SOCIAL SECURITY AMENDMENTS OF 1967

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETIETH CONGRESS

FIRST SESSION

ON

H.R. 12080

AN ACT TO AMEND THE SOCIAL SECURITY ACT TO PROVIDE AN INCREASE IN BENEFITS UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, TO PROVIDE BENEFITS FOR ADDITIONAL CATEGORIES OF INDIVIDUALS, TO IMPROVE THE PUBLIC ASSISTANCE PROGRAM AND PROGRAMS RELATING TO THE WELFARE AND HEALTH OF CHILDREN, AND FOR OTHER PURPOSES

PART 2

AUGUST 28, 29, 30, AND 31,
SEPTEMBER 11, 12, 18, AND 19, 1967

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE
83-231 WASHINGTON : 1967

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price, $2.25

COMMITTEE ON FINANCE

RUSSELL B. LONG, Louisiana, *Chairman*

GEORGE A. SMATHERS, Florida
CLINTON P. ANDERSON, New Mexico
ALBERT GORE, Tennessee
HERMAN E. TALMADGE, Georgia
EUGENE J. McCARTHY, Minnesota
VANCE HARTKE, Indiana
J. W. FULBRIGHT, Arkansas
ABRAHAM RIBICOFF, Connecticut
LEE METCALF, Montana
FRED R. HARRIS, Oklahoma

JOHN J. WILLIAMS, Delaware
FRANK CARLSON, Kansas
WALLACE F. BENNETT, Utah
CARL T. CURTIS, Nebraska
THRUSTON B. MORTON, Kentucky
EVERETT McKINLEY DIRKSEN, Illinois

TOM VAIL, *Chief Counsel*
EVELYN R. THOMPSON, *Assistant Chief Clerk*

CONTENTS

PART 2

WITNESSES

COMMUNICATIONS

SOCIAL SECURITY AMENDMENTS OF 1967

MONDAY, AUGUST 28, 1967

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

The committee met, pursuant to notice, at 10 a.m., in room 2221, New Senate Office Building, Senator Clinton P. Anderson, presiding.

Present: Senators Anderson, Talmadge, Harris, Williams, Carlson, Curtis, and Morton.

Senator ANDERSON. The hearing will come to order.

Today, we continue our hearings on the administration's social security bill. Last week, we heard the Secretary of Health, Education, and Welfare and his staff make the case for enlarging the schedule of cash payments under the bill and raising the taxable base and tax rate above the levels provided in the House bill. In addition, the Secretary recommended that the restrictive welfare amendments added by the House bill be deleted.

This week, we will be receiving testimony from the interested public. Our first witness today is the Honorable George Aiken, U.S. Senator, from Vermont. Senator Aiken is well-known in this body for work he has performed in furthering social legislation. He is a longtime advocate of the medicare program. Senator Aiken has a rather important bill pending before this committee, S. 110. In reading it, I am struck by two facets:

First, he would provide for the coverage of drugs in the medicare program in a manner quite similar to that approved by the Senate in an amendment to the Foreign Investors Tax Act. Unfortunately, the House conferees forced us to delete it from the bill.

In addition, he would provide for payment of physicians' services under a schedule of maximum fees to replace the reasonable charge concept that is now in the law.

We are glad to have you here, Senator Aiken. We are anxious to hear your testimony. Thank you very much for appearing.

STATEMENT OF HON. GEORGE D. AIKEN, A U.S. SENATOR FROM THE STATE OF VERMONT

Senator AIKEN. Well, Mr. Chairman, I appreciate this opportunity to appear before this committee. I am greatly concerned over the urgent need of our older citizens for increased social security benefits, but I am confident that your committee will take good care of that.

My appearance here today is to present evidence indicating that the medicare amendments to the Social Security Act need to be drastically revised.

Everyone expects a new law as complex and as sweeping as medicare to have imperfections.

When this important legislation was under consideration by the Congress, it was generally recognized that medicare would have to be revised in the light of actual experience.

Congress did a good job of launching this program, and the acting chairman of today had a considerable part to play in that, as I recall, but what we did then was only a start.

Medicare today is far from meeting the intended requirements. This is due in part to the herculean task of setting up the necessary administrative machinery.

It is also because the law is understandably inadequate and imperfect—just as we expected it would be.

Shortly after medicare went into effect, I began to receive letters from my constitutents indicating clearly that medicare was not doing what our older people had been led to believe it would do.

These letters, almost without exception, told a story of financial hardship, confusion and distress among sick persons trying desperately to get by on low, fixed incomes.

As a constructive start in refining medicare, and to provide the services the beneficiaries expected it to provide, I offered 10 amendments last January.

These amendments are now pending before your committee in my bill, S. 110 and are intended to accomplish these things:

1. Eliminate all deductibles and coinsurance. This simplifies the law, relieves beneficiaries from many additional charges that have been proving to be a costly and difficult burden. The cost is negligible, compared with other costs of government today.

2. Reduce the age limit for women from 65 to 62. I would like to reduce that still further for both women and men, but I realize that is not practicable at the present time.

3. Reinstate the system, long established in our hospitals, for providing specialists' services—pathologists, radiologists, anesthesiologists, and so forth—as part of the hospital service. The medicare law as passed by the Senate preserved the old system, but it was amended in conference to allow specialists to bill patients separate from the hospital bill. This has caused much hardship and confusion and should be ended.

4. Fee schedules for physicians. This is the amendment that would establish physicians' fees, just as Blue Shield has provided surgeons' fee schedules for many years. Under this proposal fees would be established in various localities according to the prevailing rates.

5. Drug amendment. This is the same as the amendment passed by the Senate last year. Drugs are one of the costliest expenses old people have to face. They need help on this. Annual bills, whether one is hospitalized or not, run into the hundreds of dollars. The only change from the bill as passed by the Senate in 1965 is the addition of wording to permit the formulary committee to approve "an acceptable version" of a drug, rather than require that the lowest cost drug on the market be used. This guarantees low-cost quality drugs rather than just cheap drugs.

I understand the drug amendment I have proposed is similar to one offered by the Senator from New Mexico, Mr. Montoya. A drug amend-

ment of this kind will be costly, but the need is critical. I strongly urge adoption of a drug amendment this year.

6. Emergency hospital service outside the United States. This is a revision of the 1965 amendment which I proposed. As enacted this applied only to persons stricken in the United States. The new amendment allows a person to be 25 miles across the border when stricken and taken to a nearby Canadian or Mexican hospital.

7. Permit elderly persons to be referred directly to nursing homes. This is the proposal which I submitted in 1965 and which was rejected. Hospitalization prior to referral to nursing homes is costly and frequently unnecessary. Physicians should be allowed to use their own good judgment as to whether a person needs office care, outpatient clinical care or hospital care prior to going to a nursing home.

8. Extend coverage to eyeglasses, dental care. Present exclusions in the law are removed. This means that old people will get far more of the kind of help they need—thorough eye and dental care, prosthetic devices, hearing aids, etc.

9. Annual routine physical checkups. Now excluded, this gives every beneficiary the right to go to the doctor and have a complete physical. If additional checks are needed requiring outpatient or in-hospital tests, the physician can refer the patient accordingly. In the long run, this should keep costs down by enabling physicians to prevent sickness before it occurs.

10. Medical and other health services across border. Patients taken to hospitals in the Canadian and Mexican border areas will have not only hospital coverage but all the medical and other health services they would receive in the United States during the period of the emergency hospitalization.

As for this amendment, and the closely related proposal to provide emergency hospital service outside the United States, there is a real need to protect medicare beneficiaries while on short trips across the border.

Some of the proposals embodied in S. 110 have been previously passed by the Senate but killed in conference.

Some of them may not be approved at all for some time and there may be good reasons why some are not feasible at this time.

Of this I am certain: Medicare should be made to work more effectively.

I don't believe either the Congress or the country wants to give it up at this time.

Since introducing S. 110 I have been flooded with letters from all parts of the Nation.

This mail shows a crying national need for revision of the law, not next year but now;

This mail falls into six broad categories:

(1) Those who want all 10 amendments enacted.

(2) Those who express frustration and despair over rapidly rising medical costs.

(3) Sick people desperately needing help to pay for inexcusably high drug bills.

(4) Beneficiaries confused and hard-pressed by the complicated details of the law regarding deductibles and coinsurance.

(5) Persons living on a hand-to-mouth basis of so-called respectable poverty who need more efficient reimbursement for medicare bills they had to pay out of their own slim resources. In some cases, these people had to borrow so the doctors could be paid first.

(6) Those wanting the law enlarged to include the high cost of eye and ear care, hearing aids, eyeglasses and prosthetic devices they cannot afford.

For example, a 77-year-old woman in Michigan wrote that she had been wearing the same glasses for 18 years but really needs a new pair and hasn't any way to pay for them. I could submit, Mr. Chairman, a hundred specific cases but I know this committee has several times that number of its own.

When the original medicare bill was before your committee I submitted an amendment to permit beneficiaries to be assigned by a competent physician to nursing homes for short-time treatment without the wasteful, costly, and totally unnecessary stay of 3 days in a hospital before admission to a nursing home.

I have submitted this specific amendment again, and I urge this committee to reconsider this problem.

I am not confusing this with long-term custodial care, which has no place under medicare as we know it now.

With hospital costs rising at a rate more than double that of 6 months ago—an increase of some 17 percent in 1967 is anticipated—and since this testimony was prepared I read that costs have gone up 20 percent over a year ago, the removal of the 3-day mandatory hospitalization would be a help.

When an aged person is sick and his doctor knows he needs temporary nursing care to recover, it is unreasonable to require him to enter a hospital and undergo costly tests and endless examinations for 3 days when all he needs is considerate medical care in an accredited nursing home.

To force him into an already overcrowded hospital is costly, an added hardship in his time of sickness, and a burden on the community.

While my primary concern is for the people who need the assistance medicare offers, I am also concerned over the ability of our hospitals to absorb this new assignment.

I therefore wrote to each hospital in Vermont last January, asking for detailed comments.

These comments showed a sincere desire to make medicare work.

The complaints by hospitals centered largely around the increased administrative costs, especially the complicated and frustrating problems caused by deductibles and coinsurance, the high cost of split billings, and in some cases slow reimbursement by the medicare fiscal intermediary.

The acute bed shortage and the lack of adequate staff in all departments—custodial, nursing, laboratory, and administrative—have further aggravated the problem.

In July I again wrote to these same institutions asking if conditions had improved.

Reimbursements from medicare are on the whole improved but to a considerable degree the same problems they cited last January still remain.

Thirteen of sixteen Vermont hospitals complained to me about deductibles and coinsurance, urging that they be eliminated.

Ten of the sixteen complained strongly about split billings.

Billings and collections as a whole were a major problem in every hospital in the State.

Medicare has imposed heavy new burdens on the hospitals and these in turn have necessarily been passed along to the patients—those who are least able to pay and those least able to understand the complicated billing procedures medicare has imposed.

If my survey of conditions in Vermont is a good yardstick, and I am sure it is, then there is a very real and urgent need to do something to simplify the system without delay.

Split billings require the beneficiary to pay sometimes as much as five or six separate doctor bills instead of having specialists' bills included in the hospital bill.

Doctors are naturally reluctant to accept the assignment of bills, so the poor person living on a limited retirement income has to pay the bills first and then wait for medicare to reimburse him.

I would hope that some way could be found by the doctors and hospitals to ease the extremely heavy burden split billings, coinsurance, and deductibles place upon the beneficiaries.

If this cannot be done, Congress will have to enact the necessary corrective legislation that will simplify these procedures.

I hope this committee will look favorably upon my proposals.

Senator ANDERSON. Thank you, Senator Aiken.

I am sure we all value this testimony very much.

The very first thing you said is that we eliminate all deductibles. Have you any idea how much it would cost to eliminate all deductibles?

You do suggest elimination of all deductibles?

Senator AIKEN. Yes, indeed. I know it would cost money——

Senator ANDERSON. But in part B of Medicare, the cost would rise from $6 a month now to roughly $12 a month. It is at least several hundred millions a year. Do you worry at all about those high costs?

Senator AIKEN. About $200 million a year. That would carry on the war 3 days, almost, not quite. And if we can spend that amount of money in a year for better purposes I wouldn't worry in the least.

Senator WILLIAMS. I have no questions except to thank you for your constructive suggestions and they certainly will be considered at the time we proceed to mark up this bill.

Senator AIKEN. I thank the Senator from Delaware.

Senator CARLSON. I want to say just simply this: My mail indicates that the confusion that results from the billings of various programs of types and charges is what simply ought to be taken care of. Simplification of the entire program is what our people seem to be worrying about.

Senator AIKEN. There has been some confusion where several doctors are involved, who depend on the patient, and the patient depends on medicare for the payment.

Senator CARLSON. That is all.

Senator TALMADGE. Senator Aiken, many Vermonters live near the Canadian border. Do you have any special problem regarding that?

Senator AIKEN. We have some sizable towns in Vermont where the Canadian border goes right through the middle of the town. We have

a store in the town of Norton where the Canadian border goes between the two counters in the store, and we now have lots and lots of people going to Expo 67, which is about 40 miles over the Vermont border, and I wouldn't say there have been any serious troubles there now, yet the metropolitan area does extend, I would say, almost down into Vermont at the present time, coming nearer all the time, and people are likely to have accidents over the border and likely to need hospitalization over the border. And I don't know how true this is of the Mexican border, probably to a little lesser extent, but when they come to grief over the border they should be permitted to go into a Canadian hospital to get the same treatment that they do from a hospital on our side.

I know the State Department says this would involve a lot of unwieldy redtape, but up in Vermont we haven't been too much handicapped by redtape when it comes to dealing with Canadians.

Senator TALMADGE. We have a number of hospitals in the United States for one reason or another which have not been approved for medicare. I have proposed an amendment if some individual goes to a hospital that is not approved he could nonetheless for a 2-year period recover three-fourths of the costs that he otherwise would be entitled to. A lot of these people are rushed to the nearest hospital when they are critically ill and if they happen to go to a hospital that is not covered by medicare why should they be out of luck, through no fault of their own. It seems to me the Congress ought to recognize that fact.

Senator AIKEN, I would certainly support the proposal of the Senator from Georgia, whose proposals are usually good. I would even go further and say if by accident they had to be treated in a hospital not yet approved by medicare for one reason or another that he should be taken care of to the fullest extent intended by the program.

Senator TALMADGE. Thank you very much, Senator, for your helpful suggestion.

Senator ANDERSON. Senator Curtis.

Senator CURTIS. I will not take any time. But I am delighted you were here and testified.

