saying that is necessarily the dominant motivation), then paying on the basis of fee-for-service means that the more service you give, and the higher the level of service, the more money there is. When you price each service individually there is an economic incentive to provide more service. If you pay so much per head for a period of time regardless of the services given the organization itself becomes interested in holding down on the more expensive services, such as hospitalization. The Kaiser plans on the west coast, for instance, which operate this way, have quite convincing information about their success in holding down hospital utilization.

The second point is that from the patient's standpoint there is an advantage in not having to seek out each part of care. He doesn't have to look for a nursing home, an extended care facility, this specialist or that specialist, but rather the health maintenance organization takes the responsibility for providing him what is appropriate. The organization has an incentive to get to him early and give services, hopefully, on a preventive basis.

I want to turn now to the next chart, Mr. Chairman, to go through rather quickly the additional provisions for program control in the medicare area that are in the bill. There are quite a number of them, and I do not want to take the time of the committee to go into them in great detail. Some of them you are already very familiar with.

ADDITIONAL PROVISIONS FOR PROGRAM CONTROL

1. Pay customary charges if less than cost
2. Bar providers who abuse the program
3. Withhold payment where UR finds admission not warranted
4. Cost sharing for services in luxury institutions
5. Experimentation with community-wide utilization review mechanisms
6. Reimbursement of teaching physicians
7. Prohibition against reassignment of claims

Mr. BALL. For instance, the first one is in a bill Senator Anderson introduced some time ago. I believe the provision also appears in bills introduced by some other Senators, as well. The proposal deals with situations where today our cost reimbursement of a hospital actually turns out to be more than what it is charging the public.

That does not happen often, but if it is a heavily endowed institution, it may have public charges below the cost of providing the service. We think that for us to pay more than other patients are charged is a bad public posture to be in, at the very least. The proposal is to pay only the customary charges of the hospital or other institution if those charges are less than cost.

You are familiar—because we have discussed this before—with the next proposal, which would give us authority, with proper safeguards of administrative appeal rights and court appeal rights, to bar the providers who have abused the program. Today, if a physician has consistently overcharged or misused the program in a variety of ways, the only recourse we have is to put a very careful bill review on each bill that he sends in. His services are still reimbursed by the program. As long as he keeps his license, any services he renders could be covered and all we can do is to review each bill as it comes in. The proposal would allow us to bar his services from reimbursement under the program.

Turning to the next proposal—at the present time a utilization review committee disallowance automatically applies to long-stay cases. We do not pay after the committee has found that an individual should no longer be in the hospital, for example, in a long-stay case. The committees also do sample reviews in short-time cases. We think they ought to automatically notify the intermediary in those cases, too, and that we ought not to reimburse when they make the same type of finding for a short-term case.

The next proposal gives us authority to set limits on reasonable costs. At the present time we are paying the reasonable costs of hos-

pitals and extended care facilities in some instances where the services are at a level beyond what is ordinarily thought to be necessary for health purposes.

Particularly in the nursing home area, there are some quite plush institutions, and a relatively unlimited cost reimbursement really underwrites that type of activity. However, we are not saying people should not go into such institutions. The proposal is rather that for services that are beyond what is necessary for quality health care—because the institution is a luxury institution—that the institution ought to be allowed to charge the individual an extra amount rather than having the medicare program picking it up.

As the chart indicates, various kinds of experiments authorized by the bill would extend the utilization review concept to a community-wide basis.

Also, we are still struggling with the problem that the committee has been into many times, the reimbursement of teaching physicians. The House bill, we think, moves in the right direction. But we do not think it goes far enough. It shifts, in part, the reimbursement of teaching physicians to a cost basis. But, in our judgment, more needs to be done with that provision, and we would like to talk with you on that in more detail later.

Then there is a provision prohibiting payment under a reassignment of claims. Payment would be confined to the patient, the physician himself, or an institution if he is required to turn over fees to an institution he works for on a salary, for example. This provision, in part, is aimed at those associations of physicians that get payments under reassignment from individual physicians. Such payments would be cut under the bill.

The final area in the medicare part of the presentation, Mr. Chairman, and one that I will run through quite quickly, is five improvements in the coverage of the program or improved protection for individuals growing out of changes in the way the program is operated.

IMPROVEMENTS IN MEDICARE PROTECTION

1. Prior approval of ECF and home health coverage
2. Hospital insurance for uninsured
3. Independently practicing physical therapists
4. Payment for inpatient hospital services furnished in Canada and Mexico to border residents
5. Elimination of 3-year enrollment deadline under SMI

Mr. BALL. First, the advance approval of extended-care facility or home health coverage deals with a problem that I know is very troublesome to many of you in your own States, as well as to us in administering the program. I am referring to the situation where on review our carrier has come to the conclusion that an individual did not meet the conditions for getting his care covered under medicare in an ECF or under a home health plan, and there has been a retroactive denial when the individual thought he had the coverage. In these cases either he has to pay—and it may be quite a large bill—or the extended care facility is stuck with the bill.

This proposal is designed to cut down that problem of retroactive denial just as much as we can. The way we would do it is to set up, with medical advice, minimum periods in an extended care facility or for a home health agency service that you would guarantee to pay an individual for the amount of the minimum guarantee would depend upon his medical condition.

If he had been in the hospital a certain length of time, and he has a particular diagnosis, we could say, "In your case you can be sure you have at least 15 days' coverage in an extended care facility, and the carrier will not come along and overrule the guarantee retroactively. You can count on it."

The idea is to guarantee a minimum. If during that period the physician thinks the individual ought to be in for a longer period, then you have that period to work in to decide that instead of 15 days, in this case it should be 25 days.

The whole proposal is aimed at helping to solve this difficult problem of retroactive denial.

Next, hospital insurance for the uninsured. You will remember that at the beginning of the medicare program you blanketed in practically all of the people over 65 whether they were covered under Social Security or not.

The cost of this was paid through general revenues. However, there was a phaseout of that provision so that many people who are becoming 65 today and are not covered under social security are not getting medicare's hospital insurance protection. At the same time many private plans—Blue Cross, Blue Shield, and commercial companies—have rewritten their over-65 policies to be supplementary to medicare. So there is a growing group of people who find it difficult to get hospital insurance.

The provision in the bill would allow these people to elect coverage under the hospital insurance part of Medicare as they do today under the supplementary medical insurance part, provided they pay the full cost of the coverage. The premiums would start at $27 a month, and then would rise, as the premium for SMI would rise, if costs go up in the future.

There is a provision also for extending coverage of physical therapy services under certain circumstances. It would be limited to $100 a year and would cover services of physical therapists who practice in their own offices independently if the conditions specified in the bill are met. At the present time physical therapy services are covered only

when provided through various kinds of health organizations. I might say we did not recommend this extension of coverage. We are not very enthusiastic about it. It is in the House bill, nevertheless.

The bill also deals with a problem in relation to hospital services furnished in Canada and Mexico that has been of interest to the Senate on several occasions.

At the present time such services are covered only if it is an emergency, if the emergency occurred in the United States, and if it is closer to rush the patient to a Canadian or Mexican hospital. This amendment would expand coverage of care outside the United States so that a border resident, living in the United States is covered, if he goes to a closer and more convenient hospital across the border, even if it were not an emergency situation.

The last item on this chart concerns a matter that has come up in a lot of correspondence with the various Members of Congress. The proposal is to eliminate the absolute barrier that now exists for coverage under the voluntary medical insurance plan if an individual lets 3 years go by after he is first eligible without signing up.

We had thought at first the barrier might be necessary to prevent adverse selection. But we have very complete coverage—95 percent of all the aged are under the voluntary part of the program—and we would retain the provision that you have to pay more if you come in late. We now feel—our actuaries believe—that it is not necessary to maintain this time limit. So people who missed their final chance to come under medicare would have another chance under this proposal and be able to come in in any open enrollment period.

Mr. Chairman, the final section of the presentation deals with the financing of the bill. The first chart shows the changes proposed in the contribution rates for employers and employees.

CONTRIBUTION RATES FOR EMPLOYEES AND EMPLOYERS

	CASH BENEFITS		HOSPITAL INSURANCE		TOTAL	
YEAR	PRESENT LAW	PROPOSAL	PRESENT LAW	PROPOSAL	PRESENT LAW	PROPOSAL
1970	4.2%	4.2%	0.60%	0.6%	4.80%	4.8%
1971-72	4.6	4.2	0.60	1.0	5.20	5.2
1973-74	5.0	4.2	0.65	1.0	5.65	5.2
1975	5.0	5.0	0.65	1.0	5.65	6.0
1976-79	5.0	5.0	0.70	1.0	5.70	6.0
1980-86	5.0	5.5	0.80	1.0	5.80	6.5
1987¢ AFTER	5.0	5.5	0.90	1.0	5.90	6.5

Mr. BALL. As you will remember, I mentioned earlier that the earnings base would go to $9,000 under the bill, and then be kept up-to-date automatically in the future. The chart shows the contribution rates. Across the top of the chart we have, first, the rates related to cash benefits, under present law and under the proposal; then the rates for hospital insurance, present law and proposal; and then the combined rates for present law and proposal are compared. The first line shows the rates in effect now.

Today we are collecting 4.2 percent for cash benefits and for hospital insurance we are collecting 0.6 for a total of social security contributions of 4.8 percent each for the employer and the employee.

Now, under present law, the rate was going to go up next year—next January—to a combined rate of 5.2 percent. But under present law the rate of 5.2 percent was going to be divided 4.6 percent for cash benefits and 0.6 percent for hospital insurance.

Our proposal is to retain the same total rate for next year—5.2 percent—but to shift the division of that rate, holding the 4.2-percent rate for cash benefits through the year 1974. As I will indicate to you on a later chart, in the cash-benefit area there is a very substantial excess of income over outgo under present law for many years, and it is not necessary to build up such huge reserves. On the other hand, as you know so well, the hospital insurance fund is in serious difficulty. We need quickly to have additional money for hospital insurance.

So our proposal is to increase the 0.6 percent for hospital insurance to a 1-percent rate, and to hold that on into the future.

Summarizing the changes: The cash-benefit program involves a stretchout in the contribution rate. Under present law it would go to 4.6 percent in 1971, and then to 5 percent in 1973. That is the ultimate rate under present law, and coming to it so quickly results in very large increases in the cash benefit trust funds.

The proposal is to stretch out these rates, still keeping the trust funds sufficiently large for any conceivable contingency, but not depending so much for financing on interest earnings on huge trust funds in the long-range future. The rate for cash benefits would go to 5 percent in 1975, and then to an ultimate rate in 1980 of 5½ percent. Accompanying this would be a level rate of 1 percent for hospital insurance beginning in 1971.

In the last column you have the combined totals, getting to an ultimate combined rate of 6.5 percent in 1980, as compared with 5.9 percent under present law in 1987.

Mr. Chairman, this next chart indicates why we felt it was desirable to slow down the schedule for increases in the contribution rate for cash benefits.

I might say that we would have recommended this stretchout in the cash rate even if there had been no such thing as the hospital insurance program. It seemed to us that the excess of income over outgo that would begin to occur by 1973—$12 billion a year—is not necessary in a social insurance system. In the past the Congress has always, as we have approached a contribution rate that would produce large excesses of income over outgo like this, postponed the higher contribution rates to a time when they are needed to maintain slightly greater income than outgo.

ESTIMATED PROGRESS OF THE CASH-BENEFITS TRUST FUNDS Under Present Law and under Proposal, 1970-1973
(In Billions)

CALENDAR YEAR	INCOME		OUTGO		NET INCREASE IN FUNDS	
	PRESENT LAW	PROPOSAL[1]	PRESENT LAW	PROPOSAL[1]	PRESENT LAW	PROPOSAL
1970	$ 36.6	$ 36.6	$ 33.1	$ 33.1	$ 3.5	$ 3.5
1971	41.8	40.1	34.9	38.5	6.9	1.6
1972	44.2	42.6	36.3	40.5	7.9	2.1
1973	49.9	45.3	37.5	42.0*	12.4	3.3
(1973)				(43.1)		(2.1)

[1] ASSUMES AUTOMATIC INCREASE IN EARNINGS BASE TO $9,600 (AUTOMATIC BENEFIT INCREASE OF 3% IN 1973.)
* start of $9,600 base

Mr. BALL. This chart, then, shows the estimated progress of the cash benefit trust funds under the proposal, taking into account both increased benefits and the new contribution rates and $9,000 base. As you see, present law results in quite large trust fund increases even in 1970, and going next year to almost $7 billion in excess of income over outgo. With the increases in benefits and the postponement of rate increases under the proposal you have still $1.6 billion excess of income over outgo for the cash benefits program. In 1972 you still have $2.1 billion excess under the proposals as compared with $7.9 billion under present law. And, of course, it really gets dramatic in 1973, when contribution rates under present law would have gone to 5 percent for cash benefits. Even though we are holding the rates down under the proposal, you still have an excess of $3.3 billion in 1973.

I have included in the parenthetical figures the possible effect of the automatic benefit provisions. Through 1973 the figures I have already referred to do not take account of the automatic provisions on the benefit side, but they do assume that there would be an increase in the contribution base in 1973 from $9,000 to $9,600. The parenthetical figures show that if there were an increase in the cost of living amounting to as much as 3 percent, it would trigger a benefit increase for January of 1973, and then the outgo, instead of being $42 billion, would be $43.1 billion, and the net increases, instead of being $3.3 billion, would be $2.1 billion.

Senator WILLIAMS. I do not want to interrupt you, but did you figure the increases in the other years for the automatic increase in cost of living?

Mr. BALL. The later years, Senator?

Senator WILLIAMS. No; the years prior to 1973.

Mr. BALL. Under the bill 1973 is the first time it could go into effect.

Senator WILLIAMS. How did you get the $9,600?

Mr. BALL. The first time that the automatic increase in the base could go into effect under the bill is 1973. The base of $9,000 goes in in 1971.

Now, the figure of $9,600 arises by comparing the first quarter of 1972 with the first quarter of the base year, which is back in 1971. That is how we get the $9,600, and it is effective in 1973.

Now, for the hospital insurance trust fund, the result in the short run of the financing changes, that I have previously explained are shown on this chart.

ESTIMATED PROGRESS OF THE HOSPITAL INSURANCE TRUST FUND Under Present Law and under Proposal, 1970-1973 (In Billions)

CALENDAR YEAR	INCOME		OUTGO		NET INCREASE IN FUNDS	
	PRESENT LAW	PROPOSAL[1]	PRESENT LAW	PROPOSAL	PRESENT LAW	PROPOSAL
1970	$5.7	$5.7	$6.0	$6.0	-$0.3	-$0.3
1971	6.0	10.1	7.0	7.0	-1.0	3.1
1972	6.2	10.8	8.2	8.2	-2.0*	2.6
1973	6.9	11.7	9.4	9.4	-2.5	2.3

[1] ASSUMES AUTOMATIC INCREASE IN EARNINGS BASE TO $9,600 IN 1973.
* FUND EXHAUSTED IN 1972 UNDER PRESENT LAW

Mr. BALL. Let me say, first that, there are no proposed benefit improvements in hospital insurance that have a significant cost. There are no major proposals in the hospital insurance program except those that are intended to be of a cost-saving nature.

Under present law, as you can see, in the present year we expect about a $300 million deficit. We expect it to increase in the next calendar year to $1 billion. Under the present law the trust fund would actually be exhausted in 1972.

So it is very important, of course, to increase the income to this fund quickly as well as to plan for the long run these fundamental changes in the way the program is operated that have longrun cost-saving effects, and also to have the various program control features put in as quickly as possible.

Under the proposal for the level contribution rate of 1 percent, the fund starts building up substantially. It goes up by somewhat over $3 billion in 1971. In the cash benefits part of the program, where for a long period in the future there is clearly more than enough money under present law, we have changed the rate schedule so that we are not collecting so much excess of income over outgo. For funds which have been the problem—the hospital insurance fund—we are proposing a level rate which, for the early years, builds quite a substantial fund, and then, of course, levels out in the later years since costs increase later on.

Now, on this next chart, Mr. Chairman, we have a summary of the long-range actuarial balance for the cash-benefits program.

FINANCING SOCIAL SECURITY CASH BENEFITS

	LONG-RANGE ACTUARIAL BALANCE
PRESENT PROGRAM*	-0.08%
EFFECT OF USING 1970 EARNINGS	+0.28%
EFFECT OF BENEFIT PROPOSALS	-1.09%
NET EFFECT OF FINANCING PROPOSALS	+0.74%
PROPOSED PROGRAM	-0.15%

* TRUSTEES' REPORT, APRIL, 1970

Mr. BALL. This is the 75-year estimate as a percentage of covered payroll. The present program has a lack of actuarial balance of 0.08 percent of payroll, which is, of course, less than 1 percent of the total cost of the program. An estimated deficit of this small amount has never been thought to be a matter of concern. We start with this estimate as shown in the trustees' report of April 1970, which was based on 1969 earnings assumed to be level on into the future. Every year when the actuaries reevaluate the program they update the earnings level. They use as a wage assumption the earnings level of the current year. The work on the trustees' report, of course, to get it out in April 1970, was done largely back in 1969, and that is when 1969 earnings were used.

During the course of the consideration of these proposals by the Ways and Means Committee, they suggested, and the actuaries agreed, that it would be reasonable now to project 1970 wages as the level wage assumption on into the future. This change in assumption resulted in adding a little over a quarter percent of payroll to the balance.

The various benefit proposals that I have outlined earlier together have a cost of a little over 1 percent—1.09 percent—and then the effect of the higher contribution rates—a schedule going up to 5½ percent for each benefit as well as the $9,000 wage base, give plus 0.74 percent for a net balance of −0.15 percent.

I might point out, Mr. Chairman, that when the Ways and Means Committee reported out its bill, this imbalance was −0.12 percent of payroll. There was action on the House floor that increased the cost of the program by 0.03 percent. What was added on the House floor was the President's proposal for a change in the retirement, carrying the one-for-two provision all the way up—that added 0.03 percent to the cost of the retirement cost change making the imbalance −0.15 percent.

It is true, Mr. Chairman, that if one wanted to press a particular point that has been made to us—the automatic provisions in the House-passed bill are somewhat less expensive than the automatic provisions

that the administration originally sent up—and if you want to reflect the lower cost of that difference, then you could reduce this −0.15 percent figure somewhat.

I have felt that there is not enough certainty to claim credit for the House bill provisions where they differ from the administration's proposal. I much prefer to remain with the general policy position that the automatic provisions for benefit increases are balanced by the automatic provisions for financing, rather than to claim an additional credit and show a reduced estimate of the actuarial imbalance. But it could be done; there is actuarial support for doing so. I would prefer to be on the conservative side.

FINANCING HOSPITAL INSURANCE BENEFITS

	LONG-RANGE ACTUARIAL BALANCE
PRESENT PROGRAM*	-0.48%
NET EFFECT OF FINANCING PROPOSALS	+0.37%
PROPOSED PROGRAM	-0.11%

*TRUSTEES' REPORT, APRIL, 1970

Mr. BALL. On this chart we show the comparable figures for hospital insurance. The present hospital insurance program has a long-range actuarial imbalance of a little less than a half percent of payroll under the assumption that the maximum earnings base will be kept up to date in the future. The proposal greatly reduces the amount of the imbalance in the hospital insurance program.

The net effect of the various financing provisions in hospital insurance brings the imbalance down to −0.11 percent. This is a 25-year estimate in hospital insurance.

Let me say here that we have not taken any credit whatsoever in this −0.11 percent figure for the possible cost effects of all of the proposals in this bill that are designed to reduce costs. We have felt that they ought to be proven to some extent before we start reducing this estimated actuarial imbalance. So there is a cushion here in the various cost control proposals. The possible reductions could be estimated and result in a reduction in the figure of −0.11 percent, but no credit whatsoever has been taken for those now. This balance is the same as if present law continued in effect except for the changes in the financing provisions—the contribution rate change and the earnings base change.

The final chart in the whole presentation, Mr. Chairman, is a summary of the effect of the bill for the first 12 months in terms of the numbers of people affected, and the amount of money that would be paid out in a 12-month period. This information is shown separately for the major proposals.

ADDITIONAL PAYMENTS IN FIRST 12 MONTHS AND NUMBER OF PEOPLE AFFECTED

PROVISION	ADDITIONAL PAYMENTS (IN MILLIONS)	BENEFICIARIES IMMEDIATELY AFFECTED (IN THOUSANDS)	NEWLY ELIGIBLE PEOPLE (IN THOUSANDS
5% BENEFIT INCREASE	$1,700	26,200	6 1/
MODIFICATION OF RETIREMENT TEST	570	900	400 2/
AGE 62 COMPUTATION POINT	925	10,200	60
INCREASE IN WIDOW'S BENEFITS	700	3,300	--
DISABILITY IMPROVEMENTS	42	55	48
OTHER IMPROVEMENTS	60	230	10
TOTAL	$3,997	(3/)	(3/)

1/ NONINSURED PEOPLE AGED 72 AND OVER WHO CAN NOT GET BENEFITS UNDER PRESENT LAW.
2/ PEOPLE WHO CAN GET NO BENEFITS FOR 1971 UNDER PRESENT LAW BUT WHO WOULD GET SOME BENEFITS UNDER THE PROPOSAL.
3/ FIGURES ARE NOT ADDITIVE BECAUSE A PERSON MAY BE AFFECTED BY MORE THAN ONE PROVISION.

Mr. BALL. The 5-percent benefit increase for the first 12 months, amounting to $1.7 billion, goes to the somewhat over 26 people on the rolls next January. The increase makes eligible about 6,000 additional people under the so-called Prouty amendment, where we pay people who are uninsured and not eligible for other Government benefits in excess of the Prouty amendment. As the amount of that payment rises a few more people become eligible.

The modification of the retirement test, going to a $2,000 exempt amount and dropping the $1-for-$1 reduction provision, would result in paying $570 million in the first 12 months. This would go to about 900,000 people who now receive some benefits and to about 400,000 people who are not getting them at all today and who under the proposal would be eligible for some but not all benefits.

Senator BENNETT. 400 million?

Mr. BALL. 400,000. I am sorry.

Senator BENNETT. Twice the population.

Mr. BALL. The age 62 computation point for men, as I indicated earlier, the benefits of about 10.2 million people on the rolls would be recomputed, and that would account for $925 million additional payments. Some people would be made newly eligible because the provision applies to eligibility as well as benefit computations.

As I said, about 3.3 million aged widows would have their benefits recomputed, and about $700 million would be paid in additional benefits. The various miscellaneous matters, such as disability improve-

ments, are shown here. Taking all the improvements together, total payments out in the first 12 months are about $4 billion additional over present law. Obviously you cannot add these other figures because the 26.2 million are all the beneficiaries that there are.

Mr. Chairman, that concludes the initial presentation of the bill as passed by the House. As I indicated, when the Under Secretary comes before the committee he will give particular attention to the health maintenance organization option, with a special presentation on that. In addition, we have not yet touched in any detail on the medicaid proposals except as Secretary Black referred to them in his opening statement.

Senator ANDERSON (presiding). Senator Miller.

AUTOMATIC COST-OF-LIVING INCREASES

Senator MILLER. Thank you, Mr. Chairman.

I want to commend the Department on the presentation. The only comment I want to make on it is that when you develop the automatic cost-of-living increase program, I cannot tell you how deeply I appreciate it. I have been striving for that provision since 1962, as you know, Mr. Ball.

Mr. BALL. Yes, I know, Senator.

Senator MILLER. I am pleased to say that we have been gaining increasing support, and I hope that the committee will certainly adopt this portion of the program. I know several members who formerly were opposed to it who have come around, one who was not able to be present today, I think is Senator Hartke, and I do not think anybody could have laid out the program any better than you did.

I thought I heard myself speaking when you were laying out that cost-of-living increase program, and I want to commend you on a very fine job.

Mr. BALL. Thank you, Senator.

It may be of interest to the committee that there has been so much interest lately in these automatic provisions that it appeared as a plank in the party platforms of both parties the last time, as well as being now a major recommendation of this administration.

Senator WILLIAMS. Mr. Chairman, I understand that we are to have a vote in the Senate very soon, and I am just wondering whether it would not be just as well to suggest that we eliminate the questioning at this time. You would be back at a later date, and we can resume then.

The CHAIRMAN. I just want to ask about one or two questions and then we can go vote.

Now, with regard to those charts that you provided, Mr. Ball, it seems to me we ought to put medicare in there to see what it would look like when you add that in. So far as people over 65 are concerned, they pay very little compared to what they get in benefits; isn't that correct?

Mr. BALL. Yes, if you are talking about a current contribution to both parts A and B. They only pay $4 at the present time—$5.30 next

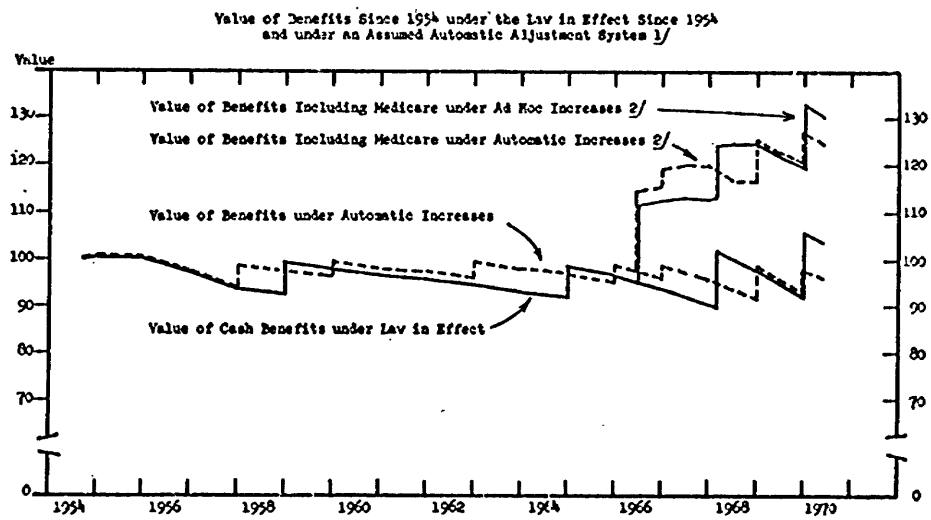
month—and on for the voluntary part and that amount is matched by the Government, so they only pay half the cost. As far as hospital insurance is concerned—which is now worth about $27 a month—whatever contribution they made was when they were working and generally not currently when they have the protection.

The CHAIRMAN. Well, it just seems to me then if you go back and you take these automatic increases to which you made reference, and fix a chart that would crank in these medicare benefits it would look as though Congress has been more generous to the retired people than your chart indicates. I think that will be added to it, because it is all right for me to deduct for what they are paying for in view of what they are getting, and it makes a better showing.

Mr. BALL. We will be glad to do that, Mr. Chairman. Of course, that applies only to the beneficiaries 65 and older, and there are a lot of other social security beneficiaries.

The CHAIRMAN. That is right.

(The Department subsequently submitted the following chart:)



1/ It is assumed that the Administration's proposal for automatic adjustment of benefits to increases in prices was in effect since 1954.

2/ This value of Medicare is an average and will vary greatly from individual to individual. Medicare benefits are available only for people age 65 and over; one-third of the nearly 26 million social security beneficiaries are under age 65.

7/10/70

The CHAIRMAN. Now, in addition to that, our staff has acquired some charts which would show this. If you compare your automatic increases, let us say, to how it would look on the chart if you used a different reference year, for example, if you used the year 1940, 1950—we will use those 2 years—it looks entirely different.

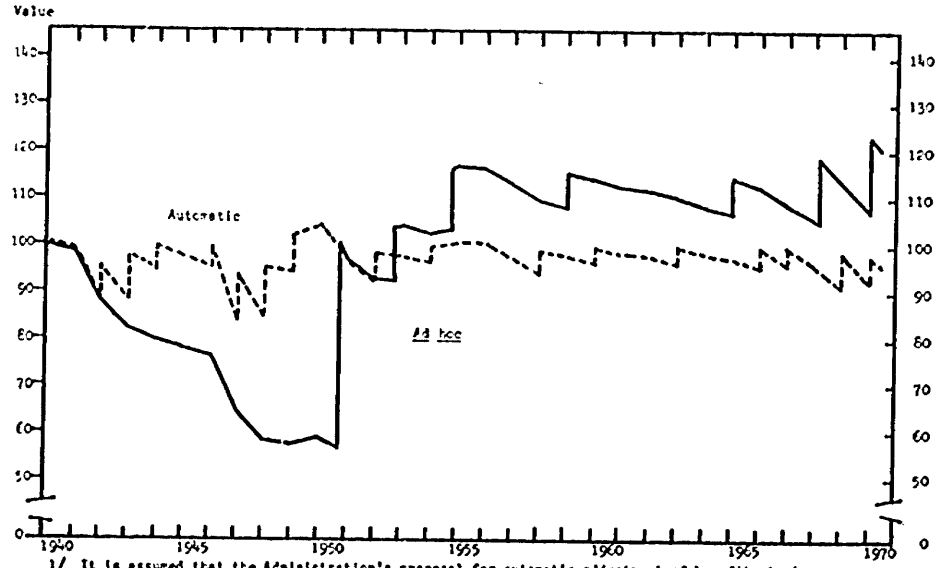
In other words, a lot of these things depend upon your point of view. If you are standing on the top of a mountain you are measuring everything in terms of how far down everything is.

If you are standing at sea level you measure everything on how far up it is.

So I will ask unanimous consent to put in the record at this point these two charts showing how the thing would look if you looked at it the other way around, and put the figures in to back it up.

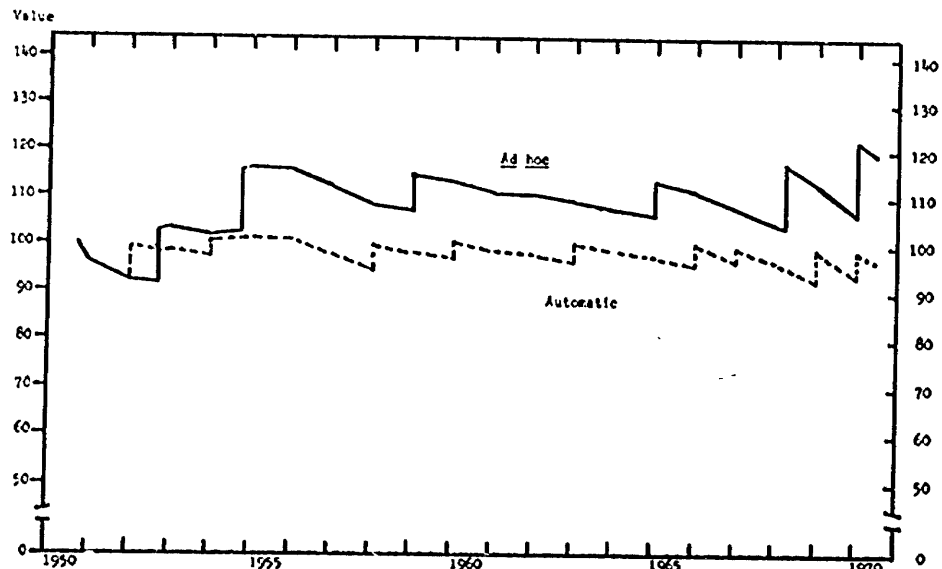
(The charts referred to follow:)

Value of Benefits Since 1940
Under the Increases Enacted Since 1940
And under an Assumed Automatic Adjustment System 1/



1/ It is assumed that the Administration's proposal for automatic adjustment of benefits to increases in prices was in effect since 1940.

Value of Benefits Since 1950
Under the Increases Enacted Since 1950
And under an Assumed Automatic Adjustment System 1/



1/ It is assumed that the Administration's proposal for automatic adjustment of benefits to increases in prices was in effect since 1950.

Mr. BALL. Mr. Chairman, I think it is fair to say that the Congress improved the fundamental level of benefits between 1950 and 1954. You will remember there were no changes in the program from 1940 until 1950 of any significance.

The CHAIRMAN. Right.

Mr. BALL. Then in 1950 the program was about brought up to date from 1940.

Then between 1950 and 1954 the Congress substantially improved the general level of benefits. You had a new benefit level established in 1954, and that is why I started with that year.

Then from 1954 on benefit levels have about kept up to date.

INFLATION

The CHAIRMAN. Here is one thing that concerns me, Mr. Ball. This program has been something of a drag on inflation by collecting more in tax than it pays out in benefits. In other words, it has tended, up to this point, to help hold back the inflationary rise of things. If we pass the bill the way the House sent it to us we are taking our foot off the brake, in effect, and letting this program jump ahead every time the cost of living goes up 3 percent. That would be the way it would, It take it?

Mr. BALL. Once a year.

The CHAIRMAN. Once a year. So it might remain a slight drag on inflation, but generally speaking it would jump ahead.

Now, I have sometimes wondered how long we should go ahead deceiving ourselves, misleading ourselves, about these various things that tend to be inflationary.

For example, in my own home State, in my own hometown, labor just got through negotiating new contracts which I think will set a pattern for future increases, a new wage contract which would call for approximately a 42-percent increase in wages over the next 2 years.

Now, there is no doubt in my mind that as the other wage contracts are negotiated, they will require at least a 42-percent increase over 2 years, which would almost by definition have to exceed productivity.

Sometimes it makes me think just to be fair we ought to make all these people who have the benefits of collective bargaining under the National Labor Relations Act negotiate all their contracts at the same time, and then give management the opportunity to raise their prices, and when this thing goes into effect, give Congress a chance to help the less fortunate all at the same time.

For example, many of the people who draw social security benefits need an increase just as much as our laboring people need one, and among laboring people, a fellow working for the minimum wage probably needs his increase even more than a fellow making $5 an hour. Doesn't that figure? Doesn't it make sense?

Mr. BALL. Yes, Mr. Chairman. These matters are all very much interrelated. I would personally not like to see automatic provisions in social security that were any more generous than those recommended. I think this is kind of a bare minimum in that it just restores purchasing power.

On whether the automatic provision is inflationary or not, I think is arguable, at least. You see what happens if you do not have an auto-

matic provision is that you wait longer to increase benefits, and then the decision to do it is not very often related to the inflationary situation. It is that pressure has built up and the Congress finally does have to act.

But when Congress does act it has to make up for more, because the increase has been delayed longer than with the automatic provision. The impact then, I think you could argue, is more inflationary than taking it in smaller bites on an automatic basis.

The CHAIRMAN. Do you believe that the changes that you want drafted in the bill will make it a better bill?

Mr. BALL. We do have a few changes to suggest, Mr. Chairman, in the House bill. They are not large scale, but we do have some changes. The President has urged the passage of the bill, but there are some relatively minor changes we would suggest.

The CHAIRMAN. How do you feel about the welfare bill; by the way, do you think we have a better bill? [Laughter.]

Mr. BLACK. The answer to that is "Yes."

The CHAIRMAN. I personally think that the changes have been for the best.

Is Mr. Howard Cohen here?

Mr. BLACK. Yes, sir; right here.

The CHAIRMAN. Mr. Cohen, you are quoted as telling the Ripon Society that "They should stop bitching and get in; they don't know what it is like here slugging it out with the Eastlands of the world."

Is that a correct quote?

Mr. COHEN. Yes, it is, Mr. Chairman.

The CHAIRMAN. Would you mind elaborating upon that; would you mind explaining to us what your experience has been, "slugging it out with the Eastlands"?

Senator WILLIAMS. The moral of that is don't write and don't speak. [Laughter.]

Mr. COHEN. No, I do not mind explaining that at all, Mr. Chairman.

What I meant by that quote was that there was a Ripon Forum survey to rate each Senator, and, according to the five criteria looked at by the Ripon Society, some came out higher than others.

Senator Eastland came out with a rather low score. We looked at things such as a Senator's position relative to trade, and a number of other criteria, which I would be happy to submit for the record. I meant that in working here on the Hill some people are easier to convince and work with than others. A number of my fellow Ripon Society members just sit on the sidelines. They are not in Government, and they are always complaining. What I thought they ought to do is just either shut up or come in, try to help us, and work within the system.

(The article referred to follows:)

[From Forum, March 1970]

BEYOND THE LIBERAL/CONSERVATIVE DICHOTOMY—TOWARD A NEW CONGRESSIONAL RATING SYSTEM

The Ripon Society does not put much stock in rating Congressional voting records. Neither virtue nor wisdom nor courage can be adequately scored on a percentage basis. For this reason, we have previously refrained from issuing annual ratings on the model of Americans for Democratic Action, Americans for Constitutional Action, the AFL–CIO's Committee on Political Education, etc.

However, the very fact that the Congressional rating business has been left to such groups has helped to engender a pervasive misapprehension that the

only basic cleavage in Congress is the one that preoccupies most of the raters, namely, the split between conservatives and liberals. The only fundamental dispute among the rates is which side of the cleavage is the wrong one.

The trouble with this view is that the liberal-conservative dichotomy still is defined in terms of the fading problems of the New Deal: Higher appropriations versus budget cuts, internationalism versus isolationism, the welfare state versus laissez faire. We believe that such battle lines are becoming increasingly irrelevant now that both parties are irreversably committed to an affirmative social and economic role for government at home and abroad and now the major beneficiaries of the welfare state include well-to-do skilled unionists, corporate farmers and Medicare doctors.

BEYOND THE NEW DEAL

Discussion in the Forum in coming months will seek to elucidate cleavages more relevant to the realities of the Seventies. We have sought, as a first pass at the problem, to find Senate roll call votes that reflect new cleavages. We have taken for our norm values that are central to the traditions (and the rhetoric) of the Republican Party:

Devolution of power from the Executive to Congress, to local institutions (both private and public) and to individual citizens;

Relying on, and expanding the benefits of, the free market system in national and international dealings, and, conversely, refusing to subsidize inefficient enterprise;

A national economic policy aimed at correcting basic imbalances rather than treating symptoms through direct controls;

A foreign policy which shuns national proselytizing and provocation in favor of private and multilateral initiatives; and

Substantive legal and economic equality of the races.

If the ranking of these Senators bears some resemblance to the more conventional liberal/conservative rankings it is because the Senate did not have the opportunity to vote on several post-New Deal issues such as draft reform, Nixon's Family Security proposals, federal tax sharing with the states or fundamental questions involving civil liberties. Moreover, many votes were influenced by ideological battle lines of previous decades, especially when they dealt with Democratic-patented programs such as OEO.

CONVERGING WITH NIXON

Although a number of conventional liberal Democrats score high on the Ripon scale, it should be noted that several Republicans score higher than any Democrat and that many Democrats score lower than any Republican. A Senator could be assured of a minimum score of 34% if he merely supported the announced position of the President on the ten votes on which the President's announced view coincided with ours. (Our positions diverged from Nixon's four times.)

These ratings should not be judged as our selection of the "best" and "worst" Senators, if for no other reason than that the crucial business of Congress usually takes place off the floor. Furthermore, our giving equal weight to announced positions and votes actually cast enhances the score of, for instance, those labor-backed Senators who found it convenient merely to announce their support for the Philadelphia Plan, rather than to see to it in person that it passed.

Even every *viva voce* pro-Ripon vote cannot be valued equally. Surely the votes of Republican Senators who defied threats of political opposition and economic reprisal to oppose the Haynsworth nomination are more laudable than the identically-weighted vote of Senator Dodd, who cravenly waited outside the Senate chamber until the issue was decided before casting his vote.

KEY

V---------- Record vote for Ripon position
(X)--------- Record vote against Ripon position
O---------- Absent, general pair, present, or did not announce or answer Congressional Quarterly poll
(V)--------- Paired for, announced for or CQ poll for Ripon position
X---------- Paired against, announced against or CQ poll against Ripon position
*---------- Ripon position the same as announced position of the President
#---------- Ripon position in opposition to announced position of President

KEY TO ROLLCALL VOTE NUMBERS

Devolution of Power

50. National Commitments Resolution affirming the role of Congress with respect to making military and economic commitments to other nations. (Vote yea)

70. Schweiker amendment providing for periodic audit reports to Congress on major defense contracts by the General Accounting Office. (Vote yea)

79. Fulbright amendment to cut funds for Pentagon research by $45,000,000 and to bar military funding of non-military research projects. (Vote yea)

121. Murphy amendment, providing that state governors could effectively veto local OEO legal assistance programs. (Vote nay)

128. Ellender amendment to cut funds for Congressional staffing by $1.4 million to delete authority for Senators to hire additional clerks. (Vote nay)

249. Javits amendment to delete provision in education aid bill cutting off funds to colleges which do not take steps satisfactory to the Secretary of HEW to suppress campus disorders. (Vote yea)

207. Dominick motion to delete provisions of OEO bill earmarking funds for local initiative programs and making members of the armed forces eligible for legal services. (Vote nay)

Anti-Subsidy

54. Goodell motion to suspend rules in order to set $10,000 limit on agricultural subsidies payable to any individual. (Vote yea)

97. Williams (R-Del.) amendment cutting maritime industry subsidies from $145 million to $15.9 million. (Vote yea)

210. Dole-McIntyre amendment sheltering the intangible drilling expenses of "small" oil producers even from the token minimum income tax provisions of the tax reform bill. (Vote nay)

230. Javits amendment permitting repairs of naval vessels to be made in any port within 350 miles of their home port when there is no competitive bidding and when repairs are not made in the home port. (Vote yea)

251. Proxmire amendment to cut funds for prototype Supersonic Transport. (Vote yea)

Free Market/Free Trade

58. Confirmation of the nomination of Carl J. Gilbert as U.S. Special Representative for Trade Negotiations. (Vote yea)

133. Vote to loosen provisions of Export Control Act to permit greater trade with Communist nations. (Vote yea)

152. Bennett amendment to strike the provision of S2577 authorizing the Federal Reserve Board to institute a "voluntary" credit restraint program. (Vote yea)

200. Cotton amendment authorizing the President to impose tariffs and other import restrictions which he deems necessary. (Vote nay)

Foreign Policy/Foreign Aid

65. Smith (R-Me.) amendment prohibiting funds to be used for the Safeguard ABM system. (Vote yea)

146. Young (D-Ohio) amendment cutting funds for the Pentagon's civil defense activities by $8.3 million. (Vote yea)

271. Mansfield motion to table the House version of the Foreign Aid bill, which would provide unrequested funds for jet fighters for Nationalist China. (Vote yea)

34. Vote on HR33, providing for an additional $480,000,000 in funding for the United States participation in the International Development Association. (Vote yea)

225. Javits amendment to provide $20,000,000 funding for the Overseas Private Investment Corporation, an organization designed to guarantee private American investments in foreign business and housing. (Vote yea)

Fiscal Responsibility

61. Williams Amendment to extend surtax beyond December 30, 1969 at a 5% rate through June 30, 1970. (Vote yea)

63. Final passage of bill to extend surtax at 10% through December 30, 1969. (Vote yea)

159. Byrd (D-Va.) amendment to allow the surtax to lapse at the end of 1969. Some liberals said they voted against the surtax extension in votes 61 and 63 because they wished to maximize their bargaining power in fighting for tax reforms. A similar vote on this roll call, taken after the bargaining was finished, could not be defended on those grounds. (Vote nay)

222. Williams motion to recommit tax bill to delete revenue-losing "Christmas Tree" provisions. (Vote yea)

Civil Rights/Civil Liberties

138. Mathias amendment increasing funds for the Equal Employment Opportunity Commission from $11.5 million to $15.0 million. (Vote yea)

154. Confirmation of Judge Clement Haynsworth as Justice of the Supreme Court. Although most of the debate on Haynsworth was cast in terms of judicial ethics, we agree with those Senators on both sides of the issue who said that the fundamental issue involved was Haynsworth's conservative views on the rights of blacks and unions. (Vote nay)

247. Scott amendment adding the words "unless otherwise required by the Constitution" to an amendment authored by Rep. Jamie Whitten prohibiting certain desegregation initiatives by the federal government. Who voted against this amendment? The strict constructionists, of course. (Vote yea)

274. Mansfield motion that the Senate recede on its position opposing the Philadelphia Plan. (Vote yea)

RICHARD A. ZIMMER.

VOTE BY VOTE TABULATION OF RATINGS

State	Senator	%	DEVOLUTION OF POWER							ANTI-SUBSIDY					FREE MARKET FREE TRADE				FOREIGN POLICY/ FOREIGN AID					FISCAL RESPONSIBILITY				CIVIL RIGHTS/ CIVIL LIBERTIES				
			#50	70	79	121	128	*249	257	54	97	210	229	#251	*58	133	152	200	#65	146	271	*34	*225	*61	62	*159	*222	*138	#154	*247	*274	
Ala.	Sparkman	24	(V)	X	X	X	O	X	X	X	(X)	X	(X)	X	X	O	X	X	X	O	V	V	V	X	V	V	X	O	X	X	X	6/25
	Allen	14	V	X	X	X	X	X	X	X	V	X	X	V	X	X	X	X	X	(X)	V	X	X	X	X	X	X	X	X	X	X	4/29
Alaska	Gravel	64	V	V	V	V	O	V	O	(X)	X	X	X	X	V	V	X	V	V	O	O	(V)	V	V	V	X	X	V	X	V	(V)	16/25
	Stevens	55	V	O	X	O	O	V	O	X	X	X	V	X	(V)	O	V	X	X	X	O	V	V	V	(V)	X	X	V	X	V	O	12/22
Ariz.	Fannin	24	X	X	X	X	X	X	X	X	V	X	V	X	X	X	V	X	X	(X)	X	X	X	V	V	V	V	(X)	X	X	X	7/29
	Goldwater	20	X	X	X	X	X	X	O	X	O	(X)	V	X	X	O	O	(X)	X	O	O	X	(X)	V	V	O	(V)	O	X	X	O	4/20
Ark.	McClellan	7	V	X	X	X	X	X	X	X	X	X	X	X	X	O	X	X	X	O	X	X	X	X	V	O	X	X	X	X	X	2/26
	Fulbright	60	V	V	V	O	X	V	(V)	X	(V)	(X)	V	V	V	V	(X)	O	V	V	V	V	X	X	X	V	X	O	X	X	X	15/26
Calif.	Murphy	37	(X)	X	X	X	V	X	(X)	X	(X)	X	V	X	V	X	V	X	X	X	O	X	V	V	V	V	V	V	X	X	O	10/27
	Cranston	75	V	X	V	V	V	V	V	X	X	V	X	(V)	V	V	X	V	V	V	V	V	V	X	V	V	X	O	V	V	V	21/28
Colo.	Allott	31	X	X	X	X	X	X	X	X	V	X	V	X	V	X	V	X	X	X	X	X	V	V	V	V	V	X	X	X	(X)	9/29
	Dominick	28	X	X	X	X	V	X	X	X	V	X	V	X	V	X	V	X	X	X	X	X	X	V	X	V	X	X	X	V	X	8/29
Conn.	Dodd	39	X	X	X	O	V	X	V	X	X	X	V	X	V	X	X	X	X	X	X	V	V	X	V	X	X	V	V	V	V	11/28
	Ribicoff	71	(V)	X	V	V	V	V	V	(V)	(X)	V	(V)	(V)	V	V	(X)	X	V	X	V	(V)	X	X	V	O	X	(V)	V	V	(V)	20/28
Del.	Williams	59	V	V	V	X	X	X	O	V	V	V	V	X	V	X	V	V	X	V	O	X	X	V	V	V	V	X	V	X	X	16/27
	Boggs	64	V	X	V	X	V	X	X	V	V	X	V	X	V	V	V	X	X	X	O	V	V	V	V	V	V	V	X	V	V	18/28
Fla.	Holland	24	V	X	X	X	X	X	V	X	X	X	X	V	X	X	X	X	X	X	X	V	X	X	V	V	V	X	X	X	X	7/29
	Gurney	19	X	X	X	X	O	X	X	X	X	X	V	X	X	X	V	X	X	O	X	X	X	V	V	V	X	X	X	X	X	5/27
Ga.	Russell	22	(V)	X	X	X	V	O	O	X	O	V	O	(X)	X	(X)	X	X	X	X	O	X	X	X	V	X	V	X	X	X	O	5/23
	Talmadge	4	V	X	X	X	X	X	O	X	X	X	X	X	X	X	X	X	X	X	O	X	X	X	V	X	V	X	X	X	O	1/25
Haw.	Fong	42	O	X	X	X	V	X	V	X	X	X	X	X	V	V	V	X	X	X	X	(V)	V	V	V	X	X	O	X	V	O	11/26
	Inouye	58	V	X	V	V	V	O	O	X	X	X	X	(X)	V	V	X	X	V	X	O	V	V	X	V	(V)	X	V	V	(V)	V	15/26
Idaho	Church	63	V	V	V	O	X	V	V	X	V	X	X	V	V	O	X	X	V	V	O	V	X	X	X	(X)	X	V	V	V	V	17/27
	Jordan	44	V	X	X	X	V	X	X	X	V	V	V	X	V	O	V	X	X	X	O	X	V	X	X	V	V	X	V	X	X	12/27
Ill.	Percy	86	V	V	(V)	(V)	(V)	V	O	V	V	X	V	X	V	V	V	V	V	X	(X)	V	V	V	V	V	V	V	V	V	V	24/28
	Smith	37	O	O	O	O	X	X	(X)	(X)	X	X	X	X	V	O	V	X	X	O	(X)	(X)	V	V	O	V	X	(V)	X	X	V	7/20
Ind.	Hartke	71	V	V	V	V	X	V	V	V	O	V	X	V	V	O	X	X	V	O	V	O	V	O	X	V	X	O	V	V	V	17/24
	Bayh	67	O	O	V	V	O	V	V	V	X	X	V	X	V	V	X	X	V	V	V	(V)	V	X	X	O	X	O	V	V	V	16/24
Iowa	Miller	48	V	X	X	X	X	X	X	V	X	X	(X)	X	V	V	(V)	X	X	(X)	X	V	(V)	V	X	V	V	O	V	X	V	14/29
	Hughes	71	(V)	V	V	V	O	V	V	X	X	V	X	V	V	V	X	V	V	X	V	(V)	V	X	V	X	X	V	V	V	V	20/28
Kan.	Pearson	68	V	V	V	X	V	V	O	X	X	X	V	X	V	O	V	X	V	X	O	V	V	V	V	V	V	V	X	V	O	17/25
	Dole	50	V	X	V	(X)	V	V	X	X	V	X	V	X	X	O	V	X	V	X	O	X	V	V	V	V	V	V	X	V	X	13/28
Ky.	Cooper	95	V	V	V	X	O	O	O	V	V	V	O	O	V	V	V	X	V	X	O	V	V	V	V	V	V	O	V	V	O	19/20
	Cook	52	V	V	V	O	V	V	X	V	X	X	X	V	X	X	O	X	V	V	V	O	V	X	X	(X)	X	O	X	V	O	13/25
La.	Ellender	31	V	X	V	X	X	X	X	X	X	X	X	X	V	V	X	X	V	V	X	X	X	X	V	(V)	(V)	X	X	X	(X)	9/29
	Long	32	V	X	X	X	V	X	O	O	X	(X)	X	O	V	V	X	X	X	O	O	X	O	X	V	V	(V)	O	X	X	(X)	7/22
Me.	Smith	41	X	X	X	X	X	X	X	X	X	V	V	V	X	V	V	X	V	X	X	V	X	V	V	V	V	X	V	X	X	12/28
	Muskie	67	V	V	X	O	O	V	V	X	X	V	V	V	X	V	X	X	V	X	V	V	V	X	V	V	X	V	V	V	V	18/27
Md.	Tydings	76	O	V	V	V	V	V	O	X	X	V	O	(V)	O	V	X	V	V	X	V	O	O	X	V	X	O	V	V	V	V	16/21
	Mathias	89	V	V	V	V	V	V	V	V	X	V	X	(X)	(V)	V	V	V	V	O	V	O	V	V	V	V	V	V	V	V	V	23/26
Mass.	Kennedy	80	V	V	V	V	O	(V)	V	V	(X)	V	O	(V)	O	(V)	X	V	V	O	V	O	V	V	V	O	X	V	V	(V)	V	20/25
	Brooke	90	V	V	X	(V)	(V)	V	V	V	X	V	V	V	V	V	V	X	V	V	V	V	V	V	V	(V)	V	V	V	V	V	26/29
Mich.	Hart	82	V	V	V	V	V	V	V	V	O	V	V	V	V	V	(X)	V	V	(V)	V	(V)	V	X	X	X	X	V	V	V	V	23/28
	Griffin	61	X	X	V	X	V	V	X	O	X	X	X	X	V	O	X	V	X	X	V	V	V	V	V	V	V	V	V	V	V	17/28
Minn.	McCarthy	68	V	V	V	O	O	V	O	X	O	(V)	V	O	V	O	X	V	O	X	O	O	X	X	V	X	X	V	V	V	V	13/19
	Mondale	79	V	V	V	V	V	V	V	X	X	V	X	V	V	V	(X)	V	V	O	O	V	V	X	V	V	X	V	V	V	V	22/28
Miss.	Eastland	9	V	X	O	O	O	X	O	X	X	X	X	X	X	O	X	X	X	O	O	X	X	X	V	V	X	X	X	X	O	2/23
	Stennis	15	V	X	X	X	V	X	X	X	(X)	X	X	X	X	O	X	X	X	O	O	X	X	X	V	V	X	X	X	X	O	4/27

Mo.	Symington	68	V	X	V	V	V	O	O	X	(V)	(V)	O	(X)	V	V	X	O	V	V	O	X	V	X	X	V	O	V	V	(V)	O	15/ 11
	Eagleton	69	V	(V)	V	V	O	V	V	X	X	(X)	X	V	V	O	X	V	V	O	V	V	X	X	V	V	X	V	V	V	V	18/26
Mont.	Mansfield	64	V	V	V	O	V	V	V	X	X	X	X	(X)	V	(V)	(X)	X	V	X	V	V	X	X	V	(V)	X	V	V	V	(V)	17/28
	Metcalf	60	V	V	V	V	O	V	V	X	X	X	X	X	V	V	X	V	V	O	O	V	X	X	X	X	X	O	V	V	(V)	13/25
Neb.	Hruska	28	V	X	X	X	X	X	X	X	X	X	V	X	V	X	V	X	X	X	X	X	X	V	V	V	V	X	X	X	X	8/29
	Curtis	31	V	(X)	X	X	X	X	X	X	V	X	V	X	V	X	V	X	X	X	X	(X)	X	V	V	V	V	X	X	X	X	9/29
Nev.	Bible	16	V	X	O	V	O	X	X	X	X	X	X	X	O	X	X	X	X	V	O	X	X	X	X	X	X	X	V	X	X	4/25
	Cannon	35	V	(X)	X	V	(V)	X	V	O	(X)	X	X	X	V	O	X	X	V	O	X	X	V	X	X	X	X	V	V	X	X	9/26
N. H.	Cotton	25	V	X	X	X	V	X	X	X	X	X	V	X	X	X	V	X	X	X	X	X	X	V	X	V	V	X	X	X	O	7/28
	McIntyre	54	V	V	X	V	V	X	X	X	(X)	X	V	X	X	V	X	X	V	O	V	V	V	X	V	V	X	X	V	V	V	15/28
N. J.	Case	86	V	V	V	V	V	V	O	V	V	V	V	V	V	V	X	V	V	(X)	V	V	V	X	V	V	X	V	V	V	(V)	24/28
	Williams	76	O	V	V	V	V	V	V	V	(X)	V	(V)	O	V	V	(X)	V	V	O	O	V	V	X	X	X	X	V	V	V	V	19/25
N. M.	Anderson	56	V	X	X	V	V	O	O	O	O	O	O	(X)	V	V	(X)	O	X	X	O	V	O	X	V	V	(X)	V	V	O	O	10/18
	Montoya	48	V	V	X	V	V	V	V	X	X	X	X	X	V	V	(X)	X	V	X	X	X	V	X	X	X	X	V	V	V	V	14/29
N. Y.	Javits	85	V	V	V	V	O	V	V	V	O	V	V	X	V	(V)	X	V	V	X	X	V	V	V	V	V	V	V	V	V	V	23/27
	Goodell	96	O	V	V	(V)	V	V	V	V	X	V	V	(V)	V	V	(V)	V	V	V	V	(V)	V	V	V	(V)	V	V	V	V	V	27/28
N. C.	Ervin	19	V	X	X	X	O	X	V	X	X	X	X	(V)	X	O	X	X	X	X	X	X	X	X	V	(V)	X	X	X	O	(X)	5/26
	Jordan	15	V	X	X	X	V	X	X	X	X	X	X	X	V	X	X	X	X	O	X	X	(X)	X			X	O	X	O	X	
N. D.	Young	29	V	X	X	X	V	X	X	X	O	X	X	X	V	V	V	X	X	X	X	X	X	V	V	V	X	X	X	X	X	8/28
	Burdick	54	V	V	V	V	X	V	V	X	X	X	X	V	V	V	(X)	V	V	O	V	X	X	X	X	X	X	V	V	V	X	15/28
Ohio	Young	63	V	V	V	V	X	V	V	V	X	V	X	(V)	V	V	X	X	V	V	O	V	X	X	X	X	X	V	V	V	O	17/27
	Saxbe	67	V	V	(V)	V	V	V	V	V	X	V	V	X	X	O	X	X	V	O	V	O	X	V	X	(X)	V	O	V	V	O	16/24
Okla.	Harris	71	V	V	V	O	(V)	V	V	X	X	X	X	V	V	X	V	V	X	V	V	V	V	X	V	V	X	V	V	V	V	20/28
	Bellmon	42	X	V	X	X	V	X	X	X	O	X	X	X	(V)	O	V	X	X	X	X	V	O	V	V	V	X	V	X	V	V	11/26
Ore.	Hatfield	76	V	V	V	X	V	V	V	V	X	V	V	V	V	(V)	X	V	V	V	V	V	V	X	X	X	X	V	V	V	(V)	22/29
	Packwood	72	V	V	V	X	V	V	X	V	X	V	X	X	V	V	X	V	X	X	X	V	V	V	V	V	V	V	V	V	V	21/29
Pa.	Scott	76	V	V	V	V	V	V	V	V	V	X	V	X	X	V	V	X	X	X	X	V	V	V	V	(V)	V	V	V	V	V	22/29
	Schweiker	86	V	V	V	V	V	V	V	V	X	V	V	X	V	V	V	X	V	V	V	V	V	V	V	V	X	V	V	V	V	25/29
R. I.	Pastore	59	V	V	V	V	X	V	(V)	V	X	V	V	X	X	V	X	X	X	(X)	V	V	X	V	X	(X)	V	V	V	V	V	17/29
	Pell	74	V	V	V	V	O	V	V	V	X	V	V	X	X	O	X	X	V	X	V	V	V	V	V	V	X	V	V	V	V	20/27
S. C.	Thurmond	21	X	X	X	X	(X)	X	X	X	(X)	X	X	X	X	X	V	X	X	X	X	X	V	V	V	V	V	(X)	X	X	X	6/28
	Hollings	17	O	X	X	X	V	O	O	X	X	X	X	(X)	X	V	X	X	X	O	O	V	V	X	X	X	X	O	X	(X)	(X)	4/23
S. D.	Mundt	38	V	X	X	X	O	O	O	X	V	O	O	(X)	V	O	V	O	X	X	O	X	O	V	V	O	O	X	X	O	O	6/16
	McGovern	64	V	V	V	V	V	V	V	X	X	V	X	V	V	V	(X)	X	V	V	V	V	X	X	X	X	X	O	V	V	V	18/28
Tenn.	Gore	58	(V)	O	O	V	X	V	V	V	O	(V)	X	V	V	O	(X)	V	V	X	V	X	O	X	V	X	X	V	V	X	X	14/24
	Baker	44	V	(X)	X	X	V	V	X	X	X	X	V	X	V	O	V	X	X	X	O	V	V	V	X	(V)	V	V	X	X	X	12/27
Tex.	Yarborough	58	V	V	(V)	V	V	V	V	X	X	X	X	X	V	V	X	V	V	O	V	V	O	X	X	(X)	X	0	V	V	(X)	15/26
	Tower	29	X	X	X	X	X	X	(X)	X	X	X	V	X	X	(X)	(V)	X	X	(X)	(X)	V	V	V	V	V	V	(X)	X	X	O	8/28
Utah	Bennett	41	X	X	X	X	V	X	X	X	O	X	V	X	X	X	V	X	X	X	O	V	(V)	V	V	V	V	V	X	X	V	11/27
	Moss	60	O	V	(V)	V	O	V	V	X	X	X	X	X	O	V	X	V	V	V	V	(V)	V	X	X	X	X	O	V	V	V	15/25
Vt.	Aiken	82	V	V	V	X	V	V	V	X	V	V	V	X	V	V	V	V	V	X	V	O	X	V	V	V	V	O	X	V	V	21/27
	Prouty	50	V	V	V	X	X	V	X	(X)	X	X	V	X	X	V	X	X	X	X	V	O	V	X	V	X	V	V	X	V	V	14/28
Va.	Byrd	21	V	V	X	X	X	X	X	X	X	X	X	V	V	X	X	X	X	O	V	X	X	X	V	X	X	X	X	X	X	6/28
	Spong	36	V	V	V	X	O	X	V	X	X	X	X	(V)	V	X	X	X	X	X	V	X	V	X	V	X	X	X	V	X	X	10/28
Wash.	Magnuson	55	V	X	X	V	V	X	V	(X)	(X)	V	V	X	V	V	(X)	X	V	X	V	V	V	X	V	X	X	V	V	(X)	V	16/29
	Jackson	55	X	X	X	V	V	V	V	X	X	V	(X)	X	V	V	X	V	X	X	X	V	V	X	V	(X)	V	(V)	V	(V)	V	16/29
W. Va.	Randolph	45	V	V	V	V	V	X	X	X	X	X	X	X	X	V	X	X	V	V	V	X	V	X	V	(V)	X	X	X	(V)	X	13/29
	Byrd	11	V	X	V	X	V	X	X	X	X	X	X	X	X	(X)	(X)	X	X	O	O	X	X	X	X	X	(X)	X	X	X	X	3/27
Wisc.	Proxmire	66	V	V	V	V	X	X	V	V	V	V	X	V	V	V	X	V	V	V	V	V	X	X	X	X	X	V	V	V	X	19/29
	Nelson	76	V	V	V	V	V	V	V	(V)	(V)	V	X	V	V	V	X	V	V	V	V	V	X	X	X	(X)	X	V	V	V	(V)	22/29
Wy.	McGee	48	X	X	V	V	V	V	O	X	X	X	X	X	V	V	X	X	X	X	X	V	V	X	V	V	X	V	V	V	O	13/27
	Hansen	24	X	X	X	X	V	X	X	X	X	X	V	X	X	X	V	X	X	(X)	X	X	X	V	V	V	V	X	X	X	X	7/29

The CHAIRMAN. Well, let me see, how long have you been here now with the Government?

Mr. COHEN. I have been at HEW 1 year as of yesterday, and I worked 2 years on Capitol Hill.

The CHAIRMAN. Who were you working with on Capitol Hill?

Mr. COHEN. I worked with Congressman Donald Rumsfeld, now an assistant to the President, and with Senator Charles Percy, of Illinois.

The CHAIRMAN. Well, my thought about the matter is that some of us here who have been advocating some pretty liberal things in years gone by, some very costly things, from time to time find that we ought to get a better run for our money when we vote for more of these programs. I guess I number myself among those I do not know whether it makes me an Eastland or not, but I would submit that so far the Justice Department has made out better in the Judiciary Committee with Jim Eastland as chairman of that committee than your Department has made out with this committee. They did not send a bill back to you.

Mr. COHEN. We are hoping to catch up, Mr. Chairman.

The CHAIRMAN. Pardon me?

Mr. COHEN. We are hoping to catch up. [Laughter.]

The CHAIRMAN. This committee catch up with Eastland's you mean? [Laughter.]

Mr. COHEN. I meant with the success of the various other committees, Senator.

The CHAIRMAN. Well, what we want to do is to pass legislation in the national interest. I just wanted to understand what you have done to slug it out with the Eastlands so far. It seems to me what we are trying to do is to improve on a bill that the House sent us, and I think we will succeed, and you certainly are welcome to suggest to us how it can be improved.

But I suggest to you when it was brought back to you every Republican voted for that.

Mr. COHEN. I think we improved the bill, Mr. Chairman, pursuant to suggestions of the committee, and the discussions we have had. We hope we will return very shortly, and we will go into the various proposals in greater depth.

The CHAIRMAN. If we are just adjudged by previous experience the way these social security bills have worked so far is that the administration sent something down that will cost about $2 billion, and then the House committee pushes it up to about $4 billion, and by the time it gets over here—mind you, they had the benefit of a closed rule oftentimes over there, so the House on the floor cannot raise it—but when it gets over here then the committee pushes it up to about $6 billion, and then the Senate pushes it up to about $12 billion, and sometimes more than that, and by the time we go to conference, it is not those Senate conferees, it is your people trying to urge us not to buy all the things that the Senate votes for. Sometimes your Department is put in the position of being the conservatives saying that we cannot pay for this. If you have any ideas more generous than what the Senate voted by the time we get through with these bills, please let me know.

Mr. COHEN. I certainly will, Mr. Chairman.

The CHAIRMAN. Thank you very much. That concludes this morning's session.

(Thereupon, at 12:05 p.m. the hearing recessed, subject to the call of the Chair.)

SOCIAL SECURITY AMENDMENTS OF 1970

TUESDAY, JULY 14, 1970

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to notice, at 10:05 a.m., in room 2221, New Senate Office Building, Senator Russell B. Long (chairman), presiding.

Present: Senators Long, Anderson, Talmadge, McCarthy, Harris, Byrd, Jr., of Virginia, Williams of Delaware, Bennett, Curtis, Jordan of Idaho, and Hansen.

The CHAIRMAN. The hearing will come to order.

This morning, the committee resumes its hearings on H.R. 17550, the Social Security Amendments of 1970.

We are pleased to have as our chief witness today the Honorable Elliot L. Richardson, newly appointed Secretary of the Department of Health, Education, and Welfare.

Before Mr. Richardson begins his statement, let me state for the record that it is the committee's intention to hear administration witnesses on this social security bill this week. Next week we plan to hear administration witnesses on the family assistance plan. And early in August, it is our hope to begin hearing public witnesses on the family assistance bill.

During the period between hearing the Secretary and hearing the public witnesses, we expect to hear from other Departments of this Government and perhaps the Secretary of Labor.

After that hearing is completed, the committee will then hear public witnesses on the social security bill. Following these hearings, at which nearly 400 witnesses have asked to testify, the committee will consider both bills in executive session.

Mr. Richardson, we are pleased to have you back with us so soon after your confirmation hearing. I would suggest that you proceed with your statement in chief in your own fashion, and we shall withhold questions until you have completed.

I might just continue for 1 minute longer. Members of this committee have requested information to complete the record of the hearing on the family assistance plan. We hope that when we resume hearings on that bill next week this information will be available. It is to appear in the printed hearings at page 211 in two places, and information will be provided at pages 212, 217, 221, 226, 229, at two places on page 230, on page 233, pages 235, 245, 249, 262, at two

places on 264, on pages 265, 269, 281, 295, 299, 313, 348, 349, 350, and 366.

I direct your attention, Mr. Secretary, to the fact that we are waiting for a lot of information, and we have been waiting for it for two and a half months. We would like to have it provided when we take up that bill next week.

STATEMENT OF HON. ELLIOT L. RICHARDSON, SECRETARY OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY JOHN G. VENEMAN, UNDER SECRETARY; ROBERT M. BALL, COMMISSIONER OF SOCIAL SECURITY; AND HOWARD N. NEWMAN, COMMISSIONER, MEDICAL SERVICES ADMINISTRATION

Secretary RICHARDSON. Mr. Chairman, I shall be glad to see that this material is submitted in satisfactory form. I am informed that we have submitted responses to the request for material, some of which we are refining in light of discussions with your staff.

The CHAIRMAN. I understand, in view of our staff having looked at it, that that is not fully in response to what we have requested. We would like to get the material that we are asking for.

Secretary RICHARDSON. We will make sure that you get it.

Mr. Chairman, members of the committee, I am accompanied this morning by Under Secretary John Veneman on my left and Commissioner Robert Ball of the Social Security Administration on my right. To Mr. Veneman's left is the Commissioner of the Medical Services Administration, Mr. Howard Newman. Questions may well arise which they are better qualified to answer than I am. In any case, Mr. Veneman and Mr. Ball will be available for further testimony before the committee on matters not covered in my testimony or in the questioning which follows.

I am pleased, Mr. Chairman, and members of the committee, to testify before your committee today on H.R. 17550, the Social Security Amendments 1970. The bill embodies practically all of the proposals submitted for the consideration of the Congress by the President in his September 25, 1969, message on social security, and other proposals, such as the health cost effectiveness amendments, that were submitted later by the administration. The legislation will improve the protection afforded by the social security cash-benefits program and improve the medicare, medicaid, and maternal and child health programs with regard to both overall effectiveness and potential for control of health care costs. The President has endorsed the major provisions of the bill.

AUTOMATIC COST OF LIVING ADJUSTMENTS

H.R. 17550 provides for automatic adjustment of social security benefits to increases in the cost of living. In my opinion, this proposal is the most important one in the bill concerning the cash-benefits program. Both political parties included it in their 1968 national convention platforms, and there is widespread support for it among both contributors to the program and beneficiaries. This is a proposal whose time has come.

Over the years Congress has established a policy of restoring the purchasing power of benefits when price increases have eroded their value. Sometimes, however, there have been long periods during which benefits have remained unchanged and beneficiaries have had to get along on these benefits while the cost of living increased substantially. On the other hand, the Congress has occasionally set new and higher benefit levels than had previously been established, actually increasing the purchasing power of the benefit in real terms.

Here is what has happened: there were no general benefit increases between 1940, when monthly benefits were first payable and 1950. Then the benefit level was increased to about make up for the rise in prices that had occurred during the 1940's. As result of the amendments of 1952 and 1954, the Congress established a somewhat higher level of benefits in real terms. Then, during the next 15 years, three across-the-board benefit increases were enacted that approximately restored the purchasing power of the benefits as they were established in 1954. The 15-percent benefit increase earlier this year again established a somewhat higher level of benefits in real terms.

Although Congress has established a policy of restoring the purchasing power on benefits, and indeed, on occasion, increasing the real level of benefits, there have been substantial time lags between the increases in price levels and the increase in benefits. For example, there were no increases between 1940 and 1950, although the purchasing power of the benefits declined by about 37 percent. There was no general increase in benefits between 1959 and 1965 although the purchasing power of the benefits declined by about 8 percent.

When substantial time lags occur between increases in price levels and benefit increases, congressional action increasing benefits cannot make up for the hardships beneficiaries endure while awaiting such action. Older people, widows, orphans, and disabled people, who have had to get along for years on benefits that were declining in purchasing power, have suffered hardships during those years that cannot be overcome by a later restoration of the purchasing power of the benefits.

The automatic adjustment provision controls the time lag and adds predictability to the increase. Writing the established congressional policy into the law will give both beneficiaries and covered workers the peace of mind that comes with the certainty that the purchasing power of their benefits will not be eroded by future price increases. Had this provision been in effect during the last 15 years, instead of the four benefit increases that occurred in 1959, 1965, 1968, and 1970, there would have been seven benefit increases. Thus, beneficiaries who were on the rolls during those years would have had the purchasing power of their benefit maintained throughout the period at a level much closer to the purchasing power of the benefit level established in 1954. The somewhat higher level of benefits established this year would have required congressional action.

To take account of price increases occurring during this calendar year, 1970, the bill provides an across-the-board 5-percent increase in benefits effective January 1, 1971. The 5-percent-benefit increase will go to more than 26 million beneficiaries and will total $1.7 billion during the first 12 months the increase is in effect. The first automatic benefit increase could take place in January 1973, based on an increase in the cost of living from 1971 to 1972, if that increase is at least 3 percent.

INCREASE IN THE CONTRIBUTION AND BENEFIT BASE

The House bill also provides for increases in the contribution and benefit base—the amount of a worker's annual earnings that is subject to social security contributions and counted toward social security benefits. The base would be increased from the present $7,800 to $9,000 effective for 1971. Thereafter, the base would be automatically adjusted on a regular basis—but no more often than once in 2 years—as earnings levels rise.

The Congress has clearly established a policy of adjusting the contribution and benefit base as earnings levels rise, just as it has with respect to the adjustment of benefits to prices. Here again, a provision for automatic increases in the base to keep it in line with increases in earnings levels would write into the law already established congressional policy, thus giving greater assurance to workers who earn higher wages in the future that they will get credit toward benefits for those higher earnings. The automatic increases in the base, in line with rising wages, would also provide adequate financing for the automatic benefit increases.

The contribution and benefit base was originally established at $3,000 in 1935. No action was taken to increase the base until 1950, when it was set at $3,600. At this level it covered 81 percent of payrolls and all of the earnings of a little over 75 percent of covered workers. Since that time, through legislative changes, the percentage of payrolls covered has been maintained at about 80 percent, and the percentage of covered workers who have all their earnings covered has been maintained at about 75 to 80 percent. The increase in the base to $9,000 in 1971 will restore the relationship between the base and earnings levels generally that was established in 1950 and that has been maintained by Congress over the last 20 years, and the provision in the bill for automatic adjustment in the base would mean that similar relationships would be maintained automatically.

These provisions would not delegate to the executive branch any discretion whatsoever. The power to increase taxes would remain in the hands of the Congress. What this provision does is to provide a specific formula in the law that determines what the social security tax base shall be. The base would be increased only in direct proportion to increases in average earnings for all workers in covered employment.

RETIREMENT TEST

H.R. 17550 improves the social security program's retirement test. This is the provision under which social security benefits for an individual under age 72 are withheld or reduced if he earns more than the exempt amount—currently $1680—in any year.

In his message to the Congress last September the President expressed his concern about this provision. He said:

> The present retirement test actually penalizes social security beneficiaries for doing additional work or taking a job at higher pay. This is wrong.

As you know, the Congress has on a number of occasions made changes designed to minimize this effect. Yet, a problem remains under the present retirement test because benefits are reduced dollar-for-dollar on earnings above $2,880 in a year. Because of taxes and

work expenses, a beneficiary's spendable income—that is, his social security benefits plus his earnings after taxes—may be less if he earns somewhat more than $2,880 than his income would be if he earned less than $2,880. The bill remedies this by eliminating the dollar-for-dollar reduction and providing that social security benefits be reduced by only $1 for each $2 of earnings above the annual exempt amount, regardless of how much is earned.

The bill also increases the retirement test annual exempt amount from $1,680 to $2,000. This change takes account of increases in general earnings levels that have occurred since the present $1,680 exempt amount became effective.

The bill also provides for the future automatic upward adjustment of the retirement test as earnings levels rise, similar to the automatic adjustment provision for raising the contribution and benefit base. This change would prevent hardships to beneficiaries that have sometimes occurred because there was a lag in updating the test.

Under present law, benefits are not withheld under the retirement test for months when a beneficiary is age 72 or older. However, earnings for the entire year of age 72 are counted in determining whether benefits for months before he reaches age 72 should be withheld. The bill provides that only earnings before the month in which a beneficiary reaches age 72 would be used for retirement test purposes. This change would avoid hardships that now result when beneficiaries have to refund overpayments of benefits they accepted due to their misunderstanding of the law.

The retirement test changes in the bill would result in about $570 million in additional benefits being paid in 1971. These benefits would go to about 1.3 million beneficiaries, including 400,000 who would not receive benefits under present law.

INCREASE IN WIDOW'S BENEFITS

Surveys of social security beneficiaries show that, as a group, widows have less regular income than most other classes of beneficiaries and in general are financially worse off. Under present law, a widow cannot be paid more than 82½ percent of the benefit amount her husband would have received if he started getting benefits at or after age 65. We believe that widow should not be expected to live on less than her husband would have been paid if he had lived.

H.R. 17550 would increase benefits for aged widows and widowers. For those who become entitled to benefits at or after age 65, the benefit amount would be increased to 100 percent of the amount which the widow's deceased husband would have received if he had lived and his benefits had started at or after age 65. For those becoming entitled to benefits before age 65, the 100-percent amount would be reduced in a way similar to the way in which the worker's benefit is reduced if he elects to receive it before age 65.

Some 3.3 million widows and widowers on the rolls at the end of January 1971 would receive higher benefits under this provision. Additional benefit payments in the first 12 months would total $700 million.

UNIFORM COMPUTATION METHOD FOR MEN AND WOMEN

Under present law, the computation of retirement benefits for men is different from the computation for women. The result is that a man

who has had the same earnings as a woman may in many cases get benefits that are lower than hers. Under the bill, benefits for men would be calculated in the same way as they are for women under present law. As a result, the retirement benefits payable to men, the benefits payable to their wives, and the benefits payable to survivors of men who live beyond age 62 would be increased.

Approximately 10 million people on the rolls in January 1971 would have their benefits increased under this provision, and additional numbers would become eligible for benefits in the future because of the change in the eligibility requirements. In the first 12 months after the provision goes into effect, an additional $925 million in benefits would be paid.

ELIMINATION OF REDUCTION IN BENEFITS IN CERTAIN CASES

Under present law, when a person receives a benefit in one category that is actuarially reduced because it is taken before age 65, and also receives another benefit in a different benefit category beginning with the same or a later month, the second benefit is generally reduced to reflect the reduction in the first benefit. For example, when a woman applies for a retirement benefit prior to age 65, it is computed under the actuarial reduction formula; if she applies for a spouse's benefit at age 65 or later, it is reduced to take account of the fact that she took her retirement benefit early.

The bill would eliminate the actuarial reduction of the spouse's benefit in such cases. The same rule would apply to dependent husbands entitled to spouses' benefits.

Approximately 100,000 beneficiaries would be immediately affected by this provision, which would result in additional benefit payments estimated at $10 million during the first 12 months.

OTHER CHANGES IN SOCIAL SECURITY CASH BENEFITS

The bill also contains a number of other important, but less far-reaching improvements in the social security cash-benefits program. For example, the bill would improve social security protection for some veterans and their families and for the families of some deceased or disabled veterans; it would improve social security disability protection for children disabled after reaching age 18 and before 22; and it would extend eligibility for benefits to additional numbers of blind workers.

The only problem the administration finds in the cash benefit provisions of the bill relates to the liberalization of the ceiling for combined workmen's compensation and social security disability benefits. The ceiling on total income from workmen's compensation and disability benefits was established because of concern that if the income was in excess of the worker's earnings prior to disability it would adversely affect his motivation for rehabilitation. It is somewhat doubtful whether the proposed increased ceiling would still meet the offset provisions' objective. We urge that this proposal be deferred at this time and, instead, referred for recommendation by the Advisory Council on Social Security.

REHABILITATION FOR DISABILITY BENEFICIARIES

We recommend that a provision be added to H.R. 17550 to increase from 1 to 2 percent of the previous year's disability benefits the amount of social security trust fund moneys that can be used to reimburse State vocational rehabilitation agencies for costs of rehabilitation services provided to disabled social security beneficiaries. Experience under the present provisions has been increasingly favorable and we anticipate significant savings to the trust funds. Increasing the authorization from 1 to 2 percent would help restore additional disabled beneficiaries to productive employment and permit them to become self-supporting.

Mr. Chairman, the committee will recall that when HEW representatives testified here in February, they emphasized the need to take steps to encourage changes in structure and to improve the operation of the Nation's health care delivery system.

Inefficiencies and discontinuities in that system underlie a significant part of the extraordinary increase in the costs of health care that has been experienced throughout the Nation in recent years. It is one of the highest priority objectives of this administration to have Government programs distribute to improving the Nation's health-care system to the greatest extent possible. We believe that the medicare and medicaid programs have a special responsibility in this regard.

MEDICARE

With about 20 million people protected under the hospital insurance part of medicare and more than 19 million people enrolled in the medical insurance part, this program is the major federally operated health insurance plan and, indeed, by far the largest single plan in the United States. Overall, medicare payments in fiscal year 1969 accounted for about 70 percent of the expenditures of the aged for hospital and physicians' care. We believe that medicare, which has done much to alleviate the financial burden of health care for the aged, can be a powerful force in improving the system on which we all rely for health care.

There are four major provisions in H.R. 17550 designed to affect over the long run the cost of delivering quality health care to the American people. One of the most significant of these provisions is the one which would establish, under medicare, a health maintenance organization option.

We believe that enactment of the HMO option will have the effect of stimulating the Nation's voluntary health system to offer new choices to individuals and families and to organize new ways of delivering health care.

Under this provision, doctors, hospitals, and other providers of service could receive payments from the public program under terms that encourage prudent management of utilization.

Several types of existing health organizations and plans have shown evidence that payment arrangements with physicians can make a difference in the utilization of a broad spectrum of health services. Payment to these organizations on a per capita instead

of a straight fee-for-service basis provides incentives for early diagnosis and treatment, an important factor in the success the organizations have had in reducing the incidence and duration of high-cost institutional care.

This method of payment also shifts motivation away from the provision of high cost services and toward the provision of less expensive levels of medically appropriate care. We believe that with encouragement by the Federal Government and with the removal of legal barriers which exist at the State level, more of these organizations can be developed.

Health maintenance organizations are, essentially, organizations which will contract to provide to medicare eligibles all services covered by part A and part B of the program in return for a fixed annual sum per enrollee. The fixed annual sum, which would be determined in advance, would be less than the Government now pays on the average for conventional medicare benefits. Prospective payments to health maintenance organizations, HMO's, would be determined annually, taking into account the organization's regular premiums, and would not exceed 95 percent of average per capita payments under parts A and B in the locality—with appropriate actuarial adjustments for expected cost differentials due to such factors as age and sex variations in membership composition of an organization. Thus, the economic incentive of the provider and the health interests of consumer more closely aline because the provider bears all the financial risk of ill health. Both parties will have, therefore, an interest in the maintenance of good health.

When a health maintenance organization offers membership opportunities in a community, the individual medicare beneficiary could choose whether to continue under the present parts A and B arrangements or to elect the HMO option. For medicaid recipients, sufficient authority currently exists under title XIX for the States to contract with these same health maintenance organizations to provide a defined scope of services, on a negotiated per capita basis.

This proposal represents a significant departure from the more traditional approach in which the individual patient must largely find his own way among the various types and levels of services. Under the health maintenance organization option, a single organization will have the responsibility for determining the covered services a patient needs and then delivering those services.

These two features of the proposal—first, the introduction of economic incentives to control unnecessary utilization and assure effective early treatment; and, second, the requirement that an HMO be responsible for all phases of covered services—will result in a greater assurance of medically appropriate care.

There are a variety of health maintenance organizations already in existence. I would like to emphasize, however, that we do not think any particular structure or sponsorship is a prerequisite for a health maintenance organization. Indeed, we think the country will benefit, by diversity and competition among different kinds of HMO's and between HMO's and other providers of health care.

One of our goals is to open the market place and provide opportunities for new delivery systems. The capacity of existing HMO's—essentially, group practice prepayment plans—is limited, so that

only a very small proportion of medicare and medicaid recipients will, in the beginning, be able to receive services through them. We hope that HMO's, and their use by beneficiaries, will expand greatly in the future, and we believe that there can be significant long-run savings in program costs due to the HMO option.

We will want to discuss with the committee at a later time some specific suggestions for technical changes that we believe will substantially improve the provision.

When representatives of the Department last discussed the medicare and medicaid programs before this committee, we urged moving as quickly as possible to a system of prospective reimbursement to institutional providers under these programs. At least a part of the increase in hospital costs can be attributed to the fact that reimbursement determined retroactively offers little incentive for an institution to contain its costs. We believe that prospective reimbursement will not only help to moderate program costs but will also stimulate administrators and health professionals to seek the most efficient manner of delivering health care services. This, of course, would benefit health-care consumers generally.

The House has endorsed the principle of prospective reimbursement and has directed the Department to experiment with and evaluate alternative methods for setting reimbursement on a prospective basis, and to recommend to the Congress by July of 1972 specific methods for the full implementation of a prospective reimbursement system. This, in our view, is a major step forward.

We recommend, however, that the House-passed bill be revised to provide authority for the Department to implement desirable methods for reimbursement as soon as they can be worked out by agreement with providers, without having to wait for further congressional action. We think that statutory language requiring that the committees receive reports on the proposed experiments and projects before they can be implemented is unnecessary. Such a requirement could result in delays in the implementation of projects.

Considering the fact that a great deal of research and analysis must be completed within a very short period of time, any delays in implementing projects and experiments may be costly. For this reason, we recommend the deletion of the reporting requirement in section 222.

Another major change relating to medicare reimbursement that was recommended by the administration and adopted by the House is one that would make medicare recognition of prevailing charge levels for medical services more closely related to general economic trends. Under this provision, physicians would still ordinarily be reimbursed on the basis of the customary charge that they made for a specific procedure to their patients generally. However, the overall maximum set in terms of the prevailing charges in a community would be allowed to rise in the future only in relation to rises in prices and the general earnings level.

It is true that over the long run past physicians' fees have not risen quite as fast as earnings generally, and if this were to continue to be the case, the proposed amendment would ordinarily not have any effect. However, the amendment is needed as a guarantee that this would indeed be the case in the future. We are faced with a sub-

stantial shortage of physicians in a period of rapidly increasing demand, and there may be, therefore, a tendency for fees to rise out of proportion to other economic indexes.

Although there is a clear need to achieve balance in and improved distribution of health-care facilities, there is also a need to assure that improvements will be accomplished in ways which avoid the duplication or random growth of health care facilities that would result in inefficient use of the facilities and, therefore, in unduly high health care costs.

Under H.R. 17550, the Secretary of Health, Education, and Welfare would be given authority to withhold or reduce reimbursement to providers of service for depreciation and interest for capital expenditures that are found to be inconsistent with State or local health facility plans. The Secretary's determination would be based on findings and recommendations submitted by qualified planning agencies in the States—organizations which have consumer representation and which will be designated by agreement between each State and the Department. If the Secretary determines, however, after consultation with a national advisory council, that withholding or reduction of reimbursement in a given case would be inconsistent with effective organization and delivery of health services he would be authorized to make reimbursement without such withholding or reduction. As the committee will recall, a proposal with the same general objectives passed the Senate in 1967.

Another provision would add to the conditions of participation for medicare the requirement that providers of service have a written plan which includes an operating budget and a capital expenditures budget. These budgets would be reviewed and updated annually by the institution itself under the direction of the governing body of the institution. Such a plan would be required before the provider would be allowed to participate in the medicare program. What we are aiming at is a means of helping provider institutions make sure that effective budgeting and planning techniques are brought into play at the grassroots level.

H.R. 17550 also authorizes the establishment of limits on costs that will be recognized as reasonable under medicare and, thus, will result in cost-sharing by beneficiaries who chose luxury services. These limits will be based on estimates of the costs necessary in the efficient delivery of needed health services to medicare beneficiaries. It is expected that the reasonable limits would be set sufficiently above average costs previously experienced by a class of institutions so that only institutions with exceptionally high expenses would be subject to the limits imposed. We feel that the authority is very useful in clarifying the congressional intent that under medicare it would not be necessary to reimburse providers of services for costs that are substantially out of line in comparison with costs in comparable settings.

The House-passed bill establishes the concept of an advance approval of benefits for extended care and home health services. This provision addresses itself to the exceedingly difficult problem of retroactive denial of benefits. In some instances, a determination that a patient did not require the level of care that is necessary to qualify for extended care or home health benefits becomes necessary when a claim for services furnished is presented and it is apparent that his condition did not warrant services covered under the law. As a result,

some individuals have been denied benefits that they thought would be payable. Retroactive denials have sometimes caused financial distress for beneficiaries and their families as well as difficulties for extended care facilities and home health agencies. The provision in the House-passed bill would alleviate a part of this problem by providing the Secretary with authority to establish, by medical condition, specific periods of time after hospitalization during which a patient would be presumed to require an extended-care-facility or home-health level of services. For the patient who needs covered care beyond the specified minimum period, additional coverage would of course be available, as under present law. But the period during which the need for covered care will be presumed to exist will allow time for making a decision about further coverage, so the problem of retroactive denials should be significantly diminished.

When medicare was enacted in 1965, people who were at the time aged 65 and over and not eligible for hospital insurance protection under regular social security requirements were made eligible under a transitional provision. Coverage for such persons is financed out of general revenues. There are now an estimated 300,000 persons who are younger than those who were covered under the transitional provision and who are not eligible for hospital insurance protection under existing law. H.R. 17550 contains a provision which would make hospital insurance coverage available to those persons on a voluntary basis. The cost of this coverage would be fully financed by those who elect to enroll for this protection.

We are now taking, as you know, a variety of administrative steps to improve the surveillance of utilization under medicare and medicaid, and the bill contains a number of provisions that would lend support to these efforts. The bill would modify utilization review procedures to provide for payment cutoff where unnecessary utilization is discovered in the course of a sample review of hospital or extended care admissions, and it would authorize experiments with the use of areawide or communitywide utilization review and medical review mechanisms.

The bill includes a provision under which the primary liability for individuals with coverage under a Federal Employees Health Benefits (FEHB) plan, as well as medicare, would no longer be assumed by medicare after December 31, 1971, unless the Secretary has certified that the FEHB plan has been modified to provide for coordination of the two programs.

We believe that a more effective solution to the problem of dual eligibility for medicare and FEHB insurance protection would be to extend medicare coverage to all Federal employees and to assure that such coverage includes arrangements that would permit employees with limited years of remaining Federal service to qualify for medicare at age 65. However, we are not prepared to recommend enactment of this approach until such time as we have had an opportunity to explore in depth its cost implications both for the Federal Government and for its employees and annuitants.

The House-passed bill contains a considerable number of other medicare provisions which I have not discussed. In large part, these provisions are aimed at improving the operating effectiveness and the administration of the medicare program. They include the adminis-

tration's health cost effectiveness amendments, previously presented to this committee.

Among these proposed amendments are those relating to authority to terminate payments to suppliers of services who abuse the medicare program, authority to base payments to institutional providers on charges where these are less than cost, and expanded authority to conduct experiments and demonstration projects to develop incentives for economy in the provision of health services.

In addition, the bill makes provision for advance approval of benefits for extended care and home health services. Under this provision, the Secretary would be authorized to establish specific periods of time, related to medical condition, during which a patient would be presumed, for payment purposes, to require a level of institutional services available only in an extended-care-facility setting.

The most difficult, as well as the most important, area of program controls relates to determinations of medical necessity for the volume and type of service provided. These determinations, of course, can be made only by the medical profession reviewing the actions of its own members. There are several features of the present law which are directed to this problem, including the requirements of a physician's certification of medical necessity for many types of service and the requirements for utilization review committees in hospitals and extended care facilities.

As I mentioned previously, the House bill provides for some additional strengthening by utilization review procedures and for experiments with the use of areawide utilization review mechanisms.

However, this is an exceedingly difficult area of administration, and we welcome the opportunity to examine additional approaches which might have the effect of strengthening peer review of the utilization of medical services. The approach, recently outlined by Senator Bennett, for example, represents a possibility that might be most helpful.

As is indicated in the Senator's statement appearing in the Congressional Record of July 1, the objective of greater physician participation in and responsibility for reviewing and evaluating utilization cannot be implemented at once, but will require a great deal of careful planning. It would be impossible, for example, and I believe in many ways undesirable, to supplant entirely the present medicare administrative system of conducting utilization reviews and to substitute new review organizations. Even in areas where review organizations exist, it may be both desirable and necessary to approach their full implementation in stages.

The Senator's proposal warrants careful consideration, and the Department is eager to collaborate with the committee in developing a sound and effective system of professional peer review.

MEDICAID

As I have stated earlier, I believe we are now at a time when significant new Federal initiatives should be taken in the health field. You are all aware of the President's announcement of June 10 that this administration is committed to the reform of the medicaid program and to the development and implementation of a family health insurance program for low-income families. We believe that this proposal, which we will discuss with you in more detail in the future,

will effectively integrate the Nation's major health program for the poor with the proposed family assistance program—FAP. This strategy will fundamentally restructure the medicaid program for families with children.

In addition, there are other, less critical changes which should be made at this time. Let me turn the committee's attention for a moment, if I may, to some of the strengths and weaknesses of the current medicaid program.

Few can deny that the title XIX program has moved a long way in a short time toward achieving its goal of improving the availability and accessibility of medical care and services for the Nation's poor. More than 12 million people will receive medical care with medicaid's help this year. This is more than double the number who received federally aided medical assistance in 1965.

Medicaid is providing health care for children whose families have enough money for their daily needs but not enough for special medical needs. From 1965 to 1969, the number of children who received federally supported medical assistance rose from 1.5 million to 5.9 million; about half the children in the latter group were not in families receiving AFDC payments. We believe it is important to recognize the achievements of this program and to maintain our commitment to improving and expanding health programs for the poor until medical services are available to all who require them but cannot afford to pay.

Clearly, however, there have been serious problems with the medicaid program. The health system has severe problems in the supply and distribution of facilities, manpower, and services, as well as in the organization and delivery of care.

In addition, the medicaid program, itself, has been difficult to administer—partly because of the title XIX legislation, partly because of the nature and administration of the welfare program it has supplemented, and partly because medicaid has been a Federal-State program. Medicaid, as you know, has operated not as one but as 52 separate and distinct programs. Each program is different in design, varying according to the people it covers, and in the services offered. Serious geographic and other inequities have, therefore, resulted.

We know that medicaid has been an expensive program, placing heavy fiscal burdens on the States and the Federal Government. Because of program variations, a disproportionate share of Federal matching funds has been spent in support of programs in only a few of our States.

We have been aware of the need to undertake fundamental reforms of the medicaid program to deal with these problems. We were also concerned with the difficulties, pointed out by your committee, of meshing the current medicaid program with a reformed welfare system. The sudden death loss of medicaid benefits when income reaches a specified level—the so-called notch problem—is an unacceptable defect in the current structure of Medicaid.

I can assure you that the Department has given the most serious consideration to these issues. They are not problems which lend themselves to easy or quick solutions. Some months' time will be necessary before we can present you with our final legislative proposals on the family health insurance program and with the related proposals

dealing with broad reforms in our health care system. We will continue to work with the committee staff as we develop these proposals.

In the meantime, we believe there are important immediate steps that can and should be taken to amend title XIX to make it a more effective and economical vehicle for financing health care. We think these improvements should be made before the family health insurance plan becomes an operating program, since title XIX will continue to support health care for those in the adult assistance programs.

We propose to require that the State health agency be responsible for establishing and maintaining health standards for institutions in which title XIX beneficiaries receive care and services. The same agency shall be responsible for maintaining, to the maximum extent practical, uniformity or consistency of determinations relating to eligibility of institutions for participation in the titles XVIII, XIX, and V programs.

As your committee has pointed out, some of the most serious problems of medicaid relate to the lack of adequate information systems for surveillance, rigorous claims review, utilization review, and program evaluation. This is caused, in part, by the lack of capability in the States to develop the necessary systems. We are, therefore, requesting authorization for Federal payment of 90 percent of the costs incurred by the States in the design, development, and installation of mechanized claims processing and information systems.

The Federal Government would also pay 75 percent of the cost of operating such approved systems. States would not be eligible to receive this increased Federal support until they have developed the capacity to furnish each recipient with a notice and explanation of health care paid for on his behalf by the program—a suggestion made by this committee. We are currently designing information systems for the States to use as models.

Providers have been reluctant in many instances to care for potential medicaid eligibles because frequently the patient has not applied for medicaid prior to his illness and, therefore, the providers would not be eligible to receive payment for their services. Thirty-one States have dealt with this problem by providing payment for care of eligibles for periods up to 3 months prior to the month of application. We propose to make 3 months' retroactive coverage mandatory on all States having title XIX programs.

This bill also includes a provision, in line with earlier suggestions by the Congress, to prohibit reassignment of benefits, except in specified cases, in order to prevent vendor payments from being made to independent collection and bill discount agencies.

We are hopeful that in this, and other programs, we will establish a more consistent policy of aiding the States to help themselves. Although we will provide technical assistance and models, the States will be encouraged to develop and operate their own systems.

The President, in his message sent to the Congress on February 26, suggested changes in the Federal matching percentage for medical assistance that would encourage States to substitute less expensive care for more expensive care when it is equally beneficial. Our proposal, adopted in the House-passed bill, provides for increased matching to encourage use of selected outpatient health services and for decreased Federal matching to discourage the States from permitting overutilization of institutional services.

This provision would permit the Federal Government to institute a reasonable cost differential between reimbursement made to skilled nursing homes and to intermediate care facilities, thereby incorporating another useful suggestion made earlier by your committee. Reimbursement disincentives for nursing home care are expected to increase placement of patients in intermediate care facilities—institutions that provide care that is more custodial in nature and at a more appropriate level for many of those in nursing home and mental institutions—and use of home health services.

We are aware of your committee's concern about ways to restrain the increases in cost arising from the relatively open-ended medicaid program, including the use of insurance carriers, capitation arrangements, and changes relating to eligibility. We agree that there are apparent defects that will be remedied ultimately only by changing the structure of the program. But while we are moving toward a complete change in the program's nature, we need to gain experience with different approaches to providing the benefits, different approaches to eligibility, underwriting, administration, and organization and delivery of services.

We are, therefore, asking Congress to make changes in title XIX to authorize the States to conduct experiments on a statewide, areawide, county, city, or neighborhood basis. We are interested in encouraging experiments with preenrollment of adult categories on an annual basis, the use of different combinations of benefits and different types of benefit packages for different population groups, and limited use of copayments and deductibles for medically needy.

We need to experiment in the way of risk-sharing with private insurance companies, foundations, prepaid group practices, and health maintenance organizations. We would use the authority in this provision to experiment in these types of areas: purchasing private insurance for medicaid eligibles, capitation or contract payments to States for specified groups, and capitation arrangements with prepaid groups, neighborhood health centers, foundations, and medical societies.

We are also proposing that the Secretary be permitted, through experiments or demonstration projects, to make payment to organizations and institutions for services which are not currently covered under titles V, XVIII, and XIX. These new services would have to be provided in addition to services already covered under these programs, and their inclusion would have to offer the promise of program savings without any loss in the quality of care. The Secretary could also authorize experimentation with the use of rates established by a State for administration of one or more of its own laws for payment or reimbursement to health facilities located in such State.

FINANCING PROVISIONS FOR SOCIAL SECURITY CASH BENEFITS AND MEDICARE

To meet the cost of the proposed changes in the social security cash benefits program and to bring the hospital insurance program into closer actuarial balance, H.R. 17550 would revise the social security contribution rate schedules. Under present law, the current contribution rate for cash benefits of 4.2 percent is scheduled to go to 4.6

percent each for employers and employees for 1971 and 1972, and to 5 percent for 1973 and thereafter. Under this schedule, there would be unnecessarily large accumulations in the trust funds in the near future years. For example, the funds would increase by $7 billion in 1971, about $8 billion in 1972, about $12.5 billion in 1973, and much more in future years.

Under the bill, for these reasons, the present rate of 4.2 percent for the cash benefits program would remain in effect through 1974, would go to 5 percent for 1975 through 1979, and then would rise to an ultimate rate of 5.5 percent for 1980 and thereafter. Maintaining the present rate of 4.2 percent through 1974 is consistent with past decisions by the Congress to delay scheduled increases in the rates so as to avoid unnecessarily large accumulations in the cash benefit trust funds. Under the bill, the funds would increase by $1.6 billion in 1971, $2.1 billion in 1972, and $3.3 billion in 1973.

The bill would also make changes in the contribution rate scheduled for the hospital insurance program. The hospital insurance fund requires additional income over and above that scheduled under present law in near future years. Under the bill, the contribution rate scheduled for 1971 and 1972 would be increased from 0.6 percent for employees, employers, and the self-employed to 1 percent each. The rate would then be kept at 1 percent. Under present law it would be gradually increased from 0.6 percent in 1970 to 0.9 percent in 1987 and after.

With the revisions in the contribution rate schedules, the combined contribution rate for cash benefits plus hospital insurance in 1971 would be 5.2 percent each for employees and employers—the same as present law. The acturarial balances would be —0.15 percent of taxable payroll for the cash benefits program and —0.11 percent of taxable payroll for the hospital insurance program.

The estimate for the hospital insurance program takes no account of the saving that should result from the cost control provisions of the bill, and not taking account of these potential savings represents some margin of safety. The long-range deficit of 0.11 percent of payroll indicated in the estimates, if it actually does develop, would not result in a decline in the HI trust fund before at least 15 years from now.

ADVISORY COUNCIL ON SOCIAL SECURITY

These, then, Mr. Chairman, are the major provisions of H.R. 17550. We think they go a long way toward improving all of the programs affected. The administration, as you know, is continuing to study the social security program with the aid of the statutory Advisory Council on Social Security, which Secretary Finch appointed in May 1969.

We recognize that there are several social security matters of importance to members of this committee and other members of the Senate that are not included in H.R. 17550. These matters will be included in the study being made by the council, which is reviewing every social security proposal pending before the Congress. As you know, the council is required to study all aspects of the program and to submit its findings and recommendations not later than January 1, 1971.

FEDERAL BUDGET STRAINED

However, I would like to offer one important cautionary note. The Federal budget is severly strained. I urge the committee to weigh this

point carefully in its consideration of H.R. 17550. Substantial changes, particularly in the total cost or financing techniques, might upset the delicate balance with the requirements of our economy that this bill now enjoys. I sincerely hope that the bill will meet with your approval so that its prompt enactment into the law can be insured.

For the present, I believe the changes in H.R. 17550 represent significant progress, and I urge enactment of the bill with the changes I have mentioned and the more minor ones referred to in the statement I will be submitting for the record.

The CHAIRMAN. Thank you very much, Mr. Secretary.

I would like to ask each member of the committee to limit himself to 10 minutes and ask our staff to keep time on us during the present round of questions directed toward the Secretary. I will start out by calling on Senator Byrd.

Senator BYRD. Thank you, Mr. Chairman.

Mr. Secretary, on page 20 of your statement, you say "some months time will be necessary before we can present you with our final legislative proposal on the family health insurance program." Does your statement today take into account the possible cost of that program?

Secretary RICHARDSON. No; it does not, Senator Byrd. My statement today takes into account only costs that would be paid by the trust funds and the changes in medicaid which eventually would be supplanted by the family health insurance program for families with children. Generally speaking, the changes I am discussing today would not result in increased costs. Some would result in savings.

DELAYED CONTRIBUTION RATE INCREASE

Senator BYRD. Now, on page 24 of your statement, you recommend that the increase which normally would go into effect of the current contribution rate, 4.2 percent, which would be increased to 4.6 percent the beginning of 1971, you recommend that that increase be delayed because you will have a substantial surplus in those funds when the new rate goes into effect. Is my understanding correct?

Secretary RICHARDSON. Yes, Senator, that is correct as applied to the cash benefit fund.

Senator BYRD. Now, the changes which you recommend, I assume, will increase, perhaps substantially increase the cost of the program, will it not?

Secretary RICHARDSON. Yes, the aggregate effect of the benefit changes will be to increase the cost; the net actuarial impact would be 1.09 percent of payroll.

Senator BYRD. What I am trying to get clear in my mind is although the cost of the program will be substantially increased, you are recommending that the rates paid by both the employee and the employer not be increased.

Secretary RICHARDSON. The ultimate rate is increased. As you know, Senator, it would go to 5.5 percent for 1980 and thereafter. What we are doing, in effect, is slowing the rate of increase in the size of the trust funds over the next few years; the increase in the funds would be unnecessarily rapid if the presently-scheduled rate increase were to go into effect.

Senator BYRD. That is right. That is what I am trying to get clear. As I understand it, then, you feel that you can substantially increase the benefits to the citizenry and yet do this without any increase in cost for the next 3 years?

Secretary RICHARDSON. Yes; that is the conclusion on which these recommendations are based. I am not sure whether the committee has this pamphlet containing the charts which Commissioner Ball used in his testimony last month. But it shows, in effect, what the testimony also points out, that the present schedule, which provides for an increase to 4.6 percent of payroll on employers and employees in 1971 and 1972 would produce unnecessarily large trust fund increases, on the order of $7 billion in 1971 and $8 billion in 1972. So rather than collect those amounts in those years, we are proposing to defer the increase in the rate to 4.6 percent by maintaining the level at 4.2 percent through 1972, and go then to 5 percent in 1975. This permits concurrent increasing of the tax rate applicable to the hospital insurance trust fund to 1 percent, effective in 1971 and thereafter, without increasing the combined rate beyond the rate of 5.2 percent called for in present law.

TRUST FUNDS AND THE UNIFIED BUDGET CONCEPT

Senator BYRD. What's the trust fund surplus for fiscal 1970?

Secretary RICHARDSON. $7 billion.

Senator BYRD. Then looking at the bottom of page 24, you say under the bill, the funds will increase by $1.6 billion in 1971. Is that $1.6 billion added to the $7 billion you anticipate or——

Secretary RICHARDSON. No, that is in place of the $7 billion increase for 1971 that would occur if the scheduled 4.6 tax rate were to go into effect. This assumes the rate proposed by the bill, 4.2 percent, and thus a lower increase in the trust fund.

Senator BYRD. Well, the trust fund under the unified budget concept—trust funds are being utilized to bring the budget more nearly into balance than it is at the present time. If you delay the increase—I am not objecting to the delay, but if you delay it, that will mean a larger budget deficit, will it not?

Secretary RICHARDSON. Well, not larger than the deficit would otherwise be, because deferring the scheduled rate increase for the cash benefits trust fund is being offset by a corresponding increase in the hospital insurance trust fund. Thus the net effect on the budget is a wash for 1971 and 1972.

Senator BYRD. The net effect on the budget is a wash for 1971, 1972, and 1973? Is that correct?

Secretary RICHARDSON. Commissioner Ball points out that this is not quite true. It is a wash on the intake side, but the expenditures would be higher than they would be under present law.

Senator BYRD. That is what I am getting at. So it appears to me that you are reducing the trust fund surpluses which up to this point have been utilized under the unified budget concept in an endeavor to bring the budget closer into balance?

Secretary RICHARDSON. Well, I think, Senator and Mr. Chairman, the problem is essentially one of approaches to the funding of the social security system and the sufficiency of the trust funds. We must

look first to the integrity of the system and to the question of whether the trust funds are being built up at an unnecessary rate.

Senator BYRD. I agree with that, Mr. Secretary, and I also disagree with the concept of the unified budget. So I am not objecting to your program; I am merely trying to understand it and understand the effect it will have on the total budget.

Mr. Chairman, my time is up. I assume that the witness will be back this afternoon. Is that your plan?

The CHAIRMAN. We will have him tomorrow.

Senator BYRD. Thank you.

Thank you, Mr. Secretary.

The CHAIRMAN. Senator Jordan?

DEMAND FOR INCREASED PROFESSIONAL SERVICES IN HEALTH CARE FIELD

Senator JORDAN. Thank you, Mr. Chairman.

Mr. Secretary, on page 10 of your statement, you talk about the Health Maintenance Organization Option. You go into some detail describing howthis might operate. You say payment to these organizations—that is, the health organizations—on a per capita, instead of a straight fee for service basis, provides incentives for early diagnosis and treatment, an important factor in the success that the organizations have had in reducing the incidence and duration of high cost institutional care. We all agree that this is a laudable objective, but are you not making, by this procedure, an unusual demand for increased professional services that are not now available?

Secretary RICHARDSON. Well, Senator, the experience with group practice prepayment plans tends to show that while there may be some greater use of physician services on an outpatient diagnostic basis and in the physician's office, this has the effect of reducing aggregate long-term demand for physicians' services by the group covered. It tends to result in earlier detection and diagnosis of problems that might otherwise require hospitalization, and it also permits the provision of services, including medical and laboratory tests, on an outpatient basis, in cases in which, under other approaches, patients have been hospitalized.

The experience we have certainly suggests an aggregate lower use of hospitalization and a more efficient use of physicians' services. At any rate, this is the concept and the hope.

Senator JORDAN. Preventive care would, in the long run, result in a lower demand on professional services?

Secretary RICHARDSON. Yes, exactly.

Senator JORDAN. All right. Then, on page 14, you do express the need for more doctors, when you say "We are faced with a substantial shortage of physicians in a period of rapidly increasing demand and there may be, therefore, a tendency for fees to rise out of proportion to other economic indices." And you go on to say how you would solve that.

What steps are being recommended by the administration to meet this growing need for more professional people—doctors, nurses, people who work in the health field?

Secretary RICHARDSON. We have a great many programs already in effect and others under consideration. This is perhaps the single

most urgent concern which faces Dr. Roger Egeberg, my Assistant Secretary for Health and Scientific Affairs, and his associates. It is also a concern of the National Institutes of Health and their health manpower training program. We are, I think it is fair to say in brief form, focusing above all on trying to expand the number of our medical schools, increase the number of students taken in by our existing schools and make more efficient use of the time spent by candidates for medical degrees in their medical education. We are encouraging experiments along these lines which are also of great interest to the medical profession itself.

Meanwhile, we are encouraging the use of paramedical personnel wherever possible in order to reduce pressures on the time of the most highly trained participants in providing medical care.

We have programs that are designed to encourage individuals to enter the health professions through the provision of student assistance, and we are hopting to stimulate the interest of potential participants in the paramedical professions by strengthening 2-year and community college training programs in those areas.

Additionally, we have in process measures that are designed to encourage a large number of veterans who have received medical training of some form in military service to remain with the health care field. In short, this is a problem that is receiving a great deal of attention. I am not yet satisfied, because I am not yet sufficiently familiar with it, that it is getting enough attention. But I can assure you that we will be evaluating everything we have in the works now very carefully between now and the next session of Congress, to see what we could do within budgetary limitations to focus more attention on this problem.

Senator JORDAN. If I understand your statement correctly, you are recommending that measures be taken to insure that doctors' fees do not increase higher than the general level of price increases. Is this not a disincentive for more young people to go into the medical profession?

Secretary RICHARDSON. Well, I would hope not, Senator. In the first place, I think the evidence tends to show that the average levels of compensation for doctors provide a very substantial economic reward relative to what other professions provide, and what is proposed here essentially is that so far as the public tax dollar pays for their services, it should not do so on a basis rising any faster than the relative compensation of other professions.

Beyond that, I would hope that the medical profession would continue to attract, among the principal number of its recruits, those who look forward to the satisfaction of providing healing and care itself.

POSSIBLE EFFECTS OF A DEPRESSION ON THE AUTOMATIC ADJUSTMENTS IN BENEFITS

Senator JORDAN. On another matter, if payments are adjusted to escalate as the cost of living rises, what happens if we get into a depression and the cost of living declines?

Secretary RICHARDSON. Well, I trust that we will not have to face an economic downturn of those proportions. But the maximum on

payment of medicare reimbursement is the prevailing charge level for medical services. So if such a situation as you visualize were to develop, the prevailing charges would follow the trend of the general economy, and thus the medicare reimbursement levels would also go down. There is no provision here for assurance that the medical charges go down as fast as——

Senator JORDAN. In other words, we are on an escalator in perpetuity.

Secretary RICHARDSON. It would be easy enough to adjust this language, Senator, to insure that the process involved here, which provides that increases hereafter be permitted only in relation to the overall rise in professional earnings, would work both ways. There no reason in principle why that could not be done.

Senator JORDAN. Do you not think it would give balance to legislation if that were included?

Secretary RICHARDSON. Well, I think it certainly would be symmetrical. I hope it would not imply that we foresaw a downturn to be as equally likely as an upturn.

Senator JORDAN. We had considerable trouble with the notch problem in the family assistance plan. Now, you are suggesting that again on page 20 when you say: "The sudden death loss of medicaid payments when income reaches a specified level—the so-called notch problem—is an unacceptable defect in the current structure of medicaid.

"I can assure you that the Department has given the most serious consideration to these issues," and so on. How far have you gotten toward eliminating those notches in this program?

Secretary RICHARDSON. Well, we think we have been pretty successful in doing that in the relationship between the family assistance plan and our family health insurance program proposal, which is referred to here, but which we will not be able to submit in legislative form until next February, together with the proposals we have made in this context with the food stamp plan and public housing. These, I take it, will be aspects of the family assistance plan on which I would expect to be crossexamined when I reappear next week.

Senator JORDAN. I am sure you will be. My time is up.

The CHAIRMAN. Senator Hansen stepped out of the room briefly.

Do you care to interrogate the Secretary at this time, Senator?

Senator HANSEN. If I may, since I was away, may I just pass my turn for now, Mr. Chairman?

The CHAIRMAN. Senator Talmadge?

APPEAL MECHANISM NEEDED IN SECRETARY'S DENIAL OF CAPITAL EXPENDITURES

Senator TALMADGE. Mr. Secretary, in the medicare and medicaid programs, you have the authority to approve or disapprove reimbursement for capital expenditures. Section 221 of the House bill defines capital expenditures as an expenditure which is not properly chargeable as an expense of operation and maintenance and exceeds $100,000, changes the facility's bed capacity, or substantially changes the facility's service. This section also provides that there shall be no appeal from the Secretary's decision as to reimbursement of capital expenditures.

I can understand why you need the authority to approve or disapprove such large expenditures. Do you not think there should be an appeal mechanism to insure that there is no unjust administrative denial?

Secretary RICHARDSON. I think, Senator, that the proposal we have before you now in effect does provide that there can be review where the Secretary determines—I am referring to page 15 in my testimony—after consultation with the National Advisory Council, that withholding or reducing of reimbursement in a given case would be inconsistent with the effective organization and delivery of health services. In that case, the Secretary would be authorized to make reimbursement without such withholding or reduction.

While the proposal does not specifically provide for an appeal in so many words, it does provide for a review mechanism involving outside advice.

And, of course, there is always the ultimate recourse of appeal to the courts.

Senator TALMADGE. Well, that is your testimony now. But let me read this section of the bill:

> Any person dissatisfied with the determination under the section may request reconsideration by the Secretary up to 6 months after notification. Such determination is not subject to other administrative or judicial review.

Secretary RICHARDSON. Well, I think there is always, of course, an ultimate recourse to the courts in the assertion that——

Senator TALMADGE. Well, this language precludes the court. It says there shall be no judicial review. The only review is by yourself.

Secretary RICHARDSON. I do not know why we have said that there shall be no judicial review when, in effect, there is always an opportunity of going to a Federal court to seek to maintain the proposition that the Secretary has acted arbitrarily or beyond his authority. What this means, in effect, is that there is no judicial review strictly on the administrative basis of determinations made within the scope of the Secretary's discretion. And here, I take it that the rationale was that if a State planning mechanism is in effect and if the determination is made in the first instance on a local or regional basis, subject to review by the State, and if the Secretary then has an opportunity to consider whether or not an exception should be made on the basis of the advice of an outside advisory council, and he concludes that it should not, that the institution has already had comprehensive review of the determination in question, and that to provide specifically for still another review would be excessive.

Senator TALMADGE. Am I to understand, then, from your answer, that you would not object to some form of review?

Secretary RICHARDSON. I would not object to having made clear in the legislation that there is opportunity to go to court to seek to establish that the Secretary has acted arbitrarily or capriciously or beyond the scope of his statutory authority.

Mr. VENEMAN. Senator, I think perhaps a little clarification as to how this procedure actually operates might be helpful because the Secretary's power is not quite as arbitrary as it might appear.

A facility's request must have already been rejected three times before it reaches the Secretary's office.

LIMITATIONS ON COVERAGE OF COSTS UNDER MEDICARE PROGRAM

Senator TALMADGE. And, Mr. Secretary, section 223 of the House bill states that the costs—the payment of the hospital reimbursement under the medicare program—would be limited to the costs actually incurred, excluding therefrom any part of the incurred costs found to be unnecessary in the efficient delivery of needed health services. This appears to be a reasonable provision if hospitals are provided with objective standards which will allow them to determine exactly which costs would be allowed. I know how awfully hard it is to write objective standards which would be applicable across the board. However, I think it is necessary that you establish such standards, either by law or regulation, so the hospitals will know exactly what they can be reimbursed for.

Are you attempting now to write such regulations?

Secretary RICHARDSON. I will have to ask Commissioner Ball to what extent these criteria are actually embodied in regulations.

Mr. BALL. Senator, as you know, the present reimbursement regulations and instructions on what can be included by a hospital or an extended care facility as reimbursable costs are extremely detailed and consist of many, many pages. As regards this new provision, you are quite right that this is a somewhat difficult area, and we would have to do just what you suggest, make absolutely clear how we were expecting to apply this provision. Its objective, as I am sure you realize, Senator, is to say that in the relatively small number of luxury type institutions in the country, medicare will not reimburse for a luxury level of service, and that we would limit the reimbursement to what is considered necessary for health purposes.

POSSIBILITY OF COMBINED SOCIAL SECURITY AND WORKMEN'S COMPENSATION EXCEEDING EMPLOYEE'S WAGES

Senator TALMADGE. I have a question for you, Mr. Ball. Under present law, a disability insurance beneficiary may not receive combined social security and workmen's compensation payments exceeding 80 percent of his former average wages. I understand that something more than 60,000 people, disabled workers and their dependents, now get reduced benefits. If we adopt the House provision, how many people would be affected by this provision and how many would get as much as or more than their previous earnings?

Mr. BALL. Of that 60,000, I am told, Senator, 55,000 now get reduced benefits, and 5,000 have their benefits completely withheld. I do not know whether we have a figure for additional benefits which would be involved as a result of enactment of the provision.

Now, you ask how many would get more than their previous——

Senator TALMADGE. More benefits than their previous earnings, yes.

Mr. BALL. The provision in the House bill is to change the present 80 percent limitation to 100 percent. Thus presumably, the combination of the disability benefit under social security and the workmen's compensation benefit would be limited to past earnings and in no case would it exceed past average earnings. But there would be many—55,000—who would be getting an amount equivalent to their past average earnings.

Senator TALMADGE. All of that would be tax exempt, would it not? So a beneficiary would actually be better off if he did not work, wouldn't he?

Mr. BALL. Yes, I think that is true, Senator. We in the Department and in the administration have reservations, as you know about this provision. This 80 percent limitation was worked out in the Senate Finance Committee several years ago, as you will remember, after a great deal of discussion, and it involves the interrelationship of two programs, as well as the question of incentives. We would prefer that the committee not go along with the House provision and instead ask the current Advisory Council on Social Security to consider this whole matter and make a recommendation.

Senator TALMADGE. I have great sympathy with a disabled person, but I think if you make it more attractive economically not to work than to work, it will be a disincentive to ever return to work. Do you not agree?

Mr. BALL. Yes. I think it is important that benefits not exceed his recent earning capacity. The case was made in the House that what we are talking about here is 100 percent of the average of the recipient's past 5 years of earnings, and that it is not necessarily excessive as compared to what he was earning just before he became disabled. But nevertheless, Senator, I think it is a complicated provision that deserves more study and referral to the Advisory Council might be a very good way of accomplishing that.

Senator TALMADGE. My time has expired. Thank you very much, Mr. Secretary, Mr. Ball.

Secretary RICHARDSON. Thank you, Senator.

The CHAIRMAN. Senator Curtis?

MEDICARE-MEDICAID SECTIONS OF THE BILL IMPOSE INCREASED COSTS ON STATES

Senator CURTIS. Thank you, Mr. Chairman.

Mr. Secretary, I commend you on a very informative statement. I think you have given it continuing attention.

I have here a telegram from the Governor of Nebraska. I shall read it into the record. It will be satisfactory if, my questions in reference to it can be answered for the record.

The telegram is dated May 26, 1960:

I am extremely concerned with the effect H.R. 17550 will have upon Nebraska if it becomes law. Although general tenor of the bill is to raise the level of social security payments, its sections involving medicaid and medicare require great additional expenditures by the State. It will shift financial burden from the Federal to the State. As you know, we in Nebraska are already hard pressed for our tax dollars and this additional requirement for expenditure will have a dire effect on our economy. We estimate that the skilled nursing home section of the bill will cost the State of Nebraska an additional $1,500,000 per year.

May I interpose right there a reminder that Nebraska is a very small State populationwise.

The section limiting funds for institutions for the mentally defective will cost $1 million per year at the Beatrice State Home and $500,000 per year for other mental illness institutions. The savings provision in the bill for more Federal funding for outpatient care will result in only a $45,000 per year savings in State and county funds in Nebraska. Therefore, the net cost of the provisions of this bill will be $2,910,000 per year or $5,820,000 for a biennium. The argument that

these changes will decrease unwarranted hospitalization is without merit. I would appreciate your help in seeing that H.R. 17550 is amended and will happily send State representatives to Washington to testify.

NORBERT T. TIEMANN,
Governor, State of Nebraska.

Now, at this time—I am not suggesting that we try to get a complete answer to the Governor's telegram. I would like to ask you to do this: I would like to have identified in the record by pages those sections of the House bill and of the House committee report that affect each of these points that the Governor has raised; in connection with each one of them, the Department's position on it, whether they favor that particular section of it or not; and also any facts that you wish to add thereto in support of your position or in answer to Governor Tiemann.

Secretary RICHARDSON. Thank you, Senator Curtis. We will be very glad to do that. I can only say by way of general comment at this time that what is involved here is an effort on the part of the administration, as I have testified in my previous statement to create a greater degree of incentive to use lower cost facilities. This, of course, is particularly true with respect to the relationship between skilled nursing homes and the types of nursing homes which have lower relative component of medical care and, therefore, a lower cost.

Also involved here is the part of title XIX which brought about some assumption by the Federal Government of costs heretofore borne entirely by the States for the long-term hospitalization of people in mental hospitals and tuberculosis hospitals. I think what is reflected in these amendments is the judgment that the result has been to overshift costs to the Federal Government.

So what basically we have proposed is a corrective, economy measure. We will need to go further, too, into the question of the costs cited by the Governor of Nebraska. We have a tabulation here of the cost by States, and of distribution by States of the reduction in Federal participation in medicaid as a direct result of the principal section involved here, which is section 225 of the House bill. This shows the cost to Nebraska as only $200,000. So we will need to take a look at the data on which he bases these estimates.

We will, in addition, furnish for the record and to you personally, Senator, the references to the bill and the House report.

Senator CURTIS. Thank you.

(The Department subsequently supplied the following information:)

ESTABLISHMENT OF DIRECTIVES FOR STATES TO EMPHASIZE OUTPATIENT CARE UNDER MEDICAID PROGRAMS

The Section Senator Curtis mentioned and to which Governor Norbert T. Tiemann of Nebraska referred in his telegram is section 225, an administration proposal to provide financial incentives to encourage States to emphasize outpatient care under Medicaid programs. In the printed bill, 17550 this Section can be found on pages 83-87. The House Ways and Means Committee Report on H.R. 17550 discusses Section 225 on pages 8, 38-39, and 123-124.

The Department strongly urges the adoption of Section 225. The proposed amendment reflects, in part, the judgment that there has been excessive shifting under existing provisions of Title XIX of costs from the States to the Federal Government particularly with respect to long-term hospitalization in mental and tuberculosis hospitals.

Section 225 will improve the utilization of services under the Medicaid program and encourage more effective and lower cost patterns of service. The present law has a uniform Federal matching percentage applied to all forms of health services covered under the State Medicaid plan. In order to encourage States to make more efficient use of health services, the Department wants to create incentives to encourage outpatient services and disincentives for long stays in institutional settings. Specifically, this proposal provides for: (1) an increase in Federal matching percentage by 25 percent for outpatient hospital services, clinic services and home health services; (2) a decrease in the Federal percentage by one-third after the first 60 days of care (in a fiscal year) in a general or TB hospital; (3) a reduction in the Federal percentage by one-third after the first 90 days of care in a skilled nursing home; (4) a decrease in Federal matching by one-third after 90 days of care in a mental hospital and provision for no Federal matching after an additional 275 days of such care during an individual's lifetime; and (5) authority for the Secretary to compute a reasonable cost differential for reimbursement purposes between skilled nursing homes and intermediate care facilities.

The Department has proposed these changes in order to encourage more effective utilization of limited facilities and lower cost patterns of service. To achieve these goals we are proposing increased Federal matching for outpatient, clinic and home health services to encourage the States to provide early diagnosis and treatment of illness, preventive services and alternatives to institutional care and thereby reduce the need for the use of inpatient services.

Our proposed limitations on the length of stay in general and TB hospitals are designed to encourage the transfer of patients to less expensive facilities. They reflect the assumption that treatment in acute institutions is generally of short duration, rarely exceeding 60 days.

Our recommended reduction in matching for skilled nursing homes will encourage, whenever appropriate, early transfer of patients to alternative and lower cost facilities (such as intermediate care facilities). The provision granting authority to the Secretary to compute for reimbursement purposes a reasonable cost differential between cost of skilled nursing home services and cost of intermediate care facilities will assure that supporting care in these institutions results in decreased costs. These provisions reflect the Department's concern that many patients remain in skilled nursing homes longer than necessary, and that as a result program costs are unnecessarily increasing.

Our proposed limitations on the length of stay in mental institutions reflect the assumption that medical treatment of mental disease inpatients generally does not exceed three months, and for patients over 65 rarely continues beyond one year.

AUTOMATIC PROVISIONS IN THE BILL

Senator CURTIS. Now, in reference to your statement concerning the automatic increase in benefits, I favor an automatic increase in benefits. I think it is a good idea. Will that increase be brought about by a percentage increase?

Secretary RICHARDSON. You mean in the withholding rates?

Senator CURTIS. Yes.

Secretary RICHARDSON. No. It would be financed entirely——

Senator CURTIS. No, no, not financed. Will it be triggered by an automatic——

Secretary RICHARDSON. Oh, by the Consumer Price Index?

Senator CURTIS. No, I have not stated it correctly. How do you tabulate the increase? Is it a percentage increase? Will social security benefits, when this is triggered, go up, say 3 percent or 5 percent?

Secretary RICHARDSON. Yes.

Senator CURTIS. Or will it be in straight dollars?

Secretary RICHARDSON. No, it will be a percentage increase. If the Consumer Price Index rose in a given year by 3 percent, then an across-the-board increase in benefits of 3 percent would follow. If it rose by 4 percent in a year, then the across-the-board increase would be 4 percent. If in a given year, it rose less than 3 percent, there would

be no across-the-board increase in that year. But suppose it rose by 2 percent in 1974 and by 2 percent again in 1975. Then, effective for January, 1976, there would be an across-the-board increase of 4 percent.

WAGE BASE INCREASE

Senator CURTIS. Now, the increase in the wage base would work similarly?

Secretary RICHARDSON. It would be related to increases in average wages.

Senator CURTIS. I understand that, yes.

Secretary RICHARDSON. But instead of going into effect on an annual basis, the adjustment would be made no more often than every 2 years.

Senator CURTIS. And the same percentage——

Mr. VENEMAN. Senator, it would be in proportion to the increase in earnings of workers who are covered under social security.

Senator CURTIS. Now, that will bring an increased benefit to those who are above the existing wage rate base?

Secretary RICHARDSON. In effect, it would. The bill proposes an increase of the wage base to $9,000. The next increase that would take place under the proposed automatic increase provision would be to $9,600 when the average wages of covered workers had risen enough to require such an increase.

Senator CURTIS. Now, in applying the formula to determine someone's benefit, the amount of the covered wage is an important factor, is it not?

Secretary RICHARDSON. Yes, it is.

Senator CURTIS. So when you increase the wage base, even though there is a time lag, you increase the benefits for those higher paid workers who are affected by the increase in wage base, do you not?

Secretary RICHARDSON. Yes.

Senator CURTIS. So as the House has written their bill, as these two automatic provisions apply, the higher paid will get two automatic raises—one of them; there is a considerable time lag—and the lower paid, those, say, under the present ceiling now, they will get one automatic increase?

Secretary RICHARDSON. The difference is in the kind of increase. The rise in the Consumer Price Index would bring about an increase correlative with the cost-of-living increase itself for all benefits at all levels. The rise in the average wage level would, in effect, permit a higher maximum benefit related to the increase in the wage level. When an individual eventually retires he would get a higher benefit related to the higher earnings on which he contributed. So he would be credited, in effect, during his working lifetime, with a larger year-by-year contribution to the system, and his ultimate benefits would be based on his higher earnings. And indeed, we think that this is a very desirable feature of the automatic provisions in the bill because it would in effect assure younger workers now covered by the system that their ultimate benefits will be increased in proportion to the increase in their covered wages.

Senator CURTIS. I am merely at this time asking for the mathematics. I am not objecting to them.

FORMULA FOR DETERMINING SIZE OF SOCIAL SECURITY PRIMARY BENEFIT

Briefly, what is the formula for determining the size of the social security primary benefit now?

Secretary RICHARDSON. I think I had better ask Commissioner Ball to answer that, Senator.

Mr. BALL. Senator, as you know, the amount of primary insurance benefits is related to the average monthly earnings, which are defined in a rather detailed way in the law. Then, for each average monthly wage there is a primary insurance amount shown in a table in the law. If you were to write the table as a formula showing the relationship of the benefit to the average wage at each benefit level, you would have a very complicated formula.

In the present law, Senator, the primary benefit is approximately 81.83 percent of the first $110, plus 29.76 percent of the next $290, plus 27.81 percent of the next $150, plus 32.69 percent of the next $100. As you can well see from those figures, the table was not derived in terms of a formula. It is the result of various percentage increases that the Congress has voted on top of a formula that was in effect a long time ago.

Senator CURTIS. Mr. Chairman, my time is up, but I would like just to ask two brief questions so these figures will connect.

DETERMINING AVERAGE COVERED WAGE

In determining the average covered wage, state that as briefly as you can, how it is done.

Mr. BALL. For almost all workers under the program now, the average is arrived at by taking earnings from 1950 up to the year—for men—in which the beneficiary attained age 65, died, or became disabled, and then dropping out the 5 years of lowest earnings. If he has earnings in a year after age 65 and they are higher than earnings in an earlier year, he can substitute the earnings of the higher year in computing the average.