I notice on page 9 you say doctors are naturally reluctant to accept the assignment of bills, so the poor person living on a limited retirement income has to pay the bills first and then has to wait for medicare to reimburse him.

I think you will be interested in knowing there is an option put in the House bill already.

Senator AIKEN. There is?

Senator CURTIS. The patient can submit an itemized statement obtained from the doctor and doesn't have to show that it is paid.

Senator AIKEN. I think that has been——

Senator CURTIS. And that, I think, from a practical standpoint will be of considerable help to many people.

Senator AIKEN. I think that has been one of the more numerous complaints that we have had, and it is something that ought to be settled by the doctors and the hospitals themselves. But if it can't be——

Senator CURTIS. It is my understanding that the House bill will permit that to be done. As a matter of fact, the Ways and Means Committee have done a very good job on this bill.

Senator AIKEN. I am sure there was improvement, but I was unaware of the proposal in the House bill. I would say it is a good one.

Senator CURTIS. Mr. Chairman, I was unavoidably absent when the Department's witnesses testified. I am not asking they come back, but would like to ask unanimous consent to submit some questions to them in writing for them to include in the material that they have been asked to insert.

Senator ANDERSON. Without objection that will be done.

Senator CURTIS. Mr. Ball or Mr. Cohen.

Senator ANDERSON. Senator, submit the questions through the chairman.

Senator CURTIS. Yes.

(Questions of Senators submitted through the chairman, to the Department of Health, Education, and Welfare, appear in part 1, p. 725.)

Senator ANDERSON. Senator Morton.

Senator MORTON. No questions. I want to thank you.

Senator ANDERSON. I want to say we need more costs information on some of these deductibles. The original medicare bill was not introduced for a while because of the question of deductibles. It will still take a long time to satisfactorily decide whether we should take all deductibles off.

Thank you very much for your testimony.

Senator AIKEN. I depend largely upon the good judgment of the Senator from New Mexico. As I recall it, I voted against his first medicare bill on the grounds that it was——

Senator ANDERSON. We don't hold that against you.

Senator AIKEN (continuing). That it didn't accomplish the purpose. But after he improved it I thought it was a good bill and voted for it, although I knew it was not perfect legislation at the time.

Senator ANDERSON. We are very glad, Senator Aiken, that you are here.

Thank you very much.

Senator AIKEN. Thank you.

Senator ANDERSON. Mr. Harmon.

Senator MORTON. Mr. Chairman, I merely would like the pleasure of introducing Mr. Harmon, who is the commissioner of the Kentucky Department of Child Welfare. He has an outstanding reputation in my State, and he has done a tremendous job in this important field. We do have a unique problem in Kentucky and in Illinois, and I am sure Mr. Harmon can explain it to the committee in just a short time.

We are very happy that the committee has seen fit to hear him today.

STATEMENT OF MAURICE A. HARMON, COMMISSIONER, KENTUCKY DEPARTMENT OF CHILD WELFARE

Mr. HARMON. Thank you, Senator Morton.

Mr. Chairman, and gentlemen, incidentally although you have my testimony, Mr. Chairman, I would prefer to summarize it in my own words.

Senator ANDERSON. Go right ahead.

Mr. HARMON. I appreciate certainly the weight of worldwide decisions upon the shoulders of the U.S. Senate such as the Vietnam war

and so forth, but I would like to submit, Mr. Chairman, that the matter before you today is perhaps of even greater significance, primarily referring to the services to children since adequate services to children relates to the very sinews of our country's destiny, to our Nation's most precious resource, if you will, which is children.

I am reminded, speaking of the subject of Vietnam, and also, Mr. Chairman, to acquaint you with my own personal background in this work, that some 25 years ago, I served 3 years in the wet jungles of Guadalcanal and New Guinea, and during that time determined that if I did return to the States that I would pursue this work that I am now in, and obtaining a master's degree following my return to the States I have been involved in this child welfare work ever since.

I mention this, Mr. Chairman, to convey to the committee that I am close to this problem and that I have served as an administrator in this work in 40 States. So I do not present the narrow view necessarily of any one particular State.

Mr. Chairman, the goals and objectives of child welfare services have become the traditional standards of good child care in our country and even the entire world, whether these children are served in their own homes, or a substitute home, or in an institution. The aim has been to care for and to treat all children by these standards, not just some children, not just poor children, not just white children, not just homeless children, but all children. These standards of child care have become a sacred part of our country's heritage, a fundamental part of our very democracy, the things we stand for, the reasons that we are ready to defend our Nation's shores. The Federal Government is committed to this responsibility for its children.

And there is why, Mr. Chairman, I hasten with deep professional conviction to request a revision of H.R. 12080. I do not desire to see child welfare services submerged and dissolved by the huge eligibility apparatus which is represented by the aid to families with dependent children program.

Mr. Chairman, in my own view, it is vital in order to preserve the adequacy and integrity of child welfare services that these services not be incumbered by the overriding eligibility apparatus which is currently required in public welfare departments. What has happened around the country in the past three decades in most States is the submerging of child welfare services to stepchild status in order to handle the huge eligibility apparatus which, among other things, of course, gets into the intense and hostile arena of politics, huge State funding, and hostile reactions by both the public and legislators in regard to the relief funding of certain citizens.

By having a separate child welfare department, the States of Kentucky and Illinois took a great step ahead, and I might hasten then to add that many States hold these States in envy for their foresight in this regard. I do not wish, Mr. Chairman, to underemphasize this latter point. And whereas these two States have demonstrated a new way to approach this problem, it would seem to me that these two States should be encouraged and supported rather than being stifled, stifled in the sense of not being allowed to demonstrate new programs.

The provision of H.R. 12080 requiring "the establishment of a single organizational unit in such State or local agency" to deliver

child welfare AFDC services, I submit, is an unwarranted intrusion on the right of States to develop organizational structures best fitted to serve their own needs and to solve their own administrative problems.

Whereas I have mentioned, Mr. Chairman, the States of Illinois and Kentucky, the State of Georgia has a close relationship to this same administrative pattern, although slightly different.

The House committee has grounds for its dissatisfaction with the results of current programs in HEW, but I submit that its solution to the problem places emphasis on wrong weaknesses. The real problem has always been that services to children have been obscured in AFDC programs by the overwhelming emphasis on eligibility apparatus.

The solution to the problem is not to force child welfare and AFDC together, but to separate services from eligibility determination.

There have been no problems in understanding this separation of eligibility determination from services in the medical field. Physicians are not bothered about eligibility. They render medical services. In a like manner child welfare services are needed by children when they are abused, abandoned, neglected, or otherwise in trouble. Whether the child's parents have any particular level of income should not be relevant to protecting the best interests of the child.

The Senate Finance Committee recognized this principle of separation of services from eligibility determination in its report on H.R. 6675 in the first session of the 89th Congress when it said, and I quote: "The committee believes the States should be given the opportunity to select the agency they wish to administer the program."

Services to children are best given to agencies and employees, expert and strong in the delivery of such services.

In recent years Kentucky and Illinois and to some extent Georgia have with a new administrative departure demonstrated the strength and success of such independent programs. To reject this evidence of success for the proven failure of a singly administrated program is folly. At the least each State should have the opportunity to experiment, to demonstrate and to learn the method best suited to solution of its own unique problems.

We desire the committee to revise the bill to allow the States to place the child welfare services in whatever department it elects. Thank you, Mr. Chairman.

Senator ANDERSON. Senator Williams?

Senator WILLIAMS. No questions.

Senator ANDERSON. Senator Carlson?

Senator CARLSON. Mr. Chairman, I just wish to state this: Having served as Governor of a State, I have always been interested in children's programs, and I want to commend the States of Kentucky and Illinois for the progressive steps they have taken. I, too, have a feeling that the States which are closer to these problems than some of the Federal Government agencies should be given more authority, and I shall certainly keep that in mind when we write this legislation.

Mr. HARMON. Thank you, Senator.

Senator CURTIS. Mr. Chairman, I would like to state that your statement is very helpful. I feel that there should be sufficient latitude

that a State could do what they thought was best. I would also take this occasion to say that your State is well represented on this committee in Senator Morton, who is very diligent in these things.

I want to ask a question or two for clarification.

Mr. HARMON. Yes, sir.

Senator CURTIS. What you have in your State and what you propose is that the agency that administers to children, takes care of them, be not the agency that has to spend time determining whether or not that child comes from a family that is eligible for aid to family and dependent children.

Mr. HARMON. That is correct, sir.

Senator CURTIS. Now, do I take it then that what you do in Kentucky is you proceed, insofar as your finances will permit, to meet the whole need across the board and then after the fact you determine which ones are eligible for the Federal aid to dependent children payment?

Mr. HARMON. To a certain extent, sir. The program——

Senator CURTIS. Or, yes, go ahead, excuse me.

Mr. HARMON. The agencies are divided so that our child welfare department at the present does not handle AFDC problems unless we refer the AFDC problems to the agency which does handle them.

We handle all the other types of problems.

Senator CURTIS. You mean your child welfare agency doesn't have anything to do with administering aid to dependent children?

Mr. HARMON. Not at the present, sir.

Senator CURTIS. I see.

Mr. HARMON. We would prefer to keep it that way. However, if this bill should pass as it is it would make that possible.

Senator CURTIS. You serve some of the same children?

Mr. HARMON. Yes, indeed, we do that. But one of the problems is the funding apparatus because the child welfare program does not receive the 75–25 matching funds and consequently many of the children on AFDC are handled by the AFDC or public welfare agency. We cannot afford to handle all of them by our own State supported program.

Senator CURTIS. I see.

In those cases where those that you are administering aid to are also aid to dependent children, do you find any overlap in what you are trying to do for the same youngsters?

Mr. HARMON. Limitedly, since those children are usually handled by the program handling AFDC. This is one of the serious points, sir, because the child welfare services cannot afford to handle AFDC problems, which have the same needs for help as problems of any child. We contend that the child welfare services has the best program for delivery services, but we are not funded by the Federal Government in the same manner as AFDC so we cannot afford to extend our services beyond capacity.

Senator CURTIS. Please understand, I am not quarreling with your position.

Mr. HARMON. Yes, sir, I understand it.

Senator CURTIS. I want to make it clear. What do you do in the way of services to children in Kentucky that are from families not covered by aid to dependent children?

Mr. HARMON. Yes, sir.

We provide services to children who are abandoned, abused, neglected, dependent, homeless, delinquent, predelinquent, mentally retarded, disturbed, and so forth, and these are all children that are not within the AFDC category.

Senator CURTIS. How is that program financed?

Mr. HARMON. Child welfare services are financed, sir, primarily by the State government, but we receive an annual grant based upon a formula from the U.S. Children's Bureau. It is not matching.

Senator CURTIS. About what does that run percentagewise?

Mr. HARMON. Our total budget, sir, is $6 million. We receive in round figures $900,000 from the Federal Government on an annual basis.

Senator CURTIS. So you get about a seventh?

Mr. HARMON. About a seventh, sir. Of course, this is why, sir, we were rooting if I may say, sir, for the Fogarty bill in the House because it would have put child welfare services on a matching basis, because we don't have the funds to take in all the services that the children should have.

Senator CURTIS. I think it is important to have the record show what is the matching formula for AFDC.

Mr. HARMON. It is 75 Federal and 25 State for services.

Senator CURTIS. For services?

Mr. HARMON. Yes, sir.

Senator CURTIS. And for administrative costs?

Mr. HARMON. It is 50–50 for administrative costs.

Senator CURTIS. Thank you very much.

Mr. HARMON. Thank you.

Senator MORTON. Mr. Harmon, to further clarify this problem that we have, you liken it to the services of a physician.

Mr. HARMON. Yes, sir.

Senator MORTON. He brings medical services, and he doesn't—it is not his problem to worry with the eligibility.

Now, you have—according to your full statement which I ask be made a part of the record—you show, for example, that since the inception of this program you have increased your total graduate social workers from 8 to 31, your fieldworkers positions from 75 to 116, the average daily number of children in foster care from 319 in 1960 to 1,000 in 1967, the adoptive placements from 310 in 1960 to 504 in 1967, and your point is that under the language of the bill as passed by the House, the Department of Child Welfare in the State of Kentucky would have to go into that title of the bill which includes the AFDC program?

Mr. HARMON. Yes, sir.

Senator MORTON. And it would lose its identity?

Mr. HARMON. That is true, Senator.

Senator MORTON. Is it not also true that in that event you would have more difficulty in recruiting and retraining scheduled personnel, trained personnel?

Mr. HARMON. I would honestly think so, sir, yes, because I feel the heartbeat of graduate professional social work has been found in child welfare services, and the average professional person is not going to want to be identified with the eligibility apparatus. This is no more than a physician wants to be.

Senator MORTON. As I understand it the turnover in your depar ment has been running about 12 percent per annum as opposed to th overall in the various welfare programs of over 30 percent per annum

Mr. HARMON. That is correct, sir.

Senator MORTON. I think that your point is well taken, and I w discuss it with my colleague from Illinois, a member of this committe Senator Dirksen, and we will attempt to draw up some correctiv language and submit it to the committee in the form of an amendmen at the proper time.

Mr. HARMON. Thank you, Senator.

Senator MORTON. Thank you, Mr. Chairman.

Senator ANDERSON. Thank you for your appearance.

Mr. HARMON. Thank you, Mr. Chairman.

(The prepared statement of Mr. Harmon follows:)

STATEMENT OF MAURICE A. HARMON, COMMISSIONER, KENTUCKY DEPARTMENT OF CHILD WELFARE

Mr. Chairman and members of the committee, I am Maurice A. Harmon, Com missioner of the Department of Child Welfare for the Commonwealth o Kentucky.

The purpose of my appearance before the Senate Finance Committee is to ask for revision of H.R. 12080 in certain respects. My reasons for believing these revisions are not only desirable but necessary lie deep in the rationale of government responsibility for its citizens and in particular its children. My convictions in this area are the result of professional experience extending over the past 25 years in working with children and youth.

I believe all of us are interested in breaking the cycle of poverty which appears to plague large segments of our society today. It is clear to me, as it apparently is to the House Ways and Means Committee, that the simple monetary efforts of the categorical support programs of the Social Security Act hav failed to break those cycles of poverty for hundreds of thousands of families. Consequently, the House Ways and Means Committee has suggested some rather stern measures in their effort to make the Social Security Act more effective.

The place to break the cycle is in childhood, when the opportunity to redirect the growth potential of any individual is at its maximum. Child Welfare programs are designed not only to prevent problems from occurring, but also to protect children and to assure that they receive the maximum opportunity for achievement of their growth potential together with the assumption of full participation as a contributing member of adult society.