Now, for women, the provision is the same except that the average is from 1950 up to the year in which she becomes 62. We are proposing to change that, you know, Senator, so the computation will be the same for men and women—up to age 62.

Senator CURTIS. Equal rights for men?

Mr. BALL. Yes.

Senator CURTIS. I am for that.

INCREASE IN MINIMUM BENEFIT

My last question is how does this automatic increase affect the minimum benefit?

Mr. BALL. The minimum just rises in the same proportion as all other benefits. I mean that if the increase in the Consumer Price Index called for an increase of 3 percent, the minimum benefit would go up 3 percent; if it called for an increase of 5 percent, the minimum benefit would go up 5 percent. We have no recommendation in this provision for anything special to be done to the minimum benefit.

Senator CURTIS. Does the House increase the minimum?

Mr. BALL. It applies the 5-percent across-the-board increase to the present minimum. There is no increase in the minimum beyond that.

Senator CURTIS. That is all.

I thank you, Mr. Chairman.

The CHAIRMAN. Senator Bennett?

UTILIZATION REVIEW REQUIREMENTS

Senator BENNETT. Thank you, Mr. Chairman.

I appreciate your reference on page 17 to the program we are trying to work out as a recommendation for a new system of utilization review. I realize that any questions about that idea are at the moment premature. But I would appreciate it if for the record, so that we and the staff may have the information as we try to develop our alternative, would you describe exactly what utilization review requirements are now applicable to physicians, hospitals, nursing homes, and home health agencies, and whether or not you have added any new requirements since you testified here in February? We would like to have this for the record.

Secretary RICHARDSON. We will be very glad to do that, Senator.

(Information supplied at this point follows. Hearing continues on page 86.)

UTILIZATION REVIEW REQUIREMENTS APPLICABLE TO PHYSICIANS, HOSPITALS, NURSING HOMES, AND HOME HEALTH AGENCIES

TITLE XVIII

With respect to physicians' services, Title XVIII of the Social Security Act states that one of the functions of carriers will be utilization review. The law requires carriers to assist providers of services in the development of procedures relating to utilization practices, to make studies of the effectiveness of such procedures and methods for their improvement, to assist in the application of safeguards against unnecessary utilization of services, and to provide procedures for and assist in arranging the establishment of groups outside hospitals to make reviews of utilization.

Under the current contract, carriers are required to establish methods for identifying utilization patterns, and to institute utilization safeguards to assure that payments made are for covered services which are medically necessary, adjusting or denying the claim if the services are not medically necessary or if the claim improperly reflects the services rendered or the amount charged. In order to implement this requirement, carriers are required to have available the services of a duly licensed medical practitioner.

Since we testified in February, additional instructions have been issued to carriers to establish in their claims processing systems prepayment and postpayment computer controls to detect the possible overutilization of medical services. Prepayment controls would reject for further analysis claims where services exceeded a carrier-established parameter; postpayments controls would identify physicians with unusual patterns of practice, whose claims would then be flagged for additional review prior to disposition. These controls were instituted effective July 1, 1970.

Carriers are also required to establish a quality control system. One aspect of this system is a carrier review of the various segments of its claims process. In reviewing the claims process, carriers are to review their utilization control, looking at the guidelines themselves, the methods employed, and the use made of them by the claims processors. Carriers will also conduct a postpayment audit of cases. This involves taking a random sample of completed cases and having a quality control check made of all the actions taken on the claim, including the application of utilization safeguards. The third part of the quality review system is the external audit. The purpose of this is to verify that the services alleged on the

claims form were rendered, that the charges shown were those agreed on between the patient and physician, and that payment was received by the proper party. This audit is conducted by contacting the patient or physician, as appropriate, either by mail, in person, or by telephone.

With respect to hospitals and extended care facilities, the law establishes as a condition of participation that they have in effect a utilization review plan. This plan must apply to at least all Medicare beneficiaries in the facility and must provide for a properly established committee which includes at least two physicians, to conduct two types of case reviews. In one type, cases selected on a sample or other basis are to be reviewed with respect to medical necessity for admissions, lengths of stays, and the professional services furnished in the institutions. These reviews are intended to identify patterns that reflect the effectiveness of the facility in delivering health care services. A second type applies only to those cases which reach an extended duration point, which point must be defined each provider's utilization review plan. In these reviews the utilization review committee determines whether, as of the day of the review, continued stay is required in the institution. On the basis of this finding, the committee may terminate covered care after proper notification to the institution, the beneficiary, and the attending physician. Regulations promulgated under this title give further details on the conduct of the utilization review programs and the objectives of the reviews. We have also issued supplemental instructions to clarify the roles of State agencies and intermediaries in administering the utilization review provisions. Additional instructions provide guidelines for determining coverage of care in extended care facilities and assure payment to facilities having an effective utilization review mechanism and where the facility and the admitting physicians demonstrate their understanding of what constitutes covered care.

We are developing comparative utilization data on all short-stay hospitals participating in the Medicare program. These data reflect the average length of stays of Medicare beneficiaries in individual hospitals. For comparison purposes, an adjusted length of stay has been derived to allow for certain variables affecting lengths of stays over which the hospital has no control. This adjusted figure is being used as an indicator of the utilization of a facility. State agencies and intermediaries, as well as the providers, will use these data in their reviews and analyses of Medicare utilization.

Home health benefits can be paid under either part A or part B. Under both parts, the law requires that a plan of treatment be established by a physician and that this plan of treatment be periodically updated and reviewed. In addition, a physician must certify that a patient is confined to his home. Besides the requirement set forth in the law, the administration has issued instructions to its intermediaries defining skilled nursing care as it applies to the home health benefit. Instructions have also been issued to intermediaries on how to distinguish covered home health services as opposed to noncovered home health services.

Utilization Review of Care and Services Under Title XIX

Requirements for utilization review, as they now exist, are set forth in section 1902(a)(30) of the Social Security Act (as amended). That section stipulates that State plans must include safeguards necessary to prevent unnecessary utilization of, and payment for, care and services available under the plan. These payments cannot exceed reasonable charges.

SRS regulations to implement this section were published in the Federal Register on March 4, 1969, a copy of which is attached. No new requirements on utilization review have been instituted since that time.

[From the Federal Register, Mar. 4, 1969]

Title 45—PUBLIC WELFARE

Chapter II—Social and Rehabilitation Service (Assistance Programs), Department of Health, Education, and Welfare

Part 250—Administration of medical assistance programs

SUBPART A—GENERAL ADMINISTRATION

Utilization review of care and services

Interim Policy Statement No. 5 setting forth regulations to implement the provisions of section 1902(a)(30) of the Social Security Act as amended, with respect

to utilization review of services provided under title XIX of the act, was published in the Federal Register on July 17, 1968 (33 F.R. 10232).

Suggestions made in response to that publication were (1) utilization review should be restricted to institutions, (2) existing peer review mechanisms should be used, (3) committee organization might not be feasible in small institutions, (4) both encouragement and opposition to delegation of hospital and skilled nursing home utilization review activities to title XVIII agencies. The Department's responses to the suggestions are, respectively, (1) utilization review is required by law for all services, (2) agreement that existing peer review mechanisms should be used to the extent possible, (3) committee size and composition is not fixed, so use of committees is considered feasible, (4) the Federal Government cannot demand, in a State-administered program, that delegation be made, but delegation is encouraged to avoid duplication of effort and expense and to achieve Departmental uniformity. Changes to reflect items (2) and (4), and to provide a statement on Federal financial participation, have been made.

Accordingly, such regulations as so amended are hereby codified as Part 250—Subpart A, § 250.20 of Chapter II of Title 45 of the Code of Federal Regulations as set forth below.

§ 250.20. Utilization review of care and services.

(a) *State plan requirements.* A State plan for medical assistance under title XIX of the Social Security Act must:

(1) Provide that a process(es) of utilization review is established for each item of care or service listed in section 1905(a) of the Act that is included in the State's medical assistance program.

(i) The agency(ies) which monitors utilization review activities on inpatient hospital and extended care services under title XVIII of the Act may be designated by the single State agency to monitor those activities similarly for inpatient hospital and skilled nursing home services under title XIX. Such delegation may incorporate the monitoring of utilization review activities in provider institutions not participating under the XVIII. If such an arrangement is secured, the single State agency and the agency(ies) to which delegation is made should work closely together (in addition to any formal written agreement) in order to accommodate their mutual utilization review requirements. Such delegation is encouraged to avoid duplication of effort and expense and to achieve uniformity of utilization review requirements and methods. Such common effort is a means of striving for efficiency and economy in administration.

(ii) For all items of care or service for which utilization review is not delegated under subdivision (i) of this subparagraph, the medical assistance unit of the single State agency will perform utilization reviews itself and/or monitor those utilization reviews which may be performed by agents for the State government, or by agencies of local governments, or by individual provider organizations or institutions as in subparagraph (2)(i). Review of professional services through existing peer review mechanism is encouraged to the fullest extent possible.

(iii) Utilization review requirements for providers of inpatient hospital and extended care services under title XVIII will be considered to meet the utilization review requirements for providers of inpatient hospital and skilled nursing home services under title XIX, except as in subparagraph (2)(i)(*b*).

(2) Provide that the medical assistance unit of the single State agency is responsible for all utilization review plans and activities under the medical assistance program. If utilization review is not delegated as in subparagraph (1)(i) of this section, the following will be met in each utilization review plan:

(i) The activities of utilization review will be performed by a utilization review committee with representation appropriate to the medical care or service to be reviewed. Determination of committee composition and selection of committee membership will be made at the point where utilization review will be performed.

(*a*) A professional practitioner, e.g., physician, dentist, optometrist, etc., may not review cases in which he is the attending practitioner or in which he has (or has had) significant professional responsibility.

(b) The committee may include no member who has an ownership interest in the facility under review, except in the case of committees which conduct review on both title XVIII and XIX patients.

(ii) Utilization review will be based on a statistically significant sample or other reasonable basis of pertinent data as determined appropriate to the medical care or service under scrutiny; for example, admissions, duration of stays, number of visits, number and kind of prescriptions, relation of tests or medications to diagnosis, etc. While some services may lend themselves to review both concurrently with and subsequent to the rendering of care (e.g. institutional care), other services may be best reviewed only subsequently. Since, for many provider services, the measurements will apply to patterns of care rather than to individual episodes of care and because of the difficulties inherent in evaluating medical necessity, a postaudit procedure will be employed. Utilization review will be made within the context of medical necessity (including overutilization and underutilization and appropriateness of care rendered) and availability of facilities and services.

(iii) The utilization review process will not be limited to isolated cases, but will be considered in the context of overall utilization within an institution, or in a service area, or in a provider's total title XIX workload, etc., as appropriate to the medical care or service under scrutiny.

(iv) A utilization review plan will be developed by the agency, organization, or institution which determines the committee composition as in subparagraph (2)(i), Each plan developed by an agent, organization, or institution other than the single State agency will be submitted to the medical assistance unit of the single State agency for approval. In all cases a utilization review plan will describe:

(a) Objectives.
(b) Authority, responsibility, accountability.
(c) Organization.
(1) Composition of committee and subgroups, if any.
(2) Frequency of meetings.
(3) Format and/or description of records and minutes.
(d) Definitions.
(e) Data.
(1) Methods of case selection.
(2) Relationship of utilization review to title XIX claims administration and medical assistance unit of the single State agency.
(f) Arrangements for committee reports, recommendations, and followup.
(g) Responsibilities of related administrative staff in support of utilization review.

(v) A utilization review committee will maintain appropriate records and prepare regular reports of its activities and findings. The State Medical Advisory Committee will advise the responsible medical assistance unit of any recommendations or requirements on utilization review, consolidated reporting, etc. The medical assistance unit of the single State agency will maintain surveillance of the committees' activities and provide appropriate consultation to committees in order to insure adequate functioning.

(b) *Federal financial participation.* Federal financial participation is available for the costs of utilization review, in accordance with the conditions, and at the rates, applicable under title XIX.

(Sec. 1102, 49 Stat. 647, 42 U.S.C. 1302)

Effective date. The regulations in this section are effective on the date of their publication in the Federal Register.

Dated: January 18, 1969.

MARY E. SWITZER,
Administrator, Social and Rehabilitation Service.

Approved: January 18, 1969.

WILBUR J. COHEN, *Secretary.*

[F.R. Doc. 69-2599; Filed, Mar. 3, 1969; 8:48 a.m.]

Senator BENNETT. Also for the record I would like to know exactly what the House bill does with respect to changes in utilization review.

Apparently, under the House bill, there are provisions for utilization review teams to be set up by the Secretary and we are particularly anxious to have some more information about what it would be proposed that these teams do, how they would operate, whether they would function in more than a proforma manner, whether they would be expected regularly to review all practitioner profiles for unusual patterns, or simply respond to patient complaint. This also would be for the record.

Secretary RICHARDSON. We will be glad to do that, Senator. I think we certainly, as my testimony indicates, are thinking along parallel lines——

Senator BENNETT. I am sure we are.

Secretary RICHARDSON (continuing). On the utilization of physicans and other professionals to look at the levels and quality of service, and we certainly want to cooperate with you and the committee in strengthening and improving these elements of the law.

Senator BENNETT. Well, in your testimony, you say it would be impossible, for example, and I believe in many ways undesirable, to supplement entirely the present medicare administrative system of conducting utilization reviews and to substitute a new review organization. I agree with you, but we are anxious to know how the new idea can be meshed into the old so that we can come out with a satisfactory operating setup.

Secretary RICHARDSON. I think this is a very important point. Senator, and we have started to work with the committee staff on it. We will be glad to continue to do so to see how the existing utilization review procedures can be meshed into the kind of approach which has been proposed in your bill.

(Information supplied by the Department follows:)

1. Exactly what does the House bill do with respect to utilization review and audit activities?

The House-passed provision which provides authority to terminate payments to suppliers of services does not replace or supersede the utilization review or audit activities now in operation under the Medicare program. What this provision does is to create an additional formalized review procedure that is designed to supplement and enhance present review and audit activities.

Under this provision, the Secretary would be given authority to terminate payments under the Medicare program (parts A and B) for services rendered by any supplier of health and medical services found to be guilty of program abuses. The situations for which termination of payment could be made include overcharging, furnishing excessive, inferior, or harmful services, or making false statements to obtain payment. Also, there would be no Federal financial participation in any expenditure under titles V and XIX by the State with respect to services furnished by a supplier to whom the Secretary would not make Medicare payments.

In cases involving the submittal of false statements, the Secretary would make the decision to terminate payment without consultation with any group. However, the Secretary's decision to terminate payment in cases involving overcharging or cases involving services which either substantially exceeded the patient's needs or were grossly inferior or harmful to the patient would be contingent upon the concurrence of a program review team. The Secretary would establish one or more program review teams in each State following consultation with groups representing consumers of health services, State and local professional societies, and the appropriate intermediaries and carriers utilized in administration of title XVIII benefits. Membership in the program review teams would consist of physicians, other professional personnel in the health care field, and consumer representatives.

In addition to reviewing individual cases, the program review team would be responsible for reviewing and reporting on statistical data on program utilization (which the Secretary would periodically provide), as well as the evidence regarding

program abuse. While the entire team would perform this function and would participate in review of cases involving overcharging, only the professional members of the team would review cases involving the furnishing of excessive, inferior, or harmful services.

The House-passed bill also contains a provision which provides authority to discontinue Medicare payment where a hospital or extended care facility admission has been determined by a utilization review committee to be medically unnecessary

2. What is there to assure that program review teams will function in more than pro forma fashion?

We believe that the composition of the program review teams will do much to assure that the teams function in a conscientious and diligent manner. The professionals are charged with a great deal of responsibility under this provision because we believe that only members of the professional community can actually review the questionable practices of other professionals. Physicians have sought this additional responsibility and we believe that they will want to perform it well.

We also believe that the presence of consumer representatives on the team will do much to assure the team's success. Their involvement as community representatives should help to make this whole activity an educational one rather than being strictly punitive in nature.

3. Will the teams be expected to regularly review all individual practitioner profiles for unusual patterns or would they merely respond to patient complaints?

It is not intended that the program review teams would review all individual practitioner profiles. It seems to us at the present time that it would be infeasible administratively to require the program review teams to review all individual practitioner profiles.

In addition to complaints from patients the program review teams would respond to complaints from a variety of sources. For example, questionable cases may be brought to the attention of the review teams by carriers and intermediaries, by health care institutions, and by the Government itself. We have an increasing capability through our own ongoing statistical programs to identify aberrant patterns and practices. For example, we have instituted a statistical program with our carriers under which they identify payments to physicians in excess of $25,000.

Review of questionable cases identified through statistical or other means seems to us a more productive function for review teams to perform than review of all practitioner profiles.

DIFFICULTY OF SMALL COMMUNITY HOSPITALS

Senator BENNETT. Thank you.

I ran into another practical problem today: Small community hospitals, whose rate of vacancy is probably larger than that of the big hospitals in the big cities, are complaining that on the basis of your current reimbursement, they cannot recover their costs because while theoretically they can recover what they actually cost, the cost of maintaining a small community hospital and having it available is not taken into consideration. They are wondering whether you should be considering any kind of a special consideration for hospitals of this kind, whether there should be any variation from your rule that they may only recover their actual "out-of-pocket costs." The reason being the cost of maintaining a facility for the small community is more of a burden than it is to maintain a large hospital with a continuing demand for its services.

Secretary RICHARDSON. Well, I would have thought, Senator, that our present determinations of cost did include overhead, incorporating the ammortization and maintenance of standby facilities required in the community. We will have to take a look at this, because as I say, my impression is that these are legitimate elements of cost right now.

Senator BENNETT. There is a man coming in to see me this week who claims he is actually losing out of pocket 10 percent of his operating cost.

Secretary RICHARDSON. What is at issue here may be a question of disagreement over how the costs are measured rather than on the principle of whether or not they should be covered. We will be glad to talk with this gentleman.

Senator BENNETT. We will probably be back with you to talk about this problem. I recognize how difficult it is to try to apply a blanket system of measurement to the big ones and the little ones and to the efficient ones and the inefficient.

Secretary RICHARDSON. Of course, this is an important question as it applies, as my testimony indicates, to determining whether additional facilities should be constructed. The recognition of the existence of underutilization of present facilities through the planning mechanisms which the bill would establish is one of the things we want to encourage in order to prevent paying for unneeded facilities in the future. That is not to say that facilities are unneeded when they exist for standby reasons. But still, we want to be sure that a genuine standby need exists, and that we are not dealing with a situation in which somebody simply felt that his town wanted a bigger hospital than the one in a nearby city.

Senator BENNETT. Well, I come from a State where more than 80 percent of its people live in five contiguous counties and those counties take up probably 10 percent of the total land area of the State. So if the people in the other 90 percent of the land area of the State are go be served, and the State is 450 miles long and 250 miles wide, we have to encourage the establishment of local community hospitals out in that area. I think it is natural that they would face a problem of underutilization.

Secretary RICHARDSON. I think this is true, Senator. We would be glad to discuss the question with the representative of the hospital when he is here later this week.

Senator BENNETT. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Anderson has some questions.

PAYMENTS TO PHYSICIANS

Senator ANDERSON. Under the House bill, medicare stops payment 3 days after a hospital committee, in a sample review of admissions, determines that hospitalization is no longer necessary. Do you endorse this feature of the House bill?

Secretary RICHARDSON. Yes, we do, Senator.

Senator ANDERSON. Do you not think that we should also stop payment to a physician for hospital services to that patient 3 days after such a determination?

Secretary RICHARDSON. We do have provision for the cutoff of payments to physicians who abuse the system by making excessive services or charges. I am not sure what the timing provision of this is.

Mr. BALL. Mr. Secretary, I wonder if I could supplement that just a little.

I think it does not follow automatically, Senator Anderson, that because the individual does not need to be in the hospital, that the physician's services to the individual are unnecessary. He might need those services, you see, if he were in his own home or in an extended care facility. So I do not think you could automatically stop payment

for physician's services under those circumstances. But present law provides that we pay only for necessary medical services. If the physician is giving him services that he should not have or does not need, then he should not be reimbursed under present law.

Senator ANDERSON. The House bill authorizes the Secretary to exclude certain hospital and extended care costs from reimbursement to the extent they are excessive in relation to the cost of comparable care in the same area. Why should not the limitation on what's reasonable also include a limitation on the percentage increase in cost from one year to the next that is acceptable with respect to comparable facilities, providing comparable services, in the same geographic or medical service area?

I might point out that that is a feature in my bill, S. 1195.

Secretary RICHARDSON. I certainly think this is a sound principle, Senator. The exclusion of costs that are excessive on a comparable basis should be reviewed from year to year to redetermine what costs are reasonable and comparable. I would see no reason in principle why this could not be made explicit or at least understood.

Mr. BALL. I would like to study your exact provision a little further, Senator. Does it allow for leeway in the percentage increase if the program of the hospital has expanded so that you are not stuck with just a percentage increase? If it does, I think it moves very much in the direction that we are thinking of when we talk about moving toward a prospective rate approach.

Secretary RICHARDSON. It does that, I believe, and of course, if the focus is kept on comparability, then it would automatically take into account improvements in the quality of service, because they would simply be held up against a new standard of comparison.

At any rate, we would certainly be glad to look more closely at this proposal to see whether and how it can be reflected in the legislation.

PRESENT CARRIER PERFORMANCE UNDER MEDICARE

Senator ANDERSON. We are concerned as you are with carrier performance under medicare. What has been your specific experience with the thoroughness and quality of carrier followup on your request for a detailed review of payments of $25,000 or more to physicians with unusual payments characteristics? This is the group about which the committee inquired last year.

Secretary RICHARDSON. With your permission, Senator, I would like to ask Commissioner Ball to answer that.

Mr. BALL. Senator, I think I should begin by making the obvious point that the carrier performance is uneven. Some carriers have done a much better job than others. But taking the group as a whole in relation to the specific project of following up on the $25,000 group. I would say that we have not been satisfied, and that we have had to keep after them, reexamine their performance, and follow up, and we are still doing that in some instances. If you would like a more detailed statement on this whole process for the record, we would be glad to furnish it.

Senator ANDERSON. For the record, that would be fine.

(Information supplied follows:)

On April 8, 1970, a detailed report on the effectiveness of the carriers' performances on their review of payments to physicians whose total payments were un-

usually high was furnished to the Senate Finance Committee Staff. In this report the Bureau of Health Insurance of the Social Security Administration evaluated the carriers' performances generally and, as requested by the Committee Staff also evaluated the performance of individual carriers. In making this evaluation the Bureau of Health Insurance considered basically whether the particular carrier handled the project in a positive way and the extent to which this was demonstrated by the actions taken, i.e., prompt replies, suspending payments, determining and recovering overpayments, etc.

Any evaluation of the effectiveness of the carriers' responses to our request for individual reports on the 1328 cases of "higher than usual part B payments" should take into consideration several factors, some of which directly affected certain of the carriers' performances, and others of which help to explain some of the apparent differences in the results.

The 1328 cases which were the subject of this project were identified from the original list of some 4500 billing numbers to which carriers had paid $25,000 or more in 1968 by the application of criteria intended to screen out unusual patterns of practice or billing. The criteria were designed to identify cases in which there were higher than usual numbers of hospital and ECF visits, laboratory tests, injections, or surgery, larger than usual numbers of Medicare patients treated, and higher than usual payments for particular services; reports were requested on all billing numbers to which carriers paid $75,000 or more during 1968.

The total amount of money paid under part B during 1968 to these 1328 billing numbers was almost 100 million dollars. However, investigations revealed that approximately 200 of those numbers are used by two or more physicians. Fifteen carriers account for approximately three-fourths of the 1328 cases and total amount paid. However, the distribution of the 1328 cases both in terms of numbers and amount of payments involved was generally proportionate to the distribution of the part B workload nationally.

The carriers were asked on July 25, 1969, to report their conclusions concerning the propriety of the payments made in each of the identified cases, and to support those conclusions with an explanation of the method of analysis used and the investigative steps taken. As could be expected, the performances of the carriers varied considerably. Some carriers responded promptly with complete information and conclusions supported by facts and good rationale; others responded promptly with reports which were incomplete or inconclusive, but they cooperated thereafter and submitted the additional information or undertook requested additional development; and, finally, still others responded very slowly to our initial request and repeated followups and sent in reports that were not responsive to our requests.

A basic consideration in making an evaluation of carriers' performances is the variance among their actual capabilities to perform this kind of in-depth analysis of payments to physicians. While many of these organizations routinely perform post-payment studies to identify broad aberrant patterns and trends among participating physicians and also do special reviews of claims submitted by identified physicians, no carriers had previously been required to completely document and report their conclusions on a large number of individual cases at one time. Our request placed an added burden on the carriers' personnel and machine capabilities at a time when they were responding to numerous other requests for information which required the use of the same resources. Carrier capabilities also vary in the size and effectiveness of their utilization review departments, availability of medical staff or consultants, computer capability, and other resources necessary to achieve the kinds of results envisioned by our requests. For example, some carriers already had personnel trained to review claims against provider records and to discuss questionable cases with physicians and provider personnel, while others did not. Some carriers had the capability to quickly retrieve recorded part B charge and payment information needed for the investigations while others could not readily compile the information.

A lack of prior experience with this type of investigation makes exact evaluation of the carriers' performances, even as a group, exceedingly difficult. However, given all the surrounding facts and circumstances discussed heretofore, such as varying capabilities and cooperation, we have concluded that most of the carriers' performances were adequate, some were good or very good and a few were poor. Based on the importance we had placed on this project we were not satisfied with the large number of performances which we found to be fair or less. As mentioned previously an evaluation of each individual carrier's performance was submitted to the Committee Staff.

Carriers will soon begin their review of the "higher than usual" payments made during calendar year 1969. With the experience gained from last year, we

anticipate that this year's review and subsequent carrier reviews, will be more effective in eliminating payment for excessive medical services.

PROPORTION OF CASH BENEFIT TAXES ALLOCATED TO DISABILITY PROGRAM

Senator ANDERSON. The proportion of social security cash benefit taxes allocated to the disability insurance program has been raised again in the House bill, as it has a number of times before. What's the reason for this?

Secretary RICHARDSON. Again, Senator, I think Commissioner Ball could answer that question better than I.

Mr. BALL. Senator, as far as this year's bill is concerned, the changes are partly related to the fact that the size of the disability insurance fund would increase rapidly. In order to avoid this rapid increase, the bill would move from a fixed percent to a graduated schedule under which the allocation would be lower in the near future and higher in the longrange future than under present law. Nothing in these changes relates to the change in incidence of disability. Some of the earlier-year changes in allocation did relate to that. But you see, the allocation is a percentage of payroll for disability and a percentage of payroll for OASI. Generally, when benefits are increased, the amount that is allocated to the disability fund must be increased. This was done, for example, in the 1969 amendments.

Senator ANDERSON. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Williams?

FINANCING OF BENEFIT INCREASES SEEN ON A PAY-AS-YOU-GO BASIS

Senator WILLIAMS. Mr. Secretary, as I understand this bill, when you take it into consideration with the previous 15-percent across-the-board increase, coupling the two together means that we are adopting a new formula for the financing of social security in that you are now embracing the pay-as-you-go basis. Is that not true?

Secretary RICHARDSON. No, I do not think so, Senator. The 15-percent increase was partly catchup, partly a small increase in real benefits. The 5-percent increase in this bill would go into effect in January 1971, and roughly cover the cost-of-living increase during calendar 1970.

Senator WILLIAMS. Perhaps you misunderstood me. I was not questioning the merits of the proposal. I am just speaking of the mathematic results. Have we not moved, if we approve this bill coupled with the other, are we not approving here a pay-as-you-go basis and abandoning the basis that you build up some type of surplus over the future?

Secretary RICHARDSON. You are referring, I think, Senator, to the deferment of the scheduled rate increases for the financing of the system on the cash benefit side. In that regard we are, in the short run, putting the system more nearly on a pay-as-you-go basis. But I do not understand that we are abandoning the general principle of accumulating a trust fund. And indeed, the scheduled rate increases that are in this bill, or rather, the scheduled provisions applying to rates, cover a deferment of the increase to 4.6 percent only to 1974,

but incorporate an increase to 5 percent in 1975 and one to 5.5 percent in 1980. So the result would still be to build up a very large trust fund before the end of the present century and then continue to build a still larger fund during the early decades of the 21st century. But the general profile of the trust fund buildup has similar characteristics to those in past projections for present law.

Senator WILLIAMS. Well, I am not sure I quite concur in that. I realize that under your projections from 1980 on, you go back to the old formula of accumulated surplus. But between now and then you are on a pay-as-you-go basis. I notice that in 1970, with this increase, your benefit payments are estimated at $33.1 billion, and your income will be $36.6 billion. In 1971, $38.5 billion benefit payments and you had an accumulation of about $1.6 billion, and a contribution of $40.1 billion; and in 1972, it is $42.6 billion contributions, $40.5 in benefit payments; and right on down the line, you are keeping it on just about a pay-as-you-go basis.

Now, whether we call it that or not, that is the mathematical results of the formula you projected at least for the next 10 years. Is that not correct?

Secretary RICHARDSON. Yes; it is true for the next 5 years. It certainly is a move in that direction, Senator.

Senator WILLIAMS. Well, it is not a move, it is just——

Secretary RICHARDSON. There is still a buildup, but it is closer to pay as you go.

Senator WILLIAMS. That is what I am saying, you are pretty much on a pay-as-you-go basis. And the accumulation surpluses after 1980 are largely premised on the hope that Congress between now and then will not raise the benefit to offset those possible surpluses.

Secretary RICHARDSON. Yes, that is true.

Senator WILLIAMS. Which is a rather mild hope.

Secretary RICHARDSON. Well, I have been impressed in the years since I last was confronted in detail with the operation of the Social Security system that the Congress, the Social Security Administration and Department of HEW together have on the whole preserved a feeling toward the system that it should be maintained on a sound fiscal footing. I think this is certainly being done.

Senator WILLIAMS. I am not raising the point of whether we should or should not go on a pay-as-you-go basis. I am just raising the point that this is the mathematical result of this bill coupled with the other bill and that at least for the next 10 years, you are on a pay-as-you-go basis.

HEW TECHNICAL ASSISTANCE TO NEBRASKA IN SETTING UP DRUG PROGRAMS UNDER MEDICAID

In the hearings last July 1 and 2 here, our staff in its report called to the attention of the Secretary that we had recommended that HEW provide technical assistance to the States in setting up the medicaid control programs. The Secretary told us that he was providing such assistance and cited as such specific example the assistance being extended to the State of Nebraska and said he hoped to extend it to other States. On page 428 of those hearings, he included in the record a letter from the Governor of Nebraska acknowledging the

receipt of this technical assistance that was going to help them solve their problem.

(The letter referred to follows:)

Mr. ROBERT H. FINCH,
Secretary, Department of Health, Education, and Welfare,
Washington, D.C.

DEAR MR. SECRETARY: Cooperative effort between the Federal and State levels of government can result in lower costs and better utilization of the tax dollar. A dramatic illustration of this point is the recently completed Drug Utilization and Control Program undertaken by the Nebraska Department of Public Welfare with the assistance and advice of Dr. Bradley Neer of your staff.

Dr. Neer coordinated the development of methodology which has resulted in a considerable degree of control in our Nebraska Title XIX Medicaid Program. The savings because of this assistance is projected to be approximately $500,000 over the next biennium.

We express our appreciation to you, your staff, and particularly to Dr. Neer for this worthwhile effort.

Sincerely,

NORBERT T. TIEMANN, *Governor.*

Senator WILLIAMS. Now, who did you send out there to help on that project and what kind of an operation did he set up and how did it work out?

Secretary RICHARDSON. May I, with your permission, Senator, ask Mr. Howard Newman, who administers that program, to answer the question?

Senator WILLIAMS. Yes.

Mr. NEWMAN. Senator, the employee's name was Dr. Bradley Neer. He was in the Technical Assistance Division of the Administration. He assisted the State in the establishment of its drug program. That was the assignment in which he was——

Senator WILLIAMS. Would you use the microphone, please?

Mr. NEWMAN. The employee's name was Dr. Bradley Neer. He was assigned as a member of the Technical Assistance Division of the Medical Services Administration to work with the State of Nebraska and its welfare department in the establishment of a drug program in the State's medicaid program.

Senator WILLIAMS. How did he go about establishing that and how did it work out? Was it very satisfactory?

Secretary RICHARDSON. I did not realize, Senator, when you talked about providing technical assistance to the State of Nebraska, that you were alluding to the misconduct that was involved——

Senator WILLIAMS. I had not alluded to anything. I am just asking a question. I just wondered. That was cited as a specific example.

Secretary RICHARDSON. The answer is that it was not satisfactory.

Senator WILLIAMS. That was cited as a specific example of how they were going to help the States. This was a test case. I was wondering if you could give us specific results of what he did, how he did it, and how it worked out.

Secretary RICHARDSON. It turned out to be an unfortunate example which did not develop in a way which I am sure had been hoped for both by the Department and by the State of Nebraska. We would be glad to—I am not sure at the moment how far I should go into detail on this.

Senator WILLIAMS. I think we can discuss it. Let's go right ahead and discuss it.

Secretary RICHARDSON. Let me seek the advice of counsel here for just a moment, Senator.

Senator, the problem is that I am just not sure to what extent we would be prejudicing the rights or the reputation of Dr. Neer.

Senator WILLIAMS. Where is Dr. Neer?

Secretary RICHARDSON. What is involved basically is the allegation that he, in collaboration with a Nebraska official, created a fictitious consulting firm to which checks were allegedly made out and cashed by him in Nebraska. There have been no charges filed to date of which we are aware, although we do know that there is an investigation underway involving both this particular former HEW employee and the former welfare director of Nebraska. The former HEW employee who has been mentioned resigned before we became aware of this investigation, and our files on him have been made available to the Department of Justice for appropriate Federal investigation.

Senator WILLIAMS. How much money was involved, if you know?

Secretary RICHARDSON. My understanding is that it was some $80,000.

Senator CURTIS. Will you yield just briefly?

Senator WILLIAMS. Yes.

Senator CURTIS. This Federal investigation and the calling in of the Department of Justice, that was made near the time that I made a written request of the Department for such an investigation; was it not?

Mr. VENEMAN. That is correct, Senator Curtis. The investigation, I think, was instigated by the Department of Justice because of the U.S. attorney's action in the State of Nebraska. During that time, there was an investigation going on within the Department. As you realize, the funds that were involved were primarily State funds, but a Federal employee was allegedly involved, so we had our own investigation going. Subsequently, we turned all of our investigative records over to the Department of Justice and are cooperating with them in every way possible.

Senator WILLIAMS. Where is Dr. Neer now?

Mr. VENEMAN. We have no knowledge of his whereabouts, Senator Williams, and have not had, apparently, since he resigned from the Department. Justice may know.

Senator WILLIAMS. Justice may know? Do they know?

Mr. VENEMAN. I cannot answer that. I have not been a close party to the investigation.

Senator WILLIAMS. What was the background of Dr. Bradley Neer? Had he been with the Department, a long-time employee?

Mr. NEWMAN. He had been with the Department for several years, Senator. He is a veterinarian by training.

Senator WILLIAMS. A veterinarian?

Mr. NEWMAN. Yes.

Senator WILLIAMS. I do not think I have any more questions. [Laughter.]

Seriously, though, my time is up, but I think some explanation should be coming to the committee. I am a little puzzled that you have a veterinarian setting up a program such as we have here. That is rather interesting. All of this case is rather interesting and I would like to have the full details on it.

Secretary RICHARDSON. We will be glad to make the information available to the committee under whatever understandings are appropriate in protection of the rights of the individual involved.

Senator WILLIAMS. You might furnish the committee a list of how many more veterinarians you have in this program.

Would you do that at this point in the record?

Secretary RICHARDSON. I will be glad to do that, Senator. I hope the answer is none.

(The Department subsequently informed the committee that there were no veterinarians in the employ of the Medical Services Administration.)

COMMITTEE ON FINANCE STAFF RECOMMENDATIONS IN THE HEALTH CARE FIELD

The CHAIRMAN. I would like at this point to get just one matter straight if I can, and then go into the other matters tomorrow. There are members of this committee who are interested in debating and voting on what's on the floor this afternoon, so we will have to come back tomorrow.

As you know, Mr. Secretary, this bill and the family assistance bill combined involve an increase in spending of about $7.5 billion a year the first year they will be in full operation. That is a great deal of money. This committee feels that we ought to see to it that the Government gets value recieved for every dollar of that money that is possible. We believe that is our duty and we are going to try to make these the best bills we can at the time we report both this one and the other one.

Now, our staff started this Congress by doing a lot of work on the fact that the costs of medicare greatly exceeded all the estimates. Our staff made about a hundred recommendations and suggestions to us on ways that they thought savings could be achieved. Quite a few of those suggestions are in the bill that is now before us, incorporated by the House. I understand that members of that Ways and Means Committee had copies of our staff report and recommendations with them when they were considering that measure. Chairman Mills pointed out in his statement on this measure that the investigation done on this side was very helpful in the modifications and changes that they recommended, hoping to save quite a bit of money.

SENATOR RUSSELL B. LONG'S DRUG AMENDMENT

One matter that this Senator initiated before we even started the investigation was a proposal to try to save at least $40 million a year on what we are paying for drugs. That is a big industry involved here, a multibillion dollar industry. I can understand how they would certainly oppose something that is going to reduce their income and try to demonstrate that it will not work if they can.

One thing that came to my attention as the fact that they apparently persuaded Secretary Finch that the cost of administering that proposal would be about $111 million the first year, declining thereafter. Now, we have done some studying of that industry presen-

tation and our conclusion is that it would not cost anything like that. It would cost about $7.7 million to administer in the first year and about $4.6 million annually thereafter, which is a great deal of difference, a difference of administrative costs of, once in full operation, less than $5 million, compared to an industry estimate of $111 million.

I do not know that you have had occasion to study that, Mr. Secretary. Have you looked into that matter?

Secretary RICHARDSON. Not sufficiently, Mr. Chairman. I am aware of it. I am interested in it and I do want to follow it up.

The CHAIRMAN. I am going to ask that some of the staff just present to you a memo that I had prepared, showing why that $111 million figure is completely fallacious, and I will ask that that be made a part of the record.

(The memo referred to follows:)

ADMINISTRATIVE COSTS OF SENATOR LONG'S DRUG AMENDMENT

Secretary Gardner testified in 1967 that H.E.W. estimated initial administrative costs of about $111 million first year and less thereafter for your amendment. That extraordinarily high figure was based upon a misunderstanding by H.E.W. (later corrected) as to where the burden of proof lay for determining whether a particular drug product should be included in the Formulary. The Department assumed that every single product would have to be tested by H.E.W. to assure that it met official standards and that it was "clinically equivalent."

It was subsequently explained to them that under the Long Amendment, the intent was that the burden of proof and expense was on the manufacturer to present satisfactory evidence to the Formularly Committee that his particular drug product had "distinct, demonstrated, therapeutic" advantages over other products of that same drug which met all official standards. Further, that, in the absence of scientific evidence to the contrary products meeting official standards would be assumed equivalent. The point here is that F.D.A. has continuing responsibility to assure that all drug products sold meet official standards for the drugs involved. That is not a cost attributable to the Long Amendment.

As far as costs of establishing the initial formularly it was anticipated that the Formulary Committee would start with a listing of drugs based upon various formularies presently in use as well as upon their own experience. That listing would be modified and expanded as experience and information indicated.

Where they included a drug about which there were substantive questions concerning relative efficacy of the different products of that drug it was expected, that payment would be authorized for all products of that drug until the differences were satisfactorily resolved. Obviously this situation would occur only in a small number of cases. For the overwhelming majority of drugs no substantive questions have been raised concerning one product of a drug which met official standards being superior to another, which also met official standards.

As far as costs of tests, the testing authority given to the Formulary Committee was intended to be minimal and to be used only in exceptional instances—not as an ongoing product quality and evaluation program.

Section 405 of the Social Security Amendments of 1967 required H.E.W. to study the Long Amendment and report to the Congress. That report (attached) constitutes a virtual blanket endorsement of your proposal. It was completed after some 18 months of work and submitted to Congress on January 14, 1969.

On page 9 of the Report, you will notice their estimated first year cost of a "Long-type" drugs amendment as $7.7 million—not $111 million. They estimated cost in subsequent years at $4.6 million annually.

The CHAIRMAN. I am not going to burden you by listening to you read that at this time, but I would suggest that you study it, because there is one item that, according to department estimates, would save about $40 million initially. We are aware of the drug industry's arguments and we just do not think they are sound. We think they

are completely erroneous. But after your staff and your department told us in February that they approved of what we in the Senate did on this matter previously, the industry apparently convinced your predecessor that they were still sound in their $111 million estimate and he signed a letter dated June 23 this year endorsing that figure. Now, we think that is totally in error.

Was Mr. Finch still Secretary on June 23?

Secretary RICHARDSON. Yes, I think so.

The CHAIRMAN. Well, I will submit this letter for the record, too. It bears his signature. Apparently, he was still convinced of that error when he gave us this letter. I would like to get this matter straightened out.

(The letter referred to follows:)

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., June 23, 1970.

Mr. C. JOSEPH STETLER,
President, Pharmaceutical Manufacturers Association,
Washington, D.C.

DEAR MR. STETLER: This is in response to your letter of March 3, 1970, requesting a clarification of this Department's position on the use of a national pharmaceutical formulary and a reimbursement program based on the assumption of drug equivalency.

We are, of course, anxious to make certain that the beneficiaries of Federal health programs receive the finest available care at the most reasonable cost to the Government, and to that extent we are in agreement with the objectives of the Senate in its 1967 amendment in this regard.

However, we are also aware that the inseparability of quality from price requires that we make certain that all manufacturers' versions of every drug product available to American patients are in fact safe and effective. We are not in such a position today. We would be reluctant to impose constraints on prescribers until such time as the Department has acceptable answers to the question surrounding the equivalency of drug products. The problem is considerably more difficult than we had anticipated and will require substantial time and effort to resolve.

In addition, we are aware that calculations of dollar savings to be expected from such a program must take administrative and other expenses into consideration. The last HEW estimate of such expenses exceeded $111 million for the first year, and somewhat less thereafter. Such an expenditure could and probably would outweigh the "savings" to be expected from the proposed program.

The brief statement submitted to the Senate Finance Committee last February is not the position of this Department. The statements in the paper referred to in your letter were prepared by the staff primarily as points of reference for discussion, rather than as definitive statements of policy.

The present position of the Department on these issues is reflected in the Report of the Review Committee under the Chairmanship of John Dunlop, dated July 23, 1969. As you know, I appointed that Committee on March 24, 1969, asking it to evaluate the findings and recommendations of the Task Force, and thus to assist me in developing Departmental policy.

It is necessary, of course, that we act to contain the rising cost of medical care in our country. I am confident that you will join us in working to achieve that objective while ensuring that conditions conducive to innovation and research in the pharmaceutical field are preserved and enhanced.

Sincerely,

BOB FINCH, *Secretary.*

The CHAIRMAN. Here is the Wilbur Cohen report with the $7 million cost estimates in it. I will ask the staff to take out any surplusage and simply put in the record the studies made in your Department which indicate that the correct figure would be $7.7 million the first year and $4.6 million the second year, as compared to an industry

propaganda estimate of $111 million that they apparently sold your predecessor.

I am willing to hear their arguments and consider their position. Any time we reduce someone's sales by at least $40 million a year, we certainly should hear what they can say for that side of the argument. But I hope you would study this, Mr. Secretary, and consider Mr. Cohen's study and our staff's study as well as our estimate on this, as well as the industry position, keeping in mind that while we want to save money, we do not wantjto be unfair to them. But it would appear to me that when they undertake to say that to save $40 million on drugs would incur an additional administration cost of $111 million, they just do not have any basis. I hope we can have your full cooperation.

We are not complaining at all, but it just looks like from time to time, if they can catch us separately, they will either convince you or convince us of something we believe to be in error. I would like to have all the facts before us.

Thank you very much, Mr. Secretary.

(The report referred to; follows. Hearing continues on page 115.)

LETTER OF TRANSMITTAL

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,

Washington, January 18, 1969.

Hon. JOHN W. MCCORMACK,
Speaker of the House of Representatives,
Washington, D.C.

DEAR MR. SPEAKER: I have the honor to transmit to you the findings of the Department of Health, Education, and Welfare with respect to the establishment of quality and cost standards for drugs for which payments are made under the Social Security Amendments of 1967. This report is submitted in compliance with section 405 of the Social Security Amendments of 1967.

The Department's Task Force on Prescription Drugs has given careful study to Federal and State expenditures for drugs supplied in programs funded under the Social Security Act. In its first interim report, submitted to me in March 1968, the task force reported that the establishment of "reasonable cost" ranges for drugs which would not exceed the range at which such drugs are available by their established names, and "reasonable charge" ranges which would provide a fair dispensing fee to drug vendors, would reduce the costs of drugs to the Federal and State Governments without sacrifice of quality. I am enclosing a copy of the Fourth Interim Report of the task force and I endorse these findings.

Since its first report, the task force has completed studies on methods of determining the scope of drug benefits in a number of drug insurance programs in this country and abroad. It has reported to me its finding that the exclusion from Federal cost reimbursement of certain combination products, duplicative drugs, and noncritical products would contribute significantly to rational prescribing and would, in the task force's estimation, yield overall program savings of at least 10 percent.

The task force has further estimated that the establishment of cost ranges at which drugs are generally available by their generic names would save approximately 5 percent at the retail level.

If by mid-1971, combined Federal-State expenditures for drugs under titles V and XIX of the Social Security Act reach an estimated $300 million, the establishment of reasonable cost and charge ranges for drugs and exclusion of certain combination, duplicative, and noncritical drugs could accomplish savings of about $37 million in the first year, and somewhat more in later years. These estimates could vary significantly, however, with such factors as the inclusion of out-of-hospital prescription drugs in medicare, as I have recommended, and the extent to which the States develop additional methods of limiting drug costs.

I am enclosing a copy of the Fourth Interim Report of the Task Force on Prescription Drugs and I endorse the mechanisms described

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therein as a method of obtaining the savings indicated. I strongly recommend to the Congress that legislation be enacted to establish cost and charge ranges and limits of Federal participation in reimbursement for drugs supplied in programs funded under the Social Security Act.

Sincerely,

WILBUR J. COHEN, *Secretary.*

TASK FORCE ON PRESCRIPTION DRUGS

FOURTH INTERIM REPORT

QUALITY AND COST STANDARDS FOR DRUGS

JANUARY 10, 1969

Office of the Secretary
U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Washington, D.C.

TASK FORCE ON PRESCRIPTION DRUGS

PHILIP R. LEE, M.D., Assistant Secretary for Health and Scientific Affairs (*Chairman*)
ALICE M. RIVLIN, Ph.D.,[1] Assistant Secretary for Planning and Evaluation
ROBERT M. BALL, Commissioner, Social Security Administration
JOSEPH H. MEYERS, Deputy Administrator, Social and Rehabilitation Service
DEAN COSTON, Executive Assistant to the Secretary
JAMES F. KELLY, Assistant Secretary, Comptroller
HERBERT L. LEY, Jr., M.D.[2] Commissioner, Food and Drug Administration
WILLIAM H. STEWART, M.D., Surgeon General, Public Health Service

MILTON SILVERMAN, Ph.D., Special Assistant to the Assistant Secretary for Health and Scientific Affairs (*Executive Secretary and Staff Director*)

TASK FORCE STAFF

MARK NOVITCH, M.D. (*Assistant Staff Director*)
VINCENT GARDNER
RILEY J. JEANSONNE, R. Ph.
T. DONALD RUCKER, Ph. D.
VINCENT E. VANDRE
ALLEN J. BRANDS, R. Ph.
JUANITA P. HORTON, R. Ph.
BRADLEY P. NEER, D.V.M.
WILLIAM G. SHOEMAKER, R. Ph.
PATRICIA A. VIENNA

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[1] Succeeded William Gorham on July 1, 1968.
[2] Succeeded James L. Goddard, M.D., on July 1, 1968.

DEPARTMENT OF HEALTH, EDUCATION,
AND WELFARE,
OFFICE OF THE SECRETARY,
January 10, 1969.

Memorandum.

To: The Secretary.

From: Philip R. Lee, M.D., Assistant Secretary for Health and Scientific Affairs.

Subject: Task Force on Prescription Drugs—Progress report.

INTERIM REPORTS AND BACKGROUND PAPERS

The Task Force has completed the studies necessary to make its determination about the feasibility of including out-of-hospital prescription drugs as a Medicare benefit, and our findings were submitted to you in our Third Interim Report. As a result of these studies, considerable important background material has been developed. This is being published in a series of background papers entitled:

"The Drug Users,"
"Current American and Foreign Programs,"
"The Drug Prescribers," and
"The Drug Makers."

A fifth paper on drug insurance administrative methods is in preparation and will be ready for release shortly.

REPORT TO THE CONGRESS

Section 405 of the Social Security Amendments of 1967 states that:

(a) The Secretary of Health, Education, and Welfare is authorized and directed to study * * *

(2) quality and cost standards for drugs for which payments are made under the Social Security Act * * *

The Task Force has given careful consideration to the question of whether the Federal government can exercise more effective controls on the costs of drugs supplied in the Medicare, Medicaid, and Maternal and Child Health programs. Our preliminary report on this matter was submitted to you in our First Interim Report on March 7, 1968. We found that:

1. The drug quality control studies (undertaken by the Food and Drug Administration) are expected to be adequately if not completely up-to-date by 1970, and this will provide reasonable assurance of uniform drug quality by that time.

2. Establishment of reasonable cost and charge ranges for drugs provided under the Medicare, Medicaid, and Maternal and Child Health programs is feasible, and would reduce the cost of drugs to the Federal and State governments without sacrifice of quality.

On the basis of these findings, the Task Force recommended legislation to establish reasonable cost and charge ranges, and limits of

Federal participation in reimbursement, for drugs supplied under these programs. Except that we now project that the quality control studies will be up-to-date by 1971, we reaffirm our findings and recommendation on this matter.

Based on the Task Force report, the Department endorsed legislation introduced in both the House of Representatives (H.R. 16616) and the Senate (S. 3323) to establish such cost and charge ranges. The Department was not able, however, pending completion of Task Force studies, to endorse a provision in the Senate bill which would have required the Secretary to include for cost reimbursement only those drugs which he found "appropriate for" recipients of benefits in the Department's health-related programs. These studies are now completed and we have found that the limitation of drug benefits by means of a formulary has been shown to be feasible and medically acceptable in a wide range of government and private drug programs. We therefore endorse this provision.

INTERIM REPORT

I am pleased to submit with this memorandum the Fourth Interim Report of the Task Force with our detailed findings concerning the establishment of quality and cost standards for drugs supplied in programs funded under the Social Security Act.

TERMINOLOGY

The term *generic equivalents* is not used in this report. Although it has been widely utilized, it has been given so many different interpretations that it has become confusing. Instead, the following terms are used:

Chemical equivalents.—Those multiple-source drug products which contain essentially identical amounts of the identical active ingredients, in identical dosage forms, and which meet existing physicochemical standards in the official compendia.

Biological equivalents.—Those chemical equivalents which, when administered in the same amounts, will provide essentially the same biological or physiological availability, as measured by blood levels, etc.

Clinical equivalents.—Those chemical equivalents which, when administered in the same amounts, will provide essentially the same therapeutic effect as measured by the control of a symptom or a disease.

The following terms are also used:

Generic name.—The *established* or *official* name given to a drug or drug product.

Brand name.—The registered trademarked name given to a specific drug product by its manufacturer.

SUMMARY OF FINDINGS

Drug Quality and Clinical Equivalency

1. The Task Force finds that the drug quality studies undertaken by the Food and Drug Administration are expected to be adequately if not completely up-to-date by 1971, and thus will provide reasonable assurance of uniform drug quality by that time.

2. There should be uniform standards of quality and efficacy for each product covered in any Federally supported drug program, and it would be inappropriate to provide for differential cost ranges for products sold by proprietary designation.

Scope of Drug Benefits

3. The exclusion of certain combination products, duplicative drugs, and noncritical products from Federal reimbursement would contribute significantly to rational prescribing, and moreover, it seems reasonable to assume it could yield overall savings of at least 10 percent.

"Reasonable Cost" Ranges

4. Establishing product cost ranges reflecting the cost of drugs generally available by their generic names would save about 5 percent at the retail level.

"Reasonable Charge" Ranges

5. Although the Task Force is convinced that significant program savings could be achieved through the application of techniques designed to improve the efficiency of vendor operations, it is unable at this time to estimate the extent of these savings.

Administrative Procedures and Costs

6. Considerable time would be required to develop all the necessary administrative mechanisms. Therefore full implementation of such provisions as applied to Federal reimbursement for prescribed drugs cannot be assured in less than two years after enactment of appropriate legislation.

7. Any necessary increases in Federal expenditures for the improvement of drug standards and quality control will have benefits which apply to all users of prescription drugs and should not be attached to the implementation of cost standards for drugs supplied in Federally assisted programs.

Projected Savings

8. Establishment of reasonable cost and charge ranges for drugs provided under the Medicare, Medicaid, and Maternal and Child Health programs is feasible, and would reduce the cost of drugs to the Federal and State governments without sacrifice of quality.

Introduction

Since implementation of the Medicare and Medicaid programs, increasing public attention has been focused on the cost of prescription drugs, particularly Federal and State expenditures. Among the issues that have been raised are these:

1. *Drug Prices.*—Many brand-name drugs are available under their generic names at substantially lower prices. The Department of Health, Education, and Welfare encourages dispensing of low-cost chemical equivalents where they are available and when their use is consistent with high quality health care. However, federally-aided State programs are under no obligation to follow this policy.[1]

2. *Retail Markup.*—Many pharmacists use a percentage markup of drug acquisition cost—the margin system—as a basis for estab-

[1] U.S. Department of Health, Education, and Welfare, Task Force on Prescription Drugs: "Current American and Foreign Programs," U.S. Government Printing Office, Washington, D.C., 1968, p. 36.

lishing the retail price of a prescribed product. Although professional services rendered by the pharmacist are not generally a function of the product cost, the dollar return to the vendor increases with product cost. This practice provides at least some incentive for dispensing of a high-cost product where a choice exists. Other pharmacists have adopted a "fixed fee" system which allows the same dollar return to the vendor regardless of product cost. In the view of many pharmacists, this is not only more consistent with high professional standards but it also removes an incentive for dispensing high-cost drug products.[2]

3. *Formularies.*—A number of State programs limit reimbursement to specific drugs listed in a formulary. However, there is little consistency in formularies, and many include drugs which are felt by the formulary committees of other States to be unnecessary for rational therapy.[3]

4. *Clinical Equivalency.*—Considerable controversy has occurred in recent years about the comparative efficacy of brand-name drugs and lower-cost chemical equivalents. Recent evidence of biological nonequivalency among a few drugs has created doubts among physicians and their patients about the efficacy of low-cost chemical equivalents in general.[4]

5. *Government Expenditures.*—The Federal and State governments spent $208 million for prescription drugs for welfare recipients alone in the year ending June 30, 1968.[5] As implementation of State Title XIX programs continues, drug expenditures for the medically indigent will increase.

Legislative Proposals

The Task Force on Prescription Drugs has carefully studied whether the Federal Government can and should impose more effective controls upon costs of drugs supplied in the programs specified by the House and Senate legislation.

Several bills proposing establishment of Federal cost standards for prescription drugs supplied to patients in programs supported with Federal funds were introduced in the first session of the 90th Congress. None of the bills was reported out of the Committee to which it was referred.

The most recent of these proposals—House Resolution 16616 and Senate Bill 3323—received Administration support and were introduced following a March 1968 report of the Task Force on Prescription Drugs. The Task Force recommended legislation to permit establishment of reasonable cost and charge ranges—and limits of Federal participation in reimbursement—for drugs supplied to patients in the Medicare, Medicaid, and Maternal and Child Health Programs.

H.R. 16616 and S. 3323 were identical except for the wording of a proposed Section 1122(a)(1)(A) in S. 3323.

Each bill would require the Secretary to establish guidelines showing a "reasonable cost range" for drugs dispensed to patients under health programs supported with Federal funds. The Secretary would be re-

[2] Task Force on Prescription Drugs: "The Drug Makers and The Drug Distributors," U.S. Government Printing Office, Washington, D.C., 1968, pp. 63-67.
[3] Task Force on Prescription Drugs: "Current American and Foreign Programs," *op. cit.* pp. 87-88.
[4] (a) Task Force on Prescription Drugs: "The Drug Prescribers," U.S. Government Printing Office, Washington, D.C., 1968, pp. 22, 39.
(b) Task Force on Prescription Drugs: "Second Interim Report and Recommendations," U.S. Government Printing Office, Washington, D.C., August 30, 1968, pp. 72-74.
[5] U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service.

quired to exclude from the reasonable range those prices which varied significantly from the price of the drug when sold by its established—or generic—name. He would be empowered to recognize a differential price for a brand-name drug, however, if the manufacturer could substantiate a claim that his product possessed "distinct therapeutic advantages" over a generic-name product.

Defined in each of the bills was a "reasonable charge for drugs." This charge would be the lesser of (1) the cost of the drug within the "reasonable cost range" plus a reasonable fee or billing allowance, or (2) the pharmacist's "usual or customary charge." In addition, the Senate version would have required the Secretary, in effect, to establish a formulary of drugs appropriate for use in the Federal and State programs, a feature that was under study by the Task Force and which, for that reason, was not endorsed by the Secretary.

Task Force Studies

In its study of these proposals, the Task Force has been concerned with three major questions:

> Can the Federal Government provide adequate assurance that low-cost chemical equivalents will be of sufficiently high quality and provide essentially the same clinical effects as drugs sold by their brand names and often at higher cost?
>
> Is it feasible to limit Federal expenditures for drugs to those specified by the Secretary, with the expert advice of the medical community?
>
> Would the limitation of Federal expenditures for drugs to cost and charge ranges at which products are available by their generic names result in significant cost savings?

To all three questions, the Task Force believes, the answer is yes.

Drug Quality and Clinical Equivalency

In its first and second interim reports and in its background papers, the Task Force reported on a number of significant developments:

> Programs undertaken to evaluate the adequacy of existing drug standards and to institute changes necessary to assure the clinical equivalency of chemically equivalent drugs.[6]
>
> Steps taken by the Food and Drug Administration to strengthen the enforcement of its Good Manufacturing Practices regulations.[7]
>
> The review of efficacy, being carried out by the National Academy of Sciences Research Council, of the 2,900 drugs first marketed between 1938 and 1962.[8]
>
> The successful drug quality control programs of two of the Government's largest drug purchasers, the Department of Defense and the Public Health Service, as well as those of several foreign nations.[9]

Steady progress has been made in all of these areas despite the need for new methodology and significant budgetary constraints. In its

[6] (a) Task Force on Prescription Drugs: "First Interim Report," March 7, 1968.
(b) Task Force on Prescription Drugs: "Second Interim Report," *op. cit.*, pp. 77-79.
(c) Task Force, on Prescription Drugs: "The Drug Prescribers," *op. cit.*, pp. 25 *et seq.*
[7] (a) Task Force on Prescription Drugs: "Second Interim Report," *op. cit.*, pp. 81-83.
(b) Task Force on Prescription Drugs: "The Drug Prescribers," *op. cit.*, pp. 32-34.
[8] (a) Task Force on Prescription Drugs: "First Interim Report," *op. cit.*
(b) Task Force on Prescription Drugs: "The Drug Prescribers," *op. cit.*, pp. 36-37.
[9] (a) Task Force on Prescription Drugs: "Second Interim Report," *op. cit.*, pp. 85-87, 90-91, 102.
(b) Task Force on Prescription Drugs: "Current American and Foreign Programs," *op cit.*, pp. 3-4, 15-16, 138, *et seq.*

earlier interim reports, the Task Force indicated that the FDA's drug quality studies would be reasonably up-to-date by 1970.

As a more realistic projection, we find that the drug quality studies undertaken by the Food and Drug Administration are expected to be adequately if not completely up-to-date by 1971, and thus will provide reasonable assurance of uniform drug quality by that time.

In the case of generic-name products, the Task Force is convinced that the primary objective should be to provide the physician with every reasonable assurance that all chemical equivalents of the same drug on the market—when administered in the same manner and in the same dose—will give essentially equivalent clinical results. Unless the drugs perform reliably in the clinical situation, the physician will find himself in an intolerable situation, with the possibility that he may be placing the health or even the life of his patient in jeopardy.

Accordingly, when it becomes possible to market chemical equivalents, the original drug product—by virtue of the clinical experience accumulated through its use, and because physicians will have become familiar with its characteristics—should serve as the *reference product.*

As recommended by the Food and Drug Administration, any generic-name counterpart thereafter proposed for introduction should be required either (a) to match the reference product, through conformity with all pertinent USP, NF, or other compendium standards, and, when required by the Secretary, presentation of appropriate test data to demonstrate essentially equivalent biological availability, or (b) to present acceptable clinical evidence of safety and efficacy through the New Drug Application procedure.[10]

A chemical equivalent which does not meet one or the other of these requirements should not be accepted for reimbursement or purchase.

We therefore find that there should be uniform standards of quality and efficacy for each product covered in any Federally supported drug program, and that it would be inappropriate to provide for differential cost ranges for products sold by proprietary designation.

Scope of Drug Benefits

The Task Force has examined the use of limited drug lists or formularies in hospitals [11] and in a wide range of government and private drug programs in this country and abroad.[12, 13] In general, formularies have been found to be useful guides to rational prescribing,[14] and are an effective means of cost control when developed by or in close cooperation with physicians who represent a broad spectrum of clinical and academic experience.[15]

As a guide to predicting cost savings in Federally-supported drug programs, the experience of existing State formulary systems present some difficulties. Each formulary may cover a different range of drugs, and many have restrictions on prescription quantities. Some limit the maximum price of an individual prescription or the total annual reimbursable expenses per beneficiary. Others restrict the use of particular drugs to certain disease conditions, some encourage or require the prescribing or dispensing of low-cost chemical equivalents, while

[10] Task Force on Prescription Drugs: "The Drug Prescribers," *op. cit.*, pp. 34-35.
[11] Task Force on Prescription Drugs: "The Drug Prescribers," *op. cit.*, pp. 48-49.
[12] Task Force on Prescription Drugs: "Current American and Foreign Programs," *op. cit.*, pp. 18, 48-50, 58, 65, 71-72, 78-81, 87-88, 120, 124, 128, 129, 132, 137, *et seq.*
[13] Task Force on Prescription Drugs: "The Drug Prescribers," *op. cit.*, pp. 43, *et seq.*
[14] *Ibid.*, p. 3.
[15] *Ibid.*, pp. 43, 46.

still others are structured to favor brand-name drugs. Certain formularies omit "noncritical" drug classes, such as anti-obesity agents, non-narcotic analgesics, antacids, or tranquilizers, and some include an "escape clause" which allows the dispensing of nonlisted drugs under certain conditions.

Although all of these factors may affect the costs of a drug benefit program, it seems evident that the use of a restricted formulary can lower the costs of a drug program. This observation is borne out in reports on hospital formulary experience,[16] a comparison of State welfare programs,[17] and from the experience of social insurance programs in other countries.[18 19]

From a survey of the available evidence, the Task Force finds that the exclusion of certain combination products,[20 21] duplicative drugs,[20] and noncritical products from Federal reimbursement would contribute significantly to rational prescribing, and moreover, it seems reasonable to assume it could yield overall savings of at least 10 percent.[22]

"Reasonable Cost" Ranges

If reasonable assurance of uniform drug quality is a logical prospect by 1971, the relative costs of chemically equivalent drugs will become a significant economic factor in drug benefit programs.

To analyze the potential cost savings which could be achieved by the dispensing of generic-name products, the Task Force initiated a study of the 409 drugs most frequently dispensed to the elderly.[23] It found that 63 could have been obtained from a number of suppliers at a cost distinctly lower than the brand-name products actually dispensed. Maximum savings at the retail level would have ranged from 23 to 36 percent on these 63 drugs, or between 5 and 8 percent when applied to all 409 drugs.[24]

From studies conducted by the Task Force and others, we find that establishing product cost ranges reflecting the cost of drugs generally available by their generic names would save approximately 5 percent at the retail level.[25]

"Reasonable Charge" Ranges

Pharmacists usually apply the same pricing system to both drug and nondrug products by using a percentage markup, or margin, system. The markup for most items stocked in pharmacies averages about 50 percent of cost; for prescription drugs, it ranges from 65 to 100 percent or more of acquisition cost.[26]

The American Pharmaceutical Association and other professional groups have advocated in recent years a flat dispensing fee to reflect actual professional costs. This approach is widely used among hospital pharmacies and some government and private drug insurance programs, and it is being adopted by a number of community pharmacies. Among the advantages cited for the fixed fee system are these:

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[16] (a) Cherkasky, Martin, cited in Task Force on Prescription Drugs: "The Drug Prescribers," *op. cit.*, p. 43.
(b) McCarron, Margaret, *ibid.*, p. 43.
[17] Task Force on Prescription Drugs: "Current American and Foreign Programs," *op. cit.*, p. 87.
[18] Task Force on Prescription Drugs: "Current American and Foreign Programs," *op. cit.*, pp. 139, 171, 182, 186, 193.
[19] Wade, O. L., and McDevitt, G. D.: "Prescribing and the British National Formulary," British Medical Journal, 2: pp. 635-637 (1966).
[20] Task Force on Prescription Drugs: "The Drug Makers and The Drug Distributors," *op. cit.*, pp. 20-22.
[21] Task Force on Prescription Drugs: "The Drug Prescribers," *op. cit.*, pp. 4-5.
[22] Infra., p. 19.
[23] Task Force on Prescription Drugs: "The Drug Users," *op. cit.*, Chapter V, Appendices.
[24] *Ibid.*, pp. 36-37.
[25] *Infra.*, p. 19.
[26] Task Force on Prescription Drugs: "The Drug Makers and The Drug Distributors," *op. cit.*, p. 63.

It removes an incentive to stock and dispense high cost drug products when low-cost chemical equivalents are available.

It makes clear that the dispensing function bears little relation to product cost and therefore emphasizes the professional service rendered by the pharmacist.

By reducing the cost of high-priced medications and increasing the cost of low-priced items, it eliminates the subsidization of some patients by others.[27]

By itself, the employment of a dispensing fee allowance system does little to assure that reimbursement for pharmacy services will equitably achieve the desired economies. Rather, techniques should be developed so that the allowance will be designed to reflect only those expenses which are directly related to the dispensing function. No portion of program payments should be made for unrelated functions or for vendor services that are grossly inefficient.

Although the Task Force is convinced that significant program savings could be achieved through the application of techniques designed to improve the efficiency of vendor operations, it is unable at this time to estimate the extent of these savings.

Administrative Procedures and Costs

The establishment of reasonable cost and charge ranges for drugs, as envisaged in S. 3323 and H.R. 16616 would entail new methodology and significant administrative costs. In addition to the drug quality and equivalency activities already under way, mechanisms would be needed at both the Federal and State levels to assume other new responsibilities involved in the proposed legislation. Among these would be the following:

1. Establishment of an expert advisory committee of physicians, pharmacologists, and pharmacists, to advise the Secretary on the qualification of specific drugs and drug groups for cost reimbursement.
2. Improvement of Federal resources for the determination of drug acquisition costs, development of audit and compliance procedures, drug utilization review methods, and techniques to increase the efficiency of drug distribution.
3. Mechanisms to provide technical assistance to the States in developing and improving their drug benefit programs.

Although considerable experience has been gained at the Federal level—in part the result of Task Force activities—that would permit the swift and efficient discharge of some new responsibilities, others would take many months from the date of enactment.

We find that considerable time would be required to develop all the necessary administrative mechanisms. Therefore full implementation of such provisions as applied to Federal reimbursement for prescribed drugs cannot be assured in less than two years after enactment of appropriate legislation.

In a preliminary report to the Chairman of the Senate Finance Committee on an earlier similar proposal, S. 2299, former Secretary of Health, Education, and Welfare John W. Gardner, submitted Task Force staff estimates of administrative costs which were in excess of $100 million during the first year and approximately $34 million annually after the first five years.[28]

[27] Task Force on Prescription Drugs: "The Drug Makers and the Drug Distributors," *op. cit.* pp. 63-67
[28] U.S. Senate: Social Security Amendments of 1967, Part 1, p. 399.

The bulk of this projected expenditure would have been for improved quality control and for drug product testing to be conducted by or for the Formulary Committee envisaged in S. 2299.

Secretary Gardner recognized, however, that the improvement of drug quality would benefit not only those eligible for drug benefits in Federally assisted programs but all users of prescription drugs.

Indeed, since the staff report in 1967, the improvement of drug quality and the studies of clinical equivalency have become matters of high priority within the agencies charged with these responsibilities and these priorities are reflected in substantial budget increases.

Any necessary increases in Federal expenditures for the improvement of drug standards and quality control will have benefits which apply to all users of prescription drugs and should not be attached to the implementation of cost standards for drugs supplied in Federally assisted programs.

Significant costs would be incurred, however, solely from the enactment of the proposed legislation. If the provisions of S. 3323 were to take effect in fiscal year 1972, we estimate that the net incremental costs to the Department of Health, Education, and Welfare and the State programs would be as follows:

[In millions of dollars]

	Fiscal year 1972	Subsequent years
Determination of "appropriate" drugs	1.3	0.7
Determination of product costs	1.4	.6
Determination of dispensing allowances	.9	.5
Publication of drug lists, guides, and other informational materials	1.2	1.2
Technical assistance to State agencies and compliance review (titles V and XIX)	1.6	.6
Incremental costs of State agency audit (titles V and XIX)	.4	.4
Reviews of drug providers (for exemption from provisions of the act, title XVIII)	.5	.3
Costs of administration to nonexempt providers (title XVIII)	.4	.3
Total, administrative costs	7.7	4.6

Projected Savings

At the present time, Medicaid programs are in effect in 43 States and other jurisdictions. Of these, 36 provide reimbursement for the costs of prescription drugs. Drug expenditures under the program totaled $208 million in fiscal year 1968, approximately 6.8 percent of all Medicaid expenditures.[29] In addition, $3 million was spent for drugs under the various Maternal and Child Health programs. It is anticipated that joint expenditures for drugs under these programs may rise to approximately $300 million by mid-1971.

If drug expenditures do, in fact, reach $300 million in that year, and if the projected savings outlined earlier in this report are applied, the following program savings could be expected:

Potential savings:	
Establishment of "reasonable cost ranges"	$15, 000, 000
Specification of cost-reimbursable drugs	30, 000, 000
Subtotal	45, 000, 000
Less administrative expenses (first year)	7, 700, 000
Net savings (first year)	37, 300, 000

[29] U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service.

These figures could vary substantially, however, with such factors as the development of an out-of-hospital drug benefit program under Title XVIII, the costs to drug producers of developing and supplying data to substantiate drug quality, the extent to which the States develop their own mechanisms for limiting drug expenditures, and the effectiveness with which Federal quality and cost standards are applied at the State level.

From a consideration of the projected costs and savings, we reaffirm our earlier finding that establishment of reasonable cost and charge ranges for drugs provided under the Medicare, Medicaid, and Maternal and Child Health Programs is feasible, and would reduce the cost of drugs to the Federal and State governments without sacrifice of quality.

The CHAIRMAN. Senator Hansen missed his turn.

REDUCTION IN FEDERAL MATCHING FOR SKILLED NURSING CARE

Senator HANSEN. Thank you very much, Mr. Chairman.

First of all, I would like to ask for inclusion in the record of a letter I have from the Governor of Wyoming, Stanley Hathaway, which addresses itself to the same question, the reduction in Federal matching funds for skilled nursing care that was brought out by Senator Curtis in placing in the record a telegram from the Governor of the State of Nebraska. This letter is quite identical to that telegram from the Governor of Nebraska.

(The letter referred to follows:)

STATE OF WYOMING,
EXECUTIVE DEPARTMENT,
Cheyenne, June 15, 1970.

Hon. CLIFFORD P. HANSEN,
Senate Office Building, Washington, D.C.

DEAR CLIFF: H.R. 17550, which has been passed by the House of Representatives, reduces by thirty percent the matching for Skilled Nursing Care under Title XIX after the first three months utilization in a year. If this bill passes the Senate it will be devastating to Wyoming's Title XIX program and will force a financial burden upon us that we will not be able to handle.

I realize that the cost of Title XIX to the federal government is great. It has also been very burdensome to the states, and it seems manifestly unfair at this point to be shifting more of the financial burden from the federal government to the states. Anything that you may be able to do to prevent this from happening will be greatly appreciated.

Sincerely yours,

STAN HATHAWAY, *Governor.*

ACTUARIAL SOUNDNESS OF H.R. 17550

Senator HANSEN. If I understand correctly, Mr. Secretary, it is my impression that the figures we have used, the balances that you project, would result from the House bill which, as I understand from your testimony, would account for a $7 billion balance for the year 1971—I refer to page 24 of your testimony—about $8 billion in 1972 and around $12.5 billion in 1973. I think you propose that rather than follow the schedules in the House bill, you would like to change that so as to bring about balances of $1.6 billion for 1971, $2.1 billion in 1972, and $3.3 billion in 1973.

It is my further understanding——

Secretary RICHARDSON. Before you go on, Senator, I would like to correct just one thing. The references to the balances, $7 billion in 1971, $8 billion in 1972, and $12.5 billion in 1973, are projections based not on the House bill but on the present law.

Senator HANSEN. On the present law, I should have said. I meant to say that. Thank you for your correction.

I understand further that in response to the questions raised by the distinguished Senator from Delaware, Mr. Williams, instead of approaching this problem as an insurance company might in trying to come up with a proposal that is actuarially sound, it is the determination of the Department that we approach it rather on a pay-as-you-go basis so that we are not thinking about the contribution that an individual taxpayer may make and what he may eventually

take out of the program so much as we are thinking in terms of what the input on the basis of current contributions is and what the costs are. Am I right about that?

Secretary RICHARDSON. I think, Senator, that a rather important matter of terminology is involved here. I think that a basic distinction must be made between the actuarial soundness of the social security system on the one hand and the size of the accumulated reserve on the other.

Now, it is true, of course, that the social security system does not maintain, or is not required to maintain, the relative size of reserves that would be required for a private insurance company. The reason for this, of course, is simply that the financing of the social security system is made possible through the tax contributions of employees, employers, and the self-employed, and since the Congress can require that these be raised, it is not necessary that very large reserves be accumulated. But let me add that the trust fund in effect serves to eliminate the necessity for fluctuations in tax rates, so that the rates can be stable or built up at projected intervals over a long period. At the same time, the system is actuarily sound in the sense that the scheduled tax rates and rate increases are sufficient over time to meet the costs of aggregate projected benefit payments for the number of retired individuals and other beneficiaries at given foreseeable times. And I think it is fair to say that the Congress itself, this committee and the Ways and Means Committee in particular, with the periodic advice of the advisory committees like the one now deliberating, have contributed to maintaining the actuarial soundness of the system. So I do not think we should blur the question of how big it is desirable to have the trust funds at a given time with the question of the actuarial soundness of the system insofar as the scheduled tax rates are sufficient to make the system fully self-financing.

Senator HANSEN. In that regard, Mr. Secretary, as I understand it, benefit increases would be adjusted upward as prices rise. Additional revenue generated by the automatic adjustment of the wage base, however, is tied to the changes in earnings. Now, with the presently deteriorating conditions in the economy, is it not likely that program outgo may begin to exceed income to finance benefits? I have in mind, of course, obviously that prices rise faster than general earnings. That means benefits increase faster than wage base during acute inflation?

Secretary RICHARDSON. That is possible, Senator, over the short run. On the other hand, the automatic provisions do rest at the same time on the experience of the past 20 years or so, in which, wages have tended to rise faster than prices. And if that trend were to be maintained over the next foreseeable period, then the projected automatic increase would be adequately financed by the increase in the wage base.

EFFECTS OF A DOWNTURN IN THE ECONOMY ON THE ACTUARIAL SOUNDNESS OF H.R. 17550

Senator HANSEN. Unemployment, I understand, is now around 5 percent, and despite the predictions that we have rounded the corner, and I hope those are right, so far, a lot of indexes would indicate that the economy is still deteriorating. If unemployment continues,

does this not have serious potential effects for the social security system? Prices continue to skyrocket, so benefits under your proposal would rise also. Yet with rising unemployment, tax revenue will drop. What do we do then? Do we raise taxes again, or what do you propose?

Secretary RICHARDSON. I think it should be noted, Senator, that the last figure I saw on current unemployment, which were, as you say, around 5 percent, also showed that the average duration of unemployment was something like nine and a fraction weeks.

Senator HANSEN. Shorter than it has been, you mean?

Secretary RICHARDSON. Well, it is shorter than it was, for example, in the downturn of the economy in 1958, when we had a real problem of prolonged unemployment. So that what we have in this interval is an increase in the number of unemployed at a given time, but not a very significant number of people who are out of work for prolonged periods. I do not have any estimate on what the effect may be. Perhaps Mr. Ball knows to what extent projected employment levels have already been incorporated into the projected gross revenues of the system.

Mr. BALL. Mr. Secretary and Senator Hansen, I think what the Secretary said in relation to your first question is the most significant point. That is, it is quite true that if the relation of wages to prices of the immediate present and the last 2 or 3 years were to continue, then the device that we propose for financing the automatic provision could not be sustained over the long run. But I really do not believe that it is reasonable to think of the American economy not returning to a situation in which productivity of labor is again on the increase which, of course, would result in wages rising faster than prices.

As long as the system is set up so that it can sustain short periods of difficulty of this kind—and the reason for the trust fund setup is really that you not have to raise rates for a temporary period—with the estimates being made for a 75-year period, we feel that, on the basis of the past performance of the American economy and its expected performance, this would be a sound position.

Senator HANSEN. Well, I cherish the hope that your anticipation of balance will be justified. I must admit to some concern, though, as I reflect on the typical state of mind of taxpayers under the unified budget which we have. It is my understanding that the Federal budget, while badly in a state of imbalance, is not reflected in an imbalance in the unified budget. So the reaction that might be expected from most of the people is not experienced simply because we are euphorically led to believe that the economy is in balance when, in fact, it truly is not in balance. This, of course, is something which we have inherited from the previous administration, and the determination which would go into the unified budget. But is there not reason to believe that we may be generating those conditions which will continue the present imbalance, the stresses that you speak of and are certain that we now have, into the future?

Secretary RICHARDSON. Just let me add a supplement to Mr. Ball's answer and my own earlier answer with respect to the effect of employment levels. The long-term projections on which the calculations for the financing of the system are based assume a 4-percent level of unemployment. This would mean, therefore, that a 5-percent level of

unemployment would reduce expected contributions into the system during the period very slightly below the projections. And, of course, that would be offset if you had in the future, say, 3-percent unemployment in any year. In any case, the effect from year to year over time is quite small. And it is, of course, this very reason why we have the trust funds. Even the rates that are now in the bill would still bring about progressive increase in the trust funds. So, if you had a 5-percent unemployment rate over the years, instead of a 4-percent rate, you would then have marginally slower increase in the fund.

The second point you made was with respect to the reflection of the intake and outgo from the trust funds under the withholding taxes of the social security system in the Federal budget. A question of judgment was raised as to how to affect this in the budget. This has been a subject of argument over a great many years. I have really no independent view of the desirability of various alternative approaches for Federal fiscal purposes. The theory of the approach now used, I believe, is that if you are looking at Federal expenditures in light of their impact on the economy, whether inflationary, deflationary, stimulating growth, or otherwise, it is important to take into account the very significant economic impact of the social security contribution by workers and social security benefit payments.

I think it would be very unfortunate if the inclusion of the social security intake and outgo came to be manipulated to achieve short term budgetary impact. The Congress and the Administration should continue to look at the funding of the system, as they have since its inception, on a basis of assuring the integrity of the system and the responsibility of the Government to its beneficiaries.

Senator HANSEN. Mr. Chairman, my time has expired. Just let me conclude by saying that there are some wide divergences of opinion as we contemplate what may happen in the next 75 years. There are those who say we will have worlds of money and there are those who say we will be worse than broke.

I do want to compliment the Secretary for his very able presentation here this morning.

Thank you.

Secretary RICHARDSON. Thank you, Senator.

The CHAIRMAN. Let me compliment you, too, Mr. Secretary, on behalf of the committee for the very fine responses you have made to the many questions asked by the committee. In the short time that you have been in this job, we can see that you are very well aware of what your duties and responsibilities are and you have brought yourself up to date with what has happened since you were with the Department some years ago. So we are very pleased to see that you have applied yourself diligently to this vast program that you have the responsibility for administering and you seem to be right on top of your job.

We will look forward to seeing you tomorrow at 10 o'clock.

(Whereupon, at 12:35 p.m., the committee was adjourned until Wednesday, July 15, 1970, at 10 a.m.)

SOCIAL SECURITY AMENDMENTS OF 1970

WEDNESDAY, JULY 15, 1970

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to recess, at 10:05 a.m., in room 2221, New Senate Office Building, Senator Russell B. Long (chairman) presiding.

Present: Senators Long, Anderson, Talmadge, Fulbright, Byrd, Jr., of Virginia, Williams of Delaware, Bennett, Curtis, Jordan of Idaho, Hansen, and Fannin.

SENATOR RUSSELL B. LONG'S DRUG AMENDMENT

The CHAIRMAN. The hearing will come to order.

Mr. Veneman, I understand why the Secretary is not able to be here at this moment. I asked him to undertake to determine the Department's position with regard to a proposal that I have suggested for reducing the cost of drugs under the medicaid proposal. Is the Department's position fixed on that as of now?

STATEMENT OF HON. JOHN G. VENEMAN, UNDER SECRETARY OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY HOWARD N. NEWMAN, COMMISSIONER, MEDICAL SERVICES ADMINISTRATION; ROBERT M. BALL, COMMISSIONER OF SOCIAL SECURITY; THOMAS M. TIERNEY, DIRECTOR, BUREAU OF HEALTH INSURANCE; AND IRWIN WOLKSTEIN, ASSISTANT BUREAU DIRECTOR, DIVISION OF POLICY AND STANDARDS, BUREAU OF HEALTH INSURANCE, HEW

Mr. VENEMAN. Mr. Chairman, the Department's position per se is not fixed on that matter. However, we do concede in the figures that you submitted yesterday that when we compare apples to apples, the $7.7 million that you suggested as administrative costs would be accurate. The somewhat over $100 million figure was on the assumption that the testing would be done by the Federal Government. In talking with staff today, it is my understanding that your measure proposed that this kind of testing be done by the industry. So actually on the administrative cost of the program, as you suggested, we are not too far apart. We are waiting for the completion of the drug reviews, which should be completed next year.

The CHAIRMAN. Well, these things are obvious. The Food and Drug Administration has the duty and the responsibility of seeing that all these drugs meet Federal standards, and they have failed to do their duty—in fact, they have, I assume, violated the law—if they permit these drugs to be marketed that do not meet Federal standards. In other words, is it not correct to say that this Government, under the Food and Drug Administration, has the responsibility of seeing to it that these drug manufacturers should not be permitted to put a product on the market that does not meet Federal standards?

Mr. VENEMAN. That is correct. That is the purpose. It is a regulatory body for that particular purpose.

The CHAIRMAN. Now, if those Federal standards are not adequate, we should raise those standards and make them new to a higher quality of production. But so far as I know, they do have a higher standard and I find that even the larger concerns and the best known, that claim to be the best in the field, themselves complain about too much inspection, not too little. So that job has to be done, anyway.

Now, when someone comes in, if you have Squibb claiming that his product is better than Pfizer or legally claiming that his product is better than either of the other two, logically should not the burden be on him to prove it and should he not have to carry that burden at his own expense if he wants to say that you ought to buy my product rather than the other fellow's?

Mr. VENEMAN. That seems to be the logical approach to take, Mr. Chairman. I think the program we are presently carrying out is a review for efficacy of some 2,900 drugs. That is being done by the National Academy of Sciences—National Research Council. I think that when this review is completed, we would be in a better position as a department to make a recommendation that would carry out the concepts in your measure.

The CHAIRMAN. The Federal Trade Commission is not going to let you advertise that your aspirin is better than the other fellow's. As Bayer says, there is none better. I am sure that that is true. I am also sure it would be true if they said there is none worse. It is all aspirin. But they have to be in a position to prove that statement. They are not in a position to prove that statement. So they go as far as they think they can, which is to say there is none better. The other fellow has the right to say the same thing, I would assume.

So it would not be fair to assess against the cost of this amendment which I have suggested and the Senate has passed on previous occasions, the expense of what the Food and Drug Administration is already doing or the expense that a manufacturer would have to undergo himself if he wants to require that his product be purchased to the exclusion of all others. If he wants to do that, he ought to bear the burden of providing that his is better. I think you agree with that.

Mr. VENEMAN. I would say it would be a combination. I think the Food and Drug Administration has the responsibility to test for efficacy and the other things that are necessary as part of their responsibility. But I think additional testing in the direction that you are suggesting could very well be the responsibility of the industry.

The CHAIRMAN. Thank you.

DEPARTMENTAL REPORT ON WORK INCENTIVE PROGRAM

Now, I would like to call your attention to the fact that section 440 of the Social Security Act requires that your Department and the Department of Labor submit a report on the 1967 work incentive program to Congress by July 1, 1970. To date, we have received neither your report nor that of the Department of Labor. Naturally, these reports will be important in the committee's consideration of your welfare proposals next week. Will you be so kind as to contact the Secretary of Labor and see that he and you work together to get this report to us so we will have it next week?

Mr. VENEMAN. I will, Senator. I saw a letter or a memo come across my desk the other day suggesting that we did in fact have this in draft form and asking for an extension until August 1. Now, whether that came to your committee or not, I do not know. But we anticipate having a report by August 1. We regret the 30-day delay and I will contact the Department of Labor.

The CHAIRMAN. We do not have it and we want it, because we think that is fundamental to doing the job that the law or at least the Senate assigns to us.*

Mr. VENEMAN. That is correct.

The CHAIRMAN. We think that training and employment is one of the most relevant features of the family assistance plan and the proposed amendments to it. We need an effective program to put people to work and that it be more effective than it has been in the last year or two.

TAX LOOPHOLE FOR KICKBACKS

Now, I have noticed that there is an inadvertent loophole, according to the Medical World News, in the tax law that I did not intend and I do not know of anybody else who intended it. We wrote a provision to say that a person could not deduct as a necessary business expense his expenses or fines assessed upon him as a result of violating the antitrust laws.

The amendment went beyond that to say that if he had been subject to a criminal conviction, he could not deduct the expenses of bribes and kickbacks and corruption of that sort. It has come to my attention that by virtue of the manner in which that was drafted, someone is in a position to deduct some kind of referral fee and fee splitting or even kickbacks by doctors that he could not have deducted under prior law. I do not know whether it has come to your attention or not. Are you aware of it?

Mr. VENEMAN. It has not come to my attention Mr. Chairman.

The CHAIRMAN. I will just make the article available to you.

(The article referred to follows:)

[From the Medical World News, June 26, 1970]

AN INADVERTENT LOOPHOLE FOR KICKBACKS

Federal tax code now allows MDs to deduct such payments—irrespective of their state's law.

An obscure change in the Internal Revenue Code, enacted as part of the Tax Reform Act of 1969, has the effect of actually encouraging medical fee splitting,

*The report was received by the committee and printed as part of the committee print entitled "Reports on the Work Incentive Program", dated August 3, 1970.

MWN has discovered. Congressional tax authorities and medicolegal experts were startled and dismayed to learn of this effect, probably none more so than the chief sponsor of the change, Sen. Russell B. Long (D-La.).

As the federal tax code now stands, specialists are allowed to deduct as business expenses kickbacks paid to referring doctors under circumstances where the deduction formerly would have been denied. Thus, a high-bracket specialist, who formerly would have had to make such a payment entirely out of after-tax dollars, can now do it with money that otherwise would have gone largely to the government.

Under the old law, a Treasury Department ruling permitted the deduction of such payments "provided they are normal, usual, and customary in the profession and community; are appropriate and helpful in obtaining business; and do not frustrate sharply defined national or state policies evidenced by a declaration proscribing particular types of conduct."

This meant that such deductions were always disallowed in the 16 states that prohibit fee splitting under all circumstances and that consider the practice grounds for revoking a physician's license. As listed by Edwin J. Holman, the lawyer who heads the AMA's Department of Medical Ethics, those states are Alabama, Arizona, California, Colorado, Georgia, Michigan, Minnesota, Nebraska, New Mexico, New York, Ohio, Oregon, South Dakota, Virginia, Washington, and Wisconsin. In addition, Hawaii, Iowa, Louisiana, Oklahoma, and West Virginia prohibit the practice under some conditions. In these five and the 30 remaining states, deductibility depended on whether a specialist's payments met the standards of the Treasury rule.

But under the amended law, Section 162(c)(2) of the Internal Revenue Code now provides that a kickback *must be allowed* unless the taxpayer is successfully prosecuted in a criminal proceeding. Only if he is convicted, pleads guilty, or pleads *nolo contendere* may the deduction be disallowed, and in that case any related payments must also be disallowed. Asked if this change will encourage fee splitting, Holman answers, "Yes, and you may quote me."

The tax amendment originated with Senator Long, who persuaded first the Senate, and then—in conference—the House, to write it into last year's law. It is one of a package of four amendments aimed at criminal violators of the antitrust laws. (The others bar deductions for fines paid, for bribes to public officials, and for two thirds of treble damages paid.) The thought that the clause might give a green light to medical fee splitting never crossed the Senator's mind, his aides say.

The clause applies elsewhere, too. For example, a supplier who kicks back to a purchasing agent may now deduct the amount of the payment in his federal tax form, even if his act is illegal under his state's own law.

The Internal Revenue Service exchanges tax information with 30 states and the District of Columbia by computer tape and with 14 others by less sophisticated means. Nevertheless, the possibility that this information will be used by state authorities to prosecute anyone for making illegal kickbacks appears remote. Under the law, states are supposed to use the information only for purposes of tax collection, and IRS officials say they know of no instance in which a state has prosecuted on the basis of federal tax data.

Senator Long himself was away from the capital when MWN raised this issue, but aides on the Senate Finance Committee, which he heads, expressed certainty that he would look into the situation with great interest upon his return. The ranking minority member, Sen. John J. Williams (R-Del.) expressed surprise when told of the loophole, and promised to pursue the matter. The concern of these legislators is more than academic; fee splitting presumably raises medical care costs, and the finance committee has been seeking ways to hold down the expense.

The change in the tax law has nullified one tactic that might have discouraged fee splitting, a practice long held unethical by the AMA and other medical organizations. A simple change in the Medicare or Medicaid regulations to prohibit fee splitting under those programs might have met the old Treasury Department test as being a "sharply defined national policy" and could thus have ended the deductibility of all medical kickbacks in all states. That possibility no longer exists.

The CHAIRMAN. I will just ask you if you would support the addition of a provision to the Social Security Act making fraud, kick-

backs, bribes, or any activities of that sort with respect to medicare and medicaid programs a felony punishable by fine and imprisonment? Of course, this would be in addition to the other penalties in the civilian criminal code, and this new penalty provision would have to appear in every new medicaid and medicare claims form.

Mr. VENEMAN. If you would make that available, Senator, I think we could work out an amendment on that.

The CHAIRMAN. I would suggest that we work together on that, because we did not intend to open any loophole in the law. If we have, we would like to close it. If someone is evading taxes, I believe that that is one area where we could even get at it retroactively. Insofar as an error might have occurred, we would like to straighten that matter out. I will make this all available to you and we will have it in the course of the committee hearing.

Senator Fulbright was not here yesterday.

Would you care to question the witness?

Senator FULBRIGHT. Not at this time, Mr. Chairman.

The CHAIRMAN. Senator Williams?

Senator WILLIAMS. Senator Bennett has something.

SIX-MONTH DELAY FOR DISABILITY PAYMENTS UNDER SOCIAL SECURITY

Senator BENNETT. I have one question this morning.

Mr. Secretary, I received a letter from the Utah chapter of the American Cancer Society raising a problem that had never occurred to me previously.

Under the present law, payments for disability under social security may not be made until after 6 months have passed. This was obviously designed to make sure that the disability was long term. But here is a case where one of these surprise diagnoses, say a case of cancer is diagnosed as stomach cancer and is diagnosed as terminal. The man is now permanently disabled. If he has been paying into social security for 19 years and the question is raised by his family, who now find themselves without any source of income because he cannot work, whether certain exceptions can be made in the case of terminal diagnosis which will permit the collection of disability benefits without waiting for the 6-month period.

Mr. VENEMAN. Senator, I think he was not on social security for 19 years. He was paying into social security.

Senator BENNETT. Paying into it, that is right. He is 39 years old.

Mr. VENEMAN. Mr. Ball has indicated that the Advisory Council is looking into the 6-month waiting period for disability insurance benefits. Personally, I can see some problems with modifications where it might involve terminal cancer. Just as a quick reaction—quite often those diagnoses are not as accurate in the time——

Senator BENNETT. Of course, they can never predict how long a man may survive after there has been such a diagnosis. But it raises the whole question of whether there may not be types of conditions under which the disability is of such a nature that you do not need to wait 6 months to decide whether it is total.

Mr. VENEMAN. You find the same situation, I think, in a severe injury, for example. I look to Mr. Ball to respond as to whether the

Advisory Council has come to any conclusion. How near they are, I do not know.

Mr. BALL. Senator Bennett, they have not come to any conclusion yet. They are considering a proposal similar to the one you described, but also the whole question of whether the 6 months itself may be, generally speaking, too long. Of course, if they were to recommend a reduction in the 6-month period generally that would help the sort of case you have.

There are difficult borderlines each time you make an exception depend upon the diagnosis or the particular disability, because you will find other cases that will be very similar. I would suggest that perhaps it would be desirable to await the Council's consideration of this. Perhaps the committee might even want to direct special attention to the proposal, although the Council is giving it special attention already.

Mr. VENEMAN. It seems to me it would be very difficult to make an exception of a specific type of disability by cause and still have an equitable proposal. That is one of the questions we have.

Senator BENNETT. Well, if a doctor diagnoses any particular type of disability as terminal, such a diagnosis might apply to a heart condition as well as cancer. Or it might apply, though it is not so likely these days, to tuberculosis. It raises the whole question of the possibility of considering this decision that disease is terminal.

Mr. VENEMAN. I think the real issue is whether or not 6 months is too long a waiting period. I think that is the real issue, rather than the cause of disability.

Senator BENNETT. In a case like this, and I can understand the consternation of the family and of the Utah Cancer Society, every week or month you wait for the purpose of passing time is something that would represent a burden when they know the answer. That is the only question I have.

I would appreciate it if you would add this to the agenda of the Advisory Council and take a look at it from that point of view.

Mr. VENEMAN. It is on the agenda, Senator. We will advise you of whatever conclusions they may come up with with regard to the subject.

The CHAIRMAN. Senator Jordan?

REDUCED FEDERAL FUNDS FOR NURSING HOME CARE

Senator JORDAN. Thank you, Mr. Chairman.

I have a question occasioned by a letter I got from the Association of Licensed Nursing Homes in my State. They urge me to vote against section 225 of H.R. 17550 because they claim the operation of that section would be financially disastrous to them. As I understand it, under the provisions of this section, one-third of the Federal funds would be withdrawn after the first 90 days of care in a skilled nursing home. They maintain that the kind of patients they have do not improve after 90 days of care, that many of them are 80 or 90 years of age and require substantial medication, and it would be disastrous if a cutback were brought about by the operation of this section on that kind of a home.

Mr. VENEMAN. Senator, this is the same section on which questions were raised yesterday, I believe, by Senator Curtis and Senator Hansen. Both the providers in these facilities and some of the Governors

are concerned about the provision which changes the matching formula under medicaid for skilled nursing care facilities. We had two reasons for making this proposal. One of them was an effort to reduce the total cost of medicaid. The other was to be consistent in establishing our priorities. And we have suggested that for out-patient hospital services, for clinic services, for home health services, the matching formula to the States, the Federal share, be increased by 25 percent.

We also suggested that the Federal percentage after the first 60 days in a general or TB hospital would be reduced by one-third after the first 60-day period. For a mental hospital, after 90 days of care, the Federal matching would be reduced by one-third and then after a year, there would be no Federal matching. Those would be the three major ones.

The payment for skilled nursing home care would be reduced by one-third after 90 days. What we are trying to do is place the emphasis again on outpatient and lesser cost care facilities and to increase the formula there. There is a net savings to the Federal Government, we estimate, of $235 million.

Senator JORDAN. And a net increase in cost to the State of a like amount.

Mr. VENEMAN. And a net increase to the State. But I think there is one factor we should take into consideration. That is particularly in the case of a mental hospital, where we are suggesting that after 90 days, we would reduce it one-third and after a year, it would be at State cost. But bear in mind that—I helped develop California legislation at that time—that these were all State costs before medicaid. The States were absorbing all these costs for the most part, with the exception of some Kerr-Mills money and some other funds that were available. But essentially, that was a State program in which they were able to take advantage of some of the money that was brought into medicaid. We feel we should revise the formula for both equity reasons and for fiscal reasons.

Senator JORDAN. Mr. Chairman, I shall not ask any more questions. I would like to ask permission to have included in the record at this point a 1-page statement from the department of public assistance from my State showing a comparison of State fund requirements for nursing home payments under the present plan and under H.R. 17550 for fiscal year 1972, showing the burden being shifted from the Federal Government to the State government in an amount of nearly $1 million, or 17 percent of the total.

The CHAIRMAN. Without objection, that is agreed.

(The statement referred to follows:)

STATE OF IDAHO,
DEPARTMENT OF PUBLIC ASSISTANCE,
June 25, 1970.

COMPARISON OF STATE FUND REQUIREMENTS FOR NURSING HOME PAYMENTS UNDER PRESENT PLAN AND UNDER H.R. 17550 FOR FISCAL YEAR 1972

The estimated average payment per patient/month during Fiscal Year 1972 is $220.00. Under the provisions of H.R. 17550, the current federal matching ratio of 68.91% would be available only for the first three months of any fiscal year for any patient. If a patient is in a nursing home for longer than three months, federal participation would be reduced by ⅓, to 45.94%.

The breakdown of federal and state funds for the estimated average payment per patient/month is as follows:

	Total	Federal		State	
		Percent	Amount	Percent	Amount
1st 3 months	$220	68.91	$151.60	31.09	$68.40
Last 9 months	220	45.94	101.07	54.06	118.93

The estimated monthly average number of DPA nursing home patients during Fiscal Year 1972 is 1,800.

The estimated number of patients multiplied by the above estimate of federal and state fund requirements yields the following annual dollar amounts:

Federal funds:	
First 3 months, 1800×$151.60=$272,880/month×3 months	$818,640
Last 9 months, 1800×$101.07=$181,926/month×9 months	1,637,3344
Total	2,455,974
State funds:	
First 3 months, 1800×$68.40=$123,120/month×3 months	369,360
Last 9 months, 1800×$118.93=$214,074/month×9 months	1,926,666
Total	2,296,026

COMPARISON OF PRESENT PLAN WITH H.R. 17550

Fiscal year 1972	Total	Federal	State
Present plan (1800 times $220 per month times 12 months)	$4,752,000	[1] $3,274,603	[2] $1,477,397
H.R. 17550	4,752,000	2,455,974	2,296,026
Difference	0	−818,629	+818,629

[1] 68.91 percent of total.
[2] 31.09 percent of total.

INCOME AND OUTGO OF THE SOCIAL SECURITY PROGRAMS

Senator BYRD. Thank you, Mr. Chairman.

Mr. Secretary, as I understand it, you propose to eliminate the increase in social security contributions that would be made by an employee and employer. Then you offset that by an increase in the amount which the employee and employer would pay into the hospital insurance trust fund. Is that correct?

Mr. VENEMAN. That is correct, Senator. I think it was pointed out yesterday in the hearing that the rated 4.6 percent, which was the amount that the present law would have set for the cash benefit side in 1971, would have produced an excessive amount of income over outgo. However, on the hospital insurance side, the rate of 0.6 percent that the present law calls for is not producing sufficient revenues to cover the hospital insurance costs.

Based on the situation in the individual programs, we are recommending that the present 4.2 percent rate for cash benefits remain in effect until 1975, then the rate would go to 5 percent and then to an ultimate rate of 5.5 percent in 1980 and thereafter, and that the hospital insurance rate be raised to an ultimate rate of 1 percent beginning in 1971. Now, this puts both of them in a more realistic position.

Senator BYRD. In relation to each other?

Mr. VENEMAN. No; not necessarily. Looking at them independently, Senator Byrd. If we did nothing with the benefit side and left it at 4.6

percent, we would still have to raise the hospital insurance rate because it is running that far behind, according to our experts.

Senator BYRD. Except for 1 year, as I understand it, there will be no net reduction in the amount which the employee and employer will pay into the fund?

Mr. VENEMAN. The combined amount comes out the same for 1971 and 1972 and when you add the two together, that is correct. But I do think you have to look at them independently from the standpoint that if we did nothing to the law as far as the cash benefit side is concerned, we would accumulate a rather significant reserve. But we would be in the hole on the hospital insurance side and we would still have to raise the rate.

Senator BYRD. But with the exception of the year 1973–74, there will be, actually, an increase in the contributions which will go into the two funds taken together? Except for that one year?

Mr. VENEMAN. Yes; the 2-year period after 1972. Until 1972 the combined rate would be the same as present law. I will let Mr. Ball respond to that.

Mr. BALL. Yes; Senator, it is the calendar years 1973 and 1974 where the proposal would have a lower combined rate for both cash and hospital. But after those 2 years, you are quite correct.

Senator BYRD. Except for those 2 years, then, it would be an increase in all the subsequent years?

Mr. BALL. That is correct.

Senator BYRD. For the combined total?

Mr. BALL. Yes.

Senator BYRD. So what you are really doing is reducing the surplus in the social security trust funds and putting approximately that amount over into the hospital insurance trust fund?

Mr. BALL. Well, in the short range, in the next few years, that is a correct statement, Senator. I would like to perhaps quibble with you a little bit about the use of the term "surplus." It is not that the present cash program has an actuarial surplus when you look at it from the standpoint of the long range cost, but from the standpoint of the needs of the system in the near future, you are building up those funds more rapidly than you need to.

Senator BYRD. Correct. So the word surplus is probably not the word we want to use there in the sense that it is normally considered.

Mr. BALL. Yes.

Senator BYRD. But it seems to me that that again dramatizes that it is not a surplus in the accepted sense, and it again dramatizes the undesirability of this unified budget concept which takes what purports to be a surplus, but which is not actually a surplus, and uses that to indicate that we have more nearly a balanced budget than the facts warrant.

Mr. BALL. Senator, I might point out that the shift in financing of the cash benefit program so as to reduce the excess of income over outgo in the near term moves in the same direction that I think you have in mind by reducing those surpluses—those excesses of income over outgo in the near years. There is not nearly the impact on the consolidated budget that there is if you leave large excesses of income over outgo. It is the present law creating $7, $8, and $12½ billion excesses that I think mainly gives rise to your concern of having social

security involved in the consolidated budget. If income and outgo are approximately the same, then, including social security in the budget does not have the effect you fear.

Senator BYRD. That is right. You still have around $5 billion excess in the two funds, as I read these figures, in each year.

Mr. BALL. In the cash benefit trust funds, that is both disability and OASDI, under the House contribution rates—which we agree with them on—the 1971 excess for cash is $1.6 billion. And it is true, Senator, that under the estimates, by going to 1 percent on the hospital insurance, you would create an excess there of $3.1 billion in 1971.

Senator BYRD. That gives you $5 billion.

Mr. BALL. Yes; roughly $5 billion.

Senator BYRD. So it would be the same the next year, roughly $5 billion, and the same way the following year.

Mr. BALL. Yes.

Senator BYRD. So each of those 3 years, you would have an excess of roughly $5 billion?

Mr. BALL. Yes, but substantially less than the present law would produce.

Mr. VENEMAN. That is right. You see, under the existing law, you would still have a $6 billion excess, you have a $6.9 billion increase in the cash benefits side and you have a $1 billion minus on the health insurance side. So actually, you would have a $6 billion surplus against the proposal of the $5 billion surplus next year.

Senator BYRD. This is another way of saying, I suppose, that you will spend $1 billion more than you will take in under this proposal.

Mr. BALL. Under the present law.

Mr. VENEMAN. On the hospital insurance side, you would. But those are the projections of present law. We have to spend that money regardless of whether we change the contribution rate or not.

Senator BYRD. Yes. Thank you, Mr. Secretary.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Williams?

PROPOSED OFFICE OF INSPECTOR GENERAL FOR HEALTH ADMINISTRATION

Senator WILLIAMS. Mr. Veneman, were you familiar with the proposed amendment to this bill which Senator Ribicoff and I introduced on June 22, which proposed to establish the Office of Inspector General for Health Administration within the HEW?

Mr. VENEMAN. I am not familiar with it, Senator. I think Mr. Ball is familiar with it.

Mr. BALL. Only that the Senator had mentioned this at the hearing when we were here before.

Senator WILLIAMS. What would be the position with reference to that proposal?

Mr. VENEMAN. Without looking at the proposal, Senator, I do not think I should respond specifically. I believe what we would have to take a look at is to see whether or not we can effectively perform the functions that the amendment would presumably hope to perform through our present audit agency. I think we have beefed up the audit agency in the Assistant Secretary-Comptroller's Office, which has, on a continuous basis, been reviewing the medicare and medicaid pro-

grams in the States. Whether or not an additional inspector general would be necessary, I cannot respond to specifically without looking into the measure.

Senator WILLIAMS. Will you check that and give us your recommendations?

Mr. VENEMAN. I certainly will.

Senator WILLIAMS. We found that worked very well with the State Department and thought that the size of it in view of the expenditures——

Mr. VENEMAN. I know the Department of State has an inspector general. I think the Department of Agriculture also has one.

Senator WILLIAMS. And as much money as we are syphoning through this agency, some of us thought it might be wise here.

Mr. VENEMAN. I do not want to leave the impression that we are doing nothing about it. We do have an audit agency that would do that similar function.

Senator WILLIAMS. I understand that. This would not replace your audit agency, as you know.

TERMINATION OF SERVICES OF INEFFICIENT MEDICARE CARRIERS

What specific steps has your Department taken to terminate the inefficient carriers or intermediaries, since the hearing in February?

Mr. VENEMAN. We have had to change intermediaries in a couple of areas. I am not sure whether it is since February, but I do know it has occurred since we have been here. In other cases we have had to renegotiate on more restrictive terms. I think Mr. Ball can probably refer to the total number of cases, but I have personally been involved in two or three where we have had to change intermediaries because of inefficient operation.

Mr. BALL. Senator, the only actual termination since February is John Hancock in Georgia. But the Washington, D.C. operation has been completely reorganized and we continued that operation with the same basic carrier, only on the assumption of a very large degree of responsibility by the national organizations of both Blue Cross and Blue Shield. That was the one that the Under Secretary was very much involved in—in working out that kind of national responsibility for an operation that we did not feel was going well at all. We then entered on a 120-day agreement to see whether this new assumption of responsibility by the national office will work adequately. If not, we do not have to wait a year as in the usual case; we can terminate in 120 days.

Senator WILLIAMS. That was the question I was going to ask you, because the staff report shows that the District of Columbia Blue Shield was one of the poorest medicare carriers in the country. I understood that you had not renewed their contract yet. I understand it is not renewed but just on a temporary objective basis for 90 days?

Mr. VENEMAN. Ordinarily, these contracts are renewed on an annual basis. Because of discussions held and agreements that were arranged with the national associations that Mr. Ball referred to, and their willingness to go in and assist in reorganizing the functions here in the District of Columbia, we agreed that, under those conditions, we would renew the agreement for a period of 120 days. Then we would

take a look at it and see if in fact they have taken care of the problem.

Senator BENNETT. When does that period expire?

Mr. BALL. It is 120 days from July 1. From July 1, 120 days—3 months.

Senator BENNETT. From July 1?

Mr. BALL. From July 1.

Senator BENNETT. That is 4 months.

Mr. BALL. Yes.

PHYSICIAN PARTICIPATION

Senator WILLIAMS. The HEW task force on medicaid recommended last month that a physician should be expected to agree to participate by taking assignments in all cases. The staff report made a somewhat similar recommendation. What's your position?

Mr. VENEMAN. I didn't know whether to turn to Mr. Newman or Mr. Ball. It is medicare, I guess.

Mr. BALL. It is the medicaid task force making a recommendation on medicare. There is a little confusion there.

We have not adopted a final position on this recommendation yet, Senator, but I would be very glad to discuss some of the considerations which I think might be helpful to the committee. There is no way, of course, that the Federal program of medicare can compel participation by physicians. Therefore, the conditions of rendering care under a health insurance program like this must be ones that are reasonably acceptable to the physicians involved, or else you greatly reduce the number of physicians who are available to treat the patients. In the medicare structure, up until now, there are really no requirements that the physician himself has to meet. The concept of the program is one of an indemnity program, paying the patient for the cost of services that he has incurred. Then we have, as you know so well, this assignment procedure where, if both parties agree, we can pay the physician directly, but the concept is still one of relieving the patient of an expense. When the physician accepts an assignment, he must accept the reasonable charge determination. But physicians who do not want to do that still are free to give services to medicare patients and they can collect any amount over and beyond the reasonable charge determination from the patient.

Now, this proposal really says that you would not reimburse the patient for services that are rendered by a participating physician, except that, presumably, you would have to set up some other sort of indemnity approach for those patients who had bills from nonparticipating physicians.

Now, I think the critical question here is whether you can set the conditions for participation on the part of physicians and get the advantage of dealing with them, get the advantage of their accepting a reasonable charge determination, and still not shift the burden of cost substantially over to the patients who have physicians who do not agree to participate, since it has to be, of course, a voluntary matter.

I find it impossible to react to the broad principle without working out the specifics of a plan which says what the conditions are that you impose on the physician who is going to participate, and what it is that you pay the patient whose physician does not choose to participate.

The problem is to avoid unduly restricting the reimbursement to the patient who has a nonparticipating physician and to avoid unduly restricting the number of physicians who want to participate in the program.

Senator WILLIAMS. Is that affected in any way by the difference of whether you pay direct or to the doctor?

Mr. BALL. Yes; that is the way the present program works now, Senator, as you will remember. The physician is free to bill his patient direct if he wishes and let the patient file for reimbursement. The assignment method is when the physician with the permission of the patient bills the carrier directly.

DETERMINING CUSTOMARY AND PREVAILING CHARGES UNDER MEDICARE

Senator WILLIAMS. The staff has expressed great concern that payments made to doctors under Blue Shield service income policies are not generally being taken into account in determining the customary and prevailing charges under medicare as the statute demands.

Would you think it is necessary to change the law or would you enforce the statute more aggressively if the language in the committee report reiterated that position?

Mr. BALL. I think, Senator, if the committee wishes the result of using, generally speaking, Blue Shield fees as the limit on the amount paid to a physician, it would require more than a strong statement in the committee report, because the law, we believe, does not support that particular interpretation.

Senator WILLIAMS. The law does not place a limit and that was not the question. I said taking into account when you determine the customary and prevailing charges. Do you take that into account in your allowances, or do you just ignore it entirely?

Mr. BALL. Take it into account? Mr. Wolkstein has a point he wants to make here. I will let him make it directly.

Senator WILLIAMS. I just want to make it clear that the law does not state that they should be accepted as the rates, but it does suggest that you should be taking them into account when you determine the customary and prevailing charge under medicare. My question was do you take that into account in determining this allowance?

Mr. WOLKSTEIN. Yes, Senator. What I was saying to Mr. Ball is that if there were a position that Blue Shield payments should be taken into account, the issue arises as to which Blue Shield payments you really pay attention to and which one you do not. A particular Blue Shield plan may pay a very large variety of payments depending on the particular plan in which an individual is enrolled.

They may have a full payment plan regardless of income, in which some are enrolled. They may have an indemnity plan, a plan with an income ceiling above which people are not fully insured for the expenses they incur, but above which they may be asked to make an additional payment. If the committee were to take the position that Blue Shield should be followed in terms of what it pays, the issue gets to be which Blue Shield payment is determining.

With regard to the issue of whether it is better to have the policy stated in law or in committee report, we would have a question if the Senate were to take a position in its committee report and the House

were not to have a similar position of what we were mandated to do. This kind of thing in committee report produces some difficulty in terms of actual application of a policy.

So in my view, it would seem as though if a policy like this were to be established, it would be easier for us to apply if it were in the statute.

Senator WILLIAMS. Perhaps it needs clarification. Perhaps everybody else understands the answer, but I am more confused now than I was before you started.

My question was very simple. The statute now requires that you take into account in determining the customary and prevailing charges the rates that are being paid by the physicians. It does not say that you follow them, but you take them into account in determining rates. My question was do you take them into account when you determine rates or do you not?

Mr. BALL. Senator, I think I would have to say in all frankness that they have not been a very useful guide.

Senator WILLIAMS. Now, you have answered the question.

Mr. VENEMAN. However——

Senator WILLIAMS. Perhaps it needs clarification on this.

Mr. VENEMAN. However, I think if you are in a geographic area where the physicians charge is the equivalent of the Blue Shield schedule, you say it is taken into account. Because you are really dealing with physicians' charges. It says the charges shall be the usual, customary, and prevailing charges in an area. If they coincide, you can say yes, you are taking them into account. But the actual fact is that the private carriers' payment schedule, which may be different from what the physician may charge, may be somewhat less than what the doctor actually charges for a given service.

Senator WILLIAMS. I realize that. That is the reason we did not spell out that you follow them.

Mr. VENEMAN. They are considered to that extent.

Senator WILLIAMS. I understand that you consider them and Mr. Ball does not. So we had better get this together.

Mr. VENEMAN. I do not think there is any disagreement at all, because we are both talking about charges. If a Blue Shield schedule reflects the usual, customary, prevailing charge in an area, then they both come out the same.

HOSPITAL INSURANCE COST ESTIMATES

Senator WILLIAMS. At the February hearing on the staff report, both the Department and the committee discussed at great length their mutual concern as to the validity of the hospital insurance cost estimates and you indicated that an actuarial task force had been appointed to review these estimates. I think you gave us a list of the names of the task force.

Mr. VENEMAN. We did.

Senator WILLIAMS. Now, are the cost assumptions in this bill based upon the estimates furnished by this task force?

Mr. VENEMAN. I met with the task force the other day, Senator Williams, and they have not come up with a preliminary report at this time.

Senator WILLIAMS. When do you expect their report?

Mr. VENEMAN. Mr. Hsiao indicates that it will be in September. Whether or not that can be expedited, I do not know. The next meeting is September 11. Let me give you a more thorough report on that after we go back.

(The Under Secretary subsequently supplied the following:)

The committee to advise the Secretary on the assumptions of actuarial estimates will next meet on September 11, 1970. The Under Secretary will keep the Committee informed of its work.

Senator WILLIAMS. Upon what basis were your estimates made? I understand your actuaries resigned and if you have not a report from them, who guessed at these figures?

Mr. VENEMAN. I think we ought to make it clear, Senator Williams, that just one person resigned. The Office of the Actuary of the Social Security Administration is still there.

Mr. BALL. Senator, the estimates underlying this bill in hospital insurance are the same estimates as were presented in February. The same assumptions—the same basic estimates as in the trustees' report, and so forth.

Senator WILLIAMS. And they are taken on the basis, this most recent estimate would be on the basis of the revision of your welfare report? Are your estimates on that the same way?

Mr. VENEMAN. You mean as far as the Family assistance plan?

Senator WILLIAMS. Family assistance; yes.

Mr. VENEMAN. No; the estimates on those, Senator Williams, were developed early in the development of the bill by representatives from the Bureau of the Budget, from the Department of Labor, and the Department of HEW. We have a different group of statisticians working on that, though.

Some of the figures and data available from the Social Security Administration, particularly as they relate to the adult population, were used.

Senator WILLIAMS. The reason I asked that, I understood that the American Hospital Association is projecting a greater percentage increase in hospital costs than are included in the cost assumptions in the House bill. Now, is that correct, and if it is, how would it affect the cost estimates? How would they relate to the cost estimates furnished to the committee?

Mr. BALL. You are correct, Senator. The American Hospital Association is assuming that the percentage increase year by year over the next few years, for in-hospital daily rates, is somewhat higher than our actuaries have assumed in their revised estimate. I will ask for exactly what difference that would make in the cost.

On the other hand, Senator, there are two aspects to these hospital insurance cost estimates that, for a change, have an optimistic aspect to them. One of the main reasons for a major increase in the estimated hospital cost over the future was that for the first time the actuaries assumed an increase in the utilization rates of hospitals, beginning at an increase of 2 percent a year in hospital utilization, and then gradually the assuption of an increase is reduced over a period of years.

Our actual experience in 1969 was that there was no real increase in utilization. I am not claiming any credit for this at this point—I

do not want to change the estimates on account of it. I am just pointing out to you that here is an area where actual experience in the last year is better than what was expected.

Also, as the Secretary indicated yesterday, the estimates for hospital insurance do not take any credit whatsoever for any of the cost-saving features that are in the current bill. And I think that is wise. I would again not propose that until there is experience with the actual administration, that we claim credit for these changes. But again, insofar as we are all convinced that these administrative improvements and some of the fundamental changes that are proposed in this bill will reduce the long-range cost of the program—that reduction is not taken into account—there is a counterbalancing factor to the American Hospital Association's higher daily rates.

Now, I would be glad to furnish the exact amount of increase if you left all other assumptions the same and just took their increases in the daily hospital costs.

Senator WILLIAMS. Well, based on their assumption, how much had you underestimated the cost factor, assuming that they were correct, which they may or may not be?

Mr. BALL. If you left everything else the same, Senator, in our estimate, and just changed the daily hospital rates for the first 5 years as they have estimated, it would increase the cost of the program by about 7 percent.

Senator WILLIAMS. How much is that in dollars?

Mr. BALL. In the hospital insurance program—about $300 million in the first year would be a 7-percent difference, sir.

I want to make absolutely clear that because the American Hospital Association made this prediction is no basis for us to assume that they are correct and our actuaries are wrong.

Senator WILLIAMS. I appreciate that, but I am just trying to ask for the difference.

In the past, have there been any instances where your actuaries have overestimated the cost of this program?

Mr. BALL. Have overestimated the cost of the program?

Senator WILLIAMS. Yes.

Mr. BALL. Yes: I am sure there are individual items, Senator, but I would not want to make any point of that. Obviously, the great impact has been that they have been upping the estimates in the projections in all the major important parts.

Senator WILLIAMS. Seriously, though, I am asking in the past, are there any cases where your actuaries have overestimated the cost, or have they always been under?

Mr. BALL. In actual short-run operating figures, they have, Senator. This year, for example, in the hospital insurance program, we will be expending around $250 million—maybe even more—less than they predicted for this year. The big changes, of course, have been in the projections for what the program will cost over a 25-year period. There they have been upping the estimate, and you are right, they have not, as far as the long-range cost estimates are concerned, ever reduced them. They have always gone up.

But in the short run, our operating experience has this last year been better in hospital insurance than they predicted.

Senator WILLIAMS. To what extent was that due to your delayed payments and was that based on incurred costs or your cash payments?

Mr. BALL. It is based on incurred costs, Senator, and it is not related to the question of delayed payments. It would be even larger if they were taken into account. There is very slight delay in the hospital insurance program, but as compared with the previous year, there was a little bit to that. This is incurred costs that I am talking about.

Senator WILLIAMS. Would you furnish for the record at this point, and I will not ask you to put it in today, but furnish for the record the series of estimates that were furnished by your actuaries for the projected long-range cost for the medicaid program and the medicare program and submitted to the committee at the time they were studying major revisions on the program——

Mr. VENEMAN. You mean 1965?

Senator WILLIAMS. Yes, start with your projections——

Mr. BALL. I would be very glad to, sir.

Senator WILLIAMS. Along with the continuous escalation in these estimated costs.

Mr. BALL. I would be glad to, sir. I have here the latest that was furnished to your committee, the actuarial cost estimates for the hospital insurance program. This is the actuarial study which underlies the proposals in this bill—as I say, those fundamental approaches have not been changed. It is probably too long to be put in the record, but I just call it to the committee's attention.

Senator WILLIAMS. Yes, I appreciate it. I did not mean the detailed report. I want just the statistical reports of your estimates when the medicaid and medicare was first suggested and then the revisions as they came up.

Mr. BALL. I will be glad to do it, Senator.

(Information supplied by the Department follows:)

I. HOSPITAL INSURANCE (TITLE XVII)

Long-range cost estimates were prepared only for the Hospital Insurance program because it is a social insurance program financed from the payroll tax. No long-range cost estimates were prepared for the Medicaid program, which is completely different in nature and the federal share is financed from the general revenue.

When the Medicare program was enacted in 1965, the level cost of benefits and administrative expenses for the Hospital Insurance program was estimated to be 1.23% of taxable payroll. This was based on a level maximum taxable earnings base of $6,600.

The Social Security Amendments of 1967 made certain minor benefit changes in the Hospital Insurance program (transfer of outpatient diagnostic benefits to SMI and provision for a lifetime reserve of 60 days of hospital benefits). At that time, the level cost for the Hospital Insurance program was estimated to be 1.38% of taxable payroll. This was based on a level maximum taxable earnings base of $7,800.

A new cost estimate was prepared for the 1969 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund. The level cost was estimated at that time to be 1.79% of taxable payroll. This was based on a level maximum taxable earnings base of $7,800.

When legislative proposals were prepared in the fall of 1969, *preliminary* cost estimates for the Hospital Insurance program were prepared. These estimates produced a level-cost of 2.3% of taxable payroll, based on a level maximum taxable earnings base of $7,800.

The final actuarial cost estimate was completed in February 1970 for the Hospital Insurance program. This final cost estimate incorporated many major revisions in the assumptions as to the future increases in the unit costs and the utilization rates of services. The level-cost of benefits and administrative expenses was estimated to be 2.75% of taxable payroll with a level maximum taxable earnings

base of $7,800. The level cost was estimated to be 2.11% of taxable payroll with a maximum taxable earnings base of $9,000 beginning in 1971, with automatic adjustments thereafter as specified in H.R. 17550.

II. Medicaid (Title XIX)

The following is a detailed chronology of the cost estimates relating to Title XIX given by the Department to Congress from congressional consideration of the original legislation to the present date.

Data furnished during consideration of the Social Security Amendments of 1965

The Department furnished the Congress with an estimate of a $238 million increase over current vendor medical payments if the proposed Title XIX were to be implemented. The following excerpt from the 1965 Report of the Committee on Finance [1] details the information provided:

(i) Cost of medical assistance

As the accompanying table shows, if all States took full advantage of provisions of the proposed title XIX, the additional Federal participation would amount to $238 million. However, because all States cannot be expected to act immediately to establish programs under the new title and because of provisions in the bill which permit States to receive the additional funds only to the extent that they increase their total expenditures, the Department of Health, Education, and Welfare estimates that additional Federal costs in the first year of operation will not exceed $200 million. Since the new title would be effective only for the last 6 months of the fiscal year ending June 30, 1966, expenditures in that fiscal year are not expected to exceed $100 million.

Public assistance: Increased Federal funds available for medical payments under title XIX [2]

[In thousands of dollars]

Total	$238,005	Missouri	350
		Montana	27
Alabama	1,045	Nebraska	1,511
Alaska	5	Nevada	203
Arizona	19	New Hampshire	1,031
Arkansas	3,905	New Jersey	5,559
California	20,411	New Mexico	1,634
Colorado	2,680	New York	46,380
Connecticut	3,922	North Carolina	2,890
Delaware	8	North Dakota	3,809
District of Columbia	344	Ohio	2,871
Florida	684	Oklahoma	14,752
Georgia	363	Oregon	1,201
Hawaii	898	Pennsylvania	3,098
Idaho	477	Rhode Island	2,437
Illinois	18,395	South Carolina	2,133
Indiana	2,136	South Dakota	148
Iowa	5,315	Tennessee	324
Kansas	5,808	Texas	1,237
Kentucky	262	Utah	3,028
Louisiana	3,950	Vermont	330
Maine	781	Virginia	159
Maryland	141	Washington	2,290
Massachusetts	16,614	West Virginia	2,260
Michigan	3,715	Wisconsin	17,031
Minnesota	27,578	Wyoming	380
Mississippi	317		

[1] Pages 85-86 Senate Report No. 404, June 30, 1965. Identical information appears on page 75, House Report No. 213 of the Committee on Ways and Means, March 20, 1965.

[2] Based on expenditures for vendor medical payments from State and local funds for all programs combined in January 1964. If State and local expenditures were reduced, the Federal expenditure would be correspondingly lower, while increases in State and local expenditures would also result in increases in the Federal cost.

The $238 million was to be in addition to the amount previously being expended for vendor medical payments prior to passage of Title XIX. For calendar year 1965, payments under federally aided assistance programs amounted to $1,359,056 of which the Federal share was $602 million. This latter figure was rising at the rate of $60 million a year.

In addition to the estimated $238 million increase over the $602 million originally contemplated the Department provided subsequent cost estimates for several revisions to the bill. These included an estimated $75 million which would be required because of the provision of care to aged in mental institutions. The following is the summary of this provision as it appeared in the House report: [3]

Tubercular and mental patients [4]

H.R. 6675 removes the exclusion from Federal matching in old-age assistance and medical assistance for the aged programs (and for combined program, title XVI) as to aged individuals who are patients in institutions for tuberculosis or mental disease or who have been diagnosed as having tuberculosis or psychosis and, as a result, are patients in a medical institution. The bill requires as condition of Federal participation in such payments to, or for, patients in mental hospitals certain agreements and arrangements to assure that better care results from the additional Federal money. The States will receive additional Federal funds under this provision only to the extent they increase their expenditures for mental health purposes under public health and public welfare programs. The bill also removes restrictions as Federal matching for needy blind and disabled who are tubercular or psychotic and are in general medical institutions.

Effective January 1, 1966. Cost: About $75 million a year.

The other estimate of additional Federal funds required was $40 million. This represents the additional cost of a Senate floor amendment (later modified in Conference) which would provide medical assistance for children aged 18 to 21 who were not in school.

Estimates provided in 1966 during consideration of H.R. 18225

In 1966 the House had under consideration a bill, H.R. 18225, which would provide "Limitations on Federal Participation Under Title XIX of the Social Security Act."

In October 1966, Robert J. Myers, Chief Actuary of the Social Security Administration, submitted the following memorandum to the Committee on Ways and Means on "Cost estimates for vendor medical payments under public assistance." [5]

MEMORANDUM

From: Robert J. Myers.

Subject: Cost estimates for vendor medical payments under public assistance

This memorandum will present cost estimates both for the fiscal year 1967-68 and for "mature" conditions with respect to vendor medical payments under the categorical public assistance programs under various alternatives as to legislative provisions.

It is hoped that the cost picture for the estimates for fiscal year 1967-68 will thereby be presented more clearly if the transition from one legislative situation to another is taken in steps, as follows:

A. Cost of vendor medical payments if titles XVIII and XIX had not been enacted

It is estimated that the total payments would be $1,699 million and that the Federal cost would be $749 million, with the State cost (including any local government cost) being $950 million. The relatively low level of Federal funds involved results from the fact that a substantial proportion of the vendor medical payments would be above the maximum matachable limits. In other words, quite properly from an analytical approach, it is assumed that the cash-assistance payments are matched first and that the vendor medical payments come "on top" and are matched afterward.

B. Cost of vendor medical payments if title XVIII had been enacted, but title XIX had not been enacted

The estimated total vendor medical payments would be $1,174 million, of which $518 million is the Federal cost, and $656 million is the State cost.

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[3] Pp. 18–19, House Report No. 213 of the Committee on Ways and Means, Mar. 29, 1965.
[4] P. 17721, Congressional Record, July 27, 1965.
[5] Pages 7–8, House Report No. 2224, of the Committee on Ways and Means.

C. Cost of vendor medical payments if both titles XVIII and XIX had been enacted, but title XIX would apply only to cash-assistance recipients

The estimated total cost of vendor medical payments would be $1,726 million, of which the Federal cost would be $1,070 million, and the State cost would be $656 million.

D. Cost of vendor medical payments if both titles XVIII and XIX had been enacted as they actually were

The estimated total cost of vendor medical payments would be $2,167 million; the Federal cost would be $1,300 million, and the State cost would be $867 million. This Federal cost would be an increase of $551 million over the cost of the vendor medical payments of titles XVIII and XIX had not been enacted (i.e., comparing the Federal cost in this paragraph with that in paragraph A). This $551 million additional Federal cost may be compared with the estimates made at the time of enactment of the legislation. At that time, it was estimated that the additional first-year cost would be $238 million (see p. 75, H. Rept. No. 213, 89th Cong.), but to this should be added $75 million as the cost for tubercular and mental patients, since these payments are largely made in the form of vendor medical payments through title XIX (see p. 19 of H. Rept. No. 213, 89th Cong.), and a further $10 million, representing the additional medical assistance cost for children aged 18 to 21 who are not in school, which provision was added on the Senate floor (see p. 17087 of the Congressional Record for July 21, 1965). Thus, it might be said that the original cost estimate for title XIX that was made at the time of enactment was a first-year cost of $353 million, which may reasonably be compared with the current cost estimate of $551 million (although the former may be said to relate to calendar year 1966, while the latter relates to fiscal year 1967-68).

E. Cost of vendor medical payments if both titles XVIII and XIX had been enacted, and if the committee bill is enacted

The Federal cost is estimated to be reduced to $1,220 million—i.e., a reduction of $80 million.