Child Welfare is essentially a program designed to prevent later problems such as delinquency and dependency. These programs are aimed to be effective 10 to 20 years ahead of the present time. Children need the assurance of good emotional and physical care from infancy. When children have a healthy, happy start in life, they are able later to cope with the problems of adult life. Child Welfare programs are designed to prevent or mitigate the kinds of trouble which are plaguing our society, and particularly our cities, today. Adequate support for Child Welfare programs for the past 20 years could well have prevented much of the present unrest found in the youths and younger adults of today's slums. Many of these young people, although covered during their lifetimes by the Aid to Dependent Children program, did *not* receive Child Welfare services.

Proper and adequate service programs for children are the key to the future development and stability of our society. I submit the best way to achieve such programs is the strengthening of Child Welfare Service programs in the states. The federal government has failed to provide sufficient strengthening during the more than 30-year history of the Social Security Act. H.R. 12080 would practically dissolve these services if subsumed under the AFDC program.

State Child Welfare services include a wide range of work with children, their families, and other agencies working with children. The Kentucky Department of Child Welfare licenses and inspects all public and private agencies caring for children, whether full-time residential or part-time day care services. In addition, we provide adoption services, foster care, protective services to abused, abandoned or neglected children, services to unmarried mothers, day care, homemaker services, and programs to prevent juvenile delinquency. We also work

with children who are disturbed or retarded. In our state, we are also the authority for services for the juvenile delinquent.

H.R. 12080 is totally unclear as to the continuation of the quality of these several Child Welfare services for children who are not eligible for AFDC funds. The bill states merely that Title V programs would be transferred to Title IV, and I submit that this brief statement loses sight of the thousands of children served by Child Welfare programs because the AFDC eligibility apparatus will literally submerge the available services.

These services are available to *all* children who need them regardless of the income of their parents. Of course, many of the abandoned and neglected children come from families in lower socio-economic levels, but child abuse and other problems *take place at all economic levels*. We believe these services should be available to *all children*. Collecting from their parents should be a function of another agency, the one which is concerned with eligibility determination which could work with law enforcement agencies and others to see that legal responsibilities are met. In this manner, a child would not suffer neglect while long, drawn-out procedures were argued about parental responsibility. If it is determined that a parent should pay for support or service, he could be sued and prosecuted, but meanwhile the child would be receiving proper attention. Regardless of our desires to punish or coerce the parent, we need still to be concerned about the needs of the dependent child.

One need only to refer to the press coverage of H.R. 12080 to be aware of the current criticism of this bill. These criticisms are aimed primarily at what are called by some "coercive" or "punitive" aspects of the legislation. Such critics may well be correct in their observations, but I wish to aim my criticisms today in a direction which has yet to be carried in any of the multitude of press releases. This lack is due primarily, I believe, to the fact that one must have the expertise and the deep concern of child welfare administration to be aware of these flaws. In short, while many seem to be concerned about the extent and restrictions of payments to families of dependent children, it appears that little attention is paid as to how this new legislation will be administered. This is perhaps similar to the old arguments about standard versus daylight time. But in the meantime, someone has to think about setting the clock.

I contend that among other things, professional Child Welfare services as we have known them these past 30 years will be eliminated by this legislation. In their place will be substituted a giant eligibility apparatus, founded unfortunately, on actuarial principles of bureaucracy, and planned to be operated by the computer instead of professionally trained human beings. The Burke Bill, H.R. 1977, would have strengthened Child Welfare Services throughout the country and given new blood and new life to the entire program by giving matching funds for services to *all* children, not just the economically deprived. Most regretfully, the Burke Bill was swallowed up and dissolved by H.R. 12080.

In Kentucky we have had a separate Department of Child Welfare since 1960. We are unique in that we have charge of all social service programs except AFDC, including abandoned, abused, dependent, neglected, and delinquent children. Of course, we are also charged with the prevention of these conditions. We have made great progress in the seven years our Child Welfare services have operated as an independent state department.

We have been able to show the Legislature and other government officials the true needs of children in the state. Other services have grown in both quality and quantity as the following table shows. Granted that we had, and still have, a long way to go in provision of services to children, still the citizens of Kentucky are proud of our progress. We attribute much of this progress to our independent status, independent in the sense that we are not under the same giant umbrella that contains all the usual categorical welfare programs.

STAFF AND SERVICE PROGRESS, 1955-67

	1955	1960	1961	1967	Average percentage 1955-60	Average percentage 1961-67
Field work positions	(1)	(1)	75	161	(1)	19
Total graduate social workers	(1)	(1)	8	31	(1)	48
Average daily number of children in foster care	396	316	340	1,000	−4	32
Number of adoptive placements	184	310	181	504	14	30

[1] Not available.

We have more than doubled our staff and almost tripled two of our k services to children. We have also greatly increased the quality of the staff the addition of trained social workers. In comparison to the previous five yea before establishment of the independent department, services to children mo than doubled each year.

I am making these points about our progress because we believe that su progress was only possible because we were not "lost" under the weight of categorical support programs, including AFDC, with its prime emphasis eligibility determination. State Welfare Administrators must put their emphas on large monetary programs. They are seeking the greatest value for the sta dollar and tend naturally to support programs which bring the largest amoun of federal funds into the state. Services consequently are subordinated to mon tary support and eligibility determination programs. Moreover, because of thes impacts of broad monetary coverage, political considerations naturally play heavy role in such programs. Child Welfare services should not be a part these involvements.

Even after the 1962 Social Security Amendments, which placed a premiu on staff services to children by offering open-end matching funds of 75 percen federal to 25 percent state costs for services, AFDC programs *still emphasize eligibility determination* rather than service to children. I have neither the de sire nor the intention to draw invidious comparisons, *but the simple fact is, a the Ways and Means Committee pointed out, the great increase of federal fund for these programs has failed to produce results. Unfortunately, in spite of th intentions of the legislation under consideration, services will not be improved and it is the service—and only the service—which represents the hope of im provement.*

There is a fundamental difference in philosophy between Child Welfare Serv ices and Public Assistance which goes back to the very roots of the Children' Bureau in its founding in 1912. Child Welfare renders services to children. Public Assistance renders money payments. This difference is reflected amon others in the ability of our child welfare programs to attract and hold traine and qualified social workers. Turnover of social work staff in our Department during the past five years has averaged 12–13 percent per year. This average turnover compares most favorably with the latest national child welfare turn over rate of 30 percent in 1965. I am making this point because morale is vital in service programs. Service workers have to be knowledgeable, concerned peo ple, not simply checkers of lists of compliance.

All these reasons make clear to us that services to children and their families should not be given by the agency certifying eligibility. Just as in medical pro grams where the services are rendered by physicians and other medical person nel, and eligibility for government assistance is certified by a public assistance agency, we believe child welfare services should be given by a separate agency unconnected with eligibility determination. The Senate Finance Committee rec ognized the need for separation of medical services from eligibility determina tion in 1965 when it amended H.R. 6675 to provide an option to the states to allow them to determine which agency of government would render medical services under the Social Security Act. If this Committee shares the Ways and Means Committee's dismay at the failure of the recent enlargements of service components of the Social Security Act, it may well wish to encourage state demonstration of separate service programs rather than force a merger of child welfare and AFDC programs as required in the present bill. The federal govern ment should be applauding such demonstration as found in the states of Kentucky and Illinois. Instead, by its poorly founded goals of bureaucracy, it is apparent that it desires to stifle new approaches to a chronic problem.

Interestingly enough, the recent administrative reorganization of the welfare services in HEW announced by Secretary Gardner August 15 supports our view that services to children and their families should be separated from eligibility determination and support payments. Under the reorganization, the Children's Bureau will have under its jurisdiction, among others, child welfare services and services to AFDC families, while the assistance payments administration will have jurisdiction of . . . "the administration of money payment aspects of public assistance programs. . . ." If the federal administration recognizes this division of labor, why in the world should not the states have the prerogative of deciding which unit of government should best deliver the two types of services to its citizens? Is this a question of, "Do as I say, not as I do"?

It is the merged programs under a single administration which are continuing to fall under the overwhelming dominance of eligibility-determination programs. I should think the Congress would desire newer methods, would emphasize newer approaches, rather than place emphasis on the old programs with their dismal records of cycles of generations on welfare rolls. Although our national government may have appeared generous to persons in adversity, our system of handouts has made the service component a step-child. Our organization of social services must be revolutionized.

Two states, Illinois and Kentucky, are trying new methods of delivery of services to children. *They should be encouraged in these efforts rather than penalized.* The people of these two states anticipated the Congress in their dissatisfaction with services to children playing second fiddle to money relief. It was apparent in Kentucky and Illinois that children's programs were second-rate and were not delivering desired results. In both states, great progress has been made under independent departments. They are pointing the way to better services for children which are aimed at the very results desired by the Congress. Yet the present bill would force the closing down of these two state agencies under penalty of withdrawal of federal matching payments.

I recommend that the Finance Committee amend H.R. 12080 to provide that states may appoint the responsible agency to administer the services to children and their families contemplated in the Act.

I would like to discuss one other point because it influences the ways in which federally supported programs are operated in the states. There is a great fragmentation of services when they are delivered at the community level because of the separate funding authorities in Washington. For instance, at the present time, numerous agencies are giving social services to children in Kentucky communities—as well as in other states. Our own agency, the AFDC program, the Office of Economic Opportunity, Mental Health programs, Mental Retardation programs, Juvenile Delinquency programs, and local Boards of Education under Title I of the Education Act all give social services to children and their families. This fragmentation frequently leads to duplication and overlapping of services and causes confusion in the minds of recipients and the general public. Much of this fragmentation could be avoided if states and local agencies could utilize the various specialized programs under contract from the responsible agency. Federal regulations usually prohibit such devices or discourage them by administrative advice and rulings. With the exception of the Office of Economic Opportunity, all of these programs to which I referred above are in the Department of Health, Education, and Welfare. Even in a single federal department, duplication and overlapping are fostered in state programs through this fragmentation of services. Considering the difficulties that Child Welfare programs throughout the country have had over the years in securing adequate funding for needed service programs, it seems that better planning and coordination within HEW would help in clarifying and simplifying the delivery of adequate services to children.

Senator ANDERSON. Doctor Rouse.

Will you introduce the staff with you, please?

STATEMENT OF DR. MILFORD O. ROUSE, PRESIDENT, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY DR. SAMUEL R. SHERMAN, CHAIRMAN OF THE AMA'S COUNCIL ON LEGISLATIVE ACTIVITIES; DR. THOMAS H. HAYES, DIRECTOR OF THE DEPARTMENT OF DRUGS; AND BERNARD P. HARRISON, DIRECTOR OF THE LEGISLATIVE DEPARTMENT

Dr. ROUSE. Mr. Chairman, and members of the committee, I am Dr. Milford O. Rouse, a doctor of medicine and with the current honor and responsibility of serving as president of the American Medical Association. I have with me to answer any questions you may have Dr. Samuel R. Sherman of San Francisco, chairman of the AMA's Council on Legislative Activities; Dr. Thomas H. Hayes, director of

our department of drugs, Mr. Bernard P. Harrison, director of the legislative department. We appreciate this opportunity of presenting the views of the medical profession with respect to H.R. 12080 and resulted bills that are now before you.

H.R. 12080 is the result, of course, of the deliberations of the House Ways and Means Committee following public hearings on H.R. 5710 in which hearings we participated on April 4 of this year. The AMA was privileged to present its views on H.R. 5710 on April 4 of this year. I am particularly pleased to note that a number of recommendations offered by the association were incorporated into the bill which is now before this committee. While these improvements do not include all of the recommendations we have made, they do, however, offer promise that the law will become administratively more workable.

Before commenting on the Social Security Amendments of 1967, I would like to pont out that we who have leadership responsibilities in the AMA have every reason to be proud of the way the physicians of this Nation have lived with the medicare law, in spite of their lack of enthusiasm for it and their belief that it should never have been passed.

I say this because there are those who have tried to give the impression that the doctors of the United States are not working with medicare. I want to make it clear to this committee and to the Nation that no such lack of cooperation exists.

Turning now to H.R. 12080, I would like to discuss certain of its provisions.

Beginning with the provisions of title XVIII, the bill does not place the disabled of all ages under medicare as had been proposed earlier. We think the House acted wisely in establishing instead, a special advisory council to study the problems related to the inclusion of this group and to study the costs involved.

The AMA supports this action of the House. We do not question the need of some currently disabled persons for financial assistance to meet health care costs, but we do believe, however, that title XIX should be utilized for that purpose.

Title XVIII was enacted to provide assistance to one particular group of persons in the financing of their health care. Other special groups, such as children, the disabled, the blind and persons under age 65 who otherwise qualified for assistance, were not included. For them, title XIX was provided.

The inclusion of the disabled under medicare would change the direction of the program from one for older persons to one aimed at a variety of categories.

Before adopting section 140, we recommend that subsection (e) be amended to include after the period on line 23, page 67, the following additional sentence: "The council shall take into consideration the availability of assistance under title XIX of the Social Security Act." Further, we suggest that section 140 provide that included in the council be representatives of health insurance and the medical profession.

In addition to the present method of payment for physician's services, the bill provides two new options: either the physician can submit his itemized bill directly to the carrier, in which case payment of 80

percent of the reasonable charge would be made to him, providing the full charge does not exceed the reasonable charge, or to the patient at the physician's direction; or the patient may submit the itemized bill and be paid 80 percent of the reasonable charge.

From the program's inception, the AMA has urged that payment be permitted on the basis of an itemized statement of charges. While strongly continuing to support the provision for this payment method, we would suggest one further improvement in the language of the bill before you; the deletion from section 125 of the words beginning on line 21, page 47, "payment is not made" and ending with the words on line 5, page 48, "receiving the service) and,". This is in the interest of clearing up some redundancy and clarifying it.

Outpatient hospital diagnostic services would be transferred to part B of title XVIII and be subject to the deductible and coinsurance features. This is in keeping with our recommendation to the House Ways and Means Committee that outpatient services be included under part B, and so remove the administrative difficulty of distinguishing between the therapeutic and diagnostic services.

Section 126 eliminates both the requirement for initial physician certification for hospitalization of medicare patients and the requirement for physician certification for outpatient hospital services. The AMA recommended the elimination of initial certification and the subsequent recertification. We continue to recommend the addition of this second step to eliminate the requirement of any certification, since any need in this regard will be satisfied by the work of the medical review or utilization review committees.