For those estimates involving title XIX or revisions thereof, the figures are probably "maximum" ones because of the assumption that all States not now having medical assistance plans will adopt "average" plans that will go into operation before the beginning of fiscal year 1967-68.

It should be noted that, although the estimated reductions in Federal cost under the proposals to modify title XIX are relatively small, nevertheless, these proposals will well serve as a brake on undue expansion of the program in the future. It seems quite likely that under "mature" conditions, with full utilization of the provisions by those eligible to do so, and with expansion of the provisions of many of the State plans (and, similarly, with extension of the concept of medical protection as a right for those meeting the eligibility conditions, with free choice of doctors and medical facilities and with no difficulties placed in the way of using these services) so that they become much more like the New York plan, the Federal cost for title XIX as it now exists would be as much as $3 billion per year (or even more). The corresponding estimated figure for title XIX as it would be modified by the committee bill is $1½ to $2 billion per year. It should be noted that the foregoing figures do not represent the increase in cost due to the existence of title XIX, but rather, the total cost thereunder. The increase in cost should be measured against the Federal cost for vendor medical payments that would have occurred if title XIX had not been enacted (but title XVIII had been enacted), which is estimated to be about $600 to $700 million per year under "mature" conditions.

It should be noted that these estimates are based on today's population and on today's medical costs. The likely increases in the future in both of these factors would mean a further and substantial increase in the cost estimates. Furthermore, it should be noted that the estimates are based on the assumption that sufficient State funds will be available to enable the expansions of the program that are assumed to occur—such additional State funds being about $1.1 billion for the estimate of the cost of existing title XIX and about $150 to $450 million for the estimate of the cost of title XIX as it would be modified by the committee bill.

ROBERT J. MYERS.

Data furnished during consideration of the Social Security Amendments of 1967

The Department provided the Senate Finance Committee with figures for actual program costs for calendar year 1966. The total cost of the Medicaid pro-

gram for that period was $1,252,497,000, of which the Federal share was $620,995,000.[6]

In his presentation before the Senate Finance Committee on August 23, 1967, Secretary Wilbur Cohen estimated that fiscal year 1968 Medicaid payments under the existing law would total $2.4 billion, of which the Federal share would be $1.3 billion. Of the total amount spent for medical assistance, two-fifths would be for persons 65 and over and about one-fifth for children and youth under the age of 21. The Secretary noted that approximately eight million persons were expected to receive medical care under the Medicaid program in fiscal year 1968.

The following charts show further breakdowns of estimated costs as provided to Congress during its consideration of H.R. 12080:[7]

[In millions of dollars]

	Fiscal year—				
	1968	1969	1970	1971	1972
Cost of title XIX	1,391	1,913	2 239	2,690	3,118
Savings under House Ways and Means Committee bill		−336	−692	−1,058	−1,434
Savings under Senate Finance Committee bill		−45	−702	−938	−1,294
Savings under conference report		−329	−678	−,1037	−1,405

Secretary Cohen also provided the Senate Finance Committee with an identification of those States which currently had Medicaid programs. He indicated that the Department anticipated that by January 1, 1970, all 54 jurisdictions would have programs in operation. The Secretary noted that as additional States came into the program and as the population increased, costs of the program could be expected to rise from the $1.3 billion projected Federal share for fiscal year 1968.

The following excerpt from the Hearings before the Senate Finance Committee shows the program status in the various jurisdictions as of July 31, 1967:[8]

1965 AMENDMENTS (FEDERAL LAW EFFECTIVE JANUARY 1, 1966)

TITLE XIX—ACTIVITIES OF THE 54 JURISDICTIONS TO PUT INTO EFFECT THE NEW MEDICAL ASSISTANCE PROGRAM (AS REPORTED JULY 31, 1967)

A. Program in operation: 35 jurisdictions

1. Plan approved—29 jurisdictions:

California	Maryland	Pennsylvania
Connecticut	Massachusetts	Puerto Rico
Delaware	Michigan	Rhode Island
Guam	Minnesota	Utah
Hawaii	Nebraska	Vermont
Idaho	New Mexico	Virgin Islands
Illinois	New York	Washington
Kentucky	North Dakota	West Virginia
Louisiana	Ohio	Wisconsin
Maine	Oklahoma	

2. Plan not yet approved—6 jurisdictions:

Iowa	Montana	New Hampshire
Kansas	Nevada	Oregon

[6] Page 386, Hearings, before the Committee on Finance, United States Senate on H.R. 12080, part I, August 22–24, 1967.

[7] Partial presentations of estimates on p. 177 of Senate Report No. 744 of the Committee on Finance, November 14, 1967, and p. 177 of House Report No. 544 of the Committee on Ways and Means, August 7, 1967.

[8] Pages 274–275, Hearings before the Committee on Finance, United States Senate on H.R. 12080, part I, August 22–24, 1967.

B. Not in operation; plan material submitted, not approved—2 jurisdictions:

Alabama
South Dakota [1]

C. Plan material in preparation—5 jurisdictions:

Missouri*
South Carolina [2]
Texas
Wyoming**

D. Legislation enacted—1 jurisdiction:

Georgia [3]**

E. Legislation in process—2 jurisdictions:

Passed both Houses: Florida [3]**
Bill introduced: D.C.**

F. Will not implement at present—10 jurisdictions:

Alaska [4]
Arizona [5]
Arkansas
Colorado [6]
Indiana [7]
Mississippi
New Jersey [5]
North Carolina [8]
Tennessee [9]

BUDGET ESTIMATES PROVIDED TO CONGRESS DURING CONSIDERATION OF APPROPRIATIONS

The following figures are the budget estimates provided to Congress for medical assistance. A separate figure was not available for Title XIX until fiscal year 1971.

Medical assistance estimates to Congress:

Fiscal year 1966	$850,000,000
Fiscal year 1967	1,217,968,000
Fiscal year 1968	1,239,300,000
Fiscal year 1968 supplemental	568,342,000
Fiscal year 1968 total	—1,807,642,000
Fiscal year 1969	2,118,300,000
Fiscal year 1969 supplemental	278,022,000
Fiscal year 1969 total	3,396,322,000
Fiscal year 1970	3,057,025,000
Fiscal year 1970 revised	2,677,969,000
Title XIX estimate: Fiscal year 1971	3,113,685

Actual title XIX expenditures

The following are the actual Federal expenditures which have been incurred under Title XIX:

TITLE XIX EXPENDITURES

	Total	Vendor payments	Administration
Fiscal year 1966	$208,634	$193,642	$14,992
Fiscal year 1967	999,832	952,068	47,764
Fiscal year 1968	1,685,268	1,611,644	73,624
Fiscal year 1969	2,143,483	2,052,615	90,868

The CHAIRMAN. Senator Talmadge?

*Conference scheduled in Central Office for discussion of prospectus.
**Conference has been held in Central Office on prospectus or plan.
[1] Plan effective July 1, 1967, "or as soon thereafter as . . . approved".
[2] "Target date" set by State is October 1967.
[3] Awaiting Governor's signature [On 8/4/67 was vetoed by Governor.]
[4] State is interested. Has legal authority but no funds available.
[5] Needs legislation.
[6] Bill introduced in 1967 session was not enacted.
[7] Bill passed by 1967 legislature was vetoed by Governor.
[8] Interested but no action yet taken. *North Carolina*—Governor stated he will request study of effects of title XIX on existing programs.
[9] Plan material in preparation; needs appropriation. Expects to implement in July 1968.

Source: Bureau of Family Services, Division of Program Operations.

Senator TALMADGE. Mr. Secretary, section 225, I believe, provides that they reduce the payments for skilled nursing home care by one-third after 90 days. I have had a great deal of complaint from individuals in my State, from the Governor on down, from all of the people who operate the nursing homes, the profit and the nonprofit, and many of the families of those who are either there or hope to be there for some time. The Governor, I believe, states that it will cost my State $7 million in the first year and $10 million a year thereafter.

In making some inquiry of some of the people involved in these nursing homes, it seems to me that we have some lax procedures for admission thereto. In the age in which we live, many families would be glad to get rid of their parents if they could put them in a nursing home where they will receive good care, particularly if the Government will pay for it.

Are you not going about this thing in the wrong way? Rather than dumping out some paralytic that cannot be cared for, after 90 days, wouldn't the procedure be to tighten up on some utilization procedures prior to admission? I would like your comment on that.

Mr. VENEMAN. I would be glad to, Senator. This question was raised earlier by Senator Jordan. I pointed out that there were two motivations for this provision. One was fiscal and the other was establishing priorities for the lower cost facility care. What we have suggested is that we would increase the Federal percentage for outpatient hospital services, for clinic services, and for home health services.

Senator TALMADGE. Suppose this patient were paralyzed. He cannot be an outpatient.

Mr. VENEMAN. We are not suggesting, Senator, under this particular formula that the patient be kicked out after 90 days. We are only suggesting that the Federal participation be reduced by one-third.

Senator TALMADGE. If the State can't step in and take up the costs it amounts to kicking him out.

Mr. VENEMAN. I think there are some discrepancies in the State figures. This was raised yesterday and in some of the figures cited by your State officials and those we estimated, there is a wide variation.

For the State of Georgia, for example, you said $7 million is what your Governor said?

Senator TALMADGE. $6 million-plus the first year and $10 million-plus the second are the figures he gives to me.

Mr. VENEMAN. Ours would be just about half of that—not quite half. Ours would be more like $4.8 million.

Senator TALMADGE. The first year? How much the second?

Mr. VENEMAN. That would be on a full year basis. It has not been projected into the second year.

Senator TALMADGE. Would you not accomplish the same result by trying to make sure that the patient who was not entitled to skilled nursing home care was not admitted in the first instance, rather than discharging many after 90 days?

Mr. VENEMAN. You do not discharge, Senator. I think there are two things you have to keep in mind.

Senator TALMADGE. It is a question of semantics. If there is no money there, the patient is going to be discharged. It is just a question of who is going to be paying.

Mr. VENEMAN. I think from the beginning of this country, the States and local governments have traditionally taken care of the ill. In other years, it was done with local property tax revenue and local money. Subsequently, the States got into it and were taking care of it. More recently, the Federal Government has participated on a rather generous matching basis. We are saying maybe we ought to take a look at this and figure out whether or not we have placed this in the right perspective as far as the sharing arrangement is concerned and that on long-term care, where the patient is in there for an extended period of time, perhaps we should cut down on the Federal payment. That is essentially what we are doing.

In the mental hospitals, for example, we are suggesting that for care after 90 days, we reduce the Federal payment by a third. After a full year, it would become entirely a State and local cost. Thus we propose to reduce Federal matching for what had traditionally been a State responsibility.

As far as the utilization side is concerned, I couldn't agree with you more. That is the direction we are trying to go in, to make sure that the patient goes into the kind of facility that is necessary for the level of care he requires. I certainly think that Senator Bennett's suggestions—that Secretary Richardson indicated yesterday we would be pleased to work with him on—in trying to strengthen the utilization review are steps in the right direction.

Senator TALMADGE. I had one nursing home operator report to me that he had a prospective patient drive up in his own automobile and he was doing the driving. Would you describe briefly how this utilization thing works? Suppose I decide to open a nursing home for profit. Pick it up and describe it to me from there on.

Mr. VENEMAN. As far as your being a nursing home operator is concerned?

Senator TALMADGE. Yes, I want to go into the nursing home business and I want to operate for profit. How do I proceed? I want to fill it up with patients.

Mr. VENEMAN. The first thing you have to do is make a deal with a few doctors.

Senator TALMADGE. First thing you have to have is the doctors, then the nurses.

Mr. VENEMAN. No, if we are talking about patients that are being financed through medicare or medicaid. First of all, you have to have a patient who meets the eligibility requirements. That patient can't arbitrarily drive up in his own automobile and say, I want to be a patient in the nursing home and assume——

Senator TALMADGE. Whom does he have to be certified by?

Mr. VENEMAN. By a physician.

Senator TALMADGE. Any physician?

Mr. VENEMAN. In medicaid, a physician practicing under the program.

Senator TALMADGE. Suppose I get a physician to go into partnership with me on the nursing home. Can he do the certifying to help me fill up the nursing home?

Mr. VENEMAN. I will tell you, Senator, this is a problem that comes up continuously as we talk about trying to tighten up medicaid, medicare, or any other statute for that matter. How do you write a law so

tightly that you eliminate any kind of deal that can be arranged between a couple of providers? It is a difficult thing to do. I think there are always those who will find a means by which they can commit fraud and get around the law.

Senator TALMADGE. I am not saying that often occurs, but I presume there are times that it does. I know that families would be anxious to get rid of their parents. Perhaps if they could get someone to cooperate, they can say, "Well, Daddy is getting old, let's put him over in such and such a nursing home."

You say Senator Bennett is working on a formula to tighten up the eligibility standards?

Senator BENNETT. May I get into it at this point?

Senator TALMADGE. Please do.

Senator BENNETT. In addition to the proposals for the future, I am reminded that in the 1967 law, there is a provision requiring an independent audit or review by a physician not connected with the case. I do not know how far that has been carried out, but theoretically, that was a way to tighten it up. So that is one more physician this man has to corrupt to be sure of his profit.

Mr. VENEMAN. And then, Senator, you mentioned that you want to make a profit at this. Actually, all you can charge medicare is reasonable cost.

Senator TALMADGE. Do you set the reasonable cost, you and the State? The State sets the medicaid and you the medicare?

Mr. VENEMAN. I will let Mr. Newman, the Commissioner of Medical Services Administration, respond. But I think under medicaid, it is primarily that the reimbursement is based upon actual costs that can be attributed to a specific case or on agreed-upon charges.

Senator TALMADGE. That is set by the State?

Mr. VENEMAN. Primarily it would be, because they have the responsibility for administering the title XIX programs.

Senator TALMADGE. Medicare is run by HEW.

Mr. BALL. Senator, I would assume that most of your questioning has been directed at the Federal-State program of medicaid——

Senator TALMADGE. That is correct.

Mr. BALL. Because the medicare program is really quite different. We are dealing with short-stay cases, only up to 100 days in medicare and it has to be preceded by a 3-day hospital stay, and the whole situation is really quite different. There is no matching formula; the States are not involved.

Senator TALMADGE. You are correct. You refresh my memory on that now.

I would appreciate your looking into that aspect of it. I think cutting off this matching formula there after 90 days is going to do irreparable harm to many of these nursing home operators, whether for profit or nonprofit. And if the State is not in a position to make up the deficit, it is going to mean people are going to be discharged; I do not know what's going to happen to some of them, because I have heard of some real pitiful cases that have been paralyzed, and the family had no assets and no resources. What do you do under a situation like that?

Mr. VENEMAN. If the family had no assets, no resources, and the man was paralyzed and obviously needed some kind of extended nursing home care, I do not think the mere fact that we reduced the Federal matching by one-third would motivate the State to send that patient out in the street. I think the State would assume its responsibility.

Senator TALMADGE. Well, if the State does not make up the deficit on the funds, they will have no alternative. You do not expect a nonprofit or a profit nursing home to make up the deficit, do you?

Mr. VENEMAN. No; I would assume the State would assume that responsibility, Senator, as they have in the past prior to medicaid. That is what I am saying.

The CHAIRMAN. Senator Fannin, I do not believe you have had your turn yet.

Senator FANNIN. Thank you, Mr. Chairman.

Just to follow through on what Senator Talmadge was discussing, I would like to suggest an example involving a nursing home patient, 70 years old. There is a question whether he could be admitted to a hospital. But, the only way he could have coverage is to go into a hospital. Isn't that a requirement? In other words, if he stays in that nursing home, the Federal Government will pay none of the charge. But if he transfers into a hospital, then for a certain length of time, he can have coverage. Is this correct?

Mr. VENEMAN. Senator Fannin, I think you are talking about a medicare patient——

Senator FANNIN. Yes, medicare, not medicaid. I know the complaints I have from my State. Arizona is one of two States that does not have medicaid. The complaint I have had is that the patient staying in the nursing home receives no assistance, but if he transfers into a hospital, he can get assistance for a certain period of time. And the doctor can go ahead and commit him to a hospital, saying that he does need that care.

But in many instances, the doctor will admit that he would be better off and that it would be far less costly for him to stay in the nursing home.

Mr. BALL. Senator, you described the eligibility provisions of the medicare program correctly. Medicare will pay for an extended care benefit—typically this may be in a skilled nursing home that meets the standards of medicare—only after a stay in the hospital of at least 3 days. The thought was that the medicare benefit was not designed to be a long-term nursing home benefit. It was designed to be a benefit with a high content of medical treatment involved. It was to be transitional, after an individual has been sick enough to require hospital care.

The medicaid program and public assistance generally were expected to pick up the need for really long-term care, rather than the insurance program.

Now, the case has been made to us several times by different groups that perhaps there is abuse of the medicare eligibility condition along the lines some doctors have pointed out to you. That is, the person is put into the hospital even though he does not actually require hospitalization in order to make him eligible for the extended care benefit later. I can only say to you that there is no statistical evidence from

our operations to support the idea that this is happening on any large scale. One would expect that if that were going on significantly, you would see a peaking of short-term stays in hospitals—that people would be leaving after 3, 4, or 5 days and going to extended care facilities, and we just do not have that kind of evidence.

On the other hand, I am sure it happens on occasion. I am sure there are such situations. The utilization review committee, as we improve their operation, ought to catch more of this. But if you break away entirely from a hospitalization requirement, I think you will have a more expensive benefit in the medicare program.

Senator FANNIN. I realize that, and that is why I was concerned because it does cost to be moved to the hospital, it does cost extra at the hospital. And still they cannot receive any benefits if this is not done. That is why I was concerned about it. I have had people talk to me as to what they could do, and, of course, in so many instances they are in that nursing home for years and years and receiving no benefit at all. And, of course, they do not have any type of insurance program. They either must move into a State facility or a chronic facility because they would not have any benefit from the standpoint of medicare.

Mr. BALL. You understand that there is a limitation on the medicare extended care benefit of 100 days.

Senator FANNIN. Yes; I understand that, that beyond 100 days they do not receive benefits if they stay in that hospital 100 days.

Mr. VENEMAN. They pick up medicaid benefits——

Senator FANNIN. But we do not have medicaid.

Mr. BALL. Then the regular assistance program could pay for the care in the nursing homes.

Senator FANNIN. Of course, the State does not pay for any benefit, unless you go to the chronic facility or——

Mr. VENEMAN. That would be 100 percent of the costs?

Senator FANNIN. That is right.

Mr. VENEMAN. I just want to make it very clear that the point you raise is not related to section 225 of the bill, which is what Senator Talmadge was talking about.

Senator FANNIN. I see.

PHYSICIANS' FEES

I have had complaints from patients who would say that they continued going to a doctor that they have been going to for a long time and the doctors charge had been increased, but their base for medicare was on their old charge. Then they would have to make up a difference. Whereas, if they went to a new doctor that started out at the higher rate, they would be covered. I do not know whether this was discussed earlier or not.

Mr. BALL. No; it was not discussed, Senator. I am not sure I have your point exactly, but the control on the amount that is considered a reasonable charge is, of course, by individual doctor. And it is true that if the patient changed from a doctor who was charging less to a doctor who was charging more, there would be a recognition of a higher charge because that would be the customary charge of the new physician.

Senator FANNIN. I think I should get you a specific case so I can submit it to you. But I was told that this patient had been going to a

doctor. I do not recall the exact charge. But say it was $8 per call and the doctor had increased to $10. But the old base applied and the patient had to pay the difference. Whereas, if they went to a doctor that had just begun a practice and he had a $10 charge or whatever it may have been, then his full charge would be reimbursable.

Mr. BALL. This is a doctor just newly in practice, so he does not have any customary prior charge?

Senator FANNIN. Right.

Mr. BALL. I can see that could happen; yes.

Senator FANNIN. And here is a patient who says, I cannot stay with my old doctor because, if I do, I am penalized.

Mr. BALL. I would think that would be an unusual situation, Senator, where an absolutely new physician would be involved, but I can see that it would happen in that case. It gives me an opportunity to remind you, though, that the general approach in the medicare program has been to reimburse the physician or the patient, depending on the method that is used, according, generally speaking, to the customary charge that that physician is charging his other patients. That is the general idea.

Now, there are maximum limitations on that related to the prevailing charge of other physicians in the community for a similar situation. And this bill provides for some tightening upon the definition of what constitutes that maximum. But nevertheless, by and large, the approach is that you reimburse for what the physician customarily charges. So, as a patient moves from one physician to another, there may be differences in charges.

Senator FANNIN. That is right. But if that doctor customarily charged, say, $6 for a call, and then he increased his charge to $8, he would be reimbursed, but the person would just receive the benefit of the $6, I understand.

Mr. BALL. At the present time, that is correct.

Senator FANNIN. But they have to pay that doctor $8.

Mr. BALL. The real issue is when do we recognize the change in the fee.

Senator FANNIN. That is right.

Mr. BALL. At the present time, we are still operating under a general approach of recognizing increases in physician fees only in exceptional circumstances. It is our plan that as soon as this current bill is enacted we would revise the approach here and move to new charge screens that would include what physicians had been actually charging patients in the recent past.

Even so, though, there is always a question, when a physician increases his charges, whether the higher charge is a new customary charge. We have thought that there should be a lag in the recognition of the change, and the general approach is that we do not incorporate the new charge in the charge screens for about a year.

Senator FANNIN. Why I am concerned is that here is a new physician starting. He understands the situation. So he starts his fee at a higher rate, perhaps, than he would have normally just to take advantage of this.

Mr. BALL. It is a point, really—that of the new physician—I had not considered, sir.

PRIVATE INSURANCE COMPANIES IN THE MEDICAID FIELD

Senator FANNIN. When we talked about all these plans, I noticed that when the Secretary submitted his statement, he did talk about the reimbursement plans for medicare, and medicaid also. Since our State has not had a medicaid program, we have been trying to get through some type of private insurance or some plan established wherein insurance companies would have a plan supported by the Federal Government; in other words, it would be similar to what the AMA has been recommending and what several other medical groups have been recommending. I know that the President has come down with a plan.

Are you making any studies regarding the private insurance companies becoming involved in a plan to replace medicaid?

Mr. VENEMAN. Senator, we are. We are in the very preliminary stages of it. Now, as a result of our going into interim review of the family assistance bill, in order to take care of one of the notch problems that Senator Williams brought up, the President suggested that we should move in the direction of an insurance program for the family groups which relate the cost to the family to its income.

Senator FANNIN. Yes.

Mr. VENEMAN. We do not feel at the present time that we could draft that kind of legislation and have it available during this session of Congress. We are proposing to require, in the bill, that we present a proposal to Congress early next year—I think the bill says February 15.

Now, we have had discussions with private insurance groups, with the medical associations, and others. We have appointed a technical group within the Department, and also some persons within government, outside of the Department, who are presently coming up with recommendations on how to develop this legislation. We hope to recommend to the Secretary that he appoint an outside advisory committee which would have representatives from providers and insurance groups and consumers to help us develop the plan. We would also hope that we would have the cooperation of the staff of this committee and the staff of the House Ways and Means Committee in developing this kind of a program.

But we are quite a way from a developed plan, to answer your question. But we are moving in that direction.

Senator FANNIN. I know I have been very concerned. I did introduce a bill which has received AMA support. I do need more information and we need more information. I realize the difficulties of a program of this nature and would be glad to have any information that you can develop.

Mr. VENEMAN. We do feel we can develop a plan in 6 months.

Senator FANNIN. It is your recommendation, then, that we hold off on any legislation until after you have had a chance to have an in-depth study?

Mr. VENEMAN. We feel that that would be desirable. I think that all of us have a tendency to look back on medicaid a little skeptically and see what happens when you rush into major programs and fear that we might be confronted with that type of situation if we attempt to amend this particular social security bill to provide this kind of insurance program.

Senator FANNIN. That is what I was considering, whether or not I should offer my bill as an amendment at this time, as we are concerned in my State, because we do not have a medicaid program. I am being asked to go forward as rapidly as possible; at the same time, we want a carefully studied plan, one that would be practical and would be within the range of costs that might be involved.

I notice that the program was one recommended by the unions not too long ago, and would cost about $37 million.

Mr. VENEMAN. That is the Committee-of-100 recommendation.

Senator FANNIN. That, of course, is getting into a program at this time that perhaps would not be feasible, with the present economic conditions. I do not know whether such a program would ever be a practical solution to the main problem because of the fantastic cost.

Mr. VENEMAN. Well, you have some variables in there, Senator. It would depend upon the level of coverage that the Federal Government established as a national base.

Senator FANNIN. It would be full coverage, as I understand it, of everyone, and it would be for a certain income under the bill. I recommended that it would be on a family of less than $5,000 income, but the Government would pick up the full premium of the insurance involved. Now, of course, the question is how much insurance can you provide and whether it would cover catastrophic illnesses. Of course, this is the great fear that everyone has with regard to their position in life, that they will have this tremendous cost. I think this is the area in which the Federal Government can be most involved. It is very difficult for anyone to carry a policy that would cover a catastrophic illness.

Mr. VENEMAN. That, of course, would be another variable, the income level for eligibility, and the premium that would be picked up. Another problem would be the universe, how much of the population you want to cover.

What the President has suggested in the proposals that we will be discussing next week when we get to the Family Assistance Plan is that we cover the family groups, using the same eligibility provisions that we do when we use the family assistance plan, which covers the AFDC caseload plus the working poor.

Senator FANNIN. At that time, we will discuss some of the provisions I have in the bill that I have recommended. I do thank you.

Mr. VENEMAN. Thank you.

The CHAIRMAN. Senator Anderson?

Senator ANDERSON. Two questions.

DEFICIENT HOSPITALS CERTIFIED FOR MEDICARE

You have certified for medicare on one basis or another many hospitals and extended care facilities with significant deficiencies. Why should not the Secretary be required to give public notice as to those institutions which have significant deficiencies which have gone uncorrected for 60 days or more? Would that not encourage prompt upgrading and enable doctors and patients to make more informed judgments as to the quality of care in a given institution?

Mr. VENEMAN. I am not sure that we have a notification period in there, Senator Anderson, but we have had to revoke the privilege of

providing covered care to medicare patients in the past to certain facilities. I will let Mr. Ball speak to that. I know there was one in New Jersey.

Mr. BALL. I am not at all sure that we have any objection to that proposal. I would like to give it some consideration. With your permission, Senator, I would like to be able to expand in the record a report on where we stand today on the extent to which any such institutions are actually participating in medicare.

Significant deficiency, as you know, is a relative term. In the review of a hospital or extended care facility, they very often find a few instances where the institution is not exactly up to the full requirement on some relatively minor points. I would not be including that type of thing. But we have still some so-called access hospitals that have significant deficiencies. I think it might be helpful to the committee to supply, with your permission, a current updated report on where we stand on hospitals and ECF certified with deficiencies.

Mr. VENEMAN. I would like to see also the specifics on the proposal. I think if we have a very blatant situation where the facility is participating under medicare and they should not be there, we would want to withdraw medicare certification, and I am just wondering whether the 60-day notification might tend to delay our doing so.

Mr. BALL. We would have to terminate in the case that the Secretary suggests, certainly. I take it this proposal relates to those where there is a significant but not dangerous falling below the quality standards. Our present policy is to exert continual and increasing pressure on such institutions to bring them into compliance. In addition, there are also the so-called access institutions. These are confined to the hospital area now and involve a relatively few hospitals most of which serve such isolated communities. The SSA and the State agencies that help us to determine which hospitals meet medicare's requirements are regularly evaluating these facilities.

REPORT ON STATUS OF HOSPITALS AND EXTENDED CARE FACILITIES WITH DEFICIENCIES

The conditions of participation for hospitals and extended care facilities are extremely comprehensive, covering almost 500 individual items for hospitals, and more than 400 items for extended care facilities. While the conditions contain a number of individual items that must be met to assure that a facility is basically rendering adequate and safe care, the conditions, in their entirety, represent a standard of excellence that all participating providers should be working toward.

It is possible to certify a provider for participation in the Medicare program if it is in full compliance (meets all of the statutory requirements of the Social Security Act and is operating in accordance with all other requirements in the Medicare conditions of participation) or if it is in substantial compliance (meets all of the statutory requirements and all of the most important requirements in the Medicare conditions of participation). This means that all statutory conditions for compliance must be met and that deficiencies in failing to meet the regulatory requirements established by the Secretary must not be of a type that would endanger the health and safety of the patient, e.g., the facility does not have available to it the periodic services of a qualified dietitian, but its food service personnel are experienced, effectively trained and supervised, and are performing in a satisfactory manner. We believe it is quite essential, particularly in rural areas and particularly in the early years of the program, that institutions be allowed to come into full compliance gradually as long as they substantially meet the conditions of participation.

As of June 15, 1970, 6,776 hospitals and 4,656 extended care facilities were certified for participation in the Medicare program. Of these, 4,666 hospitals and 1,274 extended care facilities were certified as being in full compliance with all requirements.

INADEQUATE DATA ON CUSTOMARY CHARGES

Senator ANDERSON. The provision tightening up medicare patients to doctors, the provision in the House bill, uses calendar year 1969 prevailing charges as the base period. Our staff reported that many carriers had and some still have inadequate data on charges. Do you disagree with the findings of the staff on that point?

Mr. VENEMAN. Mr. Tom Tierney, Mr. Chairman.

Mr. TIERNEY. Senator, the House bill would establish as a base year calendar year 1969, as you stated. In the year 1968, referred to at the last hearings before the committee, it was substantially true that some carriers did not have adequate charge data on customary charges. With only one or two exceptions, we think there is adequate data on 1969 customary charges to use as a base period for future computations. I know of a couple of carriers who would not have full year data on all categories of charges, but we think that there is a sufficient mass of data in every one of the carriers now upon which to predicate future increases.

Senator ANDERSON. Thank you.

In the event the committee wanted to consider agreeing to the House provision, would you be willing to certify in writing to the committee that for each carrier area, the medicare 1969 prevailing charge data are properly constructed and are based upon comprehensive data on charges to the total population in each carrier area?

Mr. VENEMAN. I will let Mr. Tierney respond there. I think the way the question is phrased would require probably a great deal of research, Senator.

Mr. TIERNEY. I think, as the Secretary implies, before we make such a certification, we would want to take a long look, Senator Anderson. Your question is whether there is a comprehensive assemblage of data on all charges to the entire population, and I am not sure we would be able to certify that there is in every case. We do know that there is a total compilation of charges that were accumulated in 1969 to medicare beneficiaries. But I would not say to you, sir, that we could provide an absolute guarantee of a total assemblage of all charge data for all people in the States. I agree with Mr. Veneman that we would have to study that.

Senator ANDERSON. Thank you, Mr. Chairman.

Senator BENNETT. Mr. Chairman, may I have a question or two?

The CHAIRMAN. Senator Bennett.

POSSIBILITY OF LIBERALIZING ELIGIBILITY REQUIREMENTS FOR MEDICARE

Senator BENNETT. I understand that the House bill contains a provision permitting uninsured persons 65 years of age or over to buy into medicare at cost, presently estimated at $27 per month. Now, there are many medicare beneficiaries over age 65 whose spouses under 65 have great difficulty in securing health insurance. It would seem to me that if you are going to be willing to permit people over 65 to pay a fee and get the benefit of medicare, maybe the same option could be extended to the spouses of individuals who qualify for medicare. You would probably have to put a lower age limit on that—maybe 60. And it is my understanding that because they are obviously younger than those

people over 65 who might buy medicare, their actual cost of serving them would be less than the $27 a month that is proposed to be charged to permit people over 65 to apply. Would you consider an amendment that might produce that kind of result?

Mr. BALL. Senator, you have unquestionably put your finger on a very difficult situation in the present setup. Where in the past there frequently were policies that covered the man over 65 and his wife, the existence of medicare has very often——

Senator BENNETT. Has destroyed this private insurance, that is right.

Mr. BALL (continuing). Has very often made it difficult or impossible now for the wife to get coverage. I am sure we would be very glad to consider the desirability of an amendment along the lines that you are suggesting. I am not prepared right today to see all the angles of it, but you certainly have identified a real problem and we would like to work with you on a possible solution.

Senator BENNETT. I would appreciate that. I assume that by the time the hearings end or before we meet to try to write the bill up, you can have a specific suggestion for us?

Mr. BALL. Yes. It would not necessarily follow that the rate would be less, but we will take that into account. The point you make is a valid one, but there are other factors that I think we have led our actuaries to think there might be some antiselection in the group between 65 and 60 who would take advantage of this. There would be some advantage——

Senator BENNETT. There is antiselection in the group above 65. They are still free to select or not to select.

Mr. BALL. Yes, but almost all of them have no other opportunity to buy protection.

Senator BENNETT. Well, a man over 65, a male spouse over 65, and a large percentage of those are retired, is going to find it very difficult to get any kind of insurance—(a) to find any kind at all, and (b) any kind that he can afford to pay for. So I would think the negative selection would be very low in that group.

Well, work on it and see what you can come up with.

Mr. BALL. I shall be glad to, sir.

PROSPECTIVE REIMBURSEMENT

Senator BENNETT. We understand that hospitals are in favor of prospective reimbursement, which you advocate. Is it your impression that they would receive more or less money under prospective reimbursement compared to the present method, or about the same?

Mr. BALL. Senator, I feel and the administration feels that over time, the prospective rate approach will encourage economy and efficiencies in the operation of hospitals so that it would be possible for them to get full reimbursement and yet have a lower total amount paid out than would be true under the present approach.

Now, I am sure that the hospitals, in looking at prospective rates, will be arguing for the inclusion in those initial prospective rates of everything possible, and we on the other hand, in the protection of the Government interest, will not be agreeing with some of the things that they will be pressing for.

But what is important about this proposal, I believe, is not so much the first year's rate but rather to move a system where the ingenuity of the managers of hospitals throughout the country is challenged to get under those rates that year and the next year, because their hospitals will benefit from savings. The present approach of saying we will reimburse whatever costs you come up with, as long as they are reasonable, on a retroactive basis, does not seem to me to hold any hope for engaging their interest in economy and efficiency such as this prospective rate has. So I would say in total and over time, we would expect to pay out substantially less under a prospective rate approach than under the present retroactive cost reimbursement approach.

Senator BENNETT. It would also greatly simplify the bookkeeping and the control, the operation of the relations between the agency and the hospital, would it not?

Mr. BALL. It depends, Senator. I would hope it would have that effect significantly. It, of course, depends on the exact terms of arriving at these prospective rates. I do believe you are going to have to start from a basis of their past costs, so much of what is required today would continue to be required. But I think there are simplifications that can be worked out.

Mr. VENEMAN. I believe, Senator, that Mr. Ball has really put his finger on the motivation for recommending prospective reimbursement. I do not think we can anticipate a major first year saving. But it certainly should have the effect of reducing the costs as the years go by, because the incentive is in the right place. The incentive is, once you determine payment in advance, to save costs. If a person can leave a hospital one day earlier, the motivation is to move him out. At the present time, you just pay him for it. I think the extra benefit of this that perhaps we are not really looking at is—in addition to the potential saving that we may have to public funds, because of putting the initiative and the incentive on the right side—the effect the proposal would have on the general public that is paying their own hospital bill. Because the more efficiently and effectively a hospital is operated, to that extent, everybody benefits.

Mr. BALL. There is one aspect of this, Senator, that perhaps neither of us has brought out. It is not only inventives to economy and efficiency of operation as we have indicated, but a built-in resistance—as compared with the present approach—to the addition of services during the course of a year and to going along with pressures for increases in wages and salaries during the course of the year. I do not know any other part of economic life where there are as few restraints as there are in the hospital area where the Government is paying about half the cost on the basis of saying, after the fact, we will pick up those costs, rather than saying ahead of time, we want to know what the situation is.

Senator BENNETT. Do you have a program for reviewing those rates periodically? You say there is an incentive for the hospital to get its costs down under your rates. Are you going to review them so that if they presumably make significant reductions in cost, they can be reflected in significant reductions in the prospective rates?

Mr. BALL. Absolutely, Senator. That is the idea.

Senator BENNETT. You are going to have a lot of fun developing a type of arm's-length negotiation which will enable you to bargain with the hospitals. You are already having that problem now.

Mr. VENEMAN. We have the problem now, Senator. We just have to refine our ways of handling it.

TAXABLE EARNINGS BASE

Senator BENNETT. When we enacted medicare, we insisted on assuming that for purposes of hospital insurance, the taxable earning base would remain unchanged during the period of the estimate. The reason for this conservative assumption was to provide a margin of safety in the event of adverse financial experience with medicare. Now I see that this safeguard has been removed in the House report and after 5 straight years of unfavorable hospital insurance experience, is this a wise decision as a base for making future estimates?

Mr. BALL. Senator, the bill, of course, as it was amended on the floor of the House to include the President's recommendation, provides for actually writing into the law automatic increases in the earnings base. Consequently, under those circumstances, I would not think there would be any doubt but that you should take into account the actual provisions of the law.

Now, it is true that the trustees of the hospital insurance fund and the House Ways and Means Committee, as well as the Social Security Administration, feel that even without writing those provisions into the law, the performance of the Congress in keeping this wage base up to date since 1950, and the grave consequences to the cash benefit program that would exist if you had rising wages but did not raise that base, are sufficient reasons to assume that the maximum earnings base would continue to be kept roughly in line with what it was in the early 1950's as it has in the past.

Now, I think I would have the same sort of doubts that you are expressing if it were not for the fact that out of the experience with the hospital insurance program now in actual operation have come fundamental revisions in the cost estimates which, as you know, show much higher costs than originally estimated. And with those increased costs based on experience rather than the earlier speculation, I think we are in an entirely different position and can afford now to make this assumption.

Senator BENNETT. You will maintain the wage base, but change the tax rate?

Mr. BALL. No; the wage base is assumed under the estimates to rise as wages rise.

Senator BENNETT. I see.

Mr. VENEMAN. The tax rate proposed in the administration's proposal is to remain at 1 percent.

Senator BENNETT. The tax rate remains, but you would change the base?

Mr. BALL. As wages go up, the earnings base would go up automatically, under the President's proposal.

Senator BENNETT. Thank you.

No other questions, Mr. Chairman, at this time.

The CHAIRMAN. Thank you. I would like to ask a few questions here that I have been withholding so others could have their turn.

HOSPITAL INSURANCE COST ESTIMATES

At the February hearing on the staff report, both the Department and the committee expressed at length their mutual concern over the validity of the hospital insurance cost estimates. You indicated that an actuarial task force had been appointed to review those estimates. Are the costs and financial assumptions in this bill based upon the estimates we both criticized in February, or are they based on the work of the task force?

Mr. VENEMAN. These are based, Mr. Chairman, upon the actuarial estimates that you had in January. As I indicated earlier, the task force is due to meet again in September. Whether or not they will have their report at that time, I cannot respond, but I have agreed to look into it.

Mr. BALL. Mr. Chairman——

The CHAIRMAN. Then if I understand it, these estimates are of the same sort that we criticized very severely.

Mr. BALL. Mr. Chairman, I do not believe that is correct. The criticism that the committee had was of the rapid increase in the cost estimates—the fact that they had been changing over time. I do not believe there was specific criticism of the new assumptions in the cost estimates that are involved in this February document. I should make clear, too, that this outside task force has not been charged with the job of making the estimates. They have been charged with the job of examining the reasonableness of the assumptions that the actuaries have made. That is what they are going into now very thoroughly.

In the meantime, these are the latest cost estimates. They have been greatly increased, as you know, over previous estimates, and I think you can have a lot of confidence that they are high enough.

The CHAIRMAN. Well, here is what we were told about this matter by Mr. Butler in February. He said that group will be reviewing the estimates of both the medicaid title XIX and medicare programs, and we will hope to report to the committee at a later date what develops from their deliberations. Now, it was my impression that we were to have better and more firm estimates upon which these large additional taxes were to be based. That makes me wonder whether we are justified in going ahead and imposing these new taxes unless we have the benefit of these new estimates and whatever additional advice they can give us on this subject. What's your thought about it?

Mr. BALL. My thought, Senator, is that I have a great deal of confidence in these new actuarial cost estimates that were discussed with the committee in February. I know nothing from preliminary discussions with any outside groups that give me concern on this matter. But to be absolutely safe and to be sure that they were not too high or too low, we have asked this outside group to examine these assumptions which our actuaries are explaining to them and they are going over them. We will have a report from them giving their views on these assumptions in September.

As the Secretary indicated earlier, he is willing to consider whether that could be speeded up a little.

Mr. VENEMAN. And I think that is a key point, Senator. I think that perhaps what Mr. Butler was alluding to is that we would have this group look into the assumptions upon which the benefit level was

based, or the contribution scale was based. This is really what the task force is gearing itself to determine—whether or not the actuaries have taken into consideration all factors and whether or not those factors that were taken into consideration were properly determined.

The CHAIRMAN. The House report defends the future increases in the wage base for purposes of financing the hospital insurance program on the basis that although a safety factor—that is, a fiscally conservative assumption was needed when there was no firm indication of what the actual future cost experience would be: "Now good data are available to the actual current experience, and so such a margin is no longer necessary if adequate reasonable assumptions are adopted as to future trends of unit costs of services and of utilization of services."

Commissioner Ball, the actuarial assumptions have had to be revised every year since the beginning of the medicare program. In fact, they were revised twice in 1969. What makes the House confident that the present cost assumptions will not suffer the same fate?

Mr. BALL. I do not know that I can speak for the House, Mr. Chairman. But I have the same confidence—that these are reasonable estimates. Nobody can say over a period like 25 years that it may not be necessary to make changes in them. But there has been a substantial increase in the estimates as relates to how much hospital daily costs are going to increase year by year into the future. To the extent that these estimates now provide over a 10-year period a 110-percent increase, they more than double the hospital daily rate, plus the fact that we have introduced the idea that utilization will increase as well.

Now, beyond that, Senator, the way we are proposing to finance the hospital insurance program from here on is to put it on a level basis, raising the rate of 0.6 percent up to 1 percent. If it should turn out that these estimates are by any chance still understated, there is not any doubt but what that 1-percent contribution rate is adequate for many years into the future. The difficulty, if any, would arise only in the latter part of the 25-year period.

So I see no risk in moving to a 1-percent rate as adequate for many years in the future.

POSSIBILITY OF PLACING WELFARE RECIPIENTS IN THE HEALTH CARE FIELD

The CHAIRMAN. We are concerned about finding jobs for welfare recipients. HEW, representing Government health programs, has told us repeatedly of shortages of licensed practical nurses, nurses aides, and assistants of that sort. Specifically, what has HEW done or what can HEW do to involve, train, and place welfare recipients as practical nurses, nurses aides, dietary assistants, and so forth?

Mr. VENEMAN. Actually, Mr. Chairman, this deals with two programs, one of which would be the WIN program and another would be manpower training programs in which the DHEW is involved, along with the Department of Labor. For the most part, whether or not you take a specific welfare recipient and attempt to train him in these areas as the desirable thing to do, depends upon a number of factors. But I think in most of these programs, there are paramedical training courses.

We have another problem. It depends upon the State that you are involved in, too, because many of these positions on a paramedical level

require the ability to pass a State licensing course. Much of this is done. I know in California, in some cases, perhaps not so much welfare recipients, per se, but potential welfare recipients are in programs in the junior colleges and community college system which train them as nurses aides and for other paramedical positions.

The CHAIRMAN. Would you provide for us, in the record, if possible, just how many welfare recipients are involved in these various programs?

Mr. VENEMAN. All right. I think we have to look at it, though, Mr. Chairman, from two perspectives. One would be the number of actual recipients in these kinds or job training programs which would probably, I would suspect, be relatively small. But I think more significant is the potential recipient, one who could very well become the welfare recipient, who moves into a training course of job upgrading, rather than remaining in an unskilled job that might ultimately end up in dependency.

(The information requested follows:)

In the delegated program (1964–1969) Work Experience and Training under Title V of the Economic Opportunity Act, the Department of Health, Education, and Welfare directed particular attention to greater use of paraprofessionals or aides as part of the effort to alleviate manpower shortages in institutional health and related programs with particular emphasis on employment of low income persons. In most projects in this field, classroom training was combined with on-the-job training. The extent of training of personnel as paraprofessionals and aides is illustrated by the following breakdown of Title V projects during one year:

Occupation	*Number of projects with training component*
Health:	
Medical-hospital aides/lab technicians	46
Licensed practical nurse	64
Nurse's aides and orderlies	149
Dental aides/technicians	13
Home health aides	10
Other:	
School and teacher aides	36
Child/day care/nursery school aides	27
Homemaker aides	21
Home aide specialists	6

In the health and paramedical field cooperation was enlisted from many sources, including two Federal agencies: The Division of Hospitals and the Division of Indian Health in the Public Health Service, and the Veterans' Administration. The U.S. Public Health Service hospital in New Orleans, in cooperation with the Title V program, trained and employed medical aides with great success.

The scope of the training in the health field in the training of paraprofessional aides is illustrated by the following Title V assignments in one year: 175 child care and nursery aides, 27 family day care aides, 242 homemaker service aides, and more than 500 health aides. Trainees learned skills as surgical technicians, nursing assistants, therapy aides, dietary aides, pharmacy assistants and laboratory assistants.

According to information made available by the Department of Labor, there were approximately 2,300 public welfare recipients provided MDTA training in the health field during fiscal year 1969. The training included professional nurses, nurse's aides, licensed practical nurses and orderlies.

Many WIN Program trainees (AFDC) are co-mingled in Department of Labor regular manpower programs. Therefore, data are not available on the number of WIN trainees assigned to training in the health field.

(The following table shows data on employed WIN trainees:)

WIN employed terminees in health occupations[1]

DOT major occupational grouping	*Percent of employed trainees*
Occupations in medicine and health, n.e.c., e.g. medical or dental assistants, technicians, therapists	2
Attendants, hospitals, morgues and related health service, e.g. nurse's aids and orderlies	6
Occupations in social and welfare work, e.g. case aid, program aid, group work	2

[1] Based on reports for 4,788 employed WIN terminees processed through January 1970.
Source: U.S. Department of Labor Manpower Administration, Office of Manpower Management, Data Systems, July 24, 1970.

The CHAIRMAN. The nursing home associations testified last month that they had reasonably good success in taking some of these people and putting them to work in nursing homes, and believe that there is a considerable potential in that area. So if they can be used to provide service in that connection, it seems to me that in that regard, one of your programs can help the other program.

Mr. VENEMAN. I think this is the service deal that lends itself to these kinds of people. However, I do want to reiterate that as you do get into the more skilled jobs, you do run into that licensing barrier.

Mr. Newman, I think could add a little bit to that.

Mr. NEWMAN. Mr. Chairman, I would like to comment with regard to the medicaid program. The concern that you have expressed about the use of so-called nonprofessionals is directly stated in the statute authorizing the medicaid program. The statute directs us to attempt in those States in which it is feasible to use nonprofessionals in the administration of this program. We have just begun, as the result of the reorganization of the Medical Services Administration, to encourage the use of medicaid in innovative health delivery programs which would encourage use of nonprofessionals and develop community aids who can begin to fill roles in delivering health services. We have begun.

The CHAIRMAN. Well, in those areas, if you have had personal experience, you will know that when you have someone in your family who is very ill, it is just amazing how difficult it is to get someone with any competence at all, just to help or sit with a person who is very ill. Oftentimes, relatives are willing to pay whatever it takes to provide help, but they just can't get it. Yet we have all these people over here by the thousands who are drawing money and apparently are not capable of doing anything. All you are talking about in many cases is somebody to sit with the sick person and to call for the registered nurse or call for the doctor if the person takes a turn for the worse.

Now, a lot of these people who are drawing welfare money can be trained to do that kind of work. It seems to me that with the shortage of people to help in this area, one program should complement the other. You are paying money on the one hand for people who are doing nothing and on the other hand, we are trying to provide care which is very difficult to obtain because there are no people to do the work. It seems to me that one hand should help wash the other. Maybe we can get some results.

Now, some of these programs interrelate. We just passed an amendment the other day to put more money in to try to provide sanitation, water, sewage in communities that have never had it in the history of

this country, and some of those communities are more than a hundred years old. It would be better, rather than paying money under a family assistance plan, if we had that man out there working, putting water into people's homes and providing for sanitation and sewage treatment rather than to have nothing to show for it.

While in some respects, one takes the view that this program has nothing to do with that one, many times, they do. I would hope that we could relate them insofar as possible.

Mr. VENEMAN. Mr. Chairman, I would agree that this kind of program, if it should pass, would open up job opportunities. But there is the requirement requiring prevailing wage rates in certain skills. I think, as these job opportunities open, job opportunity programs dealing with welfare recipients should be geared to the kind of job that is available. So if that community was in fact putting in a water supply system and there was additional manpower needed, I would hope that the training program would be geared to provide that kind of labor from the potential public assistance market area.

The CHAIRMAN. We need people handling a program like that who know how to make it work, rather than people who know how to keep it from working.

Senator Anderson once made a statement; he said if an administrator wants to make a program work, he can usually find a way to make it work. If he does not want to make it work, he can find a thousand reasons why it will not work. He really needs some good administrators.

Mr. VENEMAN. What we are working up against, though, are barriers placed in the statutes, either at the State or Federal level.

The CHAIRMAN. That is something we want to try to do something about. I hope you will help us with it. I am going to introduce a proposal to try to provide day care for these children, try to make it available throughout this entire country.

One of the big obstacles that we have to overcome in that regard is that in all these communities they perceive that such standards would stand in the way of providing day-care services.

Mr. VENEMAN. And make it impossible for certain people to assist in it. I think Governor Williams of Mississippi participated in that recently.

The CHAIRMAN. We will set our own standards, and as long as they comply with the standards we set, our law will prevail over the local law. We are not going to try to help these people on the one hand and then find that they are trying to pass laws to keep it from working on the other. If you want it to work, do whatever is necessary to give it a chance.

How many billions of dollars in new medicare payroll taxes would be imposed in calendar 1971 under this bill? That is, how many billions of medicare taxes would you get under present law in 1971, and how many billions under the bill? Would that be 4.1 in 1971?

Mr. VENEMAN. Additional income of $4.1 billion would be correct for the hospital insurance program for 1971.

The CHAIRMAN. And how many billions of medicare taxes would you get under present law, in 1971?

Mr. BALL. Present law income would be about $6 billion.

The CHAIRMAN. That is what I estimated. How many billions under the bill?

Mr. BALL. We are talking of income now.

Mr. VENEMAN. Wait a minute. Are you in the hospital insurance side, Mr. Chairman?

The CHAIRMAN. Yes.

HOSPITAL TAX EXEMPTIONS

Mr. VENEMAN. Good; then we are on the same wavelength.

The CHAIRMAN. The House version of the tax reform law had a condition removing the requirement that with the addition of tax exemptions, hospitals provide free or below-cost care to the extent of their financial ability. The Senate deleted that provision, preferring to consider the matter when they took up medicare this year.

The Senate concern was that without the present requirement of tax exemption, hospitals might claim that medicare and medicaid paid less than their costs, and might refuse to take or might limit their admissions of medicare and medicaid patients.

Additionally, large numbers of poor people, including those on general welfare assistance, might also be denied or limited in access to the necessary hospital care.

The National Governors' Conference agreed with and supported the Senate action. What is the position of the Department of HEW on this issue?

Mr. VENEMAN. I am not sure that we have taken a position on that particular issue, Mr. Chairman. I do not think there has been a departmental position. If you would like us to review the proposal, we shall be happy to do that and place the Department's position in the record.*

CARE FOR MIGRANT WORKERS IN COMMUNITY HOSPITALS

The CHAIRMAN. What is your experience with treating migrant workers in community hospitals?

Mr. VENEMAN. It varies. I think that perhaps Mr. Newman can speak to that question better than I. I can speak to it from personal experience in California, which has a system of county hospitals.

For the most part, in California the counties care for migrant farmworkers in public facilities regardless of the duration of their stay, the amount of time they have been in the county, or anything else.

I am sure that experience in caring for migrants varies from State to State, and I shall ask Mr. Newman to answer the question more generally.

The CHAIRMAN. Would that be the case if they were purely charity patients?

Mr. NEWMAN. Yes, Mr. Chairman. A significant problem in the medicaid program is that eligibility is determined at the State level, and as you know, eligibility for cash assistance is often the only determinant for medicaid eligibility. Migrants are often shut out of medicaid because they are not eligible for cash assistance.

The CHAIRMAN. Here is a list of questions Senator Gore sent to me. I think I shall ask a few of them and then I shall submit them and you can respond for the record to the rest of them.**

*At presstime, Sept. 3, 1970, the material referred to had not been received from the Department.

**See app. B.

GORE BILL INCREASING MINIMUM MONTHLY SOCIAL SECURITY PAYMENTS

Senator Gore says that he introduced a bill, S. 3658, to increase the monthly social security benefits to $100 per month for a single person and $150 per month for a married couple. What is the administration's position on that?

Mr. VENEMAN. We oppose that proposal. Our proposal is, as far as the minimum is concerned, that the minimum be increased to $67.20 as a result of the 5-percent increase.

The CHAIRMAN. What would the cost of it be? I assume that is mainly——

Mr. BALL. I think that there are really two bases——

Mr. VENEMAN. One is whether or not you want social security to provide a minimum income level. There are people on social security who have considerable amounts of money and who get the minimum benefit. I would have some reservations about making the minimum as high as $100 or $150 for them.

Mr. BALL. It is also an expensive proposal, Mr. Chairman. I believe it would cost 0.36 percent of payroll on a level cost basis. As the Under Secretary was suggesting, I think it is important not to equate a low-paid regular wage earner with a man who gets the minimum benefit under social security.

If for the future you took a person who earns the Federal minimum wage, if he were regularly under the program, he would get benefits significantly above even the $100 minimum. He would get $139 under present law and $146 under the bill.

When you increase this minimum you tend to use the funds of the program for relatively short-term contributors who move in and out of the system, some of whom, it is true, are very poor people. Many of them have held jobs only occasionally throughout their life, and just barely qualify for benefits.

On the other hand, you also pay people who are covered principally by other retirement systems, but who work a little bit in social security, like certain Federal employees or certain State and local employees who are not in a State that has covered them by agreement under the social security program.

So on both substantive and cost grounds we have strong reservations about a proposal for a substantial increase in the minimum benefit.

The CHAIRMAN. You might be able to document your position in better and greater detail by giving us a letter on that, too, to show in categories who are the people, whether they benefit or not.

Their argument is for the same amount of money, you could more efficiently provide for those who need it most, I take it.

Mr. BALL. We must also consider the appropriateness of using this system, which is a wage-related contributory system, to pay substantial benefits that are really not wage-related. The whole principle of the minimum is that you just pay it, regardless of what people's earnings have been. Who has to pay for that? The people who have to pay for a higher minimum benefit are the regular contributors to the program.

I shall be glad to submit a letter for the record.

(The letter follows:)

JULY 29, 1970.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance, U.S. Senate,
Washington, D.C.

DEAR MR. CHAIRMAN: This is in reply to the Committee's request for further information on who would benefit from a substantial increase in the minimum payment under social security.

As you know, over the year, the minimum social security benefit has been increased—and a good deal more than proportionately to the increase in benefits above the minimum. The present minimum benefit of $64 a month ($67.20 under H.R. 17550) is payable on average monthly earnings up to $76.

One fact relevant to the size of the minimum is that eligibility requirements under the social security program are quite liberal. Men who reached age 65 (or women who reached age 62) in 1957 or earlier were able to qualify for retirement benefits with only 6 quarters of coverage. And these quarters of coverage could have been acquired with earnings of as little as $50 per quarter—a total of only $300 in covered earnings. A man reaching age 65 (or a woman reaching age 62) this year needs 19 quarters of coverage—4¾ years of work—or about one-fourth of his working lifetime after 1950 in order to qualify for benefits. In the mature program, a worker will need 40 quarters of coverage (10 years of work)—again only about one-fourth of a working lifetime—to qualify for benefits. And he can do so with earnings totalling only $2000 over a full working lifetime. Thus even a casual attachment to covered employment will enable a person to qualify for minimum benefits.

A further point is that the difference in covered earnings between a person who is barely insured and one who barely misses becoming insured may be minimal. And the difference in benefits—no benefit at all versus benefits of at least $64 each month for life—is substantial. This situation exists under present law, of course, but as the minimum benefit goes higher, the situation becomes less easily defensible.

The people who would not be helped by an increase in the minimum benefit are regular workers; such workers do not generally qualify for minimum benefits. A person who has worked regularly under the program at the level of the present Federal minimum wage ($1.60 per hour), for example, would get, under present law, not the minimum benefit of $64 but rather a benefit of $130.20 a month (at age 65) ($146.20 under H.R. 17550). And a man retiring at age 65 in 1971 with full-time earnings at the Federal minimum wage that was in effect over the years would get a benefit of $119.80 a month ($128.70 under H.R. 17550).

Another sizable group of people who in many instances would not be affected by an increase in the minimum benefit are women—about one-half million of them—who are getting minimum benefits based on their own earnings but who are also getting supplemental wife's or widow's benefits based on their husband's earnings. The maximum amount that can be paid under the law to a woman who is eligible for both her own benefit as a worker and a wife's or widow's benefit is equal to whichever of the two benefits is the larger. Where the wife's or widow's benefit is the larger, as in the case of these half million women, the woman gets her own benefit plus a wife's or widow's benefit that is equal to the difference between her own benefit and the wife's or widow's benefit she would get if she were not entitled to her on benefit. An increase in the minimum benefit would not result in any higher total benefits for a woman in this group if the new minimum is not higher than her wife's or widow's benefit. Where the new minimum is not higher, her own benefit increases, while her wife's or widow's benefit decreases, and the total amount payable remains the same.

At the end of January 1970 (after the 15-percent benefit increase) an estimated 2.2 million beneficiary families—11.8 percent of all beneficiary families on the rolls—were getting social security benefits based on a minimum primary insurance amount of $64. There were 2.7 million beneficiaries in these 2.2 million families. (These figures exclude the dually entitled wives and widows mentioned earlier—i.e., wives and widows who are getting a minimum benefit based on their own earnings and who are also getting a supplemental wife's or widow's benefit based on the earnings of a husband.)

Obviously all of the workers with minimum primary insurance amounts have very low average monthly earnings under social security; otherwise they would not be getting minimum benefits. The individual characteristics of these people vary widely, of course, but, generally speaking, they have low average monthly earnings under social security for one of three reasons.

Some people have low average earnings because they were already well past middle age when social security first covered their jobs. Prior to social security coverage they worked regularly in good-paying jobs and had high earnings. Then, as they advanced in years, they lost these jobs for one reason or another. By the time social security coverage came along they were in less well-paying jobs, which, because of advanced age or perhaps lack of skills, were the best jobs that they could get. Their average earnings under the program are low because only their years of poorest earnings were covered; their years of highest earnings occurred before social security coverage was provided. Already, though, this problem is disappearing; low employment and earnings in recent years will qualify for benefits well above the minimum because their years of high earnings as well as their years of low earnings will be covered.

Some people have low average earnings because their earnings have always been low. Some of these are domestic and agricultural workers, including those whose earnings were low and sporadic and in large part not covered because they did not work long enough for a single employer to meet the coverage test in present law. Others have lived in depressed areas where the opportunities for work may have been quite limited. Still others have been subsistence farmers—people who have had very little in the way of cash income.

Then there are those who have low average earnings under social security because their covered jobs were secondary or supplemental ones and only incidental to their regular jobs in noncovered employment—a Federal Government job, for example. Their total earnings may actually have been very high. Practically all of these people receive retirement pay under other programs. Thus they are no more dependent on the minimum social security benefit for their support in retirement than they were dependent on covered earnings for their livelihood during their working years.

It is not known exactly what proportion of the people in the 2.2 million beneficiary families mentioned above are getting minimum social security benefits in addition to some other pension. However, preliminary data from the Social Security Administration's 1968 Survey of the Aged indicate that there are not many. And some of those who are getting a minimum social security benefit in addition to some other pension are people whose working lives have been divided between two programs and who therefore get benefits under both but, because of their divided work, get small benefits under each program. Of retired workers coming on the social security benefit rolls in the latter half of 1968 and receiving minimum retirement benefits, only about 8 percent are getting payments under Federal, State, or local retirement systems for public employees (including military retirement payments). The 8 percent is made up of 4.5 percent who are getting annuities under the Federal civil service retirement system, 2.8 percent who are getting benefits under State and local retirement systems, and 0.6 percent who are getting benefits under the military retirement system. Another 7 percent are getting railroad retirement annuities in addition to minimum social security benefits. (These figures include people who are entitled to minimum benefits on their own earnings record and also to a supplemental benefit based on the earnings record of a spouse.)

The foregoing, then, are three principal reasons why people have low average monthly earnings under social security and therefore get the minimum benefit. There are of course other reasons. For example, some beneficiaries are married women who are *not* entitled to a larger wife's or widow's benefit on a husband's earnings record. The husbands themselves, for one or another of the reasons noted, had minimum or very low benefits, and the women were housewives during most of their working lifetimes but had a few years of work under the program either before they got married or at some time during their marriage. Even though they had high earnings while they worked, they worked for such a short period that their average earnings are very low and they get only the minimum benefit. Others (although not very many) receiving the minimum have had only a slight connection with covered employment because they have lived abroad for most of their working years or have lived mostly on investments and inheritances.

Any increase in the social security minimum would, of course, increase the cost of the program. By and large the increased cost has to be met—so long as the program continues to be self-sustaining—through larger contribution income or through smaller benefits paid to other beneficiaries.

Within any given level of expenditure, the more that is done for people with very low earnings in the way of paying a benefit that is unrelated to earnings

and therefore unrelated to contributions, the less can be done for the people who have worked more and earned more and contributed more.

Without any simultaneous precentage increase in benefits generally over the level that would be set if H.R. 17550 is enacted, the cost, as a percentage of taxable payroll, of various minimum benefits would be as follows:

Minimum benefit	*Present additional cost*
$70	0.02
$75	.06
$85	.11
$90	.22
$100	.36
$120	.70

Sincerely yours,

ROBERT M. BALL,
Commissioner of Social Security.

MINIMUM MONTHLY PAYMENTS

The CHARMAN. Here is a very interesting question by Senator Gore. What is the relationship between the minimum monthly benefit in the family assistance plan and the minimum monthly benefit provided in the Social Security Act?

Mr. VENEMAN. There is not any relationship, Mr. Chairman. The minimum monthly benefit that we propose for adult categories in the family assistance plan is $110 a month. The average payment under the public assistance programs would be about $70 or $75 a month. The difference would be other income that the recipient may have.

So the only connection there might be would be those persons who are eligible for the adult categories who also receive social security.

But there is no direct relationship between the two programs.

Mr. BALL. Nobody, I think, Mr. Chairman, has ever argued that the social security minimum benefit in itself was supposed to be a sufficient amount for an individual to get along on.

Mr. VENEMAN. The criterion for the public assistance is need. For social security, it is amount of earnings.

The CHAIRMAN. There is a definite relationship. As you increase social security benefits, the welfare payments have to go down, do they not?

Mr. VENEMAN. Yes, unless you specifically provide otherwise, as has been done in the past. The last time, you will recall, when the social security benefit was increased, an amount up to $4 was passed on to the public assistance recipient, who was entitled to receive both. Public assistance payments were not reduced to take account of the first $4 of the social security benefit increase.

The CHAIRMAN. Senator Gore asks, how is the minimum benefit of family assistance act financed?

Mr. VENEMAN. Are we still talking about the adult categories?

The CHAIRMAN. Yes.

Mr. VENEMAN. We would require the minimum benefit to be $110. The first $65 would be on a formula of 90 percent Federal money, 10 percent State money, and the amount above that would be 25 percent Federal money, 75 percent State money.

The CHAIRMAN. I am going to submit the remainder of these questions and ask that you provide for the record the answers to those questions for Senator Gore and the committee.

Mr. VENEMAN. We certainly will, Mr. Chairman.

(The questions with departmental replies is printed in app. B of this volume.)

The CHAIRMAN. We are supposed to vote at 12:15.

Go ahead, Senator Curtis, if you have a question.

MEDICARE EXPENDITURES

Senator CURTIS. Mr. Secretary, yesterday the Secretary's statement dealt with costs of medical care—I am talking about medicare now—and various efforts being made to lower the costs for the doctors' portion. My question is this:

In the overall of medicare, I would like to have a rough estimate of the amount of the total expenditures that go for doctors' fees—the percentage—and the percentage that goes for institutions—hospitals and extended care homes.

Mr. BALL. Senator, the entire part A program, with very few exceptions, is nonphysician cost.

Senator CURTIS. I understand that.

Mr. BALL. And in part B, 90 percent is physician cost. If you put the two parts together, about 30 percent of the total is physicians' fees and about 70 percent of it would be other.

Senator CURTIS. And further, if I had this stated this way, of the amount paid out of tax funds as contrasted to the monthly contribution made under part B, as far as that is concerned, roughly what part, excluding the contribution of the recipient on part B, what part——

Mr. BALL. How would it change that distribution?

Senator CURTIS. Yes. You may submit it.

Mr. BALL. I shall be glad to.