The bill permits payment for the purchase of durable medical equipment, where the purchase would be more economical, in addition to the present provision for rental. The AMA supported this provision in H.R. 5710, the predecessor to the bill before you, and we continue to support it.

Under the bill, the Health Insurance Benefits Advisory Council established by the present law assumes the duties of the National Medical Review Committee and is increased from 16 to 19 members. We originally supported an increase in the membership of the National Medical Review Committee. We can similarly support this change, provided that HIBAC, which will assume the functions of the National Medical Review Committee, meets the majority composition requirements of existing law for that Committee. Congress, in establishing a National Medical Review Committee under Public Law 89-97 required that "at least a majority of the members shall be physicians." We urge that a similar provision be included in section 162.

In section 131, the bill authorizes payment under part B of all "reasonable charges," without a deductible or coinsurance, for radiological or pathological services furnished by physicians to hospital inpatients. We support and have always advocated the inclusion of the services of these specialists under the part B program. While we do not favor the removal of deductibles or coinsurance from the part B program, we are aware of the need for adjustment in this specific area because of the problems encountered in the early administration of the program.

In section 141, the Secretary of HEW is to conduct a study of the need for including under part B the services of additional licensed

practitioners. While we do not oppose the making of a study at th' time, I would make the following observations:

We are concerned lest there be asserted an unwarranted and un proved need for expansion of the program. We are concerned les the door be opened to permit, under the guise of necessary health car services which may do injury to the health of the very people who neec competent medical care.

The services of optometry and podiatry, both of which had been considered for inclusion in this category, are useful within the limitations of their competence. But we would recommend against their inclusion and urge that the medicare program not be expanded in this area.

We are much more deeply concerned about a proposed inclusion o chiropractic.

It is the position of the medical profession that chiropractic is an unscientific cult whose practitioners lack the necessary training an background to disagnose and treat human disease. Chiropractic constitutes a hazard to rational health care in the United States becaus of the substandard and unscientific education of its practitioners anc their rigid adherence to an irrational, unscientific approach to diseas causation.

No chiropractic school is accredited by any recognized educationa accrediting agency in the United States. The doctor of chiropractic degree is listed as "spurious" by the U.S. Office of Education in its publication, "Academic Degrees." Chiropractors cannot practice in any hospital accredited by the Joint Commission on Accreditation of Hospitals. Chiropractors are not allowed to prescribe drugs or perform surgery in any State. Chiropractic groups publicly have opposed school immunization programs and community fluoridation programs, both of which are endorsed by the U.S. Public Health Service.

Patients should entrust their health only to those who have a broad scientific knowledge of diseases and ailments of all kinds and who are capable of diagnosing and treating them with all the resources of modern medicine. The delay of proper medical care caused by chiropractors and their opposition to the many scientific advances in modern medicine, such as lifesaving vaccines, often ends with tragic results.

We urge the committee to reject any suggestion for the inclusion of chiropractic. For the same reasons we also suggest that you remove from tile XIX any authorization for provision of chiropractic under that program.

As provided in section 138, we favor the partial removal of restrictions and recommend a greater and more equitable liberalization by the complete deletion of section 1812(c), thereby making equal benefits available to all eligible elderly persons, without regard to the physical or mental condition for which they are receiving treatment.

Section 137 would increase the number of hospital days covered by part A from 90 to 120 days, with the requirement that after 90 days the patient's coinsurance would be increased to one-half of the inpatient hospital deductible.

We would suggest that the committee give careful consideration to this provision and its probable effect on the cost of the program, and the cost to the patient.

The bill would include, under part B, these services furnished to an individual in a place of residence used as his home: physical therapy furnished under the supervision of a hospital; and diagnostic X-rays provided under the supervision of a physician.

The AMA supports both of these proposals.

Turning now to title XIX provisions of H.R. 12080, the bill provides that Federal matching funds would be available if the income level of a family does not exceed either (1) an amount one and a third times the highest amount payable under the AFDC program for a family the same size or (2) an amount one-third higher than the State per capita income for a family with four members, and comparable amounts for families of different sizes.

The AMA has long supported the title XIX concept both because it is State-administered and because it provides assistance only to those with demonstrated need. The association has continually supported limiting eligibility for title XIX benefits to persons who need financal assistance in meeting health care costs.

We understand the Federal Government's concern about its participation in the financing of State assistance programs under title XIX, which permits the States to include families of financial substance beyond the intentions of the Congress in enacting the law. On the other hand, we are concerned that using the highest amount payable in AFDC programs as the income ceiling for title XIX may serve to prohibit the assistance promised by this program to some who are in fact in actual need.

AFDC, in many States, pays benefits significantly below actual need to recipients. In 1965, the maximum amount payable under AFDC in eight States, was less than half the amount required for fundamental needs, in those States, and in 18 States was less than 70 percent of need. As we understand the application of the proposed formula, in a number of States the use of AFDC as a standard would exclude from title XIX benefits some individuals receiving cash assistance in other federally aided programs, unless the State would underwrite the full expense.

It seems to us that to change the title XIX program so that in some cases, persons who are financially destitute to the degree that they must receive monthly cash assistance, will be ineligible for any medical assistance under title XIX, will substantially change the character of the program. While it may be possible under this section that States might increase their AFDC payments in order to avert such ineligibility for the other needy, such a result could be viewed as being incompatible with the expressed overall concern about the growing expansion of the AFDC program.

We recommend, therefore, that any income limit placed on eligibility for title XIX benefits should not be so rigid as to exclude those who are clearly unable to pay for needed health care, especially those whose need is such that they are already receiving cash assistance under titles, I, IV, X, XIV, or XVI.

Section 222 continues until 1970 the present provision to allow States to buy into part B for its cash assistance recipients. It also allows States to buy in for medicaid persons not receiving cash assistance, but for whom there would be no Federal matching. It pro-

hibits Federal matching to States for services which could have b covered under part B but were not.

The AMA supports the opportunity of "buying in," but we beli there should not be imposed any penalty where the State does n choose to do so.

Under the bill, States would not have to include in medicaid persons under 65 the same benefits afforded those 65 and over fr whom benefits under part B are purchased.

The AMA supports this provision.

The bill provides 75 percent Federal matching, instead of 50 p cent, for physicians and other professional medical personnel of Sta health agencies in the administration of health responsibilities und the medicaid program, where the "single State agency" is not the hea department. We agree with this change adopted by the House.

As recommended by the American Medical Association, the b establishes an advisory council on medical assistance to advise t Secretary of HEW on matters relating to administration of the medi aid program. However, since title XIX is a medical assistance pr gram, we strongly recommend that the majority of the 21 counc members be representatives of the fields of health care.

Also as urged by the AMA, section 227 of the bill provides for fre choice of physicians and medical facilities by medicaid recipient. We strongly urge the adoption of this provision. However, we see n justification for deferring the effective date of this provision wit respect to Puerto Rico, Guam, and the Virgin Islands.

Section 230 provides that at the option of the States direct paymen is authorized to medicaid recipients who are not also cash assistanc recipients.

The AMA urges the requirement that all State title XIX plan contain an option for direct payment to beneficiaries on the basis of a itemized bill, similar to title XVIII.

The AMA supports the new provision involving basic services to b provided. Present law requires States to include five basic service by July 1, 1967. The new provision would be less restrictive, allowin the States to have in their law either any seven of 14 named benefits or the five types of benefits now required.

We generally support the provisions of title III of this bill whic relate to maternal, infant, and child health programs. We would adc that we believe the provision limiting assistance to persons who ar from low-income families, or who would not otherwise receive such assistance, will enable the better utilization of Government funds t render more adequate care to those who need it.

As I have said, a number of the suggestions made by the Americar Medical Association have been incorporated in the bill before this committee. For the most part, we believe that further substantiv changes to improve the administration of the program can await the knowledge that 1 or 2 years of additional experience will bring. However, we would like to mention one additional thought: We believe that at an appropriate time consideration should be given to restructuring the program, particularly part B. Unfortunately, part B did not receive the amount of either public or congressional debate warranted by the nature and scope of the proposal. This Congress is now

confronted with many problems inherent in the vast undertaking of the Federal Government in becoming directly involved in the total health care of almost 20 million persons.

We believe it is possible for the Congress, the medical profession, and others interested in the subject to develop a new mechanism for delivering medical care to people over 65 that would be consistent with existing private sector mechanisms.

I am sure the committee is aware of problems which still exist with the present operation of part B.

Carriers have encountered many administrative problems.

Physicians find that Government has involved itself in medicine through such regulation as rules on reasonable charges, statistical data requirements, and definitions of physicians' services.

The elderly patient is sometimes dissatisfied because he finds he is getting less than he expected; or experiences delays in being reimbursed; and often doesn't really understand the Government-physician-carrier combination that is trying to take care of him.

The Government finds it necessary to fault the carriers or the physicians, or both, for the delays and confusion, and seeks to place responsibility on them for the increasing costs.

Finally, the Congress realizes it has an open-end program with rising and perhaps uncontrollable costs.

We believe that it is possible, and would be eminently practical, to devise another approach that could solve problems which beset part B. One possibility, for example, might be to substitute for the part B program a subsidy to all eligible persons, to be used for the purchase of private health insurance. Such an approach could have many advantages.

The eligible over-65 patient would have a qualified private insurance program of his choice, at no greater expense than he has under the part B medicare program; carriers would have a greater responsibility for their own performance with an opportunity to exercise initiative; the physician would continue to deal with his over-65 patient in every respect in the same way as he did before the patient's birthday; and the Congress would have a program with defined costs, and one which would offer the Nation a comparison of mechanisms in use to meet the problems of financing health care of the elderly.

We would be glad to sit down with this committee, and with interested parties from any source, to hammer out a workable approach to solving the many complex problems in today's part B program.

The next topic I should like to discuss briefly is physician coverage under social security.

We believe that physicians, having been brought under social security, should be accorded the same privilege and opportunity for reaching a fully insured status as was accorded other professional groups when they were included in the program.

Accordingly, we urge this committee to consider the adoption for physicians of an "alternative insured status" similar to that permitted by the amendments of 1954 and 1956 which brought into the program many new groups of people and professional self-employed persons, including lawyers. Further, we urge this committee to consider amendments that would "drop out" an appropriate number of years for

physicians to make their eligibility for cash benefits both equitable and realistic.

As a final portion of this statement, I would like to address myself briefly to legislative proposals relating to methods to establish quality and cost control standards for drugs included as a benefit in Federal health care programs and the overall question of generic versus brand name prescription.

In November 1966, the AMA house of delegates adopted a policy statement that physicians should be free to prescribe drugs generically or by brand name for all of their patients, whether they are private, medicare, or indigent patients, the primary consideration, also being the best interests of the patient.

The house of delegates went on to say:

> Medical considerations must be paramount in the selection of drugs. In addition, the physician also has an obligation to be mindful to the economic consequences of the treatment he prescribes.

Our concern for the cost of drugs to the patient was further elaborated:

> The issue of cost is not simply a matter of prescribing drugs generically as opposed to brand name prescribing. Often there will be substantial variation in the cost of the same drug marketed under different brand names by a number of reputable manufacturers. However, generic prescribing alone will not assure that the least costly brand will be dispensed or that the savings will be passed on to the patient. Nor will generic prescribing alone assure the physician that his patient is receiving the produce of a manufacturer in whom he has confidence. If the physician prescribes by brand name, he designates the source of supply. If the physician prescribes generically without naming a manufacturer, the pharamacists or some other third party chooses the source of supply.

Just this last June, the AMA house of delegates again reviewed the question of generic versus brand-name prescribing, the physician's freedom to prescribe, and the cost of drugs to patients, and made this statement:

> The AMA again reaffirms its policy that physicians should be free to use either the generic or brand names in prescribing drugs for their patients; and encourage physicians to supplement medical judgment with cost considerations in making this choice.

Drug therapy is one area in which the art of medicine is practiced to its fullest extent. In order to cope with the subtle differences that are to be expected among various patients in response to drug therapy, the physician must be allowed the greatest freedom in prescribing and his drug armamentarium should be as flexible as possible.

We want our patients to receive high-quality drugs at the lowest possible cost. But we believe that competition between manufacturers and between distributors is more desirable—and probably more effective—than Government intervention and regulation to achieve this result.

We must oppose the drug legislation offered before this committee as amendments to H.R. 12080. We would suggest that rather than to enact such legislation it would be worthwhile at this time to study in depth, all the economic and therapeutic factors which enter into the use of prescription drugs.

That, Mr. Chairman and members of the committee, completes the statement of the American Medical Association. Because of the under-

standable time limitations, our review of the sections of H.R. 12080 which are of particular concern to medicine has been brief. We hope, however, that our brevity will not tend to diminish in the minds of this committee the importance we attribute to those provisions.

I would like to assure the members of this committee that we recognize the difficulty and importance of the job that lies before you in formulating legislation in these vital areas of health care and general welfare. We commend your colleagues on the House Ways and Means Committee and its chairman, the Honorable Wilbur Mills, for the work they have done prior to passing this bill to you.

We are interested in certain provisions of the House bill on which we did not testify, feeling that our views on medicare and medicaid were enough with which to consume your time on this occasion. But the medical profession's long-standing participation in programs involving employment training and retraining, and the rehabilitation of persons formerly disabled, give us a particular interest in the provisions of the bill that would restore the heads of unfortunate families to employment and to prideful self-reliance, and ultimately reduce the Federal Government's financial involvement in certain welfare programs. Gainful employment increases the self-esteem of individuals and contributes to their mental and physical well-being.

With my sincere best wishes for the success of your crucial deliberations, I thank the committee for its courtesy in allowing us to appear today on behalf of the American Medical Association and its physician members throughout the United States.

Thank you.

Senator ANDERSON. Thank you, doctor.

To avoid charges that medicare is inflating physician's fees, what would be wrong with paying doctor's bills on the basis of the benefits paid under the most widely held Blue Shield contract in each plan area?

Dr. ROUSE. May I ask you to restate the question, Mr. Chairman?

Senator ANDERSON. To avoid charges that medicare is inflating physicians' fees, what would be wrong with paying doctor bills on the basis of the benefits paid under the most widely held Blue Shield contract in each plan area?

Dr. ROUSE. Dr. Sherman, would you care to answer that, please?

Dr. SHERMAN. Mr. Chairman, I think you are alluding to the statement of Senator Aiken's testimony regarding the change in the reimbursement formula for physicians.

Senator ANDERSON. Not necessarily just that. I am referring to Blue Shield benefits—not just any fee schedules.