(Information supplied follows:)

The total cash income for both Part A and Part B of the Medicare program was $7.3 billion in fiscal year 1969. Just over $0.9 billion came from the premiums paid by the Part B enrollees.

The total cash benefit payments in fiscal year 1969 under Medicare was $6.3 billion. Approximately $1.5 billion was paid to physicians. Using these relationships, approximately 21% of the total income from general revenues and payroll taxes was paid out for physicians' services in fiscal year 1969.

Senator CURTIS. And I would like the same figures for medicaid.

Mr. VENEMAN. We have that prepared, Senator Curtis. We shall submit this to the committee.

Senator CURTIS. All right, but I do not want the whole book.

Mr. VENEMAN. I can quickly give them to you, if you would like, but I think you do realize the background.

(The information follows:)

In calendar year 1968, 13.5% of the total medical vendor payments in Title XIX States were included under the category of physician services. During this time period, 14 jurisdictions (13 States and the District of Columbia) were not included under Title XIX.

TAX RATE FOR SELF-EMPLOYED

Senator CURTIS. Under the House bill, what happens to the tax rate for the self-employed? Is it automatically increased?

Mr. BALL. Not automatically, Senator. It is the base——

Senator CURTIS. Is there a ceiling on it, or does that take the same increase of the employer-employee tax rate?

Mr. BALL. There is a ceiling on the self-employed for cash benefits. On the cash benefits, the rate for the self-employed goes to a maximum of 7.0. Under the bill it is 6.3 for 1971 through 1974 and then to 7.0 for 1975 and after.

Senator CURTIS. Because there is a vote on, I would like to state three questions, and you can supply the answers afterward.

One, I would like to know what the Department thinks about in lieu of the $50 that the beneficiary must pay on his hospital bill that a percentage of his total bill be paid by the beneficiary. I think that is worth exploring because it has to do with how expensive a room they get, and so on, as well as the length of stay.

(The Department subsequently supplied the following information:)

We doubt that such a change would represent an improvement over the present Medicare deductible and coinsurance provisions applicable to hospital services. A shift from the present Medicare deductible and coinsurance to a coinsurance amount based on a fixed percentage of hospital charges would, we believe, represent a substantial reduction in Medicare protection for a significant number of beneficiaries whose use of services is clearly appropriate.

Medicare's present deductible, approximately equivalent to the average cost of one day's hospital care (now $52), represents a substantial liability for the patient that may have some effect in deterring hospital admissions that are not really necessary, for example, admissions for diagnostic tests that could appropriately be performed on an outpatient basis. When a patient begins his 61st day in a hospital during a benefit period he becomes liable under present law for a coinsurance payment of $13 for each day of stay through the 90th day; if he uses his lifetime reserve, his liability rises to $26 per day. Such substantial coinsurance liabilities applying to the latter part of very long hospital stays may be helpful in deterring stays of such length, which are necessary only in exceptional cases.

In contrast, coinsurance equal to a fixed percentage of hospital charges would be less of a deterrent to the admission of a patient who will stay only a day or two, and would require less cost-sharing by the beneficiary with respect to the latter part of a very long hospital stay. It would tend, however, to shift much of the cost sharing burden to beneficiaries with moderate to short hospital stays who are already leaving the hospital as soon as it is possible to do so. The effect is more pronounced than may be immediately evident, because a patient typically is given more intensive services during a moderately short hospital stay (or during the early part of a longer stay) and these days of intensive treatment are the days for which the charges are highest.

Senator CURTIS. Also, I would like to have a concise statement put in the record on what the law, as well as the practice, has been in reference to beneficiaries who have been divorced and remarried, and it is later found that the divorce proceedings and papers are faulty, but that all the parties have proceeded in good faith.

I would just like to have a little general statement as to what the law is and what the practice is.

Mr. BALL. I shall be glad to furnish that, Senator.

Senator CURTIS. Thank you.

(The information follows:)

EFFECT OF INVALID MARRIAGES AND DIVORCES ON ELIGIBILITY FOR SOCIAL SECURITY BENEFITS

Generally, for purposes of determining eligibility for dependents' and survivors social security benefits, the marital status of the person is determined under applicable State law so that wife's, widow's, husband's, and widower's benefits

are generally payable to the person who is the legal spouse of the worker under the law of the State in which the worker is living at the time the spouse applies for benefits or at the time he dies.

The Social Security Act, however, contains an exception to the general rule of determining marital status according to State law. Under a provision of the 1960 amendments, a marriage that is invalid under State law because of a procedural defect in the marriage or because a prior marriage was not legally terminated can be considered a valid marriage for purposes of qualifying for social security benefits if the applicant went through a marriage ceremony in good faith without knowledge that the marriage would be defective. This provision was enacted in recognition of the fact that, since marriage and divorce laws vary among the States, many people could not qualify for social security benefits in some States because their marriage was invalid while people who were married under identical circumstances in other States could get benefits.

Under the exception, a marriage is deemed to be a valid marriage for social security purposes and wife's widow's, hunband's, or widower's benefits are payable to the spouse when the following conditions are met:

1. The spouse went through a marriage ceremony with the worker in good faith without knowledge that the marriage would be invalid.
2. The spouse was living with the worker at the time he or she applied for social security benefits or at the time the worker died.
3. There is no living legal spouse who is or was entitled to a wife's, widow's, husband's, or widower's benefit on the worker's earnings record.
4. The marriage is invalid because of a procedural defect in the marriage or because a prior marriage of the worker or the spouse was not legally dissolved.

In addition, benefits are payable to any child born of the marriage when the parents of the child went through a ceremony resulting in a marriage which was invalid because of the procedural defect in the marriage or because a prior marriage was not legally dissolved.

In the case of a couple who were divorced and where each of them later married another person without knowing that the divorce was invalid, each of the subsequent marriages would be considered valid for purposes of paying social security benefits if the above conditions were met. However, it was recognized at the time the 1960 amendments were enacted that in such cases there might also exist a valid marriage. Thus the law provided that the spouse whose marriage was valid under State law would be beneficiary. Therefore, a person who is eligible for spouse's benefits under the so-called "deemed marriage" provision is precluded from getting such benefits if another living person who is recognized under applicable State law as the legal spouse of the worker has been or is entitled to spouse's benefits on that worker's earnings record. And a person who is getting spouse's benefits under the "deemed marriage" provision will have his or her benefits terminated if the legal spouse becomes entitled to such benefits.

The CHAIRMAN. Thank you, Mr. Secretary and gentlemen.

We shall now stand in adjournment until Tuesday, when we commence hearings on the Family Assistance Plan. That will be at 10 a.m. next Tuesday.

(Thereupon, at 12:15 p.m., the hearing recessed, to reconvene on Tuesday, July 21, 1970, at 10 a.m.)

APPENDIX A

91ST CONGRESS
2D SESSION

H. R. 17550

IN THE SENATE OF THE UNITED STATES

MAY 27, 1970

Read twice and referred to the Committee on Finance

AN ACT

To amend the Social Security Act to provide increases in benefits, to improve computation methods, and to raise the earnings base under the old-age, survivors, and disability insurance system, to make improvements in the medicare, medicaid, and maternal and child health programs with emphasis upon improvements in the operating effectiveness of such programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act, with the following table of contents, may be cited as the "Social Security Amendments of 1970".

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TABLE OF CONTENTS—Continued

TITLE II—PROVISIONS RELATING TO MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH—Continued

PART B—IMPROVEMENTS IN THE OPERATING EFFECTIVENESS OF THE MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS—Con.

PART C—MISCELLANEOUS AND TECHNICAL PROVISIONS

TABLE OF CONTENTS—Continued

TITLE I—PROVISIONS RELATING TO OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE

INCREASE IN OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

SEC. 101. (a) Section 215(a) of the Social Security Act is amended by striking out the table and inserting in lieu thereof the following:

"TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS

"I		II	III		IV	V
(Primary insurance benefit under 1939 Act, as modified)		(Primary insurance amount under 1939 Act)	(Average monthly wage)		(Primary insurance amount)	(Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—		At least—	But not more than—		
.....	$16.20	$64.00	.....	$76	$67.20	$100.80
$16.21	16.84	65.00	$77	78	68.30	102.50
16.85	17.60	66.40	79	80	69.80	104.70
17.61	18.40	67.70	81	81	71.10	106.70
18.41	19.24	68.90	82	83	72.40	108.60
19.25	20.00	70.30	84	85	73.90	110.90
20.01	20.64	71.60	86	87	75.30	112.90
20.65	21.28	72.80	88	89	76.50	114.80
21.29	21.88	74.20	90	90	78.00	117.00
21.89	22.28	75.50	91	92	79.30	119.00
22.29	22.68	76.90	93	94	80.70	121.10
22.69	23.08	78.00	95	96	81.90	122.90
23.09	23.44	79.40	97	97	83.40	125.10
23.45	23.76	80.80	98	99	84.90	127.40
23.77	24.20	82.30	100	101	86.50	129.80
24.21	24.60	83.50	102	102	87.70	131.60
24.61	25.00	84.90	103	104	89.20	133.80
25.01	25.48	86.40	105	106	90.80	136.20
25.49	25.92	87.80	107	107	92.30	138.50
25.93	26.40	89.20	108	109	93.70	140.60

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"TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS—Continued

"I		II	III		IV	V
(Primary insurance benefit under 1939 Act, as modified)		(Primary insurance amount under 1939 Act)	(Average monthly wage)		(Primary insurance amount)	(Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (e)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—		At least—	But not more than—		
$26.41	$26.94	$90.60	$110	$113	$96.20	$142.80
26.95	27.46	91.90	114	118	98.40	144.80
27.47	28.00	93.30	119	122	98.00	147.00
28.01	28.68	94.70	123	127	99.50	149.30
28.69	29.25	96.20	128	132	101.10	151.70
29.26	29.68	97.50	133	136	102.60	153.60
29.69	30.36	98.80	137	141	103.80	155.70
30.37	30.92	100.30	142	146	105.40	158.10
30.93	31.36	101.70	147	150	106.80	160.20
31.37	32.00	103.00	151	155	108.20	162.30
32.01	32.60	104.50	156	160	109.80	164.70
32.61	33.20	106.80	161	164	111.10	166.70
33.21	33.68	107.20	165	169	112.60	168.90
33.69	34.50	108.60	170	174	114.10	171.20
34.51	35.00	110.00	175	178	115.50	172.30
35.01	35.80	111.40	179	183	117.00	175.50
35.81	36.40	112.70	184	188	118.40	177.60
36.41	37.08	114.20	189	193	120.00	180.00
37.09	37.60	115.60	194	197	121.40	182.10
37.61	38.20	116.90	198	202	122.80	184.20
38.21	39.12	118.40	203	207	124.40	186.60
39.13	39.68	119.80	208	211	125.80	188.70
39.69	40.33	121.00	212	216	127.10	190.70
40.34	41.12	122.50	217	221	128.70	193.10
41.13	41.76	123.90	222	225	130.10	195.20
41.77	42.44	125.30	226	230	131.60	197.40
42.45	43.20	126.70	231	235	133.10	199.70
43.21	43.76	128.20	236	239	134.70	202.10
43.77	44.44	129.50	240	244	136.00	204.00
44.45	44.88	130.80	245	249	137.40	206.10
44.89	45.60	132.80	250	253	138.00	208.80
		133.70	254	256	140.40	210.60
		134.90	259	263	141.70	212.60
		136.40	264	267	143.30	215.00
		137.80	268	272	144.70	217.60
		139.20	273	277	146.20	221.80
		140.60	278	281	147.70	224.80
		142.00	282	286	149.10	226.80
		143.50	287	291	150.70	232.80
		144.70	292	295	152.00	236.00
		146.20	296	300	153.60	240.00
		147.60	301	305	154.00	244.00
		148.90	306	309	155.40	247.20
		150.40	310	314	156.00	251.20
		151.70	315	319	159.30	255.20
		153.00	320	323	160.70	258.40
		154.50	324	328	162.30	262.40
		156.90	329	333	163.70	266.40
		157.40	334	337	165.30	269.60
		158.60	338	342	166.60	273.60
		160.00	343	347	168.00	277.60
		161.50	348	351	169.60	281.80
		162.80	353	356	171.00	284.80
		164.30	357	361	172.60	288.80
		165.60	362	365	173.90	292.00
		166.90	366	370	175.30	296.00
		168.40	371	376	176.90	300.00
		169.80	376	379	178.30	308.20
		171.30	380	384	179.90	307.20
		172.50	385	389	181.20	311.20
		173.90	390	393	182.60	314.40
		175.40	394	398	184.20	318.40
		176.70	399	403	185.60	322.40
		178.20	404	407	187.20	326.60
		179.40	408	412	188.60	329.60
		180.70	413	417	189.80	333.60
		182.00	418	421	191.10	336.80
		183.40	422	426	192.60	340.80
		184.60	427	431	193.90	344.80
		186.00	432	436	195.20	348.80
		187.30	437	443	196.70	350.60
		188.50	441	445	198.00	352.60
		189.80	446	450	199.20	354.60
		191.20	451	454	200.80	356.60
		192.40	455	459	202.10	358.60
		193.70	460	464	203.40	360.60
		195.00	465	468	204.80	362.60
		196.40	469	473	206.20	364.60
		197.80	474	478	207.50	366.60

"TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS—Continued

"I (Primary insurance benefit under 1939 Act, as modified)		II (Primary insurance amount under 1939 Act)	III (Average monthly wage)		IV (Primary insurance amount)	V (Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—		At least—	But not more than—		
		$198.90	$479	$482	$308.90	$367.20
		200.80	483	487	310.40	369.20
		201.50	488	492	311.60	371.20
		202.80	493	496	313.00	372.80
		204.20	497	501	314.50	374.80
		205.40	502	506	315.70	376.80
		206.70	507	510	317.10	378.40
		208.00	511	515	318.40	380.40
		209.30	516	520	319.80	382.40
		210.60	521	524	321.20	384.00
		211.90	525	529	322.50	386.00
		213.30	530	534	324.00	388.00
		214.50	535	538	325.30	389.60
		215.80	539	543	326.60	391.60
		217.20	544	548	328.10	393.60
		218.40	549	553	329.40	395.60
		219.70	554	556	330.70	396.80
		220.80	557	560	331.90	398.40
		222.00	561	563	333.10	399.60
		223.10	564	567	334.30	401.20
		224.30	568	570	335.60	402.40
		225.40	571	574	336.70	404.00
		226.60	575	577	338.00	405.20
		227.70	578	581	339.10	406.80
		228.90	582	584	340.40	408.00
		230.00	585	588	341.50	409.60
		231.20	589	591	342.80	410.80
		232.30	592	596	344.00	412.40
		233.50	596	598	345.20	413.60
		234.60	599	602	346.40	415.20
		235.80	603	605	347.60	416.40
		236.90	606	609	348.70	418.00
		238.10	610	612	350.10	419.20
		239.20	613	616	351.20	420.80
		240.40	617	620	352.50	422.40
		241.50	621	623	353.50	423.60
		242.70	624	627	354.90	425.20
		243.80	628	630	356.00	426.40
		245.00	631	634	357.30	428.00
		246.10	635	637	358.50	429.20
		247.30	638	641	359.70	430.80
		248.40	642	644	360.90	432.00
		249.60	645	648	362.10	433.60
		250.70	649	650	363.30	434.40
			651	656	364.00	436.40
			656	660	365.00	438.40
			661	665	366.00	440.40
			666	670	367.00	442.40
			671	675	368.00	444.40
			676	680	369.00	446.40
			681	685	370.00	448.40
			686	690	371.00	450.40
			691	696	372.00	452.40
			696	700	373.00	454.80
			701	705	374.00	456.40
			706	710	375.00	458.40
			711	715	376.00	460.40
			716	720	377.00	462.40
			721	725	378.00	464.40
			726	730	379.00	466.40
			731	735	380.00	468.40
			736	740	381.00	470.40
			741	745	382.00	472.40
			746	750	383.00	474.40",

(b) Section 203 (a) of such Act is amended by striking out paragraph (2) and inserting in lieu thereof the following:

"(2) when two or more persons were entitled (without the application of section 202 (j) (1) and section 223 (b)) to monthly benefits under section 202 or 223 for January 1971 on the basis of the wages and self-employment income of such insured individual and at least one such person was so entitled for December 1970 on the basis of such wages and self-employment income, such total of benefits for January 1971 or any subsequent month shall not be reduced to less than the larger of—

"(A) the amount determined under this subsection without regard to this paragraph, or

"(B) an amount equal to the sum of the amounts derived by multiplying the benefit amount determined under this title (including this subsection, but without the application of section 222 (b), section 202 (q), and subsections (b), (c), and (d) of this section), as in effect prior to the enactment of the Social Security Amendments of 1970, for each such person for such monuth, by 105

percent and raising each such increased amount, if it is not a multiple of $0.10, to the next higher multiple of $0.10;

but in any such case (i) paragraph (1) of this subsection shall not be applied to such total of benefits after the application of subparagraph (B), and (ii) if section 202(k)(2)(A) was applicable in the case of any such benefits for January 1971, and ceases to apply after such month, the provisions of subparagraph (B) shall be applied, for and after the month in which section 202(k)(2)(A) ceases to apply, as though paragraph (1) had not been applicable to such total of benefits for January 1971, or".

(c) Section 215(b)(4) of such Act is amended by striking out "December 1969" each time it appears and inserting in lieu thereof "December 1970".

(d) Section 215(c) of such Act is amended to read as follows:

"Primary Insurance Amount Under 1969 Act

"(c)(1) For the purposes of column II of the table appearing in subsection (a) of this section, an individual's primary insurance amount shall be computed on the basis of the law in effect prior to the enactment of the Social Security Amendments of 1970.

"(2) The provisions of this subsection shall be applicable only in the case of an individual who became entitled to bene-

fits under section 202 (a) or section 223 before January 1971, or who died before such month."

(e) The amendments made by this section shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970 and with respect to lump-sum death payments under such title in the case of deaths occurring after December 1970.

(f) If an individual was entitled to a disability insurance benefit under section 223 of the Social Security Act for December 1970 and became entitled to old-age insurance benefits under section 202 (a) of such Act for January 1971, or he died in such month, then, for purposes of section 215 (a) (4) of the Social Security Act (if applicable), the amount in column IV of the table appearing in such section 215 (a) for such individual shall be the amount in such column on the line on which in column II appears his primary insurance amount (as determined under section 215 (e) of such Act) instead of the amount in column IV equal to the primary insurance amount on which his disability insurance benefit is based.

INCREASE IN BENEFITS FOR CERTAIN INDIVIDUALS AGE 72 AND OVER

SEC. 102. (a) (1) Section 227 (a) of the Social Security Act is amended by striking out "$46" and inserting in lieu thereof "$48.30", and by striking out "$23" and inserting in lieu thereof "$24.20".

(2) Section 227(b) of such Act is amended by striking out "$46" and inserting in lieu thereof "$48.30".

(b) (1) Section 228(b) (1) of such Act is amended by striking out "$46" and inserting in lieu thereof "$48.30".

(2) Section 228(b) (2) of such Act is amended by striking out "$46" and inserting in lieu thereof "$48.30", and by striking out "$23" and inserting in lieu thereof "$24.20".

(3) Section 228(c) (2) of such Act is amended by striking out "$23" and inserting in lieu thereof "$24.20".

(4) Section 228(c) (3) (A) of such Act is amended by striking out "$46" and inserting in lieu thereof "$48.30".

(5) Section 228(c) (3) (B) of such Act is amended by striking out "$23" and inserting in lieu thereof "$24.20".

(c) The amendments made by subsections (a) and (b) shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970.

AUTOMATIC ADJUSTMENT OF BENEFITS

SEC. 103. (a) Section 215 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"Cost-of-Living Increases in Benefits

"(i) (1) For purposes of this subsection—

"(A) the term 'base quarter' means the period of 3 consecutive calendar months ending on September 30,

1971, and the period of 3 consecutive calendar months ending on September 30 of each year thereafter.

"(B) the term 'cost-of-living computation quarter' means any base quarter in which the monthly average of the Consumer Price Index prepared by the Department of Labor exceeds, by not less than 3 per centum, the monthly average of such Index in the later of (i) the 3 calendar-month period ending on September 30, 1971, or (ii) the base quarter which was most recently a cost-of-living computation quarter.

"(2) (A) If the Secretary determines that a base quarter in a calendar year is also a cost-of-living computation quarter, he shall, effective for January of the next calendar year, increase the benefit amount of each individual who for such month is entitled to benefits under section 227 or 228, and the primary insurance amount of each other individual as specified in subparagraph (B) of this paragraph, by an amount derived by multiplying such amount (including each such individual's primary insurance amount or benefit amount under section 227 or 228 as previously increased under this subparagraph) by the same percentage (rounded to the next higher one-tenth of 1 percent if such percentage is an odd multiple of .05 of 1 percent and to the nearest one-tenth of 1 percent in any other case) as the percentage by which the monthly average of the Consumer Price Index

for such cost-of-living computation quarter exceeds the monthly average of such Index for the base quarter determined after the application of clauses (i) and (ii) of paragraph (1) (B).

"(B) The increase provided by subparagraph (A) with respect to a particular cost-of-living computation quarter shall apply in the case of monthly benefits under this title for months after December of the calendar year in which occurred such cost-of-living computation quarter, based on the wages and self-employment income of an individual who became entitled to monthly benefits under section 202, 223, 227, or 228 (without regard to section 202 (j) (1) or section 223 (b)), or who died, in or before December of such calendar year.

"(C) If the Secretary determines that a base quarter in a calendar year is also a cost-of-living computation quarter, he shall publish in the Federal Register on or before December 1 of such calendar year a determination that a benefit increase is resultantly required and the percentage thereof. He shall also publish in the Federal Register at that time (along with the increased benefit amounts which shall be deemed to be the amounts appearing in sections 227 and 228) a revision of the table of benefits contained in subsection (a) of this section (as it may have been revised previously pursuant to this paragraph); and such revised table

shall be deemed to be the table appearing in such subsection (a). Such revision shall be determined as follows:

"(i) The headings of the table shall be the same as the headings in the table immediately prior to its revision, except that the parenthetical phrase at the beginning of column II shall show the effective date of the primary insurance amounts set forth in column IV of the table immediately prior to its revision.

"(ii) The amounts on each line of column I, and the amounts on each line of column III except as otherwise provided by clause (v) of this subparagraph, shall be the same as the amounts appearing in such column in the table immediately prior to its revision.

"(iii) The amount on each line of column II shall be changed to the amount shown on the corresponding line of column IV of the table immediately prior to its revision.

"(iv) The amount of each line of column IV shall be increased from the amount shown in the table immediately prior to its revision by increasing such amount by the percentage specified in subparagraph (A) of paragraph (2), raising each such increased amount, if not a multiple of $0.10, to the next higher multiple of $0.10.

"(v) If the contribution and benefit base (as

defined in section 230(b)) for the calendar year in which the table of benefits is revised is lower than such base for the following calendar year, columns III, IV, and V shall be extended. The amount in the first additional line in column IV shall be the amount in the last line of such column as determined under clause (iv), plus $1.00, rounding such increased amount (if not a multiple of $1.00) to the next higher multiple of $1.00 where such increased amount is an odd multiple of $0.50 and to the nearest multiple of $1.00 in any other case. The amount on each succeeding line of column IV shall be the amount on the preceding line increased by $1.00, until the amount on the last line of such column is equal to the larger of (I) one-thirtysixth of the contribution and benefit base for the calendar year following the calendar year in which the table of benefits is revised or (II) the last line of such column as determined under clause (iv) plus 20 percent of one-twelfth of the excess of the contribution and benefit base for the calendar year following the calendar year in which the table of benefits is revised over such base for the calendar year in which the table of benefits is revised, rounding such amount (if not a multiple of $1.00) to the next higher multiple of $1.00 where such amount is an odd multiple of $0.50 and to the nearest multiple of $1.00 in any other case.

The amount in each additional line of column III shall be determined so that the second figure in the last line of column III is one-twelfth of the contribution and benefits base for the calendar year following the calendar year in which the table of benefits is revised, and the remaining figures in column III shall be determined in consistent mathematical intervals from column IV. The second figure in the last line of column III before the extension of the column shall be increased to a figure mathematically consistent with the figures determined in accordance with the preceding sentence. The amount on each line of column V shall be increased, to the extent necessary, so that each such amount is equal to 40 percent of the second figure in the same line of column III, plus 40 percent of the smaller of (I) such second figure or (II) the larger of $450 or 50 per centum of the largest figure in column III.

"(vi) The amount on each line of column V shall be increased, if necessary, so that such amount is at least equal to one and one-half times the amount shown on the corresponding line in column IV. Any such increased amount that is not a multiple of $0.10 shall be increased to the next higher multiple of $0.10."

(b) Section 203(a) of such Act (as amended by section 101(b) of this Act) is amended—

(1) by striking out the period at the end of paragraph (3) and inserting in lieu thereof ", or", and inserting after paragraph (3) the following new paragraph:

"(4) when two or more persons are entitled (without the application of section 202(j)(1) and section 223(b)) to monthly benefits under section 202 or 223 for December of the calendar year in which occurs a cost-of-living computation quarter (as defined in section 215(i)(1)) on the basis of the wages and self-employment income of such insured individual, such total of benefits for the month immediately following shall be reduced to not less than the amount equal to the sum of the amounts derived by increasing the benefit amount determined under this title (including this subsection, but without the application of section 222(b), section 202(q), and subsections (b), (c), and (d) of this section) as in effect for such December for each such person by the same percentage as the percentage by which such individual's primary insurance amount (including such amount as previously increased) is increased under section 215(i)(2) for such month immediately following, and raising each such increased amount (if not a multiple of $0.10) to the next higher multiple of $0.10."; and

(2) by striking out "the table in section 215(a)" in the matter preceding paragraph (1) and inserting in lieu thereof "the table in (or deemed to be in) section 215(a)".

(c) (1) Section 215(a) of such Act is amended by striking out the matter which precedes the table and inserting in lieu thereof the following:

"(a) The primary insurance amount of an insured individual shall be the amount in column IV of the following table, or, if larger, the amount in column IV of the latest table deemed to be such table under subsection (i) (2) (C) or section 230(c), determined as follows:

"(1) Subject to the conditions specified in subsections (b), (c), and (d) of this section and except as provided in paragraph (2) of this subsection, such primary insurance amount shall be whichever of the following amounts is the largest:

"(i) The amount in column IV on the line on which in column III of such table appears his average monthly wage (as determined under subsection (b));

"(ii) The amount in column IV on the line on which in column II of such table appears his primary insurance amount (as determined under subsection (c)); or

"(iii) The amount in column IV on the line on which in column I of such table appears his primary insurance benefit (as determined under subsection (d)).

"(2) In the case of an individual who was entitled to a disability insurance benefit for the month before the month in which he died, became entitled to old-age insurance benefits, or attained age 65, such primary insurance amount shall be the amount in column IV which is equal to the primary insurance amount upon which such disability insurance benefit is based, except that, if such individual was entitled to a disability insurance benefit under section 223 for the month before the effective month of a new table (other than a table provided by section 230) and in the following month became entitled to an old-age insurance benefit, or he died in such following month, then his primary insurance amount for such following month shall be the amount in column IV of the new table on the line on which in column II of such table appears his primary insurance amount for the month before the effective month of the table (as determined under subsection (c)) instead of the amount in column IV equal to the primary insurance amount on which his disability insurance benefit is based."

(2) Effective January 1, 1973, section 215(b)(4) of such Act (as amended by section 101(c) of this Act) is amended to read as follows:

"(4) The provisions of this subsection shall be applicable only in the case of an individual—

"(A) who becomes entitled in or after the effective month of a new table that appears in (or is deemed by subsection (i)(2)(C) or section 230(c) to appear in) subsection (a) to benefits under section 202(a) or section 223; or

"(B) who dies in or after such effective month without being entitled to benefits under section 202(a) or section 223; or

"(C) whose primary insurance amount is required to be recomputed under subsection (f)(2).".

(3) Effective January 1, 1973, section 215(c) of such Act (as amended by section 101(d) of this Act) is amended to read as follows:

"Primary Insurance Amount Under Prior Provisions

"(c)(1) For the purposes of column II of the table that appears in (or is deemed to appear in) subsection (a) of this section, an individual's primary insurance amount shall be computed on the basis of the law in effect prior to the effective month of the latest such table.

"(2) The provisions of this subsection shall be applicable only in the case of an individual who became entitled to benefits under section 202 (a) or section 223, or who died, before such effective month."

(d) Sections 227 and 228 of such Act (as amended by section 102 of this Act) are amended by striking out "$48.30" wherever it appears and inserting in lieu thereof "the larger of $48.30 or the amount most recently established in lieu thereof under section 215 (i)", and by striking out "$24.20" wherever it appears and inserting in lieu thereof "the larger of $24.20 or the amount most recently established in lieu thereof under section 215 (i)".

INCREASED WIDOW'S AND WIDOWER'S INSURANCE BENEFITS

SEC. 104. (a) Section 202 (e) of the Social Security Act is amended—

(1) by striking out "82½ percent of" wherever it appears in paragraphs (1) and (2); and

(2) by striking out "age 62" in subparagraphs (C) (i) and (C) (ii) of paragraph (1), and in the matter following subparagraph (G) in paragraph (1), and inserting in lieu thereof in each instance "age 65".

(b) Section 202 (f) of such Act is amended—

(1) by striking out "82½ percent of" wherever it appears in paragraphs (1) and (3);

(2) by inserting ", after attainment of age 65," after "was entitled" in paragraph (1) (C); and

(3) by striking out "age 62" in the matter following subparagraph (G) in paragraph (1) and inserting in lieu thereof "age 65".

(c) (1) The last sentence of section 203 (c) of such Act is amended by striking out all that follows the semicolon and inserting in lieu thereof the following: "nor shall any deduction be made under this subsection from any widow's insurance benefit for any month in which the widow or surviving divorced wife is entitled and has not attained age 65 (but only if she became so entitled prior to attaining age 60), or from any widower's insurance benefit for any month in which the widower is entitled and has not attained age 65 (but only if he became so entitled prior to attaining age 62)."

(2) Clause (D) of section 203 (f) (1) of such Act is amended to read as follows: "(D) for which such individual is entitled to widow's insurance benefits and has not attained age 65 (but only if she became so entitled prior to attaining age 60), or widower's insurance benefits and has not attained age 65 (but only if he became so entitled prior to attaining age 62), or".

(d) (1) Section 202 (q) (1) of such Act is amended to read as follows:

"(1) If the first month for which an individual is entitled to an old-age, wife's, husband's, widow's, or widower's insurance benefit is a month before the month in which such individual attains retirement age, the amount of such benefit for such month and for any subsequent month shall, subject to the succeeding paragraphs of this subsection, be reduced by—

"(A) 5/9 of 1 percent of such amount if such benefit is an old-age insurance benefit, 25/36 of 1 percent of such amount if such benefit is a wife's or husband's insurance benefit, or 5 7/120 of 1 percent of such amount if such benefit is a widow's or widower's insurance benefit, multiplied by—

"(B) (i) the number of the months in the reduction period for such benefit (determined under paragraph (6) (A)), if such benefit is for a month before the month in which such individual attains retirement age, or

"(ii) if less the number of such months in the adjusted reduction period for such benefit (determined under paragraph (7)), if such benefit is (I) for the month in which such individual attains age 62, or (II) for the month in which such individual attains retirement age;

and in the case of a widow or widower whose first month of entitlement to a widow's or widower's insurance benefit is a

month before the month in which such widow or widower attains age 60, such benefit, reduced pursuant to the preceding provisions of this paragraph (and before the application of the second sentence of paragraph (8)), shall be further reduced by—

"(C) 43/240 of 1 percent of the amount of such benefit, multiplied by—

"(D) (i) the number of months in the additional reduction period for such benefit (determined under paragraph (6) (B)), if such benefit is for a month before the month in which such individual attains age 62, or

"(ii) if less, the number of months in the additional adjusted reduction period for such benefit (determined under paragraph (7)), if such benefit is for the month in which such individual attains age 62."

(2) Section 202 (q) (7) of such Act is amended—

(A) by striking out everything that precedes subparagraph (A) and inserting in lieu thereof the following:

"(7) For purposes of this subsection the 'adjusted reduction period' for an individual's old-age, wife's, husband's, widow's, or widower's insurance benefit is the reduction period prescribed in paragraph (6) (A) for such benefit, and the 'additional adjusted reduction period' for an individual's widow's, or widower's insurance benefit is the

additional reduction period prescribed by paragraph (6) (B) for such benefit, excluding from each such period—"; and

(B) by striking out "attained retirement age" in subparagraph (E) and inserting in lieu thereof "attained age 62, and also for any month before the month in which he attained retirement age,".

(3) Section 202 (q) (9) of such Act is amended to read as follows:

"(9) For purposes of this subsection, the term 'retirement age' means age 65."

(c) Section 202 (m) of such Act is amended to read as follows:

"Minimum Survivor's Benefit

"(m) (1) In any case in which an individual is entitled to a monthly benefit under this section (other than under subsection (a)) for any month and no other person is (without the application of subsection (j) (1) and section 223 (b)) entitled to a monthly benefit under this section or section 223 for such month on the basis of the same wages and self-employment income, such individual's benefit amount for such month, prior to reduction under subsections (k) (3) and (q) (1), shall be not less than the first amount appearing in column IV of the table in section 215 (a).

"(2) In the case of such an individual who is entitled

to a monthly benefit under subsection (e) or (f) and whose benefit is subject to reduction under subsection (q) (1), such benefit amount, after reduction under subsection (q) (1), shall not be less than the amount it would be under paragraph (1) after such reduction if such individual had attained (or would attain) retirement age (as defined in subsection (q) (9)) in the month in which he attained (or would attain) age 62.

"(3) In the case of an individual to whom paragraph (2) applies but whose first month of entitlement to benefits under subsection (e) or (f) was before the month in which he attained age 60, such paragraph (2) shall be applied, for purposes of determining the number of months to be used in computing the reduction under subparagraphs (A) and (B) of subsection (q) (1) (but not for purposes of determining the number of months to be used in computing the reduction under subparagraphs (C) and (D) of such subsection), as though such first month of entitlement had been the month in which he attained such age."

(f) In the case of an individual who is entitled (without the application of section 202 (j) (1) and 223 (b) of the Social Security Act) to widow's or widower's insurance benefits for the month of December 1970, the Secretary shall redetermine the amount of such benefits under title II of such Act as if the amendments made by this section had

been in effect for the first month of such individual's entitlement to such benefits.

(g) Where—

(1) two or more persons are entitled (without the application of section 202(j)(1) of the Social Security Act) to monthly benefits under section 202 of such Act for December 1970 on the basis of the wages and self-employment income of a deceased individual, and one or more of such persons is so entitled under subsection (e) or (f) of such section 202, and

(2) one or more of such persons is entitled on the basis of such wages and self-employment income to increased monthly benefits under subsection (e) or (f) of such section 202 (as amended by this section) for January 1971, and

(3) the total of benefits to which all persons are entitled under section 202 of such Act on the basis of such wages and self-employment income for January 1971 is reduced by reason of section 203(a) of such Act, as amended by this Act (or would, but for the penultimate sentence of such section 203(a), be so reduced),

then the amount of the benefit to which each such person referred to in paragraph (1), other than a person entitled under subsection (e) or (f) of such section 202, is entitled

for months after December 1970 shall be adjusted, after the application of such section 203(a), to an amount no less than the amount it would have been if the person or persons referred to in paragraph (2) had not become entitled to an increased benefit referred to in such paragraph.

(h) The amendments made by this section shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970.

AGE-62 COMPUTATION POINT FOR MEN

SEC. 105. (a) Section 214(a)(1) of the Social Security Act is amended by striking out "before—" and all that follows down through "except" and inserting in lieu thereof "before the year in which he died or (if earlier) the year in which he attained age 62, except".

(b) Section 215(b)(3) of such Act is amended by striking out "before—" and all that follows down through "For" and inserting in lieu thereof "before the year in which he died or, if it occurred earlier but after 1960, the year in which he attained age 62. For".

(c) In the case of an individual who is entitled to monthly benefits under section 202 or 223 of the Social Security Act for a month after December 1970, on the basis of the wages and self-employment income of an insured individual who prior to January 1971 became entitled to benefits under section 202(a), or who prior to January 1971 became

entitled to benefits under section 223 after the year in which he attained age 62, or who died prior to January 1971 in a year after the year in which he attained age 62, the Secretary shall, notwithstanding paragraphs (1) and (2) of section 215(f) of such Act, recompute the primary insurance amount of such insured individual. Such recomputation shall be made under whichever of the following alternative computation methods yields the higher primary insurance amount:

(1) the computation methods in section 215 (b) and (d) of such Act, as amended by this Act, as such methods would apply in the case of an insured individual who attained age 62 in 1971, except that the provisions of section 215(d) (3) of such Act shall not apply; or

(2) the computation methods specified in paragraph (1) without regard to the limitation "but after 1960" contained in section 215(b) (3) of such Act, except that for any such recomputation, when the number of an individual's benefit computation years is less than 5, his average monthly wage shall, if it is in excess of $400, be reduced to such amount.

(d) Section 223(a) (2) of such Act is amended—

(1) by striking out "(if a woman) or age 65 (if a man)",

(2) by striking out "in the case of a woman" and

inserting in lieu thereof "in the case of an individual", and

(3) by striking out "she" and inserting in lieu thereof "he".

(e) Section 223 (c) (1) (A) of such Act is amended by striking out "(if a woman) or age 65 (if a man)".

(f) Section 227 (a) of such Act is amended by striking out "so much of paragraph (1) of section 214 (a) as follows clause (C)" and inserting in lieu thereof "paragraph (1) of section 214 (a)".

(g) Section 227 (b) of such Act is amended by striking out "so much of paragraph (1) thereof as follows clause (C)" and inserting in lieu thereof "paragraph (1) thereof".

(h) Sections 209 (i), 213 (a) (2), and 216 (i) (3) (A), of such Act are amended by striking out "(if a woman) or age 65 (if a man)".

(i) (1) Section 303 (g) (1) of the Social Security Amendments of 1960 is amended—

(A) by striking out "Amendments of 1965 and 1967" and inserting in lieu thereof "Amendments of 1965, 1967, 1969, and 1970";

(B) by striking out "Amendments of 1967" wherever it appears and inserting in lieu thereof "Amendments of 1970"; and

(C) by inserting "(subject to section 104 (i) (2)

of the Social Security Amendments of 1970)" after "except that" in the last sentence.

(2) For purposes of monthly benefits payable after December 1970, or a lump-sum death payment in the case of an insured individual who dies after December 1970, "retirement age" as referred to in section 303 (g) (1) of the Social Security Amendments of 1960 shall mean age 62.

(j) Paragraph (9) of section 3121 (a) of the Internal Revenue Code of 1954 (relating to definition of wages) is amended to read as follows:

"(9) any payment (other than vacation or sick pay) made to an employee after the month in which he attains age 62, if such employee did not work for the employer in the period for which such payment is made;".

(k) When two or more persons are entitled (without the application of sections 202 (j) (1) and 223 (b) of the Social Security Act) to monthly benefits under section 202 or 223 of such Act for December 1970, on the basis of the wages and self-employment income of an insured individual, and the total of benefits for such persons is reduced under section 203 (a) of such Act (or would, but for the penultimate sentence of such section 203 (a), be so reduced) for the month of January 1971 and such individual's primary insur-

ance amount is increased for such month under the amendments made by this section, then the total of benefits for such persons for and after January 1971 shall not be reduced to less than the sum of—

(1) the amount determined under section 203 (a) (2) of such Act for January 1971, and

(2) an amount equal to the excess of (A) such individual's primary insurance amount for January 1971, as determined under section 215 of such Act (as amended by section 101 of this Act) and in accordance with the amendments made by this section, over (B) his primary insurance amount for January 1971 as determined under such section 215 without regard to such amendments.

(l) The amendments made by this section shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970 and with respect to lump-sum death payments made under such title in the case of deaths occurring after December 1970, except that in the case of an individual who was not entitled to a monthly benefit under title II of such Act for December 1970 such amendments shall apply only on the basis of an application filed in or after the month in which this Act is enacted.

ELECTION TO RECEIVE ACTUARIALLY REDUCED BENEFITS IN ONE CATEGORY NOT TO BE APPLICABLE TO CERTAIN BENEFITS IN OTHER CATEGORIES

SEC. 106. (a) (1) Section 202 (q) (3) (A) of the Social Security Act is amended by striking out all that follows clause (ii) and inserting in lieu thereof the following: "then (subject to the succeeding paragraphs of this subsection) such wife's, husband's, widow's, or widower's insurance benefit for each month shall be reduced as provided in subparagraph (B), (C), or (D) of this paragraph, in lieu of any reduction under paragraph (1), if the amount of the reduction in such benefit under this paragraph is less than the amount of the reduction in such benefit would be under paragraph (1)."

(2) Section 202 (q) (3) of such Act is further amended by striking out subparagraphs (E), (F), and (G).

(b) Section 202 (r) of such Act is repealed.

(c) (1) (A) Subject to subparagraph (B), subsection (a) of this section and the amendments made thereby shall apply with respect to benefits for months commencing with the sixth month after the month in which this Act is enacted.

(B) Subsection (a) of this section and the amendments made thereby shall apply in the case of an individual whose entitlement to benefits under section 202 of the Social Security Act began (without regard to sections 202 (j) (1) and

223 (b) of such Act) before the sixth month after the month in which this Act is enacted only if such individual files with the Secretary of Health, Education, and Welfare, in such manner and form as the Secretary shall by regulations prescribe, a written request that such subsection and such amendments apply. In the case of such an individual who is described in paragraph (2) (A) (i) of this subsection, the request for a redetermination under paragraph (2) shall constitute the request required by this subparagraph, and subsection (a) of this section and the amendments made thereby shall apply pursuant to such request with respect to such individual's benefits as redetermined in accordance with paragraph (2) (B) (i) (but only if he does not refuse to accept such redetermination). In the case of any individual with respect to whose benefits subsection (a) of this section and the amendments made thereby may apply only pursuant to a request made under this subparagraph, such subsection and such amendments shall be effective (subject to paragraph (2) (D)) with respect to benefits for months commencing with the sixth month after the month in which this Act is enacted or, if the request required by this subparagraph is not filed before the end of such sixth month, with the second month following the month in which the request is filed.

(C) Subsection (b) of this section shall apply with respect to benefits payable pursuant to applications filed on or after the date of the enactment of this Act.

(2) (A) In any case where an individual—

(i) is entitled, for the fifth month following the month in which this Act is enacted, to a monthly insurance benefit under section 202 of the Social Security Act (I) which was reduced under subsection (q) (3) of such section, and (II) the application for which was deemed (or, except for the fact that an application had been filed, would have been deemed) to have been filed by such individual under subsection (r) (1) or (2) of such section, and

(ii) files a written request for a redetermination under this subsection, on or after the date of the enactment of this Act and in such manner and form as the Secretary of Health, Education, and Welfare shall by regulations prescribe,

the Secretary shall redetermine the amount of such benefit, and the amount of the other benefit (reduced under subsection (q) (1) or (2) of such section) which was taken into account in computing the reduction in such benefit under such subsection (q) (3), in the manner provided in subparagraph (B) of this paragraph.

(B) Upon receiving a written request for the redeter-

mination under this paragraph of a benefit which was reduced under subsection (q) (3) of section 202 of the Social Security Act and of the other benefit which was taken into account in computing such reduction, filed by an individual as provided in subparagraph (A) of this paragraph, the Secretary shall—

(i) determine the highest monthly benefit amount which such individual could receive under the subsections of such section 202 which are involved (or under section 223 of such Act and the subsection of such section 202 which is involved) for the month with which the redetermination is to be effective under subparagraph (D) of this subsection (without regard to sections 202 (k), 203 (a), and 203 (b) through (l)) if—

(I) such individual's application for one of such two benefits had been filed in the month in which it was actually filed or was deemed under subsection (r) of such section 202 to have been filed, and his application for the other such benefit had been filed in a later month, and

(II) the amendments made by this section had been in effect at the time each such application was filed; and

(ii) determine whether the amounts which were

actually received by such individual in the form of such two benefits during the period prior to the month with which the redetermination under this paragraph is to be effective were in excess of the amounts which would have been received during such period if the applications for such benefits had actually been filed at the times fixed under clause (i) (I) of this subparagraph, and, if so, the total amount by which benefits otherwise payable to such individual under such section 202 (and section 223) would have to be reduced in order to compensate the Federal Old-Age and Survivors Insurance Trust Fund (and the Federal Disability Insurance Trust Fund) for such excess.

(C) The Secretary shall then notify such individual of the amount of each such benefit as computed in accordance with the amendments made by subsections (a) and (b) of this section and as redetermined in accordance with subparagraph (B) (i) of this paragraph, specifying (i) the amount (if any) of the excess determined under subparagraph (B) (ii) of this paragraph, and (ii) the period during which payment of any increase in such individual's benefits resulting from the application of the amendments made by subsections (a) and (b) of this section would under designated circumstances have to be withheld in order to effect the reduction described in subparagraph (B) (ii). Such indi-

vidual may at any time within thirty days after such notification is mailed to him refuse (in such manner and form as the Secretary shall by regulations prescribe) to accept the redetermination under this paragraph.

(D) Unless the last sentence of subparagraph (C) applies, a redetermination under this paragraph shall be effective (but subject to the reduction described in subparagraph (B) (ii) over the period specified pursuant to clause (ii) of the first sentence of subparagraph (C)) beginning with the sixth month following the month in which this Act is enacted, or, if the request for such redetermination is not filed before the end of such sixth month, with the second month following the month in which the request for such redetermination is filed.

(E) The Secretary, by withholding amounts from benefits otherwise payable to an individual under title II of the Social Security Act as specified in clause (ii) of the first sentence of subparagraph (C) (and in no other manner), shall recover the amounts necessary to compensate the Federal Old-Age and Survivors Insurance Trust Fund (and the Federal Disability Insurance Trust Fund) for the excess (described in subparagraph (B) (ii)) attributable to benefits which were paid such individual and to which a redetermination under this subsection applies.

(d) Where—

(1) two or more persons are entitled on the basis of the wages and self-employment income of an individual (without the application of sections 202 (j) (1) and 223 (b) of the Social Security Act) to monthly benefits under section 202 of such Act for the month preceding the month with which (A) a redetermination under subsection (c) of this section becomes effective with respect to the benefits of any one of them and (B) such benefits are accordingly increased by reason of the amendments made by subsections (a) and (b) of this section, and

(2) the total of benefits to which all persons are entitled under such section 202 on the basis of such wages and self-employment income for the month with which such redetermination and increase becomes effective is reduced by reason of section 203 (a) of such Act as amended by this Act (or would, but for the penultimate sentence of such section 203 (a), be so reduced), then the amount of the benefit to which each of the persons referred to in paragraph (1), other than the person with respect to whose benefits such redetermination and increase is applicable, is entitled for months beginning with the month with which such redetermination and increase becomes effective shall be adjusted, after the application of such section

203 (a), to an amount no less than the amount it would have been if such redetermination and increase had not become effective.

LIBERALIZATION OF EARNINGS TEST

SEC. 107. (a) (1) Paragraphs (1) and (4) (B) of section 203 (f) of the Social Security Act are each amended by striking out "$140" and inserting in lieu thereof "$166.66⅔ or the exempt amount as determined under paragraph (8)".

(2) Paragraph (1) (A) of section 203 (h) of such Act is amended by striking out "$140" and inserting in lieu thereof "$166.66⅔ or the exempt amount as determined under subsection (f) (8)".

(3) Paragraph (3) of section 203 (f) of such Act is amended to read as follows:

"(3) For purposes of paragraph (1) and subsection (h), an individual's excess earnings for a taxable year shall be 50 per centum of his earnings for such year in excess of the product of $166.66⅔ or the exempt amount as determined under paragraph (8) multiplied by the number of months in such year. The excess earnings as derived under the preceding sentence, if not a multiple of $1, shall be reduced to the next lower multiple of $1."

(b) Section 203 (f) of such Act is further amended by adding at the end thereof the following new paragraph:

"(8) (A) On or before November 1 of 1972 and of each even-numbered year thereafter, the Secretary shall determine and publish in the Federal Register the exempt amount as defined in subparagraph (B) for each month in any individual's first two taxable years which end with the close of or after the calendar year following the year in which such determination is made.

"(B) The exempt amount for each month of a particular taxable year shall be whichever of the following is the larger:

"(i) the product of $166.66\frac{2}{3}$ and the ratio of (I) the average taxable wages of all persons for whom taxable wages were reported to the Secretary for the first calendar quarter of the calendar year in which a determination under subparagraph (A) is made for each such month of such particular taxable year to (II) the average of the taxable wages of all persons for whom wages were reported to the Secretary for the first calendar quarter of 1971, with such product, if not a multiple of $10, being rounded to the next higher multiple of $10

where such product is an odd multiple of $5 and to the nearest multiple of $10 in any other case, or

"(ii) the exempt amount for each month in the taxable year preceding such particular taxable year;

except that the provisions in clause (i) shall not apply with respect to any taxable year unless the contribution and earnings base for such year is determined under section 230(b)(1)."

(c) The amendments made by this section shall apply with respect to taxable years ending after December 1970.

EXCLUSION OF CERTAIN EARNINGS IN YEAR OF ATTAINING AGE 72

SEC. 108. (a) The first sentence of section 203(f)(3) of the Social Security Act is amended by inserting "(A)" after "except that", and by inserting before the period at the end thereof the following: ", and (B) in determining an individual's excess earnings for the taxable year in which he attains age 72, there shall be excluded any earnings of such individual for the month in which he attains such age and any subsequent month (with any net earnings or net loss from self-employment in such year being prorated in an equitable manner under regulations of the Secretary)".

(b) The amendment made by subsection (a) shall

apply with respect to taxable years ending after December 1970.

REDUCED BENEFITS FOR WIDOWERS AT AGE 60

SEC. 109. (a) Section 202(f) of the Social Security Act (as amended by section 104(b)(2) of this Act) is further amended—

(1) by striking out "age 62" each place it appears and inserting in lieu thereof "age 60"; and

(2) by striking out "or the third month" in the matter following subparagraph (G) in paragraph (1) and inserting in lieu thereof "or, if he became entitled to such benefits before he attained age 60, the third month".

(b)(1) The last sentence of section 203(c) of such Act (as amended by section 104(c)(1) of this Act) is further amended by striking out "age 62" and inserting in lieu thereof "age 60".

(2) Clause (D) of section 203(f)(1) of such Act (as amended by section 104(c)(2) of this Act) is further amended by striking out "age 62" and inserting in lieu thereof "age 60".

(3) Section 222(b)(1) of such Act is amended by striking out "a widow or surviving divorced wife who has not attained age 60, a widower who has not attained age

62" and inserting in lieu thereof "a widow, widower or surviving divorced wife who has not attained age 60".

(4) Section 222 (d) (1) (D) of such Act is amended by striking out "age 62" each place it appears and inserting in lieu thereof "age 60".

(5) Section 225 of such Act is amended by striking out "age 62" and inserting in lieu thereof "age 60".

(c) The amendments made by this section shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970, except that in the case of an individual who was not entitled to a monthly benefit under title II of such Act for December 1970 such amendments shall apply only on the basis of an application filed in or after the month in which this Act is enacted.

ENTITLEMENT TO CHILD'S INSURANCE BENEFITS BASED ON DISABILITY WHICH BEGAN BETWEEN 18 AND 22

SEC. 110. (a) Clause (ii) of section 202 (d) (1) (B) of the Social Security Act is amended by striking out "which began before he attained the age of eighteen" and inserting in lieu thereof "which began before he attained the age of 22".

(b) Subparagraphs (F) and (G) of section 202 (d) (1) of such Act are amended to read as follows:

"(F) if such child was not under a disability (as

so defined) at the time he attained the age of 18, the earlier of—

"(i) the first month during no part of which he is a full-time student, or

"(ii) the month in which he attains the age of 22,

but only if he was not under a disability (as so defined) in such earlier month; or

"(G) if such child was under a disability (as so defined) at the time he attained the age of 18, or if he was not under a disability (as so defined) at such time but was under a disability (as so defined) at or prior to the time he attained (or would attain) the age of 22, the third month following the month in which he ceases to be under such disability or (if later) the earlier of—

"(i) the first month during no part of which he is a full-time student, or

"(ii) the month in which he attains the age of 22,

but only if he was not under a disability (as so defined) in such earlier month."

(c) Section 202 (d) (1) of such Act is further amended by adding at the end thereof the following new sentence: "No payment under this paragraph may be made to a child who would not meet the definition of disability in section

223 (d) except for paragraph (1) (B) thereof for any month in which he engages in substantial gainful activity."

(d) Section 202 (d) (6) of such Act is amended by striking out "in which he is a full-time student and has not attained the age of 22" and all that follows and inserting in lieu thereof "in which he—

"(A) (i) is a full-time student or (ii) is under a disability (as defined in section 223 (d)), and

"(B) had not attained the age of 22, but only if he has filed application for such reentitlement.

Such reentitlement shall end with the month preceding whichever of the following first occurs:

"(C) the first month in which an event specified in paragraph (1) (D) occurs;

"(D) the earlier of (i) the first month during no part of which he is a full-time student or (ii) the month in which he attains the age of 22, but only if he is not under a disability (as so defined) in such earlier month; or

"(E) if he was under a disability (as so defined), the third month following the month in which he ceases to be under such disability or (if later) the earlier of—

"(i) the first month during no part of which he is a full-time student, or

"(ii) the month in which he attains the age of 22."

(c) Section 202 (s) of such Act is amended—

(1) by striking out "which began before he attained such age" in paragraph (1); and

(2) by striking out "which began before such child attained the age of 18" in paragraphs (2) and (3).

(f) Where—

(1) one or more persons are entitled (without the application of sections 202 (j) (1) and 223 (b) of the Social Security Act) to monthly benefits under section 202 or 223 of such Act for December 1970 on the basis of the wages and self-employment income of an individual, and

(2) one or more persons (not included in paragraph (1)) are entitled to monthly benefits under such section 202 or 223 for January 1971 solely by reason of the amendments made by this section on the basis of such wages and self-employment income, and

(3) the total of benefits to which all persons are entitled under such section 202 or 223 on the basis of such wages and self-employment income for January 1971 is reduced by reason of section 203 (a) of such Act as amended by this Act (or would, but for the

penultimate sentence of such section 203(a), be so reduced),

then the amount of the benefit to which each person referred to in paragraph (1) of this subsection is entitled for months after December 1970 shall be adjusted, after the application of such section 203(a), to an amount no less than the amount it would have been if the person or persons referred to in paragraph (2) were not entitled to a benefit referred to in such paragraph (2).

(g) The amendments made by this section shall apply only with respect to monthly benefits under section 202 of the Social Security Act for months after December 1970, except that in the case of an individual who was not entitled to a monthly benefit under such section 202 for December 1970 such amendments shall apply only on the basis of an application filed after September 30, 1970.

ELIMINATION OF SUPPORT REQUIREMENT AS CONDITION OF BENEFITS FOR DIVORCED AND SURVIVING DIVORCED WIVES

SEC. 111. (a) Section 202(b)(1) of the Social Security Act is amended—

(1) by adding "and" at the end of subparagraph (C),

(2) by striking out subparagraph (D), and

(3) by redesignating subparagraphs (E) through

(L) as subparagraphs (D) through (K), respectively.

(b) (1) Section 202 (c) (1) of such Act is amended—

(A) by adding "and" at the end of subparagraph (C),

(B) by striking out subparagraph (D), and

(C) by redesignating subparagraphs (E) through (G) as subparagraphs (D) through (F), respectively.

(2) Section 202 (c) (6) of such Act is amended by striking out "paragraph (1) (G)" and inserting in lieu thereof "paragraph (1) (F)".

(c) Section 202 (g) (1) (F) of such Act is amended by striking out clause (i), and by redesignating clauses (ii) and (iii) as clauses (i) and (ii), respectively.

(d) The amendments made by this section shall apply only with respect to benefits payable under title II of the Social Security Act for months after December 1970 on the basis of applications filed on or after the date of the enactment of this Act.

ELIMINATION OF DISABILITY INSURED-STATUS REQUIREMENT OF SUBSTANTIAL RECENT COVERED WORK IN CASES OF INDIVIDUALS WHO ARE BLIND

SEC. 112. (a) The first sentence of section 216 (i) (3) of the Social Security Act is amended by inserting before the period at the end thereof the following: ", and except that the provisions of subparagraph (B) of this paragraph

shall not apply in the case of an individual who is blind (within the meaning of 'blindness' as defined in paragraph (1))".

(b) Section 223(c)(1) of such Act is amended by striking out "coverage." in subparagraph (B)(ii) and inserting in lieu thereof "coverage;", and by striking out "For purposes" and inserting in lieu thereof the following:

"except that the provisions of subparagraph (B) of this paragraph shall not apply in the case of an individual who is blind (within the meaning of 'blindness' as defined in section 216(i)(1)). For purposes".

(c) The amendments made by this section shall be effective with respect to applications for disability insurance benefits under section 223 of the Social Security Act, and for disability determinations under section 216(i) of such Act, filed—

(1) in or after the month in which this Act is enacted, or

(2) before the month in which this Act is enacted if the applicant has not died before such month and if—

(A) notice of the final decision of the Secretary of Health, Education, and Welfare has not been given to the applicant before such month; or

(B) the notice referred to in subparagraph

(A) has been so given before such month but a civil action with respect to such final decision is commenced under section 205(g) of the Social Security Act (whether before, in, or after such month) and the decision in such civil action has not become final before such month;

except that no monthly benefits under title II of the Social Security Act shall be payable or increased by reason of the amendments made by this section for months before January 1971.

WAGE CREDITS FOR MEMBERS OF THE UNIFORMED SERVICES

SEC. 113. (a) Subsection 229(a) of the Social Security Act is amended—

(1) by striking out "after December 1967" and inserting in lieu thereof "after December 1970"; and

(2) by striking out "after 1967" and inserting in lieu thereof "after 1956".

(b) The amendments made by subsection (a) shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970 and with respect to lump-sum death payments under such title in the case of deaths occurring after December 1970, except that, in the case of any individual who is entitled, on the basis of the wages and self-employment income of any individual

to whom section 229 of such Act applies, to monthly benefits under title II of such Act for December 1970, such amendments shall apply (1) only if an application for recomputation by reason of such amendments is filed by such individual, or any other individual, entitled to benefits under such title II on the basis of such wages and self-employment income, and (2) only with respect to such benefits for months beginning with whichever of the following is later: January 1971 or the twelfth month before the month in which such application was filed. Recomputations of benefits as required to carry out the provisions of this paragraph shall be made notwithstanding the provisions of section 215 (f) (1) of the Social Security Act, and no such recomputation shall be regarded as a recomputation for purposes of section 215 (f) of such Act.

APPLICATIONS FOR DISABILITY INSURANCE BENEFITS FILED AFTER DEATH OF INSURED INDIVIDUAL

SEC. 114. (a) (1) Section 223 (a) (1) of the Social Security Act is amended by adding at the end thereof the following new sentence: "In the case of a deceased individual, the requirement of subparagraph (C) may be satisfied by an application for benefits filed with respect to such individual within 3 months after the month in which he died."

(2) Section 223 (a) (2) of such Act is amended by

striking out "he filed his application for disability insurance benefits and was" and inserting in lieu thereof "the application for disability insurance benefits was filed and he was".

(3) The third sentence of section 223(b) of such Act is amended by striking out "if he files such application" and inserting in lieu thereof "if such application is filed".

(4) Section 223(c)(2)(A) of such Act is amended by striking out "who files such application" and inserting in lieu thereof "with respect to whom such application is filed".

(b) Section 216(i)(2)(B) of such Act is amended by adding at the end thereof the following new sentence: "In the case of a deceased individual, the requirement of an application under the preceding sentence may be satisfied by an application for a disability determination filed with respect to such individual within 3 months after the month in which he died."

(c) The amendments made by this section shall apply in the case of deaths occurring in and after the year in which this Act is enacted. For purposes of such amendments (and for purposes of sections 202(j)(1) and 223(b) of the Social Security Act), any application with respect to an individual whose death occurred in such year but before the date of the enactment of this Act which is filed within 3 months after the date of the enactment of this Act shall be deemed to have been filed in the month in which such death occurred).

WORKMEN'S COMPENSATION OFFSET FOR DISABILITY INSURANCE BENEFICIARIES

SEC. 115. (a) Section 224 (a) (5) of the Social Security Act is amended by striking out "80 per centum of".

(b) The amendment made by subsection (a) shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970.

COVERAGE OF FEDERAL HOME LOAN BANK EMPLOYEES

SEC. 116. (a) The provisions of section 210 (a) (6) (B) (ii) of the Social Security Act and section 3121 (b) (6) (B) (ii) of the Internal Revenue Code of 1954, insofar as they relate to service performed in the employ of a Federal Home Loan Bank, shall be effective—

(1) with respect to all service performed in the employ of a Federal Home Loan Bank after December 1970; and

(2) in the case of individuals who are in the employ of a Federal Home Loan Bank on January 1, 1971, with respect to any service performed in the employ of a Federal Home Loan Bank after December 1965; but this paragraph shall be effective only if an amount equal to the taxes imposed by sections 3101 and 3111 of such Code with respect to the services of all such individuals performed in the employ of Federal Home Loan Banks

after December 1965 are paid under the provisions of section 3122 of such Code by July 1, 1971, or by such later date as may be provided in an agreement entered into before such date with the Secretary of the Treasury or his delegate for purposes of this paragraph.

(b) Subparagraphs (A) (i) and (B) of section 104 (i) (2) of the Social Security Amendments of 1956 are repealed.

POLICEMEN AND FIREMEN IN IDAHO

SEC. 117. Section 218 (p) (1) of the Social Security Act is amended by inserting "Idaho," after "Hawaii,".

COVERAGE OF CERTAIN HOSPITAL EMPLOYEES IN NEW MEXICO

SEC. 118. Notwithstanding any provisions of section 218 of the Social Security Act, the agreement with the State of New Mexico heretofore entered into pursuant to such section may at the option of such State be modified at any time prior to January 1, 1971, so as to apply to the services of employees of a hospital which is an integral part of a political subdivision to which an agreement under this section has not been made applicable, as a separate coverage group within the meaning of section 218 (b) (5) of such Act, but only if such hospital has prior to 1966 withdrawn from a retirement system which had been applicable to the employees of such hospital.

PENALTY FOR FURNISHING FALSE INFORMATION TO OBTAIN SOCIAL SECURITY ACCOUNT NUMBER

SEC. 119. (a) Section 208 of the Social Security Act is amended by adding "or" after the semicolon at the end of subsection (e), and by inserting after subsection (e) the following new subsection:

"(f) willfully, knowingly, and with intent to deceive the Secretary as to his true identity (or the true identity of any other person) furnishes or causes to be furnished false information to the Secretary with respect to any information required by the Secretary in connection with the establishment and maintenance of the records provided for in section 205(c)(2);".

(b) The amendments made by subsection (a) shall apply with respect to information furnished to the Secretary after the date of the enactment of this Act.

GUARANTEE OF NO DECREASE IN TOTAL FAMILY BENEFITS

SEC. 120. (a) Section 203(a) of the Social Security Act (as amended by sections 101(b) and 103(b) of this Act) is amended by striking out the period at the end of paragraph (4) and inserting in lieu thereof "; or", and by inserting after paragraph (4) the following new paragraph:

"(5) notwithstanding any other provision of law, when—

"(A) two or more persons are entitled to

monthly benefits for a particular month on the basis of the wages and self-employment income of an insured individual and (for such particular month) the provisions of this subsection and section 202 (q) are applicable to such monthly benefits, and

"(B) such individual's primary insurance amount is increased for the following month under any provision of this title,

then the total of monthly benefits for all persons on the basis of such wages and self-employment income for such particular month, as determined under the provisions of this subsection, shall for purposes of determining the total of monthly benefits for all persons on the basis of such wages and self-employment income for months subsequent to such particular month be considered to have been increased by the smallest amount that would have been required in order to assure that the total of monthly benefits payable on the basis of such wages and self-employment income for any such subsequent month will not be less (after application of the other provisions of this subsection and section 202 (q)) than the total of monthly benefits (after the application of the other provisions of this subsection and section 202 (q)) payable on the basis of such wages and self-employment income for such particular month."

(b) In any case in which the provisions of section 1002(b)(2) of the Social Security Amendments of 1969 apply, the total of monthly benefits as determined under section 203(a) of the Social Security Act shall, for months after 1970, be increased to the amount that would be required in order to assure that the total of such monthly benefits (after the application of section 202(q) of such Act) will not be less than the total of monthly benefits that was applicable (after the application of such sections 203(a) and 202(q)) for the first month for which the provisions of such section 1002(b)(2) applied.

CERTAIN ADOPTIONS BY DISABILITY AND OLD-AGE INSURANCE BENEFICIARIES

SEC. 121. (a) Clause (i) of section 202(d)(8)(E) of the Social Security Act is amended—

(1) by inserting "(I)" after "(i)",

(2) by adding "or" after "child-placement agency,", and

(3) by adding at the end thereof (after and below clause (i)(I) as designated by paragraph (1) of this subsection) the following:

"(II) in an adoption which took place after an investigation of the circumstances surrounding the adoption by a court of competent jurisdiction within the United States, or by a person appointed

by such a court, if the child was related (by blood, adoption, or stepreIationship) to such individual or to such individual's wife or husband as a descendant or as a brother or sister or a descendant of a brother or sister, such individual had furnished one-half of the child's support for at least five years immediately before such individual became entitled to such disability insurance benefits, the child had been living with such individual for at least five years before such individual became entitled to such disability insurance benefits, and the continuous period during which the child was living with such individual began before the child attained age 18,".

(b) The amendments made by subsection (a) shall apply with respect to monthly benefits payable under title II of the Social Security Act for months after December 1967 on the basis of an application filed in or after the month in which this Act is enacted; except that such amendments shall not apply with respect to benefits for any month before the month in which this Act is enacted unless such application is filed before the close of the twelfth month after the month in which this Act is enacted.

INCREASE OF EARNINGS COUNTED FOR BENEFIT AND TAX PURPOSES

SEC. 122. (a) (1) (A) Section 209 (a) (5) of the Social Security Act is amended by inserting "and prior to 1971" after "1967".

(B) Section 209 (a) of such Act is further amended by adding at the end thereof the following new paragraphs:

"(6) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $9,000 with respect to employment has been paid to an individual during any calendar year after 1970 and prior to 1973, is paid to such individual during any such calendar year;

"(7) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to the contribution and benefit base (determined under section 230) with respect to employment has been paid to an individual during any calendar year after 1972 with respect to which such contribution and benefit base is effective, is paid to such individual during such calendar year;".

(2) (A) Section 211 (b) (1) (E) of such Act is

amended by inserting "and beginning prior to 1971" after "1967", and by striking out "; or" and inserting in lieu thereof "; and ".

(B) Section 211(b)(1) of such Act is further amended by adding at the end thereof the following new subparagraphs:

"(F) For any taxable year beginning after 1970 and prior to 1973, (i) $9,000, minus (ii) the amount of the wages paid to such individual during the taxable year; and

"(G) For any taxable year beginning in any calendar year after 1972, (i) an amount equal to the contribution and benefit base (as determined under section 230) which is effective for such calendar year, minus (ii) the amount of the wages paid to such individual during such taxable year; or".

(3)(A) Section 213(a)(2)(ii) of such Act is amended by striking out "after 1967" and inserting in lieu thereof "after 1967 and before 1971, or $9,000 in the case of a calendar year after 1970 and before 1973, or an amount equal to the contribution and benefit base (as determined under section 230) in the case of any calendar year after 1972 with respect to which such contribution and benefit base is effective".

(B) Section 213(a)(2)(iii) of such Act is amended by striking out "after 1967" and inserting in lieu thereof "after 1967 and beginning before 1971, or $9,000 in the case of a taxable year beginning after 1970 and before 1973, or in the case of any taxable year beginning in any calendar year after 1972, an amount equal to the contribution and benefit base (as determined under section 230) which is effective for such calendar year".

(4) Section 215(e)(1) of such Act is amended by striking out "and the excess over $7,800 in the case of any calendar year after 1967" and inserting in lieu thereof "the excess over $7,800 in the case of any calendar year after 1967 and before 1971, the excess over $9,000 in the case of any calendar year after 1970 and before 1973, and the excess over an amount equal to the contribution and benefit base (as determined under section 230) in the case of any calendar year after 1972 with respect to which such contribution and benefit base is effective".

(b)(1)(A) Section 1402(b)(1)(E) of the Internal Revenue Code of 1954 (relating to definition of self-employment income) is amended by inserting "and beginning before 1971" after "1967", and by striking out "; or" and inserting in lieu thereof "; and".

(B) Section 1402(b)(1) of such Code is further

amended by adding at the end thereof the following new subparagraphs:

"(F) for any taxable year beginning after 1970 and before 1973, (i) $9,000, minus (ii) the amount of the wages paid to such individual during the taxable year; and

"(G) for any taxable year beginning in any calendar year after 1972, (i) an amount equal to the contribution and benefit base (as determined under section 230 of the Social Security Act) which is effective for such calendar year, minus (ii) the amount of the wages paid to such individual during such taxable year; or".

(2) (A) Section 3121 (a) (1) of such Code (relating to definition of wages) is amended by striking out "$7,800" each place it appears and inserting in lieu thereof "$9,000".

(B) Effective with respect to remuneration paid after 1972, section 3121 (a) (1) of such Code is amended (1) by striking out "$9,000" each place it appears and inserting in lieu thereof "the contribution and benefit base (as determined under section 230 of the Social Security Act)", and (2) by striking out "by an employer during any calendar year", and inserting in lieu thereof "by an employer during the calendar year with respect to which such contribution and benefit base is effective".

(3) (A) The second sentence of section 3122 of such Code (relating to Federal service) is amended by striking out "$7,800" and inserting in lieu thereof "$9,000".

(B) Effective with respect to remuneration paid after 1972, the second sentence of section 3122 of such Code is amended by striking out "$9,000" and inserting in lieu thereof "the contribution and benefit base".

(4) (A) Section 3125 of such Code (relating to returns in the case of governmental employees in Guam, American Samoa, and the District of Columbia) is amended by striking out "$7,800" where it appears in subsections (a), (b), and (c) and inserting in lieu thereof "$9,000".

(B) Effective with respect to remuneration paid after 1972, section 3125 of such Code is amended by striking out "$9,000" where it appears in subsections (a), (b), and (c) and inserting in lieu thereof "the contribution and benefit base".

(5) Section 6413(c)(1) of such Code (relating to special refunds of employment taxes) is amended—

(A) by inserting "and prior to the calendar year 1971" after "after the calendar year 1967";

(B) by inserting after "exceed $7,800" the following: "or (E) during any calendar year after the calendar year 1970 and prior to the calendar year 1973, the wages received by him during such year exceed

$9,000, or (F) during any calendar year after 1972, the wages received by him during such year exceed the contribution and benefit base (as determined under section 230 of the Social Security Act) which is effective with respect to such year,"; and

(C) by inserting before the period at the end thereof the following: "and before 1971, or which exceeds the tax with respect to the first $9,000 of such wages received in such calendar year after 1970 and before 1973, or which exceeds the tax with respect to an amount of such wages received in such calendar year after 1972 equal to the contribution and benefit base (as determined under section 230 of the Social Security Act) which is effective with respect to such year".

(6) Section 6413 (c) (2) (A) of such Code (relating to refunds of employment taxes in the case of Federal employees) is amended by striking out "or $7,800 for any calendar year after 1967" and inserting in lieu thereof "$7,800 for the calendar year 1968, 1969, or 1970, or $9,000 for the calendar year 1971 or 1972, or an amount equal to the contribution and benefit base (as determined under section 230 of the Social Security Act) for any calendar year after 1972 with respect to which such contribution and benefit base is effective".

(7) (A) Section 6654 (d) (2) (B) (ii) of such Code (relating to failure by individual to pay estimated income tax) is amended by striking out "$6,600" and inserting in lieu thereof "$9,000".

(B) Effective with respect to taxable years beginning after 1972, section 6654 (d) (2) (B) (ii) of such Code is amended by striking out "$9,000" and inserting in lieu thereof "the contribution and benefit base (as determined under section 230 of the Social Security Act)".

(c) The amendments made by subsections (a) (1) and (a) (3) (A), and the amendments made by subsection (b) (except paragraphs (1) and (7) thereof), shall apply only with respect to remuneration paid after December 1970. The amendments made by subsections (a) (2), (a) (3) (B), (b) (1), and (b) (7) shall apply only with respect to taxable years beginning after 1970. The amendment made by subsection (a) (4) shall apply only with respect to calendar years after 1970.

AUTOMATIC ADJUSTMENT OF THE CONTRIBUTION AND BENEFIT BASE

SEC. 123. (a) Title II of the Social Security Act is amended by adding at the end thereof the following new section:

"AUTOMATIC ADJUSTMENT OF THE CONTRIBUTION AND BENEFIT BASE

"SEC. 230. (a) On or before November 1 of 1972 and each even-numbered year thereafter, the Secretary shall determine and publish in the Federal Register the contribution and benefit base (as defined in subsection (b)) for the first two calendar years following the year in which the determination is made.

"(b) The contribution and benefit base for a particular calendar year shall be whichever of the following is the larger:

"(1) The product of $9,000 and the ratio of (A) the average taxable wages of all persons for whom taxable wages were reported to the Secretary for the first calendar quarter of the calendar year in which a determination under subsection (a) is made for such particular calendar year to (B) the average of the taxable wages of all persons for whom taxable wages were reported to the Secretary for the first calendar quarter of 1971, with such product, if not a multiple of $600, being rounded to the next higher multiple of $600 where such product is a multiple of $300 but not of $600 and to the nearest multiple of $600 in any other case; or

"(2) The contribution and benefit base for the calendar year preceding such particular calendar year.

"(c) (1) When the Secretary determines and publishes in the Federal Register a contribution and benefit base (as required by subsection (a)), and

"(A) such base is larger than the contribution and benefit base in effect for the year in which the larger base is so published, and

"(B) a revised table of benefits is not required to be published in the Federal Register under the provisions of section 215 (i) (2) (C) which extends such table for such larger base on or before the effective date of such base,

then the Secretary shall publish a revised table of benefits (determined under the provisions of paragraph (2)) in the Federal Register on or before December 1 of the year prior to the effective year of the new contribution and benefit base. Such table shall be deemed to be the table appearing in section 215 (a).

"(2) The revision of such table shall be determined as follows:

"(A) All of the amounts on each line of columns I, II, III, and IV, except the largest amount in column III, of the table in effect before the revision, shall be the same in the revised table; and

"(B) The additional amounts for the extension of columns III and IV, and the amounts for purposes of

column V, shall be determined in accordance with the provisions of section 215 (i) (2) (C) (v) and (vi).

"(3) When a revised table of benefits, prepared under the provisions of paragraph (2), becomes effective, the provisions of section 215 (b) (4) and (c) and of section 203 (a) (4) shall be disregarded; and the amounts that are added to columns III and IV, or are changed in or added to column V, by such revised table, shall be applicable only in the case of an insured individual—

"(A) who becomes entitled, after December of the year immediately preceding the effective year of the increased contribution and benefit base (provided by this section), to benefits under section 202 (a) or section 223;

"(B) who dies after December of such preceding year without being entitled to benefits under section 202 (a) or section 223; or

"(C) whose primary insurance amount is required to be recomputed under section 215 (f) (2)."

(b) (1) Section 201 (c) of the Social Security Act is amended by inserting before the last sentence the following new sentence: "The report shall further include a recommendation as to the appropriateness of the tax rates in sections 1401 (a), 3101 (a), and 3111 (a) of the Internal Revenue Code of 1954 which will be in effect for the fol-

lowing calendar year, made in the light of the need for the estimated income in relationship to the estimated outgo of the Trust Funds during such year."

(2) Section 1817 (b) of such Act is amended by inserting before the last sentence the following new sentence: "The report shall further include a recommendation as to the appropriateness of the tax rates in sections 1401 (b), 3101 (b), and 3111 (b) of the Internal Revenue Code of 1954 which will be in effect for the following calendar year made in the light of the need for the estimated income in relationship to the estimated outgo of the Trust Fund during such year."

CHANGES IN TAX SCHEDULES

SEC. 124. (a) (1) Section 1401 (a) of the Internal Revenue Code of 1954 (relating to rate of tax on self-employment income for purposes of old-age, survivors, and disability insurance) is amended by striking out paragraphs (2), (3), and (4) and inserting in lieu thereof the following:

"(2) in the case of any taxable year beginning after December 31, 1968, and before January 1, 1975, the tax shall be equal to 6.3 percent of the amount of the self-employment income for such taxable year; and

"(3) in the case of any taxable year beginning

after December 31, 1974, the tax shall be equal to 7.0 percent of the amount of the self-employment income for such taxable year."

(2) Section 3101 (a) of such Code (relating to rate of tax on employees for purposes of old-age, survivors, and disability insurance) is amended by striking out paragraphs (2), (3), and (4) and inserting in lieu thereof the following:

"(2) with respect to wages received during the calendar years 1969, 1970, 1971, 1972, 1973, and 1974, the rate shall be 4.2 percent;

"(3) with respect to wages received during the calendar years 1975, 1976, 1977, 1978, and 1979, the rate shall be 5.0 percent; and

"(4) with respect to wages received after December 31, 1979, the rate shall be 5.5 percent."

(3) Section 3111 (a) of such Code (relating to rate of tax on employers for purposes of old-age, survivors, and disability insurance) is amended by striking out paragraphs (2), (3), and (4) and inserting in lieu thereof the following:

"(2) with respect to wages paid during the calendar years 1969, 1970, 1971, 1972, 1973, and 1974, the rate shall be 4.2 percent;

"(3) with respect to wages paid during the cal-

endar years 1975, 1976, 1977, 1978, and 1979, the rate shall be 5.0 percent; and

"(4) with respect to wages paid after December 31, 1979, the rate shall be 5.5 percent."

(b) (1) Section 1401 (b) of such Code (relating to rate of tax on self-employment income for purposes of hospital insurance) is amended by striking out paragraphs (1) through (5) and inserting in lieu thereof the following:

"(1) in the case of any taxable year beginning after December 31, 1967, and before January 1, 1971, the tax shall be equal to 0.6 percent of the amount of the self-employment income for such taxable year; and

"(2) in the case of any taxable year beginning after December 31, 1970, the tax shall be equal to 1.0 percent of the amount of the self-employment income for such taxable year."

(2) Section 3101 (b) of such Code (relating to rate of tax on employees for purposes of hospital insurance) is amended by striking out paragraphs (1) through (5) and inserting in lieu thereof the following:

"(1) with respect to wages received during the calendar years 1968, 1969, and 1970, the rate shall be 0.6 percent; and

"(2) with respect to wages received after December 31, 1970, the rate shall be 1.0 percent."

(3) Section 3111 (b) of such Code (relating to rate of tax on employers for purposes of hospital insurance) is amended by striking out paragraphs (1) through (5) and inserting in lieu thereof the following:

"(1) with respect to wages paid during the calendar years 1968, 1969, and 1970, the rate shall be 0.6 percent; and

"(2) with respect to wages paid after December 31, 1970, the rate shall be 1.0 percent."

(c) The amendments made by subsections (a) (1) and (b) (1) shall apply only with respect to taxable years beginning after December 31, 1970. The remaining amendments made by this section shall apply only with respect to remuneration paid after December 31, 1970.

ALLOCATION TO DISABILITY INSURANCE TRUST FUND

SEC. 125. (a) Section 201 (b) (1) of the Social Security Act is amended—

(1) by striking out "and (D)" and inserting in lieu thereof "(D)"; and

(2) by striking out "after December 31, 1969, and so reported," and inserting in lieu thereof the following: "after December 31, 1969, and before January 1, 1971, and so reported, (E) 0.90 of 1 per centum

of the wages (as so defined) paid after December 31, 1970, and before January 1, 1975, and so reported, (F) 1.05 per centum of the wages (as so defined) paid after December 31, 1974, and before January 1, 1980, and so reported, and (G) 1.15 per centum of the wages (as so defined) paid after December 31, 1979, and so reported,".

(b) Section 201 (b) (2) of such Act is amended—

(1) by striking out "and (D)" and inserting in lieu thereof "(D)"; and

(2) by inserting after "December 31, 1969," the following: "and before January 1, 1971, (E) 0.675 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1970, and before January 1, 1975, (F) 0.7875 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1974, and before January 1, 1980, and (G) 0.8625 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1979,".

TITLE II—PROVISIONS RELATING TO MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH

PART A—COVERAGE UNDER MEDICARE PROGRAM

PAYMENT UNDER MEDICARE PROGRAM TO INDIVIDUALS COVERED BY FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

SEC. 201. Section 1862 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(c) No payment may be made under this title with respect to any item or service furnished to or on behalf of any individual on or after January 1, 1972, if such item or service is covered under a health benefits plan in which such individual is enrolled under chapter 89 of title 5, United States Code, unless prior to the date on which such item or service is so furnished the Secretary shall have determined and certified that the Federal employees health benefits program under chapter 89 of such title 5 has been modified so as to assure that—

"(1) there is available to each Federal employee or annuitant upon or after attaining age 65, in addition to the health benefits plans available before he attains such age, one or more health benefits plans which offer protection supplementing the combined protection pro-

vided under parts A and B of this title and one or more health benefits plans which offer protection supplementing the protection provided under part B of this title alone, and

"(2) the Government will make available to such Federal employee or annuitant a contribution in an amount at least equal to the contribution which the Government makes toward the health insurance of any employee or annuitant enrolled for high option coverage under the Government-wide plans established under chapter 89 of such title 5, with such contribution being in the form of (A) a contribution toward the supplementary protection referred to in paragraph (1), (B) a payment to or on behalf of such employee or annuitant to offset the cost to him of coverage under parts A and B (or part B alone) of this title, or (C) a combination of such contribution and such payment."

HOSPITAL INSURANCE BENEFITS FOR UNINSURED INDIVIDUALS NOT ELIGIBLE UNDER PRESENT TRANSITIONAL PROVISION

SEC. 202. (a) Section 103(a) of the Social Security Amendments of 1965 is amended—

(1) by redesignating clauses (A) and (B) in paragraphs (2) and (4) as clauses (i) and (ii), respectively, and by redesignating paragraphs (1), (2), (3),

(4), and (5) as subparagraphs (A), (B), (C), (D), and (E), respectively;

(2) by striking out all that follows "Anyone who—" and precedes subparagraph (B) (as redesignated by paragraph (1) of this subsection) and inserting in lieu thereof the following:

"(1) (A) has attained the age of 65,";

(3) by adding "or" at the end of subparagraph (E) (as so redesignated);

(4) by striking out "shall (subject to the limitations in this section)" and all that follows down through the period at the end of the first sentence and inserting in lieu thereof the following:

"(2) (A) meets the provisions of subparagraphs (A), (C), and (D) of paragraph (1),

"(B) does not meet the provisions of subparagraph (B) of paragraph (1), and

"(C) has enrolled (i) under section 1837 of the Social Security Act and (ii) under subsection (d) of this section,

shall (subject to the limitations in this section) be deemed, solely for purposes of section 226 of the Social Security Act, to be entitled to monthly insurance benefits under such section 202 for each month, beginning—

"(i) in the case of an individual who meets the

provisions of paragraph (1), with the first month in which he meets the requirements of such paragraph, or

"(ii) in the case of an individual who meets the provisions of paragraph (2), with the day on which his coverage period (as provided in subsection (d)) begins,

and ending with the month in which he dies, or, if earlier, the month before the month in which he becomes (or upon filing application for monthly insurance benefits under section 202 of such Act would become) entitled to hospital insurance benefits under section 226 or becomes certifiable as a qualified railroad retirement beneficiary.";

(5) (A) by striking out "the preceding requirements of this subsection" in the second sentence and inserting in lieu thereof "the requirements of paragraph (1) of this subsection" and (B) by striking out "paragraph (5) hereof" and inserting in lieu thereof "subparagraph (E) of such paragraph"; and

(6) by striking out "paragraphs (1), (2), (3), and (4)" in the third sentence and inserting in lieu thereof "subparagraphs (A), (B), (C), and (D) of paragraph (1)".

(b) Section 103 (b) of such Amendments is amended (1) by inserting "(i)" after "individual" in the second

sentence, and (2) by adding before the period at the end thereof the following: ", or (ii) (with respect to an enrollment under subsection (d) (1)) for any month during his coverage period (as provided in subsection (d))".

(c) Section 103 (c) (1) of such Amendments is amended by striking out "this section" and inserting in lieu thereof "paragraph (1) of subsection (a) of this section".

(d) Section 103 of such Amendments is further amended by adding at the end thereof the following new subsections:

"(d) (1) An individual who meets the conditions of subparagraphs (A) and (B) of paragraph (2) of subsection (a) and has enrolled under section 1837 of the Social Security Act may enroll for the hospital insurance benefits provided under subsection (a).

"(2) The provisions of sections 1837, 1838, 1839, and 1840 (relating to enrollments under part B of title XVIII of the Social Security Act) shall be applicable to the enrollment authorized by paragraph (1) in the same manner, to the same extent, and under the same conditions as such sections are applicable to enrollments under such part B, except that for purposes of this subsection such sections 1837, 1838, 1839, and 1840 are modified as follows:

"(A) the term 'paragraphs (1) and (2) of section 1836' shall be considered to read 'subparagraphs

(A) and (B) of paragraph (2) of section 103 (a) of the Social Security Amendments of 1965';

"(B) the term 'March 1, 1966' shall be considered to read 'March 31, 1971';

"(C) the term 'May 31, 1966' shall be considered to read 'March 31, 1971';

"(D) the term '1969' shall be considered to read '1972';

"(E) subsection (a) (1) of such section 1838 shall be considered to read as follows:

"'(1) in the case of an individual who enrolls for benefits under subsection (a) of section 103 of the Social Security Amendments of 1965 pursuant to subsection (c) of section 1837 (as made applicable by section 103 (d) (2) of such Amendments), January 1, 1971, or, if later, the first day of the month following the month in which he so enrolls; or';

"(F) subsection (b) of such section 1838 shall be considered amended by adding at the end thereof the following new sentence: 'An individual's enrollment under subsection (d) of section 103 of the Social Security Amendments of 1965 shall also terminate (i) when he satisfies subparagraghs (B) and (E) of paragraph (1) of subsection (a) of such section, with such

termination taking effect on the first day of the month in which he satisfies such subparagraphs, or (ii) when his enrollment under section 1837 terminates, with such termination taking effect as provided in the second sentence of this subsection.';

"(G) subsection (a) of such section 1839 shall be considered to read as follows:

"'(a) The monthly premium of each individual for each month in his coverage period before July 1972 shall be $27.';

"(H) the term '1967' when used in subsection (b) (1) of such section 1839 shall be considered to read 'June 1972';

"(I) subsection (b) (2) of such section 1839 shall be considered to read as follows:

"'(2) The Secretary shall, during December of 1971 and of each year thereafter, determine and promulgate the dollar amount (whether or not such dollar amount was applicable for premiums for any prior month) which shall be applicable for premiums for months occurring in the 12-month period commencing July 1 of the next year. Such amount shall be equal to $27 multiplied by the ratio of (1) the inpatient hospital deductible for such next year, as promulgated under section 1813(b)(2), to (2)

such deductible promulgated for 1971. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1.'; and

"(J) the term 'Federal Supplementary Medical Insurance Trust Fund' shall be considered to read 'Federal Hospital Insurance Trust Fund'.

"(e) Payment of the monthly premiums on behalf of any individual who meets the conditions of subparagraphs (A) and (B) of paragraph (2) of subsection (a) and has enrolled for the hospital insurance benefits provided under subsection (a) may be made by any public or private agency or organization under a contract or other arrangement entered into between it and the Secretary if the Secretary determines that payment of such premiums under such contract or arrangement is administratively feasible."

PART B—IMPROVEMENTS IN THE OPERATING EFFECTIVENESS OF THE MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS

LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

SEC. 221. (a) Title XI of the Social Security Act is amended by adding at the end thereof the following new section:

"LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

"SEC. 1122. (a) The purpose of this section is to assure that Federal funds appropriated under titles V, XVIII, and XIX are not used to support unnecessary capital expenditures made by or on behalf of health care facilities which are reimbursed under any of such titles and that, to the extent possible, reimbursement under such titles shall support planning activities with respect to health services and facilities in the various States.

"(b) The Secretary, after consultation with the Governor (or other chief executive officer) and with appropriate local public officials, shall make an agreement with any State which is able and willing to do so under which a designated planning agency (which shall be an agency described in clause (ii) of subsection (d) (1) (B) that has a governing body or advisory body at least half of whose members represent consumer interests) will—

"(1) make, and submit to the Secretary together with such supporting materials as he may find necessary, findings and recommendations with respect to capital expenditures proposed by or on behalf of any health care facility in such State within the field of its responsibilities, and

"(2) receive from other agencies described in

clause (ii) of subsection (d) (1) (B), and submit to the Secretary together with such supporting material as he may find necessary, the findings and recommendations of such other agencies with respect to capital expenditures proposed by or on behalf of health care facilities in such State within the fields of their respective responsibilities, whenever and to the extent that the findings of such designated agency or any such other agency indicate that any such expenditure is not consistent with the standards, criteria, or plans developed pursuant to the Public Health Service Act (or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963) to meet the need for adequate health care facilities in the area covered by the plan or plans so developed.

"(c) The Secretary shall pay any such State from the Federal Hospital Insurance Trust Fund, in advance or by way of reimbursement as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in subsection (b).

"(d) (1) Except as provided in paragraph (2), if the Secretary determines that—

"(A) neither the planning agency designated in the agreement described in subsection (b) nor an

agency described in clause (ii) of subparagraph (B) of this paragraph had been given notice of any proposed capital expenditure (in accordance with such procedure or in such detail as may be required by such agency) at least 60 days prior to such expenditure; or

"(B) (i) the planning agency so designated or an agency so described had received such timely notice of the intention to make such capital expenditure and had, within a reasonable period after receiving such notice and prior to such expenditure, notified the person proposing such expenditure that the expenditure would not be in conformity with the standards, criteria, or plans developed by such agency or any other agency described in clause (ii) for adequate health care facilities in such State or in the area for which such other agency has responsibility, and

"(ii) the planning agency so designated had, prior to submitting to the Secretary the findings referred to in subsection (b), consulted with, and taken into consideration the findings and recommendations of, the State planning agencies established pursuant to sections 314 (a) and 604 (a) of the Public Health Service Act (to the extent that either such agency is not the agency so designated) as well as the public or nonprofit private agency or organization responsible for the com-

prehensive regional, metropolitan area, or other local area plan or plans referred to in section 314(b) of the Public Health Service Act and covering the area in which the health care facility proposing such capital expenditure is located (where such agency is not the agency designated in the agreement) or, if there is no such agency, such other public or nonprofit private agency or organization (if any) as performs, as determined in accordance with criteria included in regulations, similar functions;

then, for such period as he finds necessary in any case to effectuate the purpose of this section, he shall, in determining the Federal payments to be made under titles V, XVIII, and XIX with respect to services furnished in the health care facility for which such capital expenditure is made, not include any amount which is attributable to depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary facilities), or other expenses related to such capital expenditure.

"(2) If the Secretary, after submitting the matters involved to the advisory council established or designated under subsection (i), determines that an exclusion of expenses related to any capital expenditure of any health care facility would not be consistent with the effective organization and delivery of health services or the effective adminis-

tration of title V, XVIII, or XIX, he shall not exclude such expenses pursuant to paragraph (1).

"(e) Where a person obtains under lease or comparable arrangement any facility or part thereof, or equipment for a facility, which would have been subject to an exclusion under subsection (d) if the person had acquired it by purchase, the Secretary shall (1) in computing such person's rental expense in determining the Federal payments to be made under titles V, XVIII, and XIX with respect to services furnished in such facility, deduct the amount which in his judgment is a reasonable equivalent of the amount that would have been excluded if the person had acquired such facility or such equipment by purchase, and (2) in computing such person's return on equity capital deduct any amount deposited under the terms of the lease or comparable arrangement.

"(f) Any person dissatisfied with a determination by the Secretary under this section may within six months following notification of such determination request the Secretary to reconsider such determination. A determination by the Secretary under this section shall not be subject to administrative or judicial review.

"(g) For the purposes of this section, a 'capital expenditure' is an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which (1) exceeds

$100,000, (2) changes the bed capacity of the facility with respect to which such expenditure is made, or (3) substantially changes the services of the facility with respect to which such expenditure is made. For purposes of clause (1) of the preceding sentence, the cost of the studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment with respect to which such expenditure is made shall be included in determining whether such expenditure exceeds $100,000.

"(h) The provisions of this section shall not apply to Christian Science sanatoriums operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

"(i) (1) The Secretary shall establish a national advisory council, or designate an appropriate existing national advisory council, to advise and assist him in the preparation of general regulations to carry out the purposes of this section and on policy matters arising in the administration of this section, including the coordination of activities under this section with those under other parts of this Act or under other Federal or federally assisted health programs.

"(2) The Secretary shall make appropriate provision for consultation between and coordination of the work of the advisory council established or designated under para-

graph (1) and the Federal Hospital Council, the National Advisory Health Council, the Health Insurance Benefits Advisory Council, the Medical Assistance Advisory Council, and other appropriate national advisory councils with respect to matters bearing on the purposes and administration of this section and the coordination of activities under this section with related Federal health programs.

"(3) If an advisory council is established by the Secretary under paragraph (1), it shall be composed of members who are not otherwise in the regular full-time employ of the United States, and who shall be appointed by the Secretary without regard to the civil service laws from among leaders in the fields of the fundamental sciences, the medical sciences, and the organization, delivery, and financing of health care, and persons who are State or local officials or are active in community affairs or public or civic affairs or who are representative of minority groups. Members of such advisory council, while attending meetings of the council or otherwise serving on business of the council, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the maximum rate specified at the time of such service for grade GS-18 in section 5332 of title 5, United States Code, including traveltime, and while away from their homes or regular places of business they may also be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 (b) of such title 5

for persons in the Government service employed intermittently."

(b) The amendment made by subsection (a) shall apply only with respect to a capital expenditure the obligation for which is incurred by or on behalf of a health care facility subsequent to whichever of the following is earlier: (A) June 30, 1971, or (B) with respect to any State or any part thereof specified by such State, the last day of the calendar quarter in which the State requests that the amendment made by subsection (a) of this section apply in such State or such part thereof.

(c) (1) Section 505(a) (6) of such Act (as amended by section 229(b) of this Act) is further amended by inserting ", consistent with section 1122," after "standards" where it first appears.

(2) Section 506 of such Act (as amended by sections 224(c), 227(d), 230(d), and 235(b) of this Act) is further amended by adding at the end thereof the following new subsection:

"(g) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122."

(3) Clause (2) of the second sentence of section 509 (a) of such Act is amended by inserting ", consistent with section 1122," after "standards".

(4) Section 1861 (v) of such Act is amended by adding at the end thereof the following new paragraph:

"(5) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122."

(5) Section 1902 (a) (13) (D) of such Act (as amended by section 229 (a) of this Act) is further amended by inserting ", consistent with section 1122," after "standards" where it first appears.

(6) Section 1903 (b) of such Act is amended by adding at the end thereof the following new paragraph:

"(3) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122."

REPORT ON PLAN FOR PROSPECTIVE REIMBURSEMENT; EXPERIMENTS AND DEMONSTRATION PROJECTS TO DEVELOP INCENTIVES FOR ECONOMY IN THE PROVISION OF HEALTH SERVICES

SEC. 222. (a) (1) The Secretary of Health, Education, and Welfare, directly or through contracts with public or private agencies or organizations, shall develop and carry out experiments and demonstration projects designed to determine the relative advantages and disadvantages of various

alternative methods of making payment on a prospective basis to hospitals, extended care facilities, and other providers of services for care and services provided by them under title XVIII of the Social Security Act and under State plans approved under titles XIX and V of such Act, including alternative methods for classifying providers, for establishing prospective rates of payment, and for implementing on a gradual, selective, or other basis the establishment of a prospective payment system, in order to stimulate such providers through positive financial incentives to use their facilities and personnel more efficiently and thereby to reduce the total costs of the health programs involved without adversely affecting the quality of services by containing or lowering the rate of increase in provider costs that has been and is being experienced under the existing system of retroactive cost reimbursement.

(2) The experiments and demonstration projects developed under paragraph (1) shall be of sufficient scope and shall be carried out on a wide enough scale to permit a thorough evaluation of the alternative methods of prospective payment under consideration while giving assurance that the results derived from the experiments and projects will obtain generally in the operation of the programs involved (without committing such programs to the adoption of any prospective payment system either locally or nationally).

(3) In the case of any experiment or demonstration project under paragraph (1), the Secretary may waive compliance with the requirements of titles XVIII, XIX, and V of the Social Security Act insofar as such requirements relate to methods of payment for services provided; and costs incurred in such experiment or project in excess of those which would otherwise be reimbursed or paid under such titles may be reimbursed or paid to the extent that such waiver applies to them (with such excess being borne by the Secretary). No experiment or demonstration project shall be developed or carried out under paragraph (1) until the Secretary obtains the advice and recommendations of specialists who are competent to evaluate the proposed experiment or project as to the soundness of its objectives, the possibilities of securing productive results, the adequacy of resources to conduct it, and its relationship to other similar experiments or projects already completed or in process; and no such experiment or project shall be actually placed in operation until a written report containing a full and complete description thereof has been transmitted to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate.

(4) Grants, payments under contracts, and other expenditures made for experiments and demonstration projects under this subsection shall be made from the Federal Hospital

Insurance Trust Fund (established by section 1817 of the Social Security Act) and the Federal Supplementary Medical Insurance Trust Fund (established by section 1841 of the Social Security Act). Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this subsection. With respect to any such grant, payment, or other expenditure, the amount to be paid from each of such trust funds shall be determined by the Secretary, giving due regard to the purposes of the experiment or project involved.

(5) The Secretary shall submit to the Congress no later than July 1, 1972, a full report on the experiments and demonstration projects carried out under this subsection and on the experience of other programs with respect to prospective reimbursement together with any related data and materials which he may consider appropriate. Such report shall include detailed recommendations with respect to the specific methods which could be used in the full implementation of a system of prospective payment to providers of services under the programs involved.

(6) Section 1875(b) of the Social Security Act is amended by inserting "and the experiments and demonstra-

tion projects authorized by section 222(a) of the Social Security Amendments of 1970" after "1967".

(b) (1) Section 402(a) of the Social Security Amendments of 1967 is amended to read as follows:

"(a) (1) The Secretary of Health, Education, and Welfare is authorized, either directly or through grants to public or nonprofit private agencies, institutions, and organizations or contracts with public or private agencies, institutions, and organizations, to develop and engage in experiments and demonstration projects for the following purposes:

"(A) to determine whether, and if so which, changes in methods of payment or reimbursement (other than those dealt with in section 222(a) of the Social Security Amendments of 1970) for health care and services under health programs established by the Social Security Act, including a change to methods based on negotiated rates, would have the effect of increasing the efficiency and economy of health services under such programs through the creation of additional incentives to these ends without adversely affecting the quality of such services;

"(B) to determine whether payments to organizations and institutions which have the capability of providing comprehensive health care services or services other than those for which payment may be made under

such programs (and which are incidental to services for which payment may be made under such programs) would, in the judgment of the Secretary, result in more economical provision and more effective utilization of services for which payment may be made under such programs;

"(C) to determine whether the rates of payment or reimbursement for health care services, approved by a State for purposes of the administration of one or more of its laws, when utilized to determine the amount to be paid for services furnished in such State under the health programs established by the Social Security Act, would have the effect of reducing the costs of such programs without adversely affecting the quality of such services;

"(D) to determine whether payments under such programs based on a single combined rate of reimbursement or charge for the teaching activities and patient care which residents, interns, and supervising physicians render in connection with a graduate medical education program in a patient facility would result in more equitable and economical patient care arrangements without adversely affecting the quality of such care; and

"(E) to determine whether utilization review and medical review mechanisms established on an areawide or communitywide basis would have the effect of provid-

ing more effective controls under such programs over excessive utilization of services.

For purposes of this subsection, 'health programs established by the Social Security Act' means the program established by title XVIII of such Act, a program established by a plan of a State approved under title XIX of such Act, and a program established by a plan of a State approved under title V of such Act.

"(2) Grants, payments under contracts, and other expenditures made for experiments and demonstration projects under paragraph (1) shall be made from the Federal Hospital Insurance Trust Fund (established by section 1817 of the Social Security Act) and the Federal Supplementary Medical Insurance Trust Fund (established by section 1841 of the Social Security Act). Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section. With respect to any such grant, payment, or other expenditure, the amount to be paid from each of such trust funds shall be determined by the Secretary, giving due regard to the purposes of the experiment or project involved."

(2) Section 402 (b) of such Amendments is amended—

(A) by striking out "experiment" each time it appears and inserting in lieu thereof "experiment or demonstration project";

(B) by striking out "experiments" and inserting in lieu thereof "experiments and projects";

(C) by striking out "reasonable charge" and inserting in lieu thereof "reasonable charge, or to reimbursement or payment only for such services or items as may be specified in the experiment"; and

(D) by inserting before the period at the end thereof the following: "; and no such experiment or project shall be actually placed in operation until a written report containing a full and complete description thereof has been transmitted to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate".

(3) Section 1875(b) of the Social Security Act is amended by striking out "experimentation" and inserting in lieu thereof "experiments and demonstration projects".

LIMITATIONS ON COVERAGE OF COSTS UNDER MEDICARE PROGRAM

SEC. 223. (a) The first sentence of section 1861(v)(1) of the Social Security Act is amended by inserting immediately before "determined" where it first appears the fol-

lowing: "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be".

(b) The third sentence of section 1861 (v) (1) of such Act is amended by striking out the comma after "services" where it last appears and inserting in lieu thereof the following: ", may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title,".

(c) The fourth sentence of section 1861 (v) (1) of such Act is amended by inserting after "services" where it first appears the following: " (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this title)".

(d) The fourth sentence of section 1861 (v) (1) of such Act is further amended by striking out "costs with respect" where they first appear and inserting in lieu thereof the following: "necessary costs of efficiently delivering covered services".

(e) Section 1866(a) (2) (B) of such Act is amended (1) by inserting "(i)" after "(B)", and (2) by adding at the end thereof the following new clause:

"(ii) Where a provider of services customarily furnishes an individual items or services which are more expensive than the items or services determined to be necessary in the efficient delivery of needed health services under this title and which have not been requested by such individual, such provider may also charge such individual or other person for such more expensive items or services to the extent that the costs of (or, if less, the customary charges for) such more expensive items or services experienced by such provider in the second fiscal period immediately preceding the fiscal period in which such charges are imposed exceed the cost of such items or services determined to be necessary in the efficient delivery of needed health services, but only if—

"(I) the Secretary has provided notice to the public of any charges being imposed on individuals entitled to benefits under this title on account of costs in excess of the costs determined to be necessary in the efficient delivery of needed health services under this title by particular providers of services in the area in which such items or services are furnished, and

"(II) the provider of services has identified such

charges to such individual or other person, in such manner as the Secretary may prescribe, as charges to meet costs in excess of the cost determined to be necessary in the efficient delivery of needed health services under this title."

(f) Section 1861 (v) of such Act (as amended by section 221 (c) (4) of this Act) is further amended by redesignating paragraphs (4) and (5) as paragraphs (5) and (6), respectively, and by inserting after paragraph (3) the following new paragraph:

"(4) If a provider of services furnishes items or services to an individual which are in excess of or more expensive than the items or services determined to be necessary in the efficient delivery of needed health services and charges are imposed for such more expensive items or services under the authority granted in section 1866 (a) (2) (B) (ii), the amount of payment with respect to such items or services otherwise due such provider in any fiscal period shall be reduced to the extent that such payment plus such charges exceed the cost actually incurred for such items or services in the fiscal period in which such charges are imposed."

(g) Section 1866 (a) (2) of such Act is amended by adding at the end thereof the following new subparagraph:

"(D) Where a provider of services customarily fur-

nishes items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, such provider, notwithstanding the preceding provisions of this paragraph, may not, under the authority of section 1866(a) (2) (B) (ii), charge any individual or other person any amount for such items or services in excess of the amount of the payment which may otherwise be made for such items or services under this title if the admitting physician has a direct or indirect financial interest in such provider."

(h) The amendments made by this section shall be effective with respect to accounting periods beginning after the date of the enactment of this Act.

LIMITS ON PREVAILING CHARGE LEVELS

SEC. 224. (a) Section 1842(b) (3) of the Social Security Act is amended by adding at the end thereof the following new sentences: "No charge may be determined to be reasonable under this part for services rendered after June 30, 1970, and before July 1, 1971, if it exceeds the higher of (i) the prevailing charge recognized by the carrier for similar services in the same locality in administering this part on June 30, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during

the calendar year 1969. With respect to services rendered after June 30, 1971, the charges recognized as prevailing within a locality may be increased in any fiscal year only to the extent found necessary, on the basis of statistical data and methodology acceptable to the Secretary, to cover 75 percent of the customary charges made for similar services in the same locality during the last preceding elapsed calendar year but may not be increased (in the aggregate) beyond the levels described in clause (ii) of the preceding sentence except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such adjustments are justified by economic changes. In the case of medical services, supplies, and equipment that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after June 30, 1970, determined to be reasonable may exceed the lowest charge levels at which such services, supplies, and equipment are widely available in a locality only to the extent and under the circumstances specified by the Secretary."

(b) Section 1903 of such Act is amended by adding at the end thereof the following new subsection:

"(g) Payment under the preceding provisions of this section shall not be made with respect to any amount paid for items or services furnished under the plan after June 30, 1970, to the extent that such amount exceeds the charge

which would be determined to be reasonable for such items or services under the third, fourth, and fifth sentences of section 1842 (b (3)."

(c) Section 506 of such Act is amended by adding at the end thereof the following new subsection:

"(f) Notwithstanding the preceding provisions of this section, no payment shall be made to any State thereunder with respect to any amount paid for items or services furnished under the plan after June 30, 1970, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under the third, fourth, and fifth sentences of section 1842 (b) (3)."

ESTABLISHMENT OF INCENTIVES FOR STATES TO EMPHASIZE OUTPATIENT CARE UNDER MEDICAID PROGRAMS

SEC. 225. (a) (1) Section 1903 of the Social Security Act (as amended by section 228 of this Act) is further amended by inserting after subsection (d) the following new subsection:

"(e) The amount determined under subsection (a) (1) for any State shall be adjusted as follows:

"(1) With respect to the following services furnished under the State plan after December 31, 1970, the Federal medical assistance percentage shall be increased by 25 per centum thereof, except that the Federal medi-

cal assistance percentage as so increased may not exceed 95 per centum:

"(A) outpatient hospital services and clinic services (other than physical therapy services); and

"(B) home health care services (other than physical therapy services); and

"(2) with respect to the following services furnished under the State plan after December 31, 1970, the Federal medical assistance percentage shall be decreased as follows:

"(A) after an individual has received inpatient hospital services (including services furnished in an institution for tuberculosis) on sixty days (whether or not such days are consecutive) during any calendar year (which for purposes of this section means the four calendar quarters ending with June 30), the Federal medical assistance percentage with respect to any such services furnished thereafter to such individual in the same calendar year shall be decreased by 33⅓ per centum thereof;

"(B) after an individual has received care as an inpatient in a skilled nursing home on ninety days (whether or not such days are consecutive) during any calendar year, the Federal medical assistance

percentage with respect to any such care furnished thereafter to such individual in the same calendar year shall be decreased by 33⅓ per centum thereof; and

"(C) after an individual has received inpatient services in a hospital for mental diseases on ninety days occurring after December 31, 1970 (whether or not such days are consecutive), the Federal medical assistance percentage with respect to any such services furnished to such individual on an additional two hundred and seventy-five days (whether or not such days are consecutive) shall be decreased by 33⅓ per centum thereof and no payment may be made under this title for any such services furnished to such individual on any day after such two hundred and seventy-five days.

In determining the number of days on which an individual has received services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under section 1812."

(2) Section 1903(a)(1) of such Act is amended by inserting ", subject to subsection (e) of this section" after "section 1905(b)".

(b) (1) Section 1121 of such Act is amended by adding at the end thereof the following new subsection:

"(f) (1) If the Secretary determines for any calendar quarter beginning after December 31, 1970, with respect to any State that there does not exist a reasonable cost differential between the cost of skilled nursing home services and the cost of intermediate care facility services in such State, the Secretary may reduce the amount which would otherwise be considered as expenditures for which payment may be made under subsection (c) by an amount which in his judgment is a reasonable equivalent of the difference between the amount of the expenditures by such State for intermediate care facility services and the amount that would have been expended by such State for such services if there had been a reasonable cost differential between the cost of skilled nursing home services and the cost of intermediate care facility services.

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

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

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

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

(2) Section 1121 (e) of such Act is amended by adding at the end thereof the following new sentence: "Effective January 1, 1971, the term 'intermediate care facility' shall not include any public institution (or distinct part thereof) for mental diseases or mental defects."

PAYMENT FOR SERVICES OF TEACHING PHYSICIANS UNDER MEDICARE PROGRAM

SEC. 226. (a) (1) Section 1833 (a) (1) of the Social Security Act is amended by striking out "and" before "(B)", and by inserting before the semicolon at the end thereof the following: ", and (C) with respect to expenses incurred for services which are furnished to a patient of a hospital by a physician and for which payment may be made under this part, the amounts paid shall be equal to 100 percent of the reasonable cost, to the hospital or other medical service organization incurring such cost, of such services if (i) (I) such services are furnished under circumstances comparable to the circumstances under which similar services are furnished to

all persons, or all members of a class of persons, who are patients in such hospital and who are not covered by the insurance program established by this part (and not covered under a State plan approved under title XIX), and (II) none of such persons, or members of such class of persons, are required to pay the reasonable charges for such similar services even when they have private insurance covering such similar services (or are otherwise able to pay reasonable charges for all such similar services as determined in accordance with regulations), or (ii) (I) none of the patients in such hospital who are covered by such program are required to pay any charges for services furnished by physicians, or (II) such patients are required to pay reasonable charges for such services but payment of the deductible and coinsurance applicable to such services is not obtained from or on behalf of some or all of them, in addition to the portion of such charges payable as insurance benefits under this part, even though they have private insurance covering such services (or are otherwise able to pay reasonable charges for all such services as determined in accordance with regulations)".

(2) The first sentence of section 1833 (b) of such Act is amended by striking out "and" before "(2)", and by inserting before the period at the end thereof the following: ", and (3) such total amount shall not include expenses in-

curred for services to which clause (C) of subsection (a) (1) applies."

(b) Section 1861 (v) (1) of such Act is amended—

(1) by inserting "(A)" after "(1)";

(2) by striking out "(A) take" and "(B) provide" and inserting in lieu thereof "(i) take" and "(ii) provide", respectively.

(3) by inserting "(B)" immediately preceding "Such regulations in the case of extended care services"; and

(4) by adding at the end thereof the following new subparagraph:

"(C) Where a hospital has an arrangement with a medical school under which the faculty of such school provides services at such hospital and under which reimbursement to such school by such hospital is less than the reasonable cost of such services to the medical school, the reasonable cost of such services to the medical school shall be included in determining the reasonable cost to the hospital of furnishing services for which payment may be made under part A, but only if—

"(i) payment for such services as furnished under such arrangement would be made under part A to the hospital if such services were furnished by the hospital, and

"(ii) such hospital pays to the medical school the reasonable cost of such services to the medical school."

(c) (1) The amendments made by subsection (a) shall apply with respect to bills submitted and requests for payment made after the date of the enactment of this Act.

(2) The amendments made by subsection (b) shall be effective with respect to accounting periods beginning after the date of the enactment of this Act.

AUTHORITY OF SECRETARY TO TERMINATE PAYMENTS TO SUPPLIERS OF SERVICES

SEC. 227. (a) Section 1862 of the Social Security Act (as amended by section 201 of this Act) is further amended by adding at the end thereof the following new subsection:

"(d) (1) No payment may be made under this title with respect to any item or services furnished to an individual by a person where the Secretary determines under this subsection that such person—

"(A) has made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under this title or for use in determining the right to a payment under this title;

"(B) has submitted, or caused to be submitted, bills or requests for payment under this title containing charges (or in applicable cases requests for payment of costs to such person) for services rendered which the

Secretary finds, with the concurrence of the appropriate program review team appointed pursuant to paragraph (4), to be substantially in excess of such person's customary charges (or in applicable cases substantially in excess of such person's costs) for such services, unless the Secretary finds there is good cause for such bills or requests containing such charges (or in applicable cases, such costs); or

"(C) has furnished services or supplies which are determined by the Secretary, with the concurrence of the members of the appropriate program review team appointed pursuant to paragraph (4) who are physicians or other professional personnel in the health care field, to be substantially in excess of the needs of individuals or to be harmful to individuals or to be of a grossly inferior quality.

"(2) A determination made by the Secretary under this subsection shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of inpatient hospital services, posthospital extended care services, and home

health services such determination shall be effective in the manner provided in section 1866(b) (3) and (4) with respect to terminations of agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

"(3) Any person furnishing services described in paragraph (1) who is dissatisfied with a determination made by the Secretary under this subsection shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

"(4) For the purposes of paragraph (1) (B) and (C) of this subsection, and clause (F) of section 1866(b) (2), the Secretary shall, after consultation with appropriate State and local professional societies, the appropriate carriers and intermediaries utilized in the administration of this title, and consumer representatives familiar with the health needs of residents of the State, appoint one or more program review teams (composed of physicians, other professional personnel in the health care field, and consumer representatives) in each State which shall, among other things—

"(A) undertake to review such statistical data on

program utilization as may be submitted by the Secretary,

"(B) submit to the Secretary periodically, as may be prescribed in regulations, a report on the results of such review, together with recommendations with respect thereto,

"(C) undertake to review particular cases where there is a likelihood that the person or persons furnishing services and supplies to individuals may come within the provisions of paragraph (1) (B) and (C) of this subsection or clause (F) of section 1866(b)(2), and

"(D) submit to the Secretary periodically, as may be prescribed in regulations, a report of cases reviewed pursuant to subparagraph (C) along with an analysis of, and recommendations with respect to, such cases."

(b) Section 1866(b)(2) of such Act is amended by striking out the period at the end thereof and inserting in lieu thereof the following: ", or (D) that such provider has made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under this title or for use in determining the right to a payment under this title, or (E) that such provider has submitted, or caused to be submitted, requests for payment under this title of amounts for rendering services sub-

stantially in excess of the costs incurred by such provider for rendering such services, or (F) that such provider has furnished services or supplies which are determined by the Secretary, with the concurrence of the members of the appropriate program review team appointed pursuant to section 1862 (d) (4) who are physicians or other professional personnel in the health care field, to be substantially in excess of the needs of individuals or to be harmful to individuals or to be of a grossly inferior quality."

(c) Section 1903 (g) of such Act (as added by section 224 (b) of this Act) is further amended by striking out "shall not be made" and all that follows and inserting in lieu thereof the following: "shall not be made—

"(1) with respect to any amount paid for items or services furnished under the plan after June 30, 1970, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under the third, fourth, and fifth sentences of section 1842 (b) (3); or

"(2) with respect to any amount paid for services furnished under the plan after June 30, 1970, by a provider or other person during any period of time, if payment may not be made under title XVIII with respect to services furnished by such provider or person during

such period of time solely by reason of a determination by the Secretary under section 1862(d)(1) or under clause (D), (E), or (F) of section 1866(b)(2)."

(d) Section 506(f) of such Act (as added by section 224(c) of this Act) is further amended by striking out "no payment shall be made" and all that follows and inserting in lieu thereof the following: "no payment shall be made to any State thereunder—

"(1) with respect to any amount paid for items or services furnished under the plan after June 30, 1970, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under the third, fourth, and fifth sentences of section 1842(b)(3); or

"(2) with respect to any amount paid for services furnished under the plan after June 30, 1970, by a provider or other person during any period of time, if payment may not be made under title XVIII with respect to services furnished by such provider or person during such period of time solely by reason of a determination by the Secretary under section 1862(d)(1) or under clause (D), (E), or (F) of section 1866(b)(2)."

ELIMINATION OF REQUIREMENT THAT STATES MOVE TOWARD COMPREHENSIVE MEDICAID PROGRAMS

SEC. 228. Section 1903 (e) of the Social Security Act, and section 2 (b) of Public Law 91-56 (approved August 9, 1969), are repealed.

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

SEC. 229. (a) Section 1902 (a) (13) (D) of the Social Security Act is amended to read as follows:

"(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards which shall be developed by the State and included in the plan and shall not result in any part of the cost of any such services provided to individuals covered by the plan being borne by individuals not so covered or in any part of the cost of any such services provided to individuals not so covered being borne by the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861 (v) as the reasonable cost of such services for purposes of title XVIII;".

(b) Section 505 (a) (6) of such Act is amended to read as follows:

"(6) provides for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards which shall be developed by the State and included in the plan and shall not result in any part of the cost of any such services provided to individuals covered by the plan being borne by individuals not so covered or in any part of the costs of any such services provided to individuals not so covered being borne by the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861 (v) as the reasonable cost of such services for purposes of title XVIII;".

(c) The amendments made by this section shall be effective July 1, 1971 (or earlier if the State plan so provides).

AMOUNT OF PAYMENTS WHERE CUSTOMARY CHARGES FOR SERVICES FURNISHED ARE LESS THAN REASONABLE COST

SEC. 230. (a) Section 1814 (b) of the Social Security Act is amended to read as follows:

"Amount Paid to Providers

"(b) The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1813, be—

"(1) the lesser of (A) the reasonable cost of such services, as determined under section 1861 (v), or (B) the customary charges with respect to such services; or

"(2) if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such reasonable cost which the Secretary finds will provide fair compensation to such provider for such services."

(b) Section 1833 (a) (2) of such Act is amended to read as follows:

"(2) in the case of services described in section 1832 (a) (2)—80 percent of—

"(A) the lesser of (i) the reasonable cost of such services, as determined under section 1861 (v), or (ii) the customary charges with respect to such services; or

"(B) if such services are furnished by a public provider of services free of charge or at nominal

charges to the public, the amount determined in accordance with section 1814 (b) (2)."

(c) Section 1903 (g) of such Act (as added by section 224 (b) and amended by section 227 (c) of this Act) is further amended by striking out the period at the end of paragraph (2) and inserting in lieu thereof "; or", and by adding after paragraph (2) the following new paragraph:

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

(d) Section 506 (f) of such Act (as added by section 224 (c) and amended by section 227 (d) of this Act) is further amended by striking out the period at the end of paragraph (2) and inserting in lieu thereof "; or", and by adding after paragraph (2) the following new paragraph:

"(3) with respect to any amount expended for inpatient hospital services furnished under the plan to the

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

(e) Clause (2) of the second sentence of section 509 (a) of such Act (as amended by section 221 (c) (3) of this Act) is further amended by inserting "(A)" before "the reasonable cost", and by inserting after "under the project," the following: "or (B) if less, the customary charges with respect to such services provided under the project, or (C) if such services are furnished under the project by a public institution free of charge or at nominal charges to the public, an amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such reasonable cost which the Secretary finds will provide fair compensation to such institution for such services".

(f) The amendments made by subsections (a) and (b) shall apply to services furnished by hospitals and extended care facilities in accounting periods beginning after June 30,

1970, and to services furnished by home health agencies in accounting periods beginning after June 30, 1970. The amendments made by subsections (c), (d), and (e) shall apply with respect to services furnished in calendar quarters beginning after June 30, 1970.

INSTITUTIONAL PLANNING UNDER MEDICARE PROGRAM

SEC. 231. (a) The first sentence of section 1861 (e) of the Social Security Act is amended—

(1) by striking out "and" at the end of paragraph (7);

(2) by redesignating paragraph (8) as paragraph (9); and

(3) by inserting after paragraph (7) the following new paragraph:

"(8) has in effect an overall plan and budget that meets the requirements of subsection (z); and".

(b) Section 1861 (f) (2) of such Act is amended to read as follows:

"(2) satisfies the requirements of paragraphs (3) through (9) of subsection (e);".

(c) Section 1861 (g) (2) of such Act is amended to read as follows:

"(2) satisfies the requirements of paragraphs (3) through (9) of subsection (e);".

(d) The first sentence of section 1861(j) of such Act is amended—

(1) by striking out "and" at the end of paragraph (9);

(2) by redesignating paragraph (10) as paragraph (11); and

(3) by inserting after paragraph (9) the following new paragraph:

"(10) has in effect an overall plan and budget that meets the requirements of subsection (z); and".

(e) Section 1861(o) of such Act is amended—

(1) by striking out "and" at the end of paragraph (4);

(2) by redesignating paragraph (5) as paragraph (6); and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) has in effect an overall plan and budget that meets the requirements of subsection (z); and".

(f) Section 1861 of such Act is further amended by adding at the end thereof the following new subsection:

"Institutional Planning

"(z) An overall plan and budget of a hospital, extended care facility, or home health agency shall be considered sufficient if it—

"(1) provides for an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items;

"(2) provides for a capital expenditures plan for at least a 3-year period (including the year to which the operating budget described in subparagraph (1) is applicable) which includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure in excess of $100,000 related to the acquisition of land, the improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of buildings and equipment which would, under generally accepted accounting principles, be considered capital items;

"(3) provides for review and updating at least annually; and

"(4) is prepared, under the direction of the governing body of the institution or agency, by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the institution or agency."

(g) (1) Section 1814 (a) (2) (C) and section 1814

(a) (2) (D) of such Act are each amended by striking out "and (8)" and inserting in lieu thereof "and (9)".

(2) Section 1863 of such Act is amended by striking out "subsections (c) (8), (f) (4), (g) (4), (j) 10), and (o) (5)" and inserting in lieu thereof "subsections (e) (9), (f) (4), (g) (4), (j) (11), and (o) (6)".

(h) Section 1865 of such Act is amended—

(1) by striking out "(except paragraph (6) thereof)" in the first sentence and inserting in lieu thereof "(except paragraphs (6) and (8) thereof)", and

(2) by striking out the second sentence and inserting in lieu thereof the following: "If such Commission, as a condition for accreditation of a hospital, (1) requires a utilization review plan as defined in section 1861 (k) or imposes another requirement which serves substantially the same purpose, or (2) requires institutional plans as defined in section 1861 (z) or imposes another requirement which serves substantially the same purpose, the Secretary is authorized to find that all institutions so accredited by the Commission comply also with section 1861 (e) (6) or 1861 (e) (8), as the case may be."

(i) The amendments made by this section shall apply with respect to any provider of services for fiscal years (of

such provider) beginning after the fifth month following the month in which this Act is enacted.

PAYMENTS TO STATES UNDER MEDICAID PROGRAMS FOR INSTALLATION AND OPERATION OF CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS

SEC. 232. (a) Section 1903 (a) of the Social Security Act is amended by redesignating paragraph (3) as paragraph (4), and by inserting after paragraph (2) the following new paragraph:

"(3) an amount equal to—

"(A) 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such mechanized claims processing and information retrieval systems as the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of title XVIII, including the State's share of the cost of installing such a system to be used jointly in the administration of such State's plan and the plan of any other State approved under this title, and

"(B) 75 per centum of so much of the sums expended during such quarter as are attributable to

the operation of systems of the type described in subparagraph (A) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by the plan of the specific services so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services; plus".

(b) The amendments made by subsection (a) shall apply with respect to expenditures under State plans approved under title XIX of the Social Security Act made after June 30, 1970.

ADVANCE APPROVAL OF EXTENDED CARE AND HOME HEALTH COVERAGE UNDER MEDICARE PROGRAM

SEC. 233. (a) Section 1862 of the Social Security Act (as amended by sections 201 and 227(a) of this Act) is further amended by adding at the end thereof the following new subsection:

"(e) (1) In any case where post-hospital extended care services or post-hospital home health services are furnished to an individual and—

"(A) a physician provides the certification referred to in subparagraph (C) or (D) of section 1814(a)(2), as the case may be, and the condition of the individual with respect to which such certification is made is a condition designated in regulations,

"(B) such physician (in the case of such extended care services) submitted to the extended care facility which is to provide such services, prior to the admission of such individual to such facility, a plan for the furnishing of such services, or (in the case of such home health services) submitted to the home health agency which is to furnish such services, prior to the first visit to such individual, a plan specifying the type and frequency of the services required, and

"(C) there is compliance with such other requirements and procedures as may be specified in regulations,

the provisions of paragraphs (1) and (9) of subsection (a) shall not apply (except as may be provided in section 1814(a)(7)) for such periods of time, with respect to such conditions of the individual, as may be prescribed in regulations.

"(2) In specifying the conditions included under paragraph (1) and the periods for which paragraphs (1) and (9) of subsection (a) shall not apply, the Secretary shall take into account the medical severity of such conditions,

the period over which such conditions generally require the services specified in subparagraphs (C) and (D) of section 1814(a)(2), the length of stay in an institution generally needed for the treatment of such conditions, and such other factors affecting the type of care to be provided as the Secretary deems pertinent.

"(3) If the Secretary determines with respect to a physician that such physician is submitting with some frequency (A) erroneous certifications that individuals have conditions designated in regulations as provided in this subsection or (B) plans for providing services which are inappropriate, the provisions of paragraph (1) shall not apply, after the effective date of such determination, in any case in which such physician submits a certification or plan referred to in subparagraph (A) or (B) of such paragraph."

(b) The amendments made by this section shall be effective with respect to admissions to extended care facilities, and home health plans initiated, on or after January 1, 1971.

PROHIBITION AGAINST REASSIGNMENT OF CLAIMS TO BENEFITS

SEC. 234. (a) Section 1842(b) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

"(5) No payment under this part for a service provided

to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B) (ii) of paragraph (3)) the physician or other person who provided the service, except that payment may be made (A) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (B) (where the service was provided in a hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service."

(b) Section 1902 (a) of such Act is amended—

(1) by striking out "and" at the end of paragraph (29);

(2) by striking out the period at the end of paragraph (30) and inserting in lieu thereof "; and"; and

(3) by inserting after paragraph (30) the following new paragraph:

"(31) provide that no payment under the plan for any care or service provided to an individual by a physician, dentist, or other individual practitioner shall be made to anyone other than such individual or such phy-

sician, dentist, or practitioner, except that payment may be made (A) to the employer of such physician, dentist, or practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (B) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service."

(c) The amendment made by subsection (a) shall apply with respect to bills submitted and requests for payments made after the date of the enactment of this Act. The amendments made by subsection (b) shall be effective July 1, 1971 (or earlier if the State plan so provides).

UTILIZATION REVIEW REQUIREMENTS FOR HOSPITALS AND SKILLED NURSING HOMES UNDER MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

SEC. 235. (a) (1) Section 1903 (g) of the Social Security Act (as added by section 224 (b) and amended by sections 227 (c) and 230 (c) of this Act) is further amended by striking out the period at the end of paragraph (3) and inserting in lieu thereof "; or", and by adding after paragraph (3) the following new paragraph:

"(4) with respect to any amount expended for care or services furnished under the plan by a hospital or skilled nursing home unless such hospital or skilled nursing home has in effect a utilization review plan which meets the requirements imposed by section 1861(k) for purposes of title XVIII; and if such hospital or skilled nursing home has in effect such a utilization review plan for purposes of title XVIII, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this title."

(2) Section 1902(a)(30) of such Act is amended by inserting "(including but not limited to utilization review plans as provided for in section 1903(g)(4))" after "plan" where it first appears.

(b) Section 506(f) of such Act (as added by section 224(c) and amended by sections 227(d) and 230(d) of this Act) is further amended by striking out the period at the end of paragraph (3) and inserting in lieu thereof "; or", and by adding after paragraph (3) the following new paragraph:

"(4) with respect to any amount expended for services furnished under the plan by a hospital unless such hospital has in effect a utilization review plan which

meets the requirement imposed by section 1861 (k) for purposes of title XVIII; and if such hospital has in effect such a utilization review plan for purposes of title XVIII, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this title."

(c) (1) The amendments made by subsections (a) (1) and (b) shall apply with respect to services furnished in calendar quarters beginning after June 30, 1971.

(2) The amendment made by subsection (a) (2) shall be effective July 1, 1971.

ELIMINATION OF REQUIREMENT THAT COST-SHARING CHARGES IMPOSED ON INDIVIDUALS OTHER THAN CASH RECIPIENTS UNDER MEDICAID BE RELATED TO THEIR INCOME

SEC. 236. (a) Section 1902 (a) (14) of the Social Security Act is amended to read as follows:

"(14) provide that in the case of individuals receiving aid or assistance under State plans approved under titles I, X, XIV, and XVI, and part A of title IV, no deduction, cost sharing, or similar charge will be imposed under the plan on the individual with respect to services furnished him under the plan;".

(b) The amendment made by subsection (a) shall be

effective January 1, 1971 (or earlier if the State plan so provides).

NOTIFICATION OF UNNECESSARY ADMISSION TO A HOSPITAL OR EXTENDED CARE FACILITY UNDER MEDICARE PROGRAM

SEC. 237. (a) Section 1814 (a) (7) of the Social Security Act is amended by striking out "as described in section 1861 (k) (4)" and inserting in lieu thereof "as described in section 1861 (k) (4), including any finding made in the course of a sample or other review of admissions to the institution".

(b) The amendment made by subsection (a) shall apply with respect to services furnished after the second month following the month in which this Act is enacted.