Dr. SHERMAN. But it was mentioned earlier. I reacted when Senator Aiken made this statement. I think that the intent of the original legislation to reimburse physicians on the basis of usual and customary fees has been one of the good things in the program and has insured more widespread physician participation for all medicare patients.

I am not aware of widespread abuses or exceedingly high costs of the program using this modality.

Until it has been proven to our satisfaction that this method is not workable, or is causing a hardship to the physical aspects of the program, I would sincerely urge that it be maintained as one of the

structures of the program. I do not feel that a standardized fee schedule, or even some of the Blue Shield concepts that exist as service contracts in some of the country, would work well with this program.

Senator ANDERSON. This is just what Blue Shield is paying; not standardized charges, Blue Shield allowances.

Isn't Blue Shield the "Doctors' Plan"?

Dr. SHERMAN. Yes, Blue Shield is the Doctors' Plan, and in many instances in many parts of the country, Blue Shield has been paying what we consider service-type fees.

Now, this concept is gradually changing throughout the entire country. Most Blue Shield plans, to my knowledge, are changing to the same concept that is involved in medicare—in other words, the usual and customary fee concept.

Senator ANDERSON. Many doctors have complained about the medicare claims form. Is it not true that the AMA helped develop that form?

Dr. SHERMAN. The AMA, along with other people, helped develop the form. There are some complaints about the form. But there is widespread acceptance of this form among physicians of the country.

Senator ANDERSON. Senator Williams.

Senator WILLIAMS. No questions.

Senator ANDERSON. Senator Harris?

Senator HARRIS. I don't have any questions, Mr. Chairman; thank you.

Senator CURTIS. One question.

When Secretary Gardner testified last week, he recommended that depreciation funds paid to hospitals be restricted to the use for capital items which meet the requirements of a State plan for health facility planning. I realize that relates primarily to the hospitals. What I would like to know, does AMA wish to comment on this suggestion?

Dr. ROUSE. I believe we do, and Dr. Sherman has a comment which I believe is appropriate.

Dr. SHERMAN. Senator, the American Medical Association made no comment on this as far as the testimony on 12080, but when we testified regarding H.R. 5710 we had much to say on this. For the record, I should like to repeat the testimony which we presented before the House Ways and Means Committee in opposing this particular section. May I insert this in the record?

Senator ANDERSON. Well, how lengthy is it?

Dr. SHERMAN. Pardon?

Senator ANDERSON. How lengthy is it?

Dr. SHERMAN. It is very, very short. I can brief it by just stating to you that we oppose the concept of requiring compulsory planning as one of the conditions of reimbursement for hospitals in their cost formula. We think that this would set a very dangerous precedent. We urged, at that time, it not be adopted by the committee. We felt that this compulsory planning would deprive providers of services—hospitals—of certain necessary funds either for replacement of equipment, or for facilities, or the acquisition of new equipment or facilities. We feel the Federal Government under medicare has played a principal role of a financier of the costs of the services. While the program contained many regulatory controls, it did not contain any regulatory

controls as to what the provider did with the money paid to him by the Government. We also feel that such a requirement would establish a dangerous precedent.

Senator ANDERSON. That is all.

Senator CARLSON. Mr. Chairman, I regret I was called out because of a previous commitment for a few minutes. I heard part of your statement, Dr. Rouse, and I shall read the rest of it. As I understand it, you approve, generally, the provisions of the House bill?

Dr. ROUSE. Yes. Many of these were recommendations that we made during the hearing on the bill in April.

Senator CARLSON. Thank you very much.

Senator ANDERSON. On the question of planning, I think there might be some new approaches developed which might be useful in controlling costs. I went to a sanitarium in 1917, a TB sanitarium. That was all there was in Albuquerque, one small ward of one surgical group. All the rest of the patients were TB patients. There have been a lot of things which have been done since that time. Would you recommend that they rebuild the same sanitarium in the same way?

Dr. ROUSE. I am thankful to say there have been marked improvements, as you say, and we are working for optimum standards of highest quality medical care. That is one of our goals. We will continue to work with all interested parties in trying to provide not only the best care, but proper facilities.

Senator ANDERSON. Thank you very much.

Dr. ROUSE. I shall leave with your secretary a little statement on health care costs, not for the record, but available if you need it. It summarizes our feeling of responsibility to let the patient get the most out of his health-care dollars. We are interested not only in the scientific part, but in our patients as individuals. We are concerned that they receive the most for their health-care dollars. I shall leave this with your secretary.

Thank you.

(Data referred to above follows:)

AMERICAN MEDICAL ASSOCIATION

HEALTH CARE COSTS[1]

Health care is now the nation's third largest industry, after construction and agriculture. It is destined to become the nation's number 1 industry within the next decade. Expenditures for health care, public and private, have risen dramatically in recent years, and there is every indication that these expenditures will continue to rise at an accelerated rate. If inflationary forces continue their impact on the nation's economy, it can be expected that the rate of expenditure for health care will exhibit the same inflationary expansion as will other industries. Many of the same factors which are increasing the demand for health care services are causing this sharp increase in health care expenditures, such as increasing affluence, expanding population, new legislation, increasing consumer sophistication, and technological advances.

In the light of these expansionist pressures, it is necessary that the profession be conscious of its role in the control of costs which accompany increasing expenditures and demands, particularly when the supply of the services demanded often cannot increase at the same pace.

The health and well-being of his patient has always been—and must continue to be—the first concern of the physician. And, today, he can effectively serve his patient as never before.

[1] Report of the Board of Trustees, approved by the House of Delegates at the Atlantic City Meeting, June 22, 1967.

He is well trained; he has at his disposal the techniques and insights of modern medicine, including an armamentarium of truly lifesaving drugs; and he has access to hospital facilities which are second to none.

To the patient, good health continues to be his most cherished desire. And his increasing demand for medical services is a reflection of his rising insistence that "want" or "need" be followed by "fulfillment" with a minimum of delay.

Today, however, the ability of the physician to serve his patient is being handicapped by the rapidly rising prices of the various components of health care. Each increase in the price of hospital rooms, diagnostic tests, surgical and medical procedures, or drugs makes it more difficult for the patient to finance his health care needs. Indeed, if the price of health care continues to outrun slower increases in consumers income, the problem of medical indigency will assume alarming proportions.

The causes of the rapid increases in the prices of major components of health care are complex and largely beyond the control of the physician. The health care system of the nation is overburdened; and the fever of inflation is but a symptom of the strain under which the health care system is laboring. Until the nation can close the gap between a rapidly rising demand for and a more slowly increasing supply of health services, rising prices will continue to confound the attempt of the physician to serve his patient.

In such an environment, the physician—out of his concern for his patient—must accept the additional responsibility of helping his patient conserve his "health care dollars." Together, the physician and his patient must face suppliers of the other components of health care and seek to acquire the necessary services and supplies with a minimum expenditure of the patient's dollars. When the price of a hospital room increase from $30 to $40 and even to $50 per day, the physician and his patient can only seek to reduce the number of days of hospitalization to the absolute minimum compatible with quality care. If the physician is satisfied that any one of three or four drugs will be effective, he can conserve his patient's health care dollars by prescribing the drug which in his judgment is most effective and carries the lowest retail price. Faced with the availability of multiple diagnostic testing procedures, the physician can begin to take their rising prices into account in measuring their proper place on a price-benefit scale. As a member of a hospital staff, he can help to assess the value of mandatory tests to his patient in the light of rising prices.

Physicians must continue their search for ways to increase their own productivity and efficiency so that professional fees can be stabilized and perhaps lowered at times in the face of rising costs. Furthermore, the privilege of a physician to charge usual and customary fees will continue to require prudence.

In summary, for the welfare of his patient the individual physician must now extend his responsibility by addressing himself to the challenge of helping him obtain high quality care with a minimum expenditure of dollars.

Collectively, the members of the medical profession should continue to concern themselves with the overall design of the nation's health care system and the basic problems which limit its effectiveness. These include—

Inadequate numbers of new physicians and shortages of other individuals trained to function as part of the health care "team."—This problem is already under study by the profession, and evidence is mounting that the nation can increase its physician population by demanding that medical schools give the training of more new physicians the highest priority.

The present organization and management of the nation's hospitals.—Historically, hospitals have been insulated from the discipline of the marketplace. The price of hospital care is a reflection of the hospital cost curve, and now these costs appear to be out of control. The hospital's privilege of automatically translating all higher costs into higher prices must now be questioned. Incentives for increased efficiency and productivity are mandatory.

Diagnostic and therapeutic care outside of a hospital.—Lower cost facilities for the institutional care of patients whose diagnostic or therapeutic needs can be met outside of a hospital in extended care facilities, nursing or convalescent homes or domiciliary type care warrant high priority. Home centered care also must receive increased attention.

Voluntary health insurance and prepayment plans must develop more effective means for providing coverage against the cost of care in these lower priced facilities, in physicians' offices, and in the home.

Legislation in the health field.—Many of the fundamental problems now facing the nation's health care complex can be traced to well-intentioned but ill-advised legislation. When the federal or a state government steps into the marketplace to purchase additional billions of dollars worth of health care from an already overburdened complex, the effects are serious and severe. These are but some of the basic problems which will continue to concern the American Medical Association. Successful efforts to resolve them, coupled with increased concern on the part of the individual physician for the limited financial resources of the patient, are challenges today to medicine.

Senator ANDERSON. Dr. Eliot.

STATEMENT OF MARTHA M. ELIOT, M.D., CHAIRMAN, MASSACHUSETTS COMMITTEE ON CHILDREN AND YOUTH

Dr. ELIOT. I am Dr. Martha M. Eliot, former Chief of the U.S. Children's Bureau. After retiring from that post, I became professor of maternal and child health at the Harvard School of Public Health. I am now retired from that post, but I am chairman of the Massachusetts Committee on Children and Youth, a Governor's committee to concern itself with all aspects of child life in the Commonwealth of Massachusetts.

I am pleased to be able to testify once again before the Senate Committee on Finance, on this bill, H.R. 12080, as passed by the House, but I would like to limit my remarks to the amendments to title V of the Social Security Act which provides now for maternal and child health, crippled children, and child welfare services.

This was a program I was most intimately associated with when I was Chief of the Children's Bureau.

First, I want to speak briefly about the Child Welfare Services which is administered by the Children's Bureau under authority delegated by the Secretary of Health, Education, and Welfare.

Section 235 of H.R. 12080 removes part 3 of title V, including these child welfare services, and places it as part B in title IV, where it would immediately follow the provisions for aid to families with dependent children.

The amendments to the child welfare service program greatly increase the funds that would be paid as grants to the States for child welfare services and broaden the ability of the States to provide more adequate social services, especially for day care services, foster home care, and services to children in their own homes. The high child welfare standards now in effect in the States under part 3 must certainly be maintained from this point on, even if the funds are greatly increased.

The report of the House committee indicates that most of the additional funds they expect to be spent for foster care, and they have also increased the ability of the States to provide more foster care for children under the aid to families with dependent children programs.

I understand that the recently announced reorganization within the Department of Health, Education, and Welfare, as ordered by the Secretary, will give the Children's Bureau responsibility for setting standards and providing consultative services to the States for the program of social services to AFDC children as well as to the child welfare services. In my opinion, this is a very good move on the part of the Secretary.

I believe it will at long last help to carry out the 1934 proposals of certain wise persons that grants to States for social services and cash assistance to dependent children in their own home under the proposed Social Security Act should be administered by the Children's Bureau in close association with the child welfare services for children who required away from their own home in foster care.

The Congress in its wisdom did not carry out these provisions, but placed the program of the AFDC in the Social Security Board in close association with public assistance to the aged.

It will take time, I am sure, possibly several years, before the changes that I believe are necessary in the social services for the AFDC children to be reflected satisfactorily in all State and local programs for dependent and neglected children, and the Congress, I believe, and the people must not become impatient if improvements did not come about overnight. There is a long history of lack of social services for these children, and it will take time for them to be developed from now on.

To provide adequate social services for the AFDC's children is possible, I believe, if sufficient funds to train and employ enough social workers are made available by the Congress and the States that many existing problems of these children, in the AFDC program, could be solved if this can be done.

Secondly, I would like to comment at somewhat greater length at the new proposals incorporated in section 301 of H.R. 12080, which is given the short title of Child Health Act of 1967.

This section makes some very desirable changes in parts 1 and 2 of title V, the maternal and child health and crippled children's services. The principal change is to consolidate into a single program the programs for maternal and child health services (part 1 of title V) and that for services to crippled children (part 2) and, by 1972, to incorporate the programs of special projects for maternity and infant care, children and youth, and dental care in the same single plan of services. If the Senate approves what the House has included in H.R. 12080 (title III, section 301)—and I very much hope it will—each State can by 1975, if the Congress appropriates the authorized amounts, develop a single comprehensive statewide plan of operation for all types of health services, medical care for crippled children, and related services for all mothers and for children whether normal or handicapped who appropriately come within it and wish to receive the services.

A single State plan for maternal and child health and crippled children's services developed under a single set of conditions for approval of the plan, with a few exceptions, will permit the States to avoid much duplication in preparing plan material and facilitate more effective utilization of the services offered under the broad provisions of maternal and child health for identifying crippled and handicapped children.

As the program becomes statewide, all crippled children could be enrolled in the comprehensive plan of health services that would be available for all children and youth in need of them. This will be the goal of the combined program by 1975.

The services for crippled children should become even more readily available for any handicapped infant, preschool, or school age child

who receives primary service in a hospital, clinic, child or community health center, a school health program, or under the medical assistance program in title XIX of the Social Security Act. Furthermore, the combined maternal and child health and crippled children's services should be readily available for the health care of all children coming under the provisions of both parts of title IV, as set up now in this bill.

The identity of the program for medical and related care for crippled children and children suffering from conditions that may lead to crippling will not be lost for specific funds will continue to be made available for it. In the 33 States where both programs are now operated by the State department of public health the operational integration of services provided through the use of maternal and child health funds and those provided by crippled children's funds can be developed to a high degree on a statewide basis by 1965, under the proposed combined program.

In those States where the State continues to elect to operate the crippled children's program in a separate department, commission or medical school, agreements can be worked out between State agencies to assure, through effective referral and followup, that all children coming under either program can and will benefit from all the services offered through either or both.

Likewise, more effective agreements can be developed by the agencies operating the combined maternal and child health and crippled children's services with other State agencies providing for community mental health services, social services to children and families, rehabilitation of handicapped youth and adults, employment services for youth, and care and treatment of juvenile delinquents or youthful offenders. This will make available the combined comprehensive health services to a much wider group of children and youth of all ages, and will increase the number of youth who could benefit from rehabilitation services.

That there should be a single State plan integrating the maternal and child health programs and projects and the medical care and related health and social services for crippled and handicapped children is very generally agreed upon, and the amendment requiring it included in section 301 of H.R. 12080 is believed to be forward-looking. It should be approved by the Congress and by the President.

An obvious corollary to this provision in H.R. 12080 that there be a single consolidated program of maternal and child health and crippled children's services in each State is that the primary responsibility for providing consultation service to the States and for establishing Federal standards for comprehensive care and for professional services to such an integrated program should rest in one Federal agency—the Children's Bureau.

At the Federal level these programs have been administered 32 years by the Children's Bureau. This assignment of responsibility should be continued. To do otherwise would be to disregard the gains of the past three decades, including the growth of both the maternal and child health and crippled children's programs; the recent very rapid increase in the number of infants and young crippled children who have come under care of the State crippled children's agencies—a 38-per-

cent increase since 1960—the innovative and imaginative developments in the care and treatment of most serious crippling conditions among children; in the development of special maternity and infant and children and youth projects; and lastly the achievements by the Children's Bureau in establishing and maintaining high standards of medical nursing, social, and hospital services for the crippled children under the care of State agencies and in the special maternal and child health projects.

From the beginning of the operation of the maternal and child health and the crippled children's programs in 1936 to the present time, the Children's Bureau has had a single multiprofessional team of consultants in regional offices to advise the States on both programs. In 1943 the Children's Bureau merged into one Division of Health Services, the then separate administrative divisions having responsibility for MCH and CC and gave the Director and his staff responsibility for both programs. The wisdom of this action was soon apparent in program operations in many States.

The teams of consultants to the State agencies must have wide knowledge of the content of a comprehensive maternal and child health service, including care of physically, mentally, and emotionally handicapped infants, children, and adolescent youth. They must also be judicious, imaginative, and innovative to help the State agencies develop new ways of providing health services to mothers and children, new techniques, and methods to be developed in special projects. They must be wise enough to recognize quickly new, imaginative, and innovative proposals by State agencies, institutions, or organizations. They must not be harried and bogged down in their work with the States by too many details or minutiae of procedure.

The success of the development of the maternal and child health and crippled children's State programs through these first 32 years of their existence has been the result of just these innovative and imaginative qualities of the Children's Bureau staff that has provided guidance to State agencies and cross-fertilization of ideas among State agencies, institutions, and organizations.

If the current proposal to consolidate and combine these programs into a single program is approved, the Children's Bureau should continue to have a single Division of Health Services at its headquarters in Washington and regional teams of maternal and child health consultants, knowledgeable about needs of all children and youth whether normal or handicapped throughout their growth and development. This policy has not only proved to be effective for the development of new ideas, new programs, new methods, but it has been the most economical administrative procedure.

Before stopping I want to refer again to the recent reorganization order within the Department of Health, Education, and Welfare.

The growth and complexity of the programs for services to people and the many complications of administration of these various and varied services no doubt called for major changes in lines of responsibility and decentralization of routine matters to the regional offices in which increasing authority of Federal-State program control is being placed. In this process it is important that the innovative, creative, and flexible ideas and contributions of the staffs of substantive bureaus,

like the Children's Bureau, not be lost to the States, but enhanced and the professional staff freed to be increasingly helpful to the States.

In this reorganization, attention is being focused by the Secretary on the needs of three groups of people in the population—the aged, children, and the handicapped. The decisions reached in the division of responsibilities among the units included in the new social and rehabilitation services cut through many old, established organizational lines.

If, however, it is the Secretary's intention to focus on the needs of children as one population group, I believe he will need to reconsider one move he has made in the light of the current proposal in H.R. 12080 that I have been discussing. I refer, of course, to his order transferring responsibility for the crippled children's program from the Children's Bureau to the Rehabilitation Services Administration. This transfer will raise many administrative problems. For 25 years the Children's Bureau has had a small multiprofessional staff without duplication of specialists at its headquarters. All staff members have served both programs. In the region, the team of consultants—one physician, one public health nurse, one medical social worker, one nutritionist, and one administrative methods consultant—have served both programs.

If the order is sustained, a second team of specialists for each region similar to that now in each Children's Bureau regional office would have to be recruited. This is inevitable because the knowledge of the workers and the consultation with States must cover comprehensively all the needs of children throughout their growth and development period—for handicapped children quite as much as for the nonhandicapped. The Children's Bureau could not release any of its staff because each type of worker is needed to advise on the maternal and child welfare program.

If H.R. 12080, title V, section 301 is enacted, and I strongly urge that you do so, it would constitute a major progressive step in the Federal-State child health program. I believe the Secretary would reconsider his decision to transfer the crippled children's program and withdraw the order. I hope that the Congress will satisfy itself that this will be done.

I thank you for giving me time to appear.

I have, however, prepared some additional notes on the interrelations and interdependence of maternal and child health and crippled children's programs and the Children's Bureau on policy of a single unified staff, and I would like to request that they be made a part of my testimony.

Senator ANDERSON. We will accept that.

Senator Curtis?

Senator CURTIS. Just one question.

Are you familiar with what the House bill does with respect to working mothers and nurseries for the children so that more mothers return to work, and if so, do you approve of what the House bill does?

Dr. ELIOT. In respect to the provision of getting more of the mothers of AFDC children to work, I would say that the way in which these provisions are administered is most important. To me, many of these mothers should not go to work. It would be better if they stayed at home and looked after their families. Some mothers may wish to go to

work, especially when their children are older, and the situation in the home makes it possible for her to go to work and add to the family income.

To include provisions that would essentially expect the States to force many mothers to go to work seems to me ill advised. I do not believe that all these mothers should go to work. But many, I think, could, provided the conditions in the home are shown to be satisfactory.

If adequate social services are provided to these families on AFDC, and if these social workers take into consideration all the problems of the children in the families before the mother is urged to go to work, I believe some of the mothers could satisfactorily do it. Actually, I doubt whether there is a very large proportion of the mothers under AFDC who would be—for whom it would be appropriate that they should go to work.

Senator CURTIS. Thank you very much.

Dr. ELIOT. Does that take care of your question?

Senator CURTIS. That is what I wanted to have your opinion on.

Senator ANDERSON. Thank you, Dr. Eliot.

(An addendum to Dr. Eliot's statement follows:)

SOME NOTES ON THE INTERDEPENDENCE OF MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES AND THE CHILDREN'S BUREAU POLICY OF A SINGLE, UNIFIED STAFF FOR PROGRAM ADMINISTRATION AND CONSULTATION TO STATE AGENCIES

Maternal and child health services and medical and related care for crippled children were established under Title V of the Social Security Act. They represented the climax of a longtime effort by many people and agencies to eliminate the hazards of pregnancy to mother and child, to assure life and health to every child, and to bring to every family the health supervision and medical and related care needed during maternity and childhood.

From its earliest days, the Children's Bureau has worked for the positive well-being in children and the prevention of handicaps. The prevention and treatment of the ills and handicaps of children flow together. These are the longtime premises followed by the Children's Bureau in its services under the maternal and child health and crippled children's programs. They stand as useful guides today and for the future.

The concept of teamwork grew up early in the maternal and child health and crippled children's programs. The Bureau, and the State agencies, recognized that the needs of mothers and children could not be met by any one professional group. Aware that these two programs were two sides of the same coin—a preventive and health-promoting program aimed at mothers and their children—in 1943, the Bureau merged the crippled children's division and the maternal and child health division into one unit: the Division of Health Services. Since then, the two programs have been inextricably bound together with a common mission: *better health for children.*

In the Bureau, medical social workers, nutritionists, physical therapists, psychologists, is well as physicians and public health nurses, became a team to work out in common the many problems that involved economic and social circumstances of children as well as their health.

The Children's Bureau staff, also organized as a team on a regional basis, carried forward this same concept in their working relationships with States. Thus, the Children's Bureau integrated its maternal and child health and crippled children's consultative and standard-setting activities in a single multiprofessional staff that serves as an advisory team in each region on all matters related to well and handicapped children.

States followed this same pattern in staffing their programs for guidance to and consultation with local areas. As a result, the line of team expert advice, standard setting, and consultation flows from the Bureau through its central and regional staff to the States and through them to the parents of the child in the community in which they live.

The maternal and child health program—through its child health conferences, maternity clinics, special projects for the care of premature babies, health services for school children, mental retardation clinics, and home visits of public health nurses—has aided in casefinding for the crippled children's program.

In addition to early casefinding, the maternal and child health program, from the beginning, emphasized services that would prevent handicaps by premature birth, congenital malformations, Rh factor incompatability, metabolic disorders, poor nutrition of expectant mothers, mothers' attitudes toward pregnancy or themselves, or other factors.

The crippled children's program made every effort to see that the handicapped child got the care and treatment that would restore him to the fullest health and activity capable. But at the same time, everything possible was done to prevent setting apart the crippled child from normal children. For the baby born with congenital absence of an arm or leg, a defective heart, club feet, brain damage resulting in physical deformity or mental defect or emotional disturbances, or for older children with acquired handicaps from disease or trauma, the goal was normal growth and development.

Depending on the care required, children move from maternal and child health programs to crippled children's programs. Often their care is overseen by the same pediatrician in both programs.

More than 436,000 children with crippling conditions received services during 1966 under the crippled children's programs in 53 States and Territories. About 60 percent of these children were under 10 years of age.

Many research findings of recent years and new methods for their application have been put to work in both programs, such as:

Chemotherapy to combat rheumatic fever.
Drugs to control epileptic seizures.
Polio immunization.
The diagnosis and treatment of congenital heart disease.
Chemotherapy in the treatment of tuberculosis.
Special Diets to control phenylketonuria (PKU) and so prevent in the long run many cases of mental retardation.
Measles vaccine.
Genetic counseling of parents.
Family planning.

Other program areas in the Children's Bureau reinforce and supplement both maternal and child health and crippled children's services and contribute to the establishment of high standards of care for both MCH and CC programs, such as:

The primary goal of the 53 special project grants for maternity and infant care, many of which have been in operation since April 1964, is to provide comprehensive medical care and health services to pregnant women in low-income families, hard-to-reach groups who might otherwise receive no prenatal care and inadequate follow-up in the interpregnancy period. Many of these mothers are "high-risk" maternity cases with an incidence of low birth weight infants almost three times greater than the Nation as a whole and with a higher frequency of brain damage, congenital defects, and mental retardation among their infants. In the crowded urban areas where many of these projects are located steady reductions in infant mortality have followed. Infants with congenital handicapping conditions have been located and brought under the care of pediatricians in clinics, child health centers or private offices, as well as that of specialists for the specific handicapping conditions.

The Special Projects for Children and Youth made available in 1965, offer comprehensive health and medical services to preschool and school age children living in low-income areas. The programs include preventive, diagnostic and treatment services, screening for defects, such as those of vision and hearing, correction of defects, dental care, and follow-up in the child's home and in clinics or hospitals to which children and families have been referred. Handicapped children who are located under these programs are offered the same full health service as all other children.

Services for mentally retarded children, usually under maternal and child health, but not infrequently assisted by crippled children's services, have expanded rapidly since the mid-50's when the Congress earmarked MCH funds to be used by the state departments of puublic health for the diagnosis, evalua-

tion, and follow-up care of young mentally retarded children by a multidiscipline team of health workers. By the end of 1966, of 191 mental retardation clinics 134 were supported in whole or in part by MOH or CO funds, or both. Cytogenetic studies and genetic counseling to parents are important components of these services.

Other resources stimulated by the Children's Bureau for development in either the MOH or the CC state programs or in the states' programs of child welfare services for the benefit of all children and families, including the handicapped, are family planning, programs for unmarried mothers and their children, and foster family care. Foster care, provided through child welfare services in public welfare departments, is commonly utilized for children who spend long periods of time away from their own homes while being treated for crippling conditions or chronic disease. All these services, and others, are available to mentally retarded children and their families.

The children seen in the crippled children's programs and the mental retardation clinics, present increasingly more complex handicaps, especially neurological handicaps. As a result, during 1966, the Bureau put increasing emphasis on the development of multi-discipline centers for multiple handicapped children. By the end of the fiscal year, the Bureau was supporting such projects in 12 medical centers.

Health and welfare services are used in the care of children living in institutions and day care facilities.

Research and demonstration programs are used to advance the development of both of these programs of service to children and their families. These may be so broad as to include demonstrations concerned with special aspects of maternal and child health; special programs for certain handicapped children; research into causes and prevention of family breakdown; rising rates of delinquency; research concerned with services to the retarded child, foster care, special aspects of maternity care, adolescent health, day care centers, homemaker service; the influence on children of such social factors as increasing family mobility, deprived neighborhoods, the ever-spiraling costs of medical care.

Many training opportunities are made available to a variety of medical and health workers through Children's Bureau funds directly or in cooperation with universities and agencies.

Long experience shows that babies and children with physical and mental handicaps need and should receive every care and help for their growth and healthy development, according to their individual capacity under conditions most helpful to all children. A handicapped child is first of all a child. He must be so regarded by parents and all persons contributing to his physical, mental, social or emotional growth, development, and well-being. If he is to grow and develop into a healthy and productive adult and an emotionally and socially responsible individual, he must be cared for and his growth and development supported in the light of all new knowledge that will assure that development.

Children with all types of handicaps, from the least to the most disabling, deserve to have the benefit of all such knowledge as well as those children who have no discernable handicaps. The emotionally disturbed child, the mentally retarded infant, the infant or child amputee, the child disfigured from a burn, the paralyzed, the athetoid, the child with a congenitally deformed heart, the deaf or the blind child, the prematurely born infant, all require the same pediatric care and public health nursing that should be available to all well and normal children.

By developing and implementing the principle of treating a crippled child first as a child, the Children's Bureau has done an enormous service to all children and to the Nation. For more than 30 years, the Bureau has pioneered in establishing standards of medical care, health and social services for all children, the normally developed and the handicapped. The Bureau has shown courage in establishing and maintaining measures to institute and protect standards of care. This applies equally to the child welfare programs and to the maternal and child health and the crippled children's services.

An intimate relationship must exist between the maternal and child health and crippled children's programs if they are to continue to make an effective contribution to the health of mothers and children. Together they must remain close to the Bureau's social services in the matrix of all services sponsored by the Children's Bureau—services so essential to the health and welfare of children everywhere in the Nation and beyond.

Senator ANDERSON. Dr. Volpitto.

STATEMENT OF PERRY P. VOLPITTO, M.D., AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INC.

Dr. VOLPITTO. Mr. Chairman, and members of the committee, my name is Perry Volpitto, M.D., professor and chairman of the department of anesthesiology at the Medical College of Georgia and director of anesthesiology of the Eugene Talmadge Memorial Hospital of Augusta, Ga.

I am appearing on behalf of and as past president of the American Society of Anesthesiologists, Inc. I testified on this same subject before this committee in 1965, and in April of this year before the Committee on Ways and Means of the House of Representatives. I am chairman of our society's committee on legislative activities. I have with me Mr. John Lansdale, for many years counsel for our society.

I am here to oppose that part of S. 110 which would amend title XVIII of the Social Security Act to include payment under part A thereof of the costs of hospital inpatient professional services in the fields of pathology, radiology, physiatry, and anesthesiology furnished by a hospital or by others under mutually agreeable arrangements between the persons providing such services and the hospital.

As you know, the Social Security Amendments of 1965, Public Law 89-97, cover such services as physicians' services under part B of title XVIII. In our judgment this arrangement should be retained and S. 110 and similar proposals should be rejected.

Senator CURTIS. May I stop you there?

Dr. VOLPITTO. Yes, sir.

Senator CURTIS. Are these objectionable features incorporated in the bill as it passed the House?

Dr. VOLPITTO. No, sir; the bill, the features that we are referring to are not included in the House version of the bill, and we would accept the statement made by Dr. Rouse this morning in treating section 131 as to this matter. In other words the administrative problems referable to radiology and pathology, for example, are not and have not ever been a problem as far as we are concerned.

Senator CURTIS. So in speaking against S. 110, it is not to be construed that those provisions are incorporated in the House passed bill?

Dr. VOLPITTO. That is right, sir.

Senator CURTIS. Does the House passed bill clarify the situation at all over the 1965 act?

Dr. VOLPITTO. Yes; it does.

Senator CURTIS. In fact it is better?

Dr. VOLPITTO. I think so.

Senator CURTIS. All right.

Dr. VOLPITTO. The facts which I will present will necessarily be confined to the adverse effect upon anesthesiology of any legislation which would classify this specialty as a hospital service in any degree or to any extent. The other provisions of S. 110 do not affect anesthesiology specially and we, therefore, do not take a position with respect to them. You will no doubt receive comment on those provisions from those who may speak for a broader segment of medicine than we.

An anesthesiologist is a physician who specializes not only in anesthesia as related to surgery and obstetrics, but also in resuscitation,

whether respiratory or cardiorespiratory in nature, management o coma from drug overdosage, inhalation therapy as applied to acut and chronic pulmonary conditions, management of the patient i shock, whether it be a medical or surgical problem, and the diagnosis and management of acute or chronic pain occurring other than durin surgical procedures. This medical specialty is known as anesthesiology.

The physician who specializes in anesthesiology is to be distinguished from the technician or nurse anesthetist who may perform th physical act of administering anesthesia under the direction of an upon the responsibility of a physician.

Normally the anesthesiologist practices in the same manner as other physicians who have direct contact with patients in a hospital. They bill and collect for their own services. There are no circumstances requiring or suggesting any financial relationship with the hospita and in recent years there have not normally been any.

When Senator Aiken introduced S. 110 on January 11, 1967, he stated, according to the Congressional Record, that one of the major proposals of this bill is "to pay medical specialists' fees customarily provided by the hospitals." We have some knowledge of anesthesiology and with respect to that specialty Senator Aiken was misinformed by those who advised him on the subject. Anesthesiologists customarily deal directly with their patients as do other physicians. There was a good deal of testimony on this subject before this committee in 1965 but no witness claimed that anesthesiology was customarily a part of hospital service nor that anesthesiologists were customarily paid by or through the hospitals.

These basic facts were fully recognized in the Social Security Amendments of 1965 and there is no evidence to our knowledge indicating that the present arrangements are not operating satisfactorily. It does not appear that those who administer medicare have requested any change in the method of handling anesthesiology.

The necessary effect of amending the act to classify anesthesiology as a hospital service would be to subject physicians specializing in anesthesiology to tremendous pressure to become employees of hospitals so as to permit hospitals to bill and collect for their services, in order for the beneficiaries of medicare to receive the benefits intended.

This seems unfair and we are sure that is unwise. The anesthesiologists have spent many years getting out of this very position. Anesthesiology is one of the newest of the medical specialties. It has made enormous strides during recent years.

Somewhat belatedly physicians have recognized anesthesiology as a vital aspect of the practice of medicine and the number of anesthesiologists has increased at a rapid rate. It is now clear that continued advances in the art of anesthesia and increases in the number of physicians devoted to it are of prime importance to the continued advance of surgery, and the care of elderly and "poor risk" patients.

The stature of anesthesia as an independent medical specialty, practiced like other medical specialties which involve intimate contact with the patient, is of crucial importance in continuing to attract able young physicians to the specialty.

For this reason the specialty has made an enormous effort to bring the mode of practice of anesthesiology into line with the standards

which exist for the other clinical specialties. This effort has now succeeded to a substantial degree.

Recently the society conducted, with professional assistance, an intensive survey of the specialty with particular attention to how it could attract still larger numbers of able young physicians and improve the coverage and care provided for patients.

This survey demonstrates beyond peradventure that it is vital to the future of the specialty that the anesthesiologists should practice as do other independent physicians and not as a hospital service. The enactment of S. 110 and the consequent inclusion of anesthesiology in medicare as a hospital service would, we sincerely believe, have a very serious adverse impact upon the practice of medicine and thus upon the beneficiaries of medicare, without any substantial offsetting benefits to them. We, therefore, urge most strongly that S. 110 and all similar proposals be rejected.

Thank you very much for allowing us to present this statement, Mr. Chairman.

Senator ANDERSON. There was a bill relating to medical specialists introduced by Senator Douglas at one time.

Dr. VOLPITTO. Yes, sir, that is correct.

Senator ANDERSON. The Douglas amendment provided that if the hospital billed for the service it would be paid from part A, and if the physician billed directly for the service, it would be paid under part B.

Dr. VOLPITTO. We realize this, sir, but inasmuch as this involves only a very small proportion of the people involved in anesthesiology the very existence of such a provision would be detrimental to recruitment of physicians for our specialty unless a similar provision were made for all physicians.

Moreover, the deductible and coinsurance features of part A are such that the hospitals would be enabled to put unfair pressure on anesthesiologists to change to part A arrangements in order to give greater benefits to patients. This would put anesthesiologists in the unhappy position of having to choose between a mode of practice which they believe to be destructive of their specialty or denying increased benefits to their patients.

Senator ANDERSON. Anything further, Senator Curtis?

Senator CURTIS. No further questions.

Senator ANDERSON. We will resume at 10 a.m., tomorrow morning.

(Whereupon, at 11:55 a.m., the hearing was recessed until 10 a.m., Tuesday, August 29, 1967.)

SOCIAL SECURITY AMENDMENTS OF 1967

TUESDAY, AUGUST 29, 1967

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

The committee met, pursuant to notice, at 10 a.m., in room 2221, New Senate Office Building, Senator Clinton P. Anderson, presiding.

Present: Senators Long, Anderson, Talmadge, Williams, Bennett, Curtis, and Morton.

Senator ANDERSON. The hearing will come to order.

This morning we continue hearing witnesses who desire to address themselves to H.R. 12080, the Social Security Amendments of 1967. Generally speaking, today's testimony will be directed to the work and training features of the House bill. These provisions stress employment as an ultimate goal of public welfare to a greater degree than our laws previously have done.

This, in turn, has raised questions as to whether a welfare mother's proper role is to remain in the home and care for her children at Government expense, or get out and work to provide for them by her own earnings. In weighing these questions, it should not be overlooked that the House bill extends $205 million in 1968 for new services—principally child care facilities—to aid mothers who participate in work and training programs. By 1972 this new expenditure will total $700 million and the savings in welfare payments because of it will total only $130 million.

Our first witness this morning is the Honorable Robert F. Kennedy, Senator from the State of New York. Senator Kennedy has a rather comprehensive social security benefit bill pending before this committee. It provides for sharp increases in benefits with the range of benefits ranging upward from $100 per month to $362 per month. To pay for these higher benefits, his bill would increase the taxable wage base to $15,000 and provide a combined employer-employee tax of 11 percent. In addition, his bill would initiate general revenue financing under which about one-third of social security benefits would be paid out of the General Treasury.

Senator Kennedy, we are pleased to have you with us again. We know how much interest you have in this field in this connection. We are pleased to hear you and have your testimony.

STATEMENT OF HON. ROBERT F. KENNEDY, A U.S. SENATOR FROM THE STATE OF NEW YORK

Senator KENNEDY. Mr. Chairman and members of the committee, in the midst of our great affluence, there remain 30 million poor people

88-281 O—67—pt. 2——4

in this country today. That fact, more than anything else, is what these hearings are about.

For, despite the growth of our social security system over the years, a fifth of those living in poverty are over 65. These years should bring them a life of peaceful comfort and dignity—but instead retirement means a life beset with financial problems, burdened with dwindling savings and unpaid bills. Millions more approach 65 with apprehension—they know that when they stop work they begin not the golden years, but years of life in poverty.

And, despite the growth of our public welfare programs over the years, welfare at present aids less than a fourth of the 30 million poor. And, those who receive aid often do not get enough to satisfy even their barest minimum needs. For too many on welfare and for the rest of the poor, there are only days of misery without enough food for their children, and nights of fear in substandard housing, warding off marauding rats. And, for those receiving assistance, there are also complex and degrading procedures; there are rules designed to qualify eligible applicants which often serve to disqualify or discourage people in need; there are rules which force families to stay apart in order to receive aid. For too many, then, welfare is not only inadequate, but appears as a reluctant handout designed to screen the poor away from the rest of society.

These figures, these conditions, these procedures define the magnitude and importance of the task before your committee. And they also suggest the utter inadequacy of the legislation which the other body has sent over for us to consider. That legislation includes some good changes—the ideas of offering job training, day care, and work incentives to welfare recipients in order to enable them to seek productive employment; some changes that are not good enough—the increase in the minimum social security payment to $50 and the 12½ percent across-the-board increase in benefits; and far too many changes which can only be described as plainly regressive—a series of public welfare amendments which, taken together, reflect a punitive attitude reminiscent of medieval poor law philosophy and will result in reduced assistance for millions in need, and a ceiling on title XIX assistance that is unrealistic and unworkable. Let me, if I may, Mr. Chairman, discuss these matters briefly.

First, on social security. Our social security system has grown extensively over the years, so that 95 million people are now insured and 23 million receive benefits; but we have not yet succeeded in lifting millions of older Americans into a retirement of security and self-respect. Secretary Gardner told you last week that social security is the major source of income for nearly all retired beneficiaries, and the sole source for half. About 14 million retired workers and their dependents receive benefits. And last year these benefits averaged $84 a month—just $1,000 a year for individuals, and $142 a month—$1,704 annually—for couples. In light of these figures, it is not surprising that some 5 million to 7 million retired Americans live in poverty.

We in Congress must share the responsibility for the inadequacy of retirement benefits. The two increases of 7 percent which we enacted in 1958 and 1965 actually fell short of restoring the 1954 purchasing power of benefits—for the cost of living has risen about 25 percent since

that time. Thus, four-fifths of the 12½-percent increase provided in the House bill would be taken up just to give beneficiaries as much real income as they would have had in 1954. Meanwhile, wages have risen about 50 percent in those 13 years. The wealth of our Nation has steadily increased but, because of our neglect, our older citizens have not shared in that affluence—instead, more elderly couples each year retire into a life of poverty.

With 10 Senators of both parties, I introduced legislation earlier this year to make up for the ground we have lost. That bill, S. 1009, would provide benefit increases averaging over 50 percent, and, crucially, would finance these increases by a gradual infusion of general revenues. It envisioned a leveling off of general revenue contribution at 35 percent of the costs of social security by the late 1970's.

At the moment, when we are engaged in a deepening war in Vietnam which saps our resources and consumes over $2 billion each month, it seems impractical to urge the full scope of these proposals.

I believe, however, that it is time we began a partial changeover to general revenue financing.

The payroll tax is scheduled under present law to increase to 4.85 percent each on employer and employee in 1973, plus a contribution for health insurance. The House bill would raise that to 5 percent each, plus 0.65 percent for each health insurance. As members of the committee well know, a tax on payrolls is highly regressive. For low-wage employees particularly, a required contribution beyond that contemplated in the House bill would be very burdensome. Many workers already pay more in payroll taxes than they do in income taxes.

General revenue financing would be a far more equitable way to raise revenues for the social security system, particularly revenues which would be used to provide additional benefits for low-income people—for those who worked either so irregularly or at such low wages that their contributions do not really finance the benefits they receive.

I emphasize this because the proposal I shall make this morning to broaden the scope of H.R. 12080 would give relatively more help to the poorest of our elderly, to those who have the most difficulty in finding dignity and comfort in their retirement. If we are to provide a meaningful floor of protection for older people as a matter of social insurance, I believe it is only fair to other workers that we finance it through general revenues.

I propose that the committee raise the across-the-board increase in benefits to 20 percent, weighting it, if possible, toward those beneficiaries at the lower end of the spectrum. I propose, in addition, that the minimum benefit be raised to $100 a month, $150 for couples. These proposals combined would produce an average benefit increase of 29 percent.

To finance this proposal, I suggest, first, that the contribution and benefit base be raised to $8,400 next January and to $10,800 on January 1, 1971; and second, that general revenue contributions be infused at the rate of 11 percent of the total financing of the system beginning in 1972.

This plan is feasible. I am assured by officials of the Social Security Administration that it is in long-range actuarial balance.

The increases in the contribution and benefit base are no more than what the administration proposed in H.R. 5710, except that the $10,800 figure would go into effect 3 years earlier than the administration proposed. This is substantially less than was proposed in S. 1009, under which the base would have risen to $15,000 on January 1, 1971.

These increases in the earnings base are justified to bring the social security system up to date. For 87 percent of American workers the $10,800 figure would result in benefits based upon everything they earned—a comprehensiveness of coverage lost nearly 30 years ago as workers' incomes grew faster than the earnings base was increased. For the man already 50 years old, for example, this change would mean an increase of over 40 percent in the benefits he will get when he retires.

In contrast to S. 1009, the general revenue contributions would not have to begin until January 1, 1972. What this means is that we would be promising now that we would spend $4.5 billion a year beginning 4½ years from now. It does not seem to me, Mr. Chairman, that that is extreme. I think also that when we talk about social security and about welfare we must realize that our welfare payments here in the United States are a smaller percentage now of our gross national product than they were in 1950. So, although I understand all of the demands on our economy at the moment, and although I have for that reason changed some of the suggestions that I made in the original bill, S. 1009, it also seems to me that by 1972, with the increases in revenue that we will have and with the great problems that our elderly people face, we could afford $4½ billion at that time.

I believe this is a promise we can and must make. It is not a huge amount of money. Our gross national product will exceed a trillion dollars by that time, and 1972 is far enough off so that we can easily plan to set aside this amount of money. What we get for this promise is a 20-percent increase in benefits now, plus what I regard as all important—the increase in the minimum payment to $100. It is just impossible, Mr. Chairman, now for our elderly people to be able to survive on the benefits they receive under social security.

I might add that an across-the-board benefit increase of an additional 5 percent beginning January 1, 1970, could be obtained for a relatively small additional promise of general revenues, and I would urge the committee to consider that as well.

The net cost of the increase which I propose would be considerably less than the financing I have described. For the people who will benefit from this increase are people who must now turn to old-age assistance in order to eke out enough of a living to survive. Old-age assistance has decreased markedly over the years as social security benefits have been liberalized. Only 11 percent of the elderly population receives such assistance now, as opposed to 22 percent of the population in 1950. Even now, more than half those receiving old-age assistance in New York are on welfare because their social security pensions are inadequate. Thus, raising the minimum benefit to $100, and raising other benefits 20 percent or more, will correspondingly decrease the number of people on the old-age assistance rolls and the amounts which those who remain on the rolls will require.

S. 1009 contained a number of other proposals for the liberalizing and up-dating of the social security system, but I would emphasize only two at this point.

First, I would urge that the committee consider a cost-of-living provision to make social security inflation-proof, and to insure that future benefit increases granted by Congress do more than just make up for lost ground. The civil service and military retirement systems have cost-of-living adjustment features. It is time the social security system did likewise, although I emphasize that this must not be at the expense of benefit increases which allow older citizens to share in our expanding productivity.

Second, I hope the committee will consider raising the benefits for the uninsured to $50 a month for individuals and $75 for couples. The House bill raised this benefit only to $40. There are 1.2 million people, many of them quite poor, who have been helped by this constructive addition to the law. The difference in cost between the House bill and the $50 figure would be about $163 million annually from general revenues and $28 million from the trust fund. I hope the committee will decide upon the higher figure.

Mr. Chairman, what I have suggested are, I think, the minimum changes which we in the Senate must make if we are to keep faith with our older citizens. The conditions in which millions of retired Americans find themselves after having worked productively for decades are a disgrace to us all. Adoption of the proposal I have described would begin turning our social security system in the direction long advocated by experts in the field, and would allow us to provide real hope at last to our elderly poor, that they will be able to live out their lives in some measure of ease and self-respect.

About a year ago, the distinguished members of the President's Advisory Council on Public Welfare reported that welfare is "desperately handicapped" in both "legislative mandate and * * * financial resources." The Council prescribed "a major updating of our welfare system."

The House bill which is before you today not only fails to heed the Council's prescription, but is in my judgment, a major step in the other direction.

I can well understand what motivated the other body in its action. It was concerned that the welfare system as it exists today has failed to enable its recipients to obtain jobs and end their dependency. I share that concern. It was concerned at the recent rise in the number of children and mothers on aid to dependent children. I share that concern. It, therefore, sought to create a system which would train children and mothers on welfare, provide day care, and establish incentives to work. I, too, believe such a system is needed.

Indeed, I believe that we will never succeed in restoring dignity and promise to the lives of people whose frustration exploded into violence in the cities this summer until we develop a system which provides jobs—enough jobs and good jobs.

For the people of the inner city live today with an unemployment rate far worse than the rest of the Nation knew during the depths of the great depression. In the typical big city ghetto, only two out of five adult men have jobs which pay $60 a week or more—enough for each member of a family of four to eat 70 cents worth of food a day. Only half the adult men have full-time jobs at any rate of pay. Less than three out of five have any work at all.

I have suggested that we need an immediate impact project designed to put men to work and to restore some sense of hope to the young and the unemployed residents of the city slum. We should begin immediate programs of needed public tasks and works—providing jobs to build schools and roads, to restore parks and erect clinics, and to staff the schools and clinics and neighborhood centers when they are built. Our communities need these jobs done and the men of the ghetto need jobs. By matching the two we can return hope while meeting the most urgent needs of the Nation.

We must, then, work out a system to provide jobs. But, I do not believe that the approach adopted in the House bill will provide these jobs. The fact is, as the alarming unemployment and underemployment figures I have mentioned indicate, that there are not enough jobs available at the moment. We must find them, but in the meantime, it will not do to force people into training programs for jobs that are simply not there. That will only increase the pent-up frustration which has already exploded too often in the past. In the meantime, also, we must not continue to place a premium on broken homes as the condition for obtaining public assistance. And, we must not end up by venting our own frustration in a measure punishing the poor because they are there and we have not been able to do anything about them. They will still be there when we are done. It is not as though people choose to be poor, to need welfare assistance.

Consider, for example, that we have a school system in our slums which is plainly unsatisfactory. Of a quarter of a million Puerto Rican schoolchildren in New York City, only 37 went on to college last year. If young men are unskilled and unprepared for employment, then the schools which left them so heavy a burden bear a heavy share of the responsibility.

Nor, of course, is the problem merely in the schools. For the rest of ghetto life also there are statistics: 43 percent of the housing substandard and overcrowded; 14,000 people treated for rat bites every year; infant mortality at twice the normal rate; and, because of inadequate diets and medical care, mental retardation at seven times the community level.

These are matters we must look to. For these problems welfare is neither the cause nor the remedy. But, welfare has its job—helping those in need—and the bill before you will hinder it in doing that job. Indeed, instead of helping at all, it almost appears intended to punish the poor. And punish it will, particularly in areas of the country where welfare authorities have done their best to demean and degrade the recipient of welfare even under existing law.

First, the House bill says that no State may have a higher percentage of children on welfare than it had at the beginning of this year. Commissioner Ginsberg of New York City said the other day that this would force States and localities either to deny additional aid when more children are born into a family, or to come up somehow with the money needed to pay the difference. The latter, of course, would shift the burden from the level of government that can best afford it to the one that can least afford it. There is a third possibility—to find ways to cut enough families off welfare to stay within the freeze. This possibility cannot be discounted. For the House bill, with

all of the other restrictions on eligibility which it contains, is an open invitation to welfare departments in some areas of our country to find ways to tidy up their caseloads and discourage new applications.

Second, the coercive provisions on community work and training fit into this pattern. The objective of enabling welfare recipients to obtain productive employment is, of course, laudable; indeed, as I have indicated, I believe it is the only hope we have for avoiding the deep division in our society which is the creation of a permanent class of welfare poor. But, attempting to bring about employment by compulsion is not the way to do this. There are many mothers who should not work. Some, particularly in progressive States and and cities, will be excused from working. But, in other States with less enlightened welfare programs, many will either be driven off the welfare rolls or will be discouraged from applying, and they will still be poor—Mr. Chairman, a little more invisible, for the time being, than they are now, but no less poor, and no less miserable.

There is more than one State in this country which, even under existing law, has had what has come to be known as the "employable mother" rule. Under this rule, if the welfare officials judge the mother to be employable, she is stricken from the rolls. Coincidentally, these rulings tend to be made at the time of the year when people are needed to pick crops at $3 a day. This rule is being challenged in litigation, but the provisions of the House bill on compulsive work and training imply that from now on the "employable mother" rule would be sanctioned by a national policy.

Third, the punitive intent of the House bill is evident as well in the provisions on aid to children with unemployed parents. For the first time, the parent must have had a substantial connection with the labor force in order to qualify, a provision which will eliminate many men who have never had an opportunity for steady employment. In addition, the provision denying assistance to unemployed parents who have applied for or are receiving unemployment compensation will keep aid from many who need both forms of help in order to survive, and will cause some to receive neither kind of aid. The House provision will only succeed in forcing more families to break up, forcing more fathers to leave home so the family can obtain assistance by the traditional ADC route.

Fourth, the provisions giving States an incentive to provide custodial care for illegitimate children are also punitive. Once an illegitimate child is born, although we may have wished to discourage that from happening, his best hope is to grow up in some kind of family structure. Study after study shows that the worst thing that could be done is to consign him to an institution. So we punish illegitimacy by punishing the illegitimate child.

We in the Senate must go on record as opposing this almshouse approach. We must go also on record, it seems to me, as forcefully as we can that this is not the direction which we want welfare to take. We must not allow this backward step. What I would recommend, therefore, is that the Senate use H.R. 5710, President Johnson's original set of welfare recommendations, as its working bill. That bill's recommendations were limited, to be sure, but they were at least not regressive. The expanded training and day care provisions which the

House adopted can then be included but without the meat-ax compulsions which the House bill attached to them.

I would particularly urge the committee to provide a greater work incentive than the $30 a month plus one-third of additional earnings which the House enacted. This incentive is so small that it may well fail to encourage significant numbers of welfare recipients to work, and opponents of the idea may then succeed in claiming it will never work.

I also urge the committee to adopt the administration's proposal regarding the management of the community work and training program. The Department of Labor had the potential to bring a job-oriented approach to the training involved, and has a developed system of placement services. The House bill, in my judgment, will waste resources by creating an unnecessary overlap between the Department of Labor and HEW which should be avoided.

Let me emphasize again that I do think our welfare system is unsatisfactory. But, every reason why I think it is unsatisfactory will only be accentuated by the House bill.

I believe our welfare system is unsatisfactory, because, in general, it provides aid for broken families and not for whole ones. In other words, it encourages broken families, Mr. Chairman. The House bill accentuates this by refusing to adopt the recommendations of H.R. 5710 to expand aid to unemployed parents, and by restricting that program instead.

I believe our welfare system is unsatisfactory, because it imposes degrading conditions on eligibility, and encourages the enforcement of those conditions by demeaning investigation. The House bill accentuates these defects by adding a whole raft of new conditions for eligibility and a whole new set of incentives for the State to investigate welfare recipients. We started a system, and it has been done in other areas, for an affidavit procedure and it seems to me that we could at least make an effort to move in that direction. It would be more satisfactory. It would save a great deal of money, in my judgment, in the administration of the program at the moment and also be not nearly as demeaning for the recipients of these systems.

I believe our welfare system is unsatisfactory because, once a family does penetrate the bureaucratic maze and qualify for aid the benefits it receives are in many States not even enough to live on. The House bill accentuates this by refusing to require States to meet their own definitions of minimum need, as H.R. 5710 proposed, and by enacting instead a freeze on ADC payments.

The Advisory Council's report called for "a nationwide comprehensive program on public assistance based upon a single criterion: need." What a grim joke that is today as we look at the way in which the House bill gives heed to those recommendations.

A month ago, the prestigious American Public Welfare Association issued a major series of recommendations to make our welfare system into an effective program and weapon in the war on poverty. The APWA proposed simplifying eligibility for welfare and redeploying investigatory social workers to provide meaningful social services. It also proposed meaningful work incentives to allow welfare recipients to work without losing a dollar of their benefits every time they

earn a dollar. What a sad thing it is to see the twisted application of these thoughtful recommendations in the legislation before you. It seems to me, Mr. Chairman, if we say to a welfare recipient that every dollar he earns when he goes to work he is going to lose on welfare, that he is going to stay on welfare. It is more attractive for him to stay on welfare. So, it seems to me, what we want to do and I know this committee wants to do is get people off welfare and get people on jobs. The way to do that is to provide the jobs and provide the training and also make it attractive for a person to get off welfare.

It seems to me the House bill makes it attractive for them to remain on welfare and not go to work and I think that is where our emphasis must be. And, I do not think that the House bill does that.

Mr. Chairman, we must have the perspective to see that the welfare system is not something that exists by itself, that has no effect on the world in which its recipients live. We cannot afford to bury our heads in the sand. Our Nation has been ripped apart this summer by violence and civil disorder that have taken dozens of lives and caused billions of dollars of damage. We face in our cities the gravest domestic crisis to confront this Nation since the War Between the States. We are not going to solve that crisis by lopping people off the welfare rolls. We are not going to solve that crisis by forcing welfare recipients to accept training for jobs when we have absolutely no idea whether jobs will be available to them after their training. We are not going to solve that crisis by punishing the poor and hoping that they will bear that punishment silently, invisibly, graciously, without bitterness or hostility for their "benefactors."

What we should be talking about here today is the enactment of H.R. 5710, and how to improve upon it as we pass it.

We should be discussing whether we are going to require the States to meet their own minimum definitions of need; instead we are constrained to decide whether we are going to lift an unconscionable freeze on the amount of Federal aid to dependent children.

We should be discussing whether we are going to provide a greater incentive than that contained in H.R. 5710; instead we are forced to discuss whether to repeal the compulsions for work and training in the bill before us.

We should be discussing a national mandate to simplify eligibility for welfare; instead, we have to talk about whether we are going to strike restrictive conditions on eligibility added by the House bill.

We should be discussing ways to afford welfare recipients participation in making the policy of the agency which governs their lives; instead, we are confronted with a bill whose whole approach is not to listen to those recipients.

We should be discussing how we can make the welfare system more honest with itself and its recipients, how we can make sure that recipients can receive a full hearing when their benefits are in jeopardy; instead, we hear talk about ways to strike them from the rolls.

We should be talking about integrating welfare into our efforts to help poor people generally instead of viewing it as an isolated problem susceptible of being solved by new and greater restrictions.

Mr. Chairman, I urge the committee to reject title II of H.R. 12080, and develop a constructive set of proposals which the Senate can be proud to enact.

The last matter I would discuss is the provision in the House bill placing a limit on Federal participation in programs under title XIX.

The administration's proposal in H.R. 5710 was vastly different and less destructive from what the House enacted. H.R. 5710 proposed a ceiling at 150 percent of each State's public assistance definition of minimum need. This provision would have forced a significant cutback in our program in the State of New York, and I was, therefore, not happy about it. I believe that we should not default in our commitment to bring better health care to those members of our population who have difficulty in paying for medical attention. We have our problems in the State of New York, but I think the appropriate place to resolve those problems is within the State.

The House bill is much worse for all of the States and also the State of New York. Commissioner Ginsberg tells me that it will force the standard for a family of four to be cut back from $6,000 to $3,900. Since New York would have gone to $5,200 this year under the previous Federal programs, wholly apart from medicaid, this intrusion