USE OF STATE HEALTH AGENCY TO PERFORM CERTAIN FUNCTIONS UNDER MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

SEC. 238. (a) Section 1902 (a) (9) of the Social Security Act is amended to read as follows:

"(9) provide—

"(A) that the State health agency shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services, and

"(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions;".

(b) Section 1902(a) of such Act (as amended by section 234(b) of this Act) is further amended—

(1) by striking out "and" at the end of paragraph (30);

(2) by striking out the period at the end of paragraph (31) and inserting in lieu thereof "; and"; and

(3) by inserting after paragraph (31) the following new paragraph:

"(32) provide—

"(A) that the State health agency shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the

State agency described in the last sentence of this subsection; and

"(B) that the State health agency, or, if the services of another State or local agency are being utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), such other agency, will perform for the State agency administering or supervising the administration of the plan approved under this title the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan."

(c) Section 505(a) of such Act is amended—

(1) by striking out "and" at the end of paragraph (13);

(2) by striking out the period at the end of paragraph (14) and inserting in lieu thereof "; and"; and

(3) by adding after paragraph (14) the following new paragraph:

"(15) provides—

"(A) that the State health agency shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of

the appropriateness and quality of care and services furnished to recipients of services under the plan and, where applicable, for providing guidance with respect thereto to the other State agency referred to in paragraph (2); and

"(B) that the State health agency, or, if the services of another State or local agency are being utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), such other agency, will perform the function of determining whether institutions and agencies meet the requirements for participation in the program under the plan under this title."

(d) The amendments made by this section shall be effective July 1, 1971.

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

SEC. 239. (a) Title XVIII of the Social Security Act is amended by adding after section 1875 the following new section:

"PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

"SEC. 1876. (a) (1) In lieu of amounts which would otherwise be payable pursuant to sections 1814(b) and 1833(a), the Secretary is authorized to determine, by actuarial methods, as provided in this section, with respect to any health maintenance organization, a combined part A and

part B, prospective, per capita rate of payment for services provided for enrollees in such organization who are entitled to hospital insurance benefits under part A and enrolled for medical insurance benefits under part B.

"(2) Such rate of payment shall be determined annually in accordance with regulations, taking into account the health maintenance organization's premiums with respect to its other enrollees (with appropriate actuarial adjustments to reflect the difference in utilization between its members who are under age 65 and its members who are age 65 and over) and such other pertinent factors as the Secretary may prescribe in regulations, and shall be designed to provide payment at a level not to exceed 95 per centum of the amount that the Secretary estimates (with appropriate adjustments to assure actuarial equivalence) would be payable for services covered under this title if such services were to be furnished by other than health maintenance organizations.

"(3) The payments to health maintenance organizations under this subparagraph shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The portion of such payment to such an organization for a month to be paid by the latter trust fund shall be equal to 200 percent of the product of (A) the number of covered enrollees of such organization for such month, and (B) the monthly premium

rate for supplementary medical insurance for such month as has been determined and promulgated under section 1839 (b) (2). The remainder of such payment shall be paid by the former trust fund.

"(b) The term 'health maintenance organization' means a public or private organization which—

"(1) provides, either directly or through arrangements with others, health services to enrollees on a per capita prepayment basis;

"(2) provides with respect to enrollees to whom this section applies (through institutions, entities, and persons meeting the applicable requirements of section 1861) all of the services and benefits covered under parts A and B of this title;

"(3) provides physicians' services directly through physicians who are either employees or partners of such organization or under an arrangement with an organized group or groups of physicians which is or are reimbursed for services on the basis of an aggregate fixed sum or on a per capita basis;

"(4) demonstrates to the satisfaction of the Secretary proof of financial responsibility and proof of capability to provide comprehensive health care services, including institutional services, efficiently, effectively, and economically;

"(5) has enrolled members at least half of whom consist of individuals under age 65;

"(6) has arrangements for assuring that the health services required by its members are received promptly and appropriately and that the services that are received measure up to quality standards which it establishes in accordance with regulations; and

"(7) has an open enrollment period at least once every two years, under which it accepts eligible persons (as defined under subsection (d)) without underwriting restrictions and on a first-come first-accepted basis up to the limit of its capacity (unless to do so would result in failure to meet the requirement of paragraph (5)).

"(c) The benefits provided to an individual under this section shall consist of—

"(1) entitlement to have payment made on his behalf for all services described in section 1812 and section 1832 which are furnished to him by the health maintenance organization with which he is enrolled pursuant to subsection (e) of this section; and

"(2) entitlement to have payment made by such health maintenance organization to him or on his behalf for such emergency services (as defined in regulations) as may be furnished to him by a physician, supplier, or

provider of services, other than the health maintenance organization with which he is enrolled.

"(d) Subject to the provisions of subsection (e), every individual who is entitled to hospital insurance benefits under part A and is enrolled for medical insurance benefits under part B shall be eligible to enroll with a health maintenance organization (as defined in subsection (b)) which serves the geographic area in which such individual resides.

"(e) An individual may enroll with a health maintenance organization under this section, and may terminate such enrollment, as may be prescribed by regulations.

"(f) Any individual enrolled with a health maintenance organization under this section who is dissatisfied by reason of his failure to receive without additional cost to him any health service to which he believes he is entitled shall, if the amount in controversy is $100 or more, be entitled to a hearing before the Secretary to the same extent as is provided in section 205(b) and in any such hearing the Secretary shall make such health maintenance organization a party thereto. If the amount in controversy is $1,000 or more, such individual or health maintenance organization shall be entitled to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

"(g)(1) If the health maintenance organization provides its enrollees under this section only the services de-

scribed in subsection (c), its premium rate for such enrollees shall not exceed the actuarial value of the cost-sharing provisions applicable under part A and part B.

"(2) If the health maintenance organization provides its enrollees under this section with additional services over those described in subsection (c), it shall furnish such enrollees with information as to the division of its premium rate between the portion applicable to such additional services and the portion applicable to the services described in subsection (c), subject to the limitation that the latter portion may not exceed the actuarial value of the cost-sharing provisions applicable under part A and part B."

(b) Section 1866 of such Act is amended by adding at the end thereof the following new subsection:

"(f) For purposes of this section, the term 'provider of services' shall include a health maintenance organization if such organization meets the requirements of section 1876."

(c) Notwithstanding the provisions of section 1833 of the Social Security Act, any health maintenance organization which has entered into an agreement with the Secretary pursuant to section 1866 of such Act shall, for the duration of such agreement, be entitled to reimbursement only as provided in section 1876 of such Act.

(d) The effective date of any agreement with any health

maintenance organization pursuant to section 1866 of such Act shall be specified in such agreement pursuant to regulations.

(e) (1) Section 1814 (a) of such Act is amended by striking out "Except as provided in subsection (d)," and inserting in lieu thereof the following: "Except as provided in subsection (d) or in section 1876,".

(2) Section 1833 (a) of such Act is amended by striking out "Subject to" and inserting in lieu thereof the following: "Except as provided in section 1876, and subject to".

(3) Section 1866 (b) (2) of such Act is amended by inserting after "1861" in clause (B) the following: "(or of section 1876 in the case of a health maintenance organization)".

(f) The amendments made by this section shall be effective with respect to services provided on or after January 1, 1971.

PART C—MISCELLANEOUS AND TECHNICAL PROVISIONS

COVERAGE PRIOR TO APPLICATION FOR MEDICAL ASSISTANCE

SEC. 251. (a) Section 1902 (a) of the Social Security Act (as amended by sections 234 (b) and 238 (b) of this Act) is further amended—

(1) by striking out "and" at the end of paragraph (31);

(2) by striking out the period at the end of paragraph (32) and inserting in lieu thereof "; and"; and

(3) by inserting after paragraph (32) the following new paragraph:

"(33) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished."

(b) The amendments made by subsection (a) shall be effective July 1, 1971.

HOSPITAL ADMISSIONS FOR DENTAL SERVICES UNDER MEDICARE PROGRAM

SEC. 252. (a) Section 1814 (a) (2) of the Social Security Act is amended by striking out "or" at the end of subparagraph (C), by adding "or" after the semicolon at the end of subparagraph (D), and by inserting after subparagraph (D) the following new subparagraph:

"(E) in the case of inpatient hospital services in connection with a dental procedure, the individual

suffers from impairments of such severity as to require hospitalization;".

(b) Section 1861 (r) of such Act is amended by inserting after "or any facial bone" the following: ", or (C) the certification required by section 1814 (a) (2) (E) of this Act,".

(c) Section 1862 (a) (12) of such Act is amended by inserting before the semicolon the following: ", except that payment may be made under part A in the case of inpatient hospital services in connection with a dental procedure where the individual suffers from impairments of such severity as to require hospitalization".

(d) The amendments made by this section shall apply with respect to admissions occurring after the second month following the month in which this Act is enacted.

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

SEC. 253. (a) Section 1902 (a) of the Social Security Act is amended by adding at the end thereof the following new sentence: "For purposes of paragraphs (26), (28) (B), (D), and (E), and (29), and of section 1903 (g) (4), the terms 'skilled nursing home' and 'nursing home' do not include a Christian Science sanatorium operated, or

listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts."

(b) Section 1908 (g) (1) of such Act is amended by inserting after "Secretary" the following: ", but does not include a Christian Science sanatorium operated, or list d and certified, by the First Church of Christ, Scientist, Boston, Massachusetts".

(c) The amendments made by this section shall be effective on the date of the enactment of this Act.

PHYSICAL THERAPY SERVICES UNDER MEDICARE PROGRAM

SEC. 254. (a) (1) Section 1861 (p) of the Social Security Act is amended by adding at the end thereof (after and below paragraph (4) (B)) the following new sentence: "Under regulations, the term 'outpatient physical therapy services' also includes physical therapy services furnished an individual by a physical therapist (in his office or in such individual's home) who meets licensing and other standards prescribed by the Secretary in regulations, otherwise than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health agency, if the furnishing of such services meets such conditions relating to health and safety as the Secretary may find necessary."

(2) Section 1833 of such Act is amended by adding at the end thereof the following new subsection:

"(g) In the case of services described in the next to last sentence of section 1861 (p), with respect to expenses incurred in any calendar year, no more than $100 shall be considered as incurred expenses for purposes of subsections (a) and (b)."

(3) Section 1833 (a) (2) of such Act (as amended by section 230 (b) of this Act) is further amended by striking out the period at the end of subparagraph (B) and inserting in lieu thereof "; or", and by adding after subparagraph (B) the following new subparagraph:

"(C) if such services are services to which the next to last sentence of section 1861 (p) applies, the reasonable charges for such services."

(4) Section 1832 (a) (2) (C) of such Act is amended by striking out "services." and inserting in lieu thereof "services, other than services to which the next to last sentence of section 1861 (p) applies."

(b) (1) Section 1861 (p) of such Act (as amended by subsection (a) (1) of this section) is further amended by adding at the end thereof the following new sentence: "In addition, such term includes physical therapy services which meet the requirements of the first sentence of this subsection

except that they are furnished to an individual as an inpatient of a hospital or extended care facility."

(2) Section 1835 (a) (2) (C) of such Act is amended by striking out "on an outpatient basis".

(c) Section 1861 (v) of such Act (as amended by sections 221 (c) (4) and 223 (f) of this Act) is further amended by redesignating paragraphs (5) and (6) as paragraphs (6) and (7), respectively, and by inserting after paragraph (4) the following new paragraph:

"(5) Where physical therapy services are furnished by a provider of services or other organization specified in the first sentence of section 1861 (p), or by others under an arrangement with such a provider or other organization, the amount included in any payment to such provider or organization under this title as the reasonable cost of such services shall not exceed an amount equal to the salary which would reasonably have been paid for such services to the person performing them if they had been performed in an employment relationship with such provider or organization rather than under such arrangement."

(d) (1) The amendments made by subsections (a) and (b) shall apply with respect to services furnished on or after January 1, 1971.

(2) The amendments made by subsection (c) shall be effective with respect to accounting periods beginning on or after January 1, 1971.

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

SEC. 255. (a) Section 1838(b) of the Social Security Act is amended by striking out "(not in excess of 90 days)" in the third sentence, and by adding at the end thereof the following new sentence: "The grace period determined under the preceding sentence shall not exceed 90 days; except that it may be extended to not to exceed 180 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 90-day period."

(b) The amendments made by subsection (a) shall apply with respect to nonpayment of premiums which become due and payable on or after the date of the enactment of this Act or which became payable within the 90-day period immediately preceding such date; and for purposes of such amendments any premium which became due and payable within such 90-day period shall be con-

sidered a premium becoming due and payable on the date of the enactment of this Act.

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

SEC. 256. (a) Section 1842(b)(3) of the Social Security Act (as amended by section 224(a) of this Act) is further amended by adding at the end thereof the following new sentence: "The requirement in subparagraph (B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (i) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation of an officer, employee, fiscal intermediary, carrier, or agent of the Department of Health, Education, and Welfare performing functions under this title and acting within the scope of his or its authority, and (ii) the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected."

(b) The amendment made by subsection (a) shall apply with respect to bills submitted and requests for payment made after March 1968.

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

SEC. 257. (a) Section 1837 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(f) In any case where the Secretary finds that an individual's enrollment or nonenrollment in the insurance program established by this part is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Department of Health, Education, and Welfare, the Secretary may take such action (including the designation for such individual of a special initial or subsequent enrollment period, with a coverage period determined on the basis thereof and with appropriate adjustments of premiums) as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction."

(b) The amendment made by subsection (a) shall be effective as of July 1, 1966.

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

SEC. 258. Section 1837 (b) of the Social Security Act is amended to read as follows:

"(b) No individual may enroll under this part more than twice."

WAIVER OF RECOVERY OF INCORRECT PAYMENTS FROM SURVIVOR WHO IS WITHOUT FAULT UNDER MEDICARE PROGRAM

SEC. 259. (a) Section 1870(c) of the Social Security Act is amended by striking out "and where" and inserting in lieu thereof the following: "or where the adjustment (or recovery) would be made by decreasing payments to which another person who is without fault is entitled as provided in subsection (b)(4), if".

(b) The amendment made by subsection (a) shall apply with respect to waiver actions considered after the date of the enactment of this Act.

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

SEC. 260. (a) Section 1842(b)(3)(C) of the Social Security Act is amended by inserting after "a fair hearing by the carrier" the following: ", in any case where the amount in controversy is $100 or more,".

(b) The amendment made by subsection (a) shall apply with respect to hearings requested (under the procedures established under section 1842(b)(3)(C) of the

Social Security Act) after the date of the enactment of this Act.

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

SEC. 261. (a) Section 1840(a)(1) of the Social Security Act is amended by striking out "subsection (d)" and inserting in lieu thereof "subsections (b)(1) and (c)".

(b) Section 1840(b)(1) of such Act is amended by inserting "(whether or not such individual is also entitled for such month to a monthly insurance benefit under section 202)" after "1937", and by striking out "subsection (d)" and inserting in lieu thereof "subsection (c)".

(c) Section 1840 of such Act is further amended by striking out subsection (c), and by redesignating subsections (d) through (i) as subsections (c) through (h), respectively.

(d)(1) Section 1840(c) of such Act (as so redesignated) is amended by striking out "subsection (d)" and inserting in lieu thereof "subsection (c)".

(2) Section 1840(f) of such Act (as so redesignated) is amended by striking out "subsection (d) or (f)" and inserting in lieu thereof "subsection (c) or (e)".

(3) Section 1840(h) of such Act (as so redesignated)

is amended by striking out "(c), (d), and (e)" and inserting in lieu thereof "(c), and (d)".

(4) Section 1841(h) of such Act is amended by striking out "1840(e)" and inserting in lieu thereof "1840(d)".

(c) Section 1841 of such Act is amended by adding at the end thereof the following new subsection:

"(i) The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to pay the costs incurred by the Railroad Retirement Board in making deductions pursuant to section 1840(b)(1). During each fiscal year or after the close of such fiscal year, the Railroad Retirement Board shall certify to the Secretary the amount of the costs it incurred in making such deductions and such certified amount shall be the basis for the amount of such costs certified by the Secretary to the Managing Trustee."

(f) The amendments made by this section shall apply with respect to premiums becoming due and payable after the fourth month following the month in which this Act is enacted.

PAYMENT FOR CERTAIN INPATIENT HOSPITAL SERVICES FURNISHED OUTSIDE THE UNITED STATES

SEC. 262. (a) Section 1814(f) of the Social Security Act is amended to read as follows:

"Payment for Certain Inpatient Hospital Services Furnished Outside the United States

"(f) (1) Payment shall be made for inpatient hospital services furnished to an individual entitled to hospital insurance benefits under section 226 by a hospital located outside the United States, or under arrangements (as defined in section 1861 (w)) with it, if—

"(A) such individual is a resident of the United States, and

"(B) such hospital was closer to, or substantially more accessible from, the residence of such individual than the nearest hospital within the United States which was adequately equipped to deal with, and was available for the treatment of, such individual's illness or injury.

"(2) Payment may also be made for emergency inpatient hospital services furnished to an individual entitled to hospital insurance benefits under section 226 by a hospital located outside the United States if—

"(A) such individual was physically present in a place within the United States at the time the emergency which necessitated such inpatient hospital services occurred, and

"(B) such hospital was closer to, or substantially more accessible from, such place than the nearest hospital within the United States which was adequately

equipped to deal with, and was available for the treatment of, such individual's illness or injury.

"(3) Payment shall be made in the amount provided under subsection (b) to any hospital for the inpatient hospital services described in paragraph (1) or (2) furnished to an individual by the hospital or under arrangements (as defined in section 1861 (w)) with it if (A) the Secretary would be required to make such payment if the hospital had an agreement in effect under this title and otherwise met the conditions of payment hereunder, (B) such hospital elects to claim such payment, and (C) such hospital agrees to comply, with respect to such services, with the provisions of section 1866 (a).

"(4) Payment for the inpatient hospital services described in paragraph (1) or (2) furnished to an individual entitled to hospital insurance benefits under section 226 may be made on the basis of an itemized bill to such individual if (A) payment for such services cannot be made under paragraph (3) solely because the hospital does not elect to claim such payment, and (B) such individual files application (submitted within such time and in such form and manner and by such person, and containing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement. The amount payable with

respect to such services shall, subject to the provisions of section 1813, be equal to the amount which would be payable under subsection (d) (3)."

(b) Section 1861 (e) of such Act is amended—

(1) by striking out "except for purposes of sections 1814 (d) and 1835 (b)" and inserting in lieu thereof "except for purposes of sections 1814 (d), 1814 (f), and 1835 (b)";

(2) by inserting ", section 1814 (f) (2)," immediately after "For purposes of sections 1814 (d) and 1835 (b) (including determinations of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections)"; and

(3) by inserting after the third sentence the following new sentence: "For purposes of section 1814 (f) (1), such term includes an institution which (i) is a hospital for purposes of section 1814 (d), 1814 (f) (2), and 1835 (b) and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals."

(c) Section 1862 (a) (4) of such Act is amended by striking out "emergency".

(d) The amendments made by this section shall apply to services furnished with respect to admissions occurring after December 31, 1970.

STUDY OF CHIROPRACTIC COVERAGE

SEC. 263. The Secretary, utilizing the authority conferred by section 1110 of the Social Security Act, shall conduct a study of the coverage of services performed by chiropractors under State plans approved under title XIX of such Act in order to determine whether and to what extent such services should be covered under the supplementary medical insurance program under part B of title XVIII of such Act, giving particular attention to the limitations which should be placed upon any such coverage and upon payment therefor. Such study shall include one or more experimental, pilot, or demonstration projects designed to assist in providing under controlled conditions the information necessary to achieve the objectives of the study. The Secretary shall report the results of such study to the Congress within two years after the date of the enactment of this Act, together with his findings and recommendations based on such study (and on such other information as he may consider relevant

concerning experience with the coverage of chiropractors by public and private plans).

MISCELLANEOUS TECHNICAL AND CLERICAL AMENDMENTS

SEC. 264. (a) Clause (A) of section 1902(a)(26) of the Social Security Act is amended by striking out "evaluation" and inserting in lieu thereof "evaluation)", and by striking out "care)" and inserting in lieu thereof "care".

(b) Section 1908(d) of such Act is amended by striking out "subsection (b)(1)" and inserting in lieu thereof "subsection (o)(1)".

(c) Section 408(f) of such Act is amended by striking out "522(a)" and inserting in lieu thereof "422(a)".

TITLE III—MISCELLANEOUS PROVISIONS

MEANING OF TERM "SECRETARY"

SEC. 301. As used in this Act, and in the provisions of the Social Security Act amended by this Act, the term "Secretary," unless the context otherwise requires, means the Secretary of Health, Education, and Welfare.

Passed the House of Representatives May 21, 1970.

Attest: W. PAT JENNINGS,
Clerk.

APPENDIX B

QUESTIONS PROPOUNDED IN WRITING TO THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, BY SENATORS GORE AND MILLER

Questions of Senator Gore With Departmental Replies

1. I have introduced a bill (S. 3658) to increase the minimum monthly social security benefits to $100 per month for a single person and $150 per month for a married couple. What is the Administration's position on this badly needed proposal?

The Department would oppose a substantial increase in the minimum benefit. A high minimum benefit would go to a substantial number of people who worked very little in employment covered by social security and who are receiving benefits under other government programs—retired Federal, State, and local employees, for example. These people are no more dependent on the minimum social security benefit for their support in retirement than they were dependent on covered earnings for their livelihood during their working years. In addition, a number of those who are receiving minimum or near-minimum benefits, or who would receive them in the future, are people not substantially dependent upon their own earnings, such as housewives who worked only briefly under the program. A person who has worked regularly under the program at the level of the present Federal minimum wage ($1.60 per hour), for example, would get, under present law, not the minimum benefit of $64 but rather a benefit of over $139 a month (over $146 under H.R. 17550) if he became 65 and retired in 1970. And a person retiring at age 65 in 1971 with full-time earnings at the Federal minimum wage that was in effect over the years would get a benefit of over $119 per month.

Any increase in the social security minimum would, of course, increase the cost of the program. By and large the increased cost has to be met—so long as the program continues to be self-sustaining—through larger contribution income or through smaller benefits paid to other beneficiaries. Within any given level of expenditure, the more that is done in the way of paying a high minimum benefit that is unrelated to earnings and therefore unrelated to contributions, the less can be done for the people who have worked more and earned more and contributed more.

2. What is the relationship between the minimum monthly benefit provided in the Family Assistance Plan Act and the minimum monthly benefit provided in the Social Security Act? How is the minimum benefit in the Family Assistance Plan Act financed?

There is no direct relationship between the minimum monthly benefit provided under the social security program and the minimum monthly income standard provided for the aged, the blind, and the disabled under the Family Assistance Act. The proposed $110 minimum for the adult categories under public assistance is of course not a minimum monthly payment but rather a minimum income standard of assistance; that is, an aged, blind, or disabled person would get a payment that would make up the difference between his income and the $110 standard. The minimum benefit under social security is not intended to be a minimum standard of income but rather an amount that is intended to be related to a person's earnings in covered employment and yet be a significant item of income for the insured person who had low covered earnings. Beneficiaries who have no income other than the minimum social security benefit, or benefits that are less than the $110 minimum income standard, would, if the Family Assistance Act is enacted, get an assistance payment that would bring them up to that standard and possibly more where the States have a higher standard.

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In regard to the financing of the $110 minimum monthly income standard under the Family Assistance Act, the Federal Government would pay 90 percent of the first $65 per recipient and 25 percent of the remainder up to the maximum level of assistance that the Secretary of Health, Education, and Welfare determined to be the limit of financial participation by the Federal Government.

3. House bill provides for a social security tax increase by raising the taxable wage base from $7800 to $9000 in 1971. I understand that the Department contemplates a further increase to $9600 in 1973 under the cost of living provision. Please provide a table showing the tax decreases for wage earners at selected income levels up to $10,000 resulting from the tax reform act as effective in 1973 and the tax increases that would result for those same wage earners as the result of increasing the taxable wage base as outlined above.

Following is a table showing changes in income tax liability and social security contributions at various income levels for a single worker and a married worker with 2 children in 1973.

4. What is the Administration's position on my proposal to reduce the age at which widows could receive actuarially reduced benefits from 60 to 50?

Benefits under the social security program are intended to be made available at an age when it can be assumed that a large number of people, for health or other reasons, may no longer be able to work. For purposes of paying survivors benefits to a widow, it had not seemed unreasonable to use age 60 as the dividing line.

The benefits that are available to widows before age 62 are reduced to take account of the longer period over which the benefits will be paid. The reason for the reduction in benefits is to make some payment available earlier than age 62 for widows at no additional cost to the program. Under present law, a widow at age 60 can get 71½ percent of the worker's age-65 benefits. If benefits were made available at age 50 at no cost to the program, a widow would get between 40 percent and 50 percent of the worker's age-65 benefit. While it could be said that a person in need is better off with a small benefit than none at all, the payment of obviously inadequate benefits to a large number of people would create added pressures for increasing the benefit amounts. To the extent that such pressures were successful, the objective of a cost-free provision would be lost. And the cost of providing full benefits for all widows at age 50 would be substantial.

If reduced widow's benefits were provided at age 50, as they now are provided for disabled widows, it is estimated that additional benefits of $370 million would be payable under the proposal in the first full year of operation, assuming enactment of H.R. 17550.

5. Similarly, what is the Administration's position on my proposal to permit the widower's benefits to be payable at age 60?

The Administration favors the proposal, included in H.R. 17550, to reduce the age of eligibility for widowers' benefits from age 62 to 60, making it the same as that for widows under present law.

It is estimated that additional benefits of less than $500,000 would be payable under this proposal in the first full year of operation.

6. What is the Administration's position on increasing the earnings limitation to $2400 per year rather than the $2000 limit set in the House bill?

As you know, the House-passed bill makes significant improvements in the retirement test provisions of the social security law. Under the bill, $1 in benefits would be withheld for each $2 of earnings above the annual exempt amount regardless of how high the earnings might be; there would be no point at which $1 in benefits would be withheld for each $1 of earnings as is now the case for earnings above $2880. The annual exempt amount would be raised from $1680 to $2000, with future increases automatically geared to increases in earnings levels. The bill also liberalizes the test as it applies in the year a beneficiary becomes age 72. These changes would have a long-run cost of .13 percent of taxable payroll (about $570 million in additional benefits would be paid out in the first 12 months). The Administration supports the provisions in the House-approved bill.

Increasing the annual exempt amount under the retirement test from $2000 as provided in the House bill to $2400 would have a long-run cost to the social security program of .08 percent of taxable payroll in excess of the cost of the provisions in the House-passed bill (about $280 million in additional benefits in

the first year). The additional benefits would be paid to less than 8 percent of all social security beneficiaries, most of whom are working full time and earning as much as they ever did. The vast majority of beneficiaries are unable to work or do not want to, or cannot find employment—they would not be affected by increasing the annual exempt amount.

The President has asked the Advisory Council on Social Security, which is currently reviewing the entire social security program, to give particular study to the retirement test. The Administration believes that consideration of possible changes which would go beyond those contained in the House-passed bill should be deferred until after the Advisory Council has completed its study.

7. What would be the Administration's position on reducing the age at which a person can escape from the earnings limitation from 72 to 65 years of age?

Reducing the age at which the retirement test ceases to apply from age 72 to age 65 would have a long-run cost to the social security program of .52 percent of taxable payroll over the House-passed bill (about $1.5 billion in the first year). It would be very difficult to justify eliminating the test for beneficiaries aged 65 and over while retaining the test for all other beneficiaries, such as young widows with minor children, whose needs may be as great or greater. If the test were eliminated for all beneficiaries the long-run cost of the program would be increased by .56 percent of taxable payroll over the House-passed bill.

Eliminating the test would not be advantageous to as many of the social security beneficiaries as is generally supposed. Our figures show that as of January 1, 1970, there were 18.3 million people age 65 and older and eligible for social security benefits. Of these, 8.6 million were aged 72 or older—the test did not apply to them. Of the remaining 9.7 million people, 6.6 million had no earnings in the year and 1.2 million earned below $1400; it is doubtful whether very many people at these earnings levels would earn more if there were no test, and elimination of the test would not increase the benefits paid to them. Probably the main effects of eliminating the retirement test would be that benefits would be paid to about 1.5 million beneficiaries aged 65 or over who now get no benefits or only partial benefits—only about 8 percent of all beneficiaries aged 65 and over. Most of these would be people working regularly and earning as much as they can.

For the same cost as would be entailed in reducing from age 72 to age 65 the point at which the retirement test would not be applicable, one or more substantial improvements which would have more general application could be provided. For example, a 5-percent benefit increase could be provided for all beneficiaries.

As stated in the response to the preceding question, the Advisory Council on Social Security is giving particular study to possible changes in the retirement test.

8. What is the Administration's position on my proposal to prohibit any reduction in benefits to a social security beneficiary who remarries?

Under the social security program, marriage or remarriage does not affect the benefit payable to a worker who is getting benefits based on his own earnings record. And when a worker getting retirement or disability benefits marries, benefits are generally payable to his spouse and to the children. On the other hand, when a worker's dependents and survivors marry, their benefits are generally terminated. Social security benefits are payable to dependents and survivors whom a worker normally supports or has a legal obligation to support on the presumption that the beneficiary was dependent on the worker for his support and lost a source of support when the worker's earnings were cut off because of retirement in old age, severe disability, or death. Thus, the reason why benefits are generally terminated when a dependent or survivor beneficiary marries is that there is a presumption that the marriage creates a new dependency situation and the dependency relationship on which the benefits were based no longer exists.

An exception is made when a person getting dependent's or survivor's benefits marries a person who is also getting dependent's or survivor's benefits. In this situation benefits are usually payable after the beneficiaries marry, since neither beneficiary could be expected to support himself without his benefits. Another exception is made in the case of a widow age 60 or over, or a widower age 62 or over, who remarries. Under the law, a widow who remarries after age 60 receives one-half the benefit amount that would have been paid to her former husband or one-half the amount of her new husband's benefit, whichever is higher.

The Department of Health, Education, and Welfare has from time to time considered proposals that would provide for continuing full-rate benefits for dependents and survivors after marriage, but has not recommended that such proposals be enacted. It is presumed that a person who marries will ordinarly be self-supporting or will be supported by his or her spouse. The Department has not recommended providing full-rate widow's benefits after remarriage. If full-rate benefits were paid to a widow or widower after remarriage, the new couple would get considerably more in benefits than would a couple that had been married for many years, even though in both instances the workers had identical work records.

If full-rate benefits were provided for widows and widowers after remarriage, it is estimated that additional benefits of $20 million would be payable in the first full year of operation, assuming enactment of H.R. 17550.

9. What is the Administration's position on my proposal to permit a disabled wife to receive an additional social security allowance, even though she is not otherwise qualified to receive benefits, where her husband is also disabled?

As you know, wife's benefits under social security are now provided to the wife of an old-age or disability insurance beneficiary in two general types of situations: (1) where the wife has a young child and may need to stay at home to care for the child rather than seek employment, and (2) where the wife has reached age 62—an age at which it can be assumed that most wives, for health and other reasons, may no longer be able to support themselves through gainful employment. (Benefits are also payable to a dependent husband if he is aged 62 or over, and was receiving at least one-half of his support from his spouse at the time of her disablement.)

We recognize that a beneficiary's wife (or dependent husband) who is totally disabled for work is likely to be in much the same position as the wife (or husband) who is over age 62. The couple that includes a disabled spouse may also be confronted with the higher health-care expenses that are generally associated with disability.

We believe, though, that it is difficult to separate the question of providing benefits for disabled wives of disabled workers from the broader question of providing benefits for disabled wives of all beneficiaries—retired as well as disabled worker beneficiaries. (Even under a proposal intended to provide benefits for disabled wives of disabled beneficiaries only, presumably the disabled wife's benefit would be continued when the disabled worker reaches age 65 and the benefit is converted to an old-age insurance benefit.) The broader question of providing benefits for disabled wives of all beneficiaries is among the issues now being considered by the Advisory Council on Social Security. We suggest that action on your proposal be deferred pending completion of the Council's study.

It is estimated that additional benefits of $21 million would be payable to disabled wives and disabled dependent husbands of disabled worker beneficiaries in the first full year of operation. (Additional benefits of $150 million would be payable in the first full year of operation if benefits were provided to disabled wives and disabled dependent husbands of all beneficiaries.)

10. The bill eliminates the test of recently covered work for blind people. Why should this same rule not apply to all persons who are otherwise eligible for disability insurance benefits?

The provision in H.R. 17550 which eliminates the requirement of recent covered work prior to disablement from the insured-status requirements for people who are blind was not included in the Administration's social security proposals but was developed by the Committee on Ways and Means.

We recognize that eliminating the requirement of recent covered work for all workers would enable many additional totally disabled people to qualify for needed benefits. We also recognize the desirability of providing the same insured-status requirements for all disabled workers. Moreover, the present insured-status requirements for disability insurance benefits are more stringent than the requirement for old-age insurance benefits, and the change you have indicated would make the requirements comparable.

Eliminating the recent-work requirement for all workers would substantially increase the cost of the disability provisions. The cost to the social security program of such a provision is 0.23 percent of taxable payroll.

The insured-status requirements for disability benefits are among the subjects being considered by the Advisory Council on Social Security. We recommend that

consideration of a proposal to eliminate the requirement of recent work for all workers be deferred until the Council has had opportunity to complete its review.

It is estimated that additional benefits of $600 million would be payable in the first full year of operation under a proposal to eliminate the requirement of recent work for all workers, assuming enactment of H.R. 17550.

DIFFERENCES IN INCOME TAXES AND SOCIAL SECURITY CONTRIBUTIONS UNDER THE LAW IN EFFECT BEFORE AND AFTER THE TAX REFORM ACT, AND BEFORE AND AFTER H.R. 17550, IN 1973

Income [1]	Income tax liability			Social security contributions			Net decrease in income taxes and social security contributions
	Pretax Reform Act	Tax Reform Act	Difference	Pre-H.R. 17550	H.R. 17550	Difference [2]	
Single worker:							
$1,000	$16	----------	$16	$57	$52	$5	$21
$2,000	163	$37	126	113	104	9	135
$4,000	504	362	142	226	208	18	160
$6,000	886	748	118	339	312	27	145
$7,800	1,235	1,089	146	441	406	35	181
$9,600	1,641	1,454	187	441	499	−58	129
$10,000	1,472	1,530	212,	441	4999	−58	154
Worker, wife, and 2 children:							
$1,000	----------	----------	----------	57	57	5	5
$2,000	----------	----------	----------	113	104	9	9
$4,000	144	4	140	226	208	18	158
$6,000	450	294	156	339	312	27	183
$7,800	738	561	177	441	406	35	212
$9,600 [3]	1,046	844	202	441	499	−58	144
$10,000	1,114	905	209	441	449	−58	151

[1] It is assumed that income consists only of earnings covered under social security.
[2] A negative number indicates worker will pay additional contributions in 1973.
[3] Under the provisions in H.R. 17550 for automatically adjusting the contribution and benefit base as earnings levels rise, it is estimated that the base will be $9,600 in 1973.

Note.—All amounts are rounded to nearest whole dollar.

12. What would be the Administration's position on a proposal to permit a widow, who has children that have all attained age 22, to receive actuarially reduced benefits at such time when she has attained the age of 45? How much in additional benefits would be payable if this proposal were adopted?

This proposal would aggravate the problem of low benefits (discussed in connection with question 4) by providing for actuarially reduced benefits for widows as early as age 45.

In addition, it would be difficult to justify providing such benefits to a woman who has children beyond the age of 22 while denying the option to a woman who has never had children (or whose children died before the age of 22). Under present law benefits are paid to young widows on the assumption that they are needed at home to care for their children. Benefits are paid to widows at age 60 in recognition of the fact that many women who are widowed years after having left the labor market to become housewives and mothers lack the skills necessary to qualify for reasonably suitable employment. The same factors would not seem to apply to younger widows whose children have reached age 22. The Department would not favor this proposal.

It is estimated that additional benefits of $300 million would be payable under this proposal in the first full year of operation, assuming enactment of H.R. 17550.

Questions of Senator Miller With Departmental Replies

1. Section 221.—Limitations on Federal Participation for Capital Expenditures

Is it true that the great majority of planning agencies at all levels around the country are merely "paper" organizations which would be incapable of performing the functions required by this section until staffed with experts and made fully operational?

The capability of planning agencies around the country varies considerably. However, in the past few years important strides have been made in the direction

of capability on the part of planning agencies at all levels to perform the functions required by this section. Under the Comprehensive Health Planning Program all 50 States, the District of Columbia and five territories have State comprehensive health care planning agencies. On the areawide level, 127 planning agencies are receiving Federal grants; 36 of such agencies are operational. It is estimated that 153 areawide planning agencies will be receiving grants by the end of fiscal year 1971 and that more than 70 such agencies will be operational. Under the Hill-Burton program, State planning agencies have been in operation for many years and their capability and expertise has been well demonstrated. We believe that the authority and responsibility added by this provision will further stimulate the organization of additional agencies and more effective implementation of existing activities. However, in geographical areas where no planning agency is yet operational, the provision would not be implemented until an appropriate ageney is ready to function.

If a State is not willing to make an agreement with HEW to carry out the functions of this section, can HEW make these decisions on its own?

If the Secretary were unable to enter an agreement with a State this provision, of course, would have no effect in that State; however, we believe that there is sufficient lead time before this provision becomes effective to offer at least some assurance that all States will be capable and willing to enter an agreement with the Secretary.

Is it contemplated that there would be no review of or appeal from a decision by the Secretary that a capital expenditure is not reimbursable as provided under subsection (f) on page 86?

The Secretary's decision in the cases referred to is the culmination of a series of considerations and reviews which begin with the local planning agency and progress through area and State agencies, where appropriate, before reaching the Secretary. The Secretary would have a national advisory council to assist in coordination of policy matters and to provide consultation if he is considering reversal of an adverse finding at the local level. As this section indicates, a provider may request reconsideration of the Secretary's formal decision.

Any further review of the Secretary's decision seems unnecessarily time-consuming and expensive in light of the several opportunities for review which have already occurred. We would not, however, be opposed to an addition to the legislation to permit court review on the grounds that the Secretary acted arbitrarily or capriciously or that his decision was made outside the scope of his statutory authority.

Is it your understanding that section 221 could apply even if the capital expenditure involved was substantially for replacement of existing facilities and, if so, might not this seriously impair the improvement and modernization of existing hospital facilities even though there is no change in bed capacity?

Capital expenditures made for the replacement or modernization of existing facilities would come under the purview of this provision even where there is no change in bed capacity. It is appropriate for planning agencies to review plans for modernization since there are at least some instances where health facilities have not adjusted to changing community needs such as population shifts.

It should be emphasized, however, that the main thrust of this provision is to help assure that future capital expenditures are made in such a manner as to avoid a duplication or irrational growth of health care facilities that would result in the inefficient use of facilities and in unduly high health care costs. It is unlikely that proposed improvement or modernization of an existing facility which does not alter the bed capacity or nature of its services would be found out of line with planning activities unless substantial duplication already exists or the improvement would result in higher costs to consumers without corresponding increase in the quality of service.

Suppose a local health planning agency turned a hospital down with regard to a capital expenditure. What kind of appeal would there be from this?

With respect to decisions made under this section, the findings made by the local planning agency are only the first step in the review process. The local decision passes to areawide and State bodies (where appropriate) and finally to the Secretary. The Secretary can, after consultation with a national advisory council, overrule the local or State determination and authorize the payments in question if he finds that denial of reimbursement would not be consistent with

effective organization and delivery of services generally or with administration of the affected Federal programs.

2. Section 222.—Experiments and Demonstration Projects in Prospective Reimbursement

Under this section HEW would have to transmit a written report containing a full and complete description of the experiment or project to the House Ways and Means Committee and the Senate Finance Committee before placing such experiment or project in operation. Would you wait for approval by these committees or at least some indication that they do not disapprove before actually initiating such a project?

This could result in a delay in undertaking promising demonstrations and experiments. Wouldn't an annual report suffice for this purpose?

We think that the statutory language requiring that the Committees receive reports on the proposed experiments and projects before they can be implemented is unnecessary. The Committee report on the House bill indicates that the intent is to allow time for Congressional study before the experiment or project is put into effect. While this would not require waiting for approval by the Committee it does imply that some time should elapse after submission of the report and before the experiment or project is begun. We agree that such a requirement could result in delays in the implementation of projects. Considering the fact that a great deal of research and analysis would have to be completed within a very short period of time, any delays in implementing projects and experiments may be costly. Timing is particularly important in experiments related to prospective reimbursement where the provision already requires full report on completed projects and recommendations in 1972. For these reasons we are recommending the deletion of the reporting requirement in section 222.

3. Section 223.—Limitations on Coverage of Costs under Medicare Program

How can a provision such as this be administered without a tremendous increase in high cost personnel? Also, how can this be administered when historically over the past four years basic year-end auditing of hospitals has been behind at much as three years?

This provision would authorize the Secretary to establish and promulgate limits on various types of provider costs for various classes of providers based on estimates of the costs needed to efficiently deliver covered health services. It is not contemplated that this provision would apply to large numbers of institutions. Instead, the provision is aimed at luxury-type institutions with exceptionally high expenses.

If enacted, we do not believe this provision would significantly affect the administrative costs of the program or require substantial numbers of additional personnel. Naturally, some costs will be incurred in establishing the system for determining and promulgating cost ceilings, and we would expect that some redeployment of personnel might be required. However, any additional costs incurred will be more than offset by the savings that could result to the program, savings which cannot be achieved under the present law.

Final settlements with providers based on audited cost reports are not as current as we would wish them to be. However, we are not significantly behind on the steps leading to final settlement.

A chief cause of delay is that often when there is a dispute between the auditors and the providers, the provider may prefer delay to losing out. Moreover, the amounts in dispute in such cases represent a very small proportion of total cost. In any case, we feel that sufficient cost data will be available to implement the provision. Moreover, we would expect that in some cases the provision might expedite the cost settlement process. Since the provider would be aware of the cost limits in advance and could charge the beneficiaries for the costs considered "excessive," we would expect the delays in negotiations between the provider and the fiscal intermediaries to be considerably less than those that now exist when costs are retroactively denied as unreasonable.

Would it be your intention to exercise medical judgments to determine what items or services are "necessary in the efficient delivery of medical health services"? If so, how?

Our intention in administering this provision is that cost limits would initially be established for those costs that do not vary with the quality and intensity of

medical care. Such costs would include such items as food, room, laundry, administration, and medical records. We do not consider the establishment of limits on these costs to be "medical judgments."

For costs that do vary with the intensity and quality of care furnished, we would expect to set reasonable limits sufficiently above average costs per patient day so that only cases with extraordinary expenses would be subject to any limits. Again, with regard to these costs, we would not look on the establishment of such cost limits as constituting a medical judgment. Rather, based on the actual practices of comparable providers in an area, the program will have authority to exclude from reimbursement those costs which are clearly excessive. However, where these seemingly excessive costs can be justified by the provider, relief from the application of cost limits can be given.

4. Section 225.—Establishment of Incentives for States To Emphasize Outpatient Care under Medicaid Programs

Isn't it a fact that substantial savings are possible by good enforcement of proper utilization in all institutions, hospitals and nursing homes?

Savings are possible through good enforcement of proper utilization in institutions, hospitals and nursing homes. The Department has focused considerable attention in this area.

We are recommending section 225 with the specific goals of encouraging more effective utilization of limited facilities and lower cost patterns of service. We are therefore proposing increased Federal matching for outpatient, clinic and home health services to encourage the States to provide early diagnosis and treatment of illness, preventive services and alternatives to institutional care and thereby reduce the need for the use of inpatient services.

Our proposed limitations on the length of stay in general and TB hospitals are designed to encourage the transfer of patients to less expensive facilities. They reflect the assumption that treatment in acute institutions is generally of short duration, rarely exceeding 60 days.

We recommended a reduction in matching for skilled nursing homes in order to encourage, whenever appropriate, early transfer of patients to alternative and lower cost facilities (such as intermediate care facilities). The provision granting authority to the Secretary to compute for reimbursement purposes a reasonable cost differential between cost of skilled nursing home services and cost of intermediate care facilities is designed to assure that supporting care in these institutions results in decreased costs. These provisions reflect the Department's concern that many patients remain in skilled nursing homes longer than necessary, and that as a result program costs are unnecessarily increasing.

Our proposed limitations on the length of stay in mental institutions reflect the assumption that medical treatment of mental disease inpatients generally does not exceed three months, and for patients over 65 rarely continues beyond one year.

What has been done to apply the same type of surveillance in hospital utilization review admissions and length of stays as is applied in the case of nursing homes?

Surveillance of hospital admissions and length of stays is effected through the utilization review process. Utilization review is required by regulation to be based on a statistically significant sample or other reasonable basis of pertinent data as determined appropriate to the medical care or service under scrutiny. Information on hospital admissions and duration of stays has been deemed necessary for an adequate review.

Under the Medicare program, a number of steps have been taken to identify over-utilization of hospital services. Intermediaries have been instructed during the course of contract performance reviews to improve, where necessary, their claims review process to detect and deny claims representing over-utilization and an instruction is now being prepared for national distribution which contains screening guides for use by intermediaries in processing individual hospital bills.

Moreover, statistical analyses of hospital stays for various diagnoses will soon be made available to intermediaries to assist them to identify hospitals with questionable patterns of utilization. These same profiles will also be distributed to hospitals to assist their utilization review committees in evaluating utilization. To further strengthen the effectiveness of utilization review committees, regulations are being proposed which will require them to review patient stays

at a relatively early date. Also, a regulation soon to be published bars physicians with a significant financial interest in an institution from serving on its utilization review committee except under limited circumstances.

Another proposed regulation will permit pre-admission diagnostic testing procedures to be reimbursed as inpatient hospital services and should reduce the length of stay because many tests will be performed before hospital admission. Also, the change in regulations early this year to reduce the initial physician's certification of medical necessity from the fourteenth to the twelfth day of the patient's stay, and the subsequent certification from the twenty-first to the eighteenth day, is expected to result in some earlier discharges.

Has there been any extensive or factual study made to establish specified number of days coverage for specific illness, both in hospitals, RCF's, and skilled nursing homes?

No studies have been made to establish specified number of days coverage for specific illness in hospitals and RCF's. However, because of the provisions in H.R. 17550 that the Secretary specify the medical conditions and length of stay required in RCF's and IHA's, we have recently initiated the development of data to support length-of-stay presumptions for individual medical conditions requiring extended care or home health care. These data will cover the 50 most frequently occurring RCF admitting diagnoses and the 40 most frequently occurring home health diagnoses—representing about two-thirds of all RCF admitting diagnoses and also about two-thirds of all home health diagnoses. We expect to have by September tabulation showing the mean and median lengths of stay and percentage distributions of length of stay for ECF admissions in 1969 involving patients discharged prior to June 1970. By October, we expect to have tabulations on the number of visits for various kinds of home health services for persons who received covered home health care in 1969.

We are also developing comparative utilization data on all short-stay hospitals participating in the Medicare program. Those data provide for a comparison of the actual length of stay of a sample of patients discharged from a specific hospital with derived data for a standardized length of stay for the same patients. State agencies and intermediarians, as well as providers, will use these data in their reviews and analyses of Medicare utilization.

I am assuming that many of our States will be unable to pick up this added, financial burden. Do you agree that the very person we are attempting to adequately provide for could well be the victim of this economy motivated cut-back?

Our recommended changes in the Federal matching percentage for medical assistance are intended to encourage States to substitute less expensive care for more expensive care when it is equally beneficial. The assumptions upon which the Department based this proposal have been explained in response to earlier questions. We are convinced that with the proper application of this provision the majority of patients can be transferred to less expensive facilities after the specified time periods without any adverse effect on the patients. We would note that for those patients who still require more intensive care after the specified periods, Medicaid is not discontinuing but only reducing the Federal matching percentage, except in the case of persons who remain in mental institutions longer than the maximum period.

As author of the Intermediate Care Facility Amendment of 1967, I am interested that these facilities not be used as a dumping ground for critically ill skilled nursing home patients. Wouldn't the cut-back provisions of this bill encourage placement of patients in lesser care facilities, regardless of medical need?

There is no intention of "dumping" critically ill skilled nursing home patients in ICF's regardless of medical need. The amendments are intended to encourage whenever appropriate, early transfer of patients to alternative and lower cost facilities (such as ICF's). The provisions reflect the Department's concern that many patients remain in skilled nursing homes longer than necessary, and that as a result program costs are unnecessarily increasing.

What will be the effect upon patients needing skilled nursing care for a prolonged period of time at the end of 90 days when the Federal matching funds are reduced by one-third?

We would expect that an appropriate level of care would still be provided to those limited numbers of patients who require skilled nursing home care for

longer than 90 days. He would reiterate that Federal matching would not be discontinued but be provided at a reduced rate.

Is there some other way in which these savings envisioned from section 225 can be accomplished without an adverse effect upon the patients needing skilled nursing care for a long period of time?

The Department feels that the recommended provisions are the most appropriate ways of encouraging more effective utilization of limited facilities and lower cost patterns of service. As we have noted above, the Department has no intention of adversely affecting the quality of care received.

What attempts have been made to reduce administrative costs by the Department of HEW and the States in administering Title XVIII and X Title XIX programs?

Controlling excessive or improper utilization is crucial to the Department's effort to control Title XIX program costs; therefore, the Department places the highest priority on developing and strengthening State capabilities to perform utilization review. Recognizing that effective claims administration and well-designed information systems will assist the States in performing effective utilization review and in curbing abuse, the Department has strengthened MSA's capability to provide technical assistance to the States in establishing model claims processing and information retrieval systems.

The Department endorses the provisions of H.R. 17550 which seek to control costs and improve the administration of the Title XIX program. Representatives of the Department have worked with the House Ways and Means and the Senate Finance Committees to develop and refine these provisions.

MSA has recently awarded a contract for the implementation of the Medical Surveillance and Utilization Review Reporting system on a pilot basis in four States. This system encompasses a mechanized information retrieval system built on data from claims payments. It will make possible a variety of statistical analyses between the patient, doctor, and vendor. The States which have contracts (Rhode Island, Oklahoma, Colorado, and West Virginia) will report to MSA the exceptions (high and low extremes) in payment claims. The system is tied into medical peer evaluation, with the local medical society performing review of any abnormal care patterns turned up by the computer. Implementation of the system and utilization of data produced will result in capability of the States to exercise a meaningful level of fiscal control over their Title XIX programs.

The recent reorganization and increase in staffing of the Medical Services Administration has resulted in the creation of two new offices (Program Planning and Evaluation and Management Information and Payment Systems) which are charged with developing new approaches to improve the administration and control costs of the Title XIX program.

The above is supplemented by the ongoing activities of MSA's Technical Assistance and Training and Program Operations and Standards Divisions in providing consultation to States in their administration of the Title XIX program, and the surveillance of State medicaid costs by the HEW Audit Agency.

The Bureau of Health Insurance, Social Security Administration, has established a number of controls designed not only to assure containment of overall administrative costs but also to improve the quality of administration provided for each administrative dollar expended under Title XVIII. As part of ongoing operations, contractors are required to prepare and justify in detail their annual cost reports which are subjected to careful analysis and evalution. Substantial deviations of actual experience from budget estimates must be explained. Significant variances in their experience from that of other companies with comparable workloads must also be justified.

Administration of high quality, even if costly in itself, can result in reductions in overall program costs. Significant improvements in quality of work during the last fiscal year included: (1) a more thorough review of ECF bills to assure that the care and services provided were at the level covered by the law; (2) more detailed review of both parts A and B bills as a safeguard against over-utilization of services; (3) development of more sophisticated physician profiles for part B claims to insure that payments are reasonable and in accordance with the law; (4) improved part B bill review to assure prevention of potential duplicate payments; and (5) development of improved part B case control systems so that carriers will be able to respond more readily to beneficiary inquiries

on the status of their claims. As a result of these improvements, the quality of claims processing in the third year of operations was much improved over experience of the first two years of the program. Services to beneficiaries were improved, and claims were being processed faster and more accurately.

Cost experience of intermediaries and carriers has reflected considerably greater stability during the past six months than in earlier periods, both in terms of volume of claims receipts and unit costs of processing workloads, indicating that future cost estimates can be prepared with a greater degree of precision. Actual experience for fiscal 1970 is expected to be very close to the budget estimates of $208 million for intermediary and carrier administrative costs.

Auditing costs have accounted for a substantial portion (30 percent) of part A intermediary administrative expenditures. We have restricted the budgeted funds available for audit costs in fiscal 1971 to $27.3 million or 28 percent of the total part A intermediary budget. Together with the percentage reduction, we are initiating a periodic audit approach which will reduce substantially the number of cost reports which must be audited annually. Approximately one-third of the cost reports each year will actually be audited. Cost reports on which settlement is made without audit will be subject to audit for a period of three years.

5. Section 227.—Authority of Secretary to Terminate Payments to Suppliers of Services

Under this section, payments would not be made where HEW determines that a person has furnished services or supplies which are "substantially in excess of needs of individuals" or "harmful to individuals" or "of a grossly inferior quality" (page 111 of bill). Could you give us some indication of what would be covered by these various terms and particularly the last one?

Determinations of this type are, of course, to a large degree judgmental in nature and will require careful discernment on the part of health professionals to assure equitable application of the provision.

While it is impossible to be definitive about these various terms, the following examples illustrate the concepts that are involved. An example of services which are "substantially in excess of needs of individuals" would be the case where a physician has his patients visit his office every 2 or 3 days to inject a vitamin which they could just as well have taken orally at home. An example of "harmful" services would be where the physician persists in using a medication which has been proven to be ineffective—e.g., Endrate for arteriosclorosis—in preference to therapeutic measures whose efficacy has been established. An example of a course of treatment which is of "grossly inferior quality" would be where a physician has established a pattern of performing surgery in the absence of findings justifying the procedures and without consultation even in the most complex or most questionable cases.

How would these determinations be made?

Program review teams would be established in each State by the Secretary, following consultation with groups representing consumers of health services, State and local professional societies, and the appropriate intermediaries and carriers. Both the professional and nonprofessional members of the review teams would be responsible for reviewing and reporting on statistical data (which the Secretary would provide) on program utilization. Review of suspected abuses involving furnishing of excessive, inferior or harmful services would be assigned exclusively to professional members of the review team. Ordinarily such cases would be referred to the committee by the intermediary or carrier or would be noted during the course of review of data concerning patterns of care and delivery of services; cases arising from other sources would also be considered. Any decision by the Secretary to terminate payments to a supplier on the basis of furnishing excessive, inferior or harmful services would require the concurrence of the physicians and other appropriate professional members of the review team.

Doesn't this area deal to a large extent with so-called medical devices, and how can this provision be implemented without some kind of definition?

Medical devices would receive this type of scrutiny, but the scope of the review process under this provision is much broader, encompassing all items and serv-

tices covered by the program. Since the judgments would consider not only the technical qualities of the item or service but also the manner in which it is administered or provided, we believe that professional review on an individual basis at the local level is preferable to establishing rigid—and potentially cumbersome—statutory definitions for national application.

Do you support the concept of a program review team to review the quality of medical care and treatment throughout an entire State after the care has been delivered?

We support this concept as embodied in the House-passed bill. Under the bill, review of matters related to quality of care as well as such matters as appropriate use of services would be carried out by professional members of the review team with respect to individual cases only where the possibility of program abuse has been raised. In addition, the team would evaluate statistical data which throws light on patterns of care under the program and which in turn helps to identify abuses and facilitates development of norms of performance for future application.

Wouldn't this group be second-guessing the medical judgment of the physician in determining medical care?

It is not intended that the program review teams will be second-guessing the medical judgment of physicians in determining medical care. The medical profession seems to be in agreement that a formalized system of peer review is required under the Medicare program. Various forms of peer review were in existence before Medicare came into being, for example, in the form of hospital tissue-committees and review groups established under auspices of local medical societies. These activities have always been regarded as primarily educational in nature. The kinds of decisions that will be made by the teams are already being made by a variety of sources under the program today. This provision formalizes such procedures under which professionals review the work of other professionals and in addition permits the Secretary to impose disciplinary measures, upon the advice and recommendation of the program review teams, where abusive practices endanger the integrity of the program or the health and safety of its beneficiaries.

Wouldn't this section set the stage for a multiplicity of malpractice suits which would in effect increase malpractice insurance premiums over their extremely high level at the present time, thus adding to costs in the long run?

As stated previously, we believe that a chief advantage of the authority granted under this provision lies in its value as a deterrent to abusive practices. To the extent that this advantage is realized, the provision should serve to reduce (rather than increase) the number of situations involving actions which could generate malpractice charges. Moreover, since the anticipated number of formal terminations is relatively small, we do not believe that suits directly inspired by such termination action would significantly increase the overall incidence of malpractice litigation.

Isn't this provision (Section 227) in direct conflict with section 1801 of Title XVIII which provides that nothing shall be construed to authorize any Federal employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided?

We do not believe that this authority would be in conflict with section 1801. Careful distinction should be made between the practice of medicine and the payment for that practice. This provision merely permits the Secretary to withhold payments where there is substantial evidence of program abuse. It does not authorize the Secretary to force an individual physician to alter his method of providing services to his patients. Any action of this type would have to be taken by the professional organizations or the States involved under other authority.

There are other provisions in existing law which permit Medicare to refuse to pay for services. The conditions of participation for providers of services and the definition of a physician which requires that he be licensed to practice medicine both provide that we will not pay for certain services if specified conditions and requirements are not met. These requirements do not preclude facilities or individuals who do not meet them from providing care, they merely determine whether payment can be made for it. We think this section should be considered as a logical extension of provisions of present law.

6. Section 229.—Determination of Reasonable Cost of Inpatient Hospital Services under Medicaid

Won't the provisions of section 229 of H.R. 17550 result in the hospitals having to keep another set of books and be checked by another corps of auditors if the several States adopt methods of reimbursement under medicaid different from those under medicare?

Section 229 will permit States, on a controlled basis, to employ methods of payment of reasonable cost which differ from the medicare principles of reimbursement. While a great diversity in costing formulas could conceivably result from this change the Department believes that the emphasis being placed by the Congress and by the Administration on creating incentives for efficiency and economy make it imperative to permit States a degree of flexibility in developing new methods of reimbursement.

It is considered unlikely that section 229 will require hospitals to maintain separate accounts for medicaid program auditors. Hospitals maintain detailed records on costs and expenditures which are sufficient to form a nucleus of data which can be used for other methods of reasonable cost reimbursement which may be developed by the States.

Couldn't this result in a different level of care dependent on the amount of reimbursement for the poverty patient?

It is believed that existing medical society and hospital peer review groups would ensure that medicaid patients will receive the same level of care under the new method of reimbursement in spite of the possibility of reduced reimbursement to hospitals. Furthermore, there are basic inpatient hospital services which cannot be eliminated.

A greater concern rising from the reduced reimbursement would be reduced participation on the part of hospitals in the Title XIX program. Such a possibility is addressed in regulations currently being prepared by the Department which state that the criteria for approval of State plans for reasonable cost reimbursement will include—"assurance of adequate participation of hospitals and availability of hospital services of high quality to title XIX recipients."

Couldn't this destroy all hope of coordinating the administration of Medicare and Medicaid?

The provisions in section 229 of H.R. 17550 for determining the reasonable cost of inpatient hospital services under title XIX respond to a general concern that reasonable costs determined under Medicare's reimbursement formula may not accurately reflect the true costs of inpatient services furnished to the Medicaid population. The amendment essentially provides the States greater flexibility to innovate new methods of reimbursement under Medicaid than is permitted under Medicare's reimbursement formula. The use of two separate methods of determining reimbursement presents some administrative problems but we do not view them as insurmountable and will be prepared to initiate positive steps to insure that duplication of effort is eliminated.

By specifying that amounts payable under Medicare will act as a ceiling for reimbursement under Medicaid, section 229 already gives us a basis for coordinating reimbursement activities. Valuable experience has been gained from coordinating existing differences in other institutional benefits of the two programs (extended care benefits in Medicare as opposed to skilled nursing home benefits in Medicaid). Particular emphasis will be placed on coordination in both billing and auditing activities, and it is hoped that some useful innovations developed by States may be replicated and perhaps adopted by Medicare on a State basis. However, coordination should not be predicated solely on the method of reimbursement and we will be generally focusing on the range of common concerns of the two programs in the broad area of health care which transcends reimbursement methods.

7. Section 231.—Institutional Planning under Medicare Program

What will these provisions in section 231 contribute to assuring cost containment and quality of patient care and services in hospitals?

These provisions can be expected to help contain program costs by helping to assure that the governing bodies of health care institutions are knowledgeable

about the operating budgets and plans for future capital expenditures of the institutions. It may reasonably be expected that the requirement of institutional planning will stimulate greater self-examination by individual institutions and that the resulting improvements will do much to assure that scarce health dollars are being expended in a manner that will best benefit the institution and the community which it serves.

8. Section 232.—Payments to States under Medicaid Programs for Installation and Operation of Claims Processing and Information Retrieval Systems

If section 232 is designed to encourage the several States to set up their own Medicaid claims handling and processing systems rather than to contract with a third party for this purpose as is presently the procedure under Medicare, isn't this going to be costly and unnecessary?

Section 232 is intended to assist the large number of States which lack effective claims administration or adequate information storage and retrieval systems. It is expected that the financial and technical support available under section 232 will aid the States in realizing efficient and effective administration of the Medicaid programs and that it will reduce program costs through improved utilization review.

Section 232 gives the Secretary the authority to determine standards for these systems so that the States can organize their information retrieval and claims processing systems and provide basic information to recipients on services paid for. Experience with the Medicare program has indicated that beneficiary complaints about discrepancies between "explanation of benefits" form they receive and the care actually provided has been the largest single source of information on possible abuse and fraud.

Section 232 neither encourages nor discourages the use of third party contracts as opposed to State-operated claims processing and information retrieval systems. The decision is one which must be made by each State, taking into account the characteristics and needs of its Medicaid program.

States with their own claims processing and information retrieval systems are more directly responsible for the management of their Medicaid programs. Centralization and standardization of data on services and costs enhances a State's ability to perform effective utilization review and control costs.

Third-party contracts for claims processing and information retrieval systems under Medicare are usually handled by more than one intermediary, making centralization of data more difficult. Under Medicare there are often several different plans in a given State. Contracting to the same third parties for Medicaid would not give the State the well-organized data that the standardization of a State system is intended to provide. It has not been demonstrated that State systems would cost more than third party contracts. The costs of installing and operating both types of systems would be dependent on a variety of factors including the complexity of the State's Medicaid program.

9. Section 235.—Utilization Review Requirements for Hospitals and Skilled Nursing Homes under Medicaid

There as a problem facing physicians who serve on utilization review committees—namely, the potential of personal legal liability resulting from decisions of the committee. Hospitals and extended care facilities must be assured they have an effective utilization review function implemented by their physicians. If the law requires this, and institutions must provide it through the voluntary action of their affiliating physicians who donate their time, why does the Secretary not insist the law give these doctors and their institutions some specific, reasonable immunity for the discharge of their required services?

The strongest action a given utilization review committee can recommend against a physician is that his license be suspended or revoked. However, the enabling Medicaid legislation recognizes the authority of the individual jurisdictions to provide for their own licensing procedures and for the direct actions pursuant to revocation or suspension. As the law now stands, only the States can provide such immunity from personal legal liability arising from actions of a utilization review committee. Federal power is limited to withdrawing further funding in instances where the State licensing authority has not maintained necessary surveillance of the physicians it licenses.

In 1965, the Journal of the American Medical Association printed a statement made by Howard Hassord speaking for the California Medical Association at a national conference on utilization review. He indicated that where a casual connection between discharge and the subsequent death of a patient could be definitely tracted to the recommendations of a utilization review committee, legal liability can only be established where all the members of the committee can be proven to have acted "in bad faith" (J.A.M.A., Vol. 196, No. 11, p. 1008). In a subsequent issue of J.A.M.A., a statement was made on behalf of the American Medical Association indicating that the threat of personal or group legal liability should not be a deterrent to the full discharge of the responsibilities of utilization review committee (J.A.M.A., Vol. 197, No. 5, p. 349).

The present Federal view is that the responsibility for utilization review under Title XIX rests with the medical assistance unit of the single State agency. While the function of utilization review can be delegated through county medical associations to individual hospital committees, the ultimate responsibility for the actions of the respective committees rests with the designated State agency.

In terms of satisfying Federal requirements, the utilization review committee is only empowered to recommend termination of payment for a particular hospital stay; there is nothing requiring patient discharge. The General Counsel's Office for Medicare made the following statement relevant to the legal liability of physicians on utilization review committees:

"No explanatory statement has been issued on the subject of physicians' liability for utilization review committee actions for the reason that we do not deem committee actions of the kind we have described as being conducted for or on the behalf of the Federal Government. The committees are hospital committees, carrying on hospital functions on behalf of those institutions. Whatever legal consequences may result from membership on such committees would be decided by State law in the same manner as would be any other hospital proceedings conducted through individual employees or through other physicians' committee work."

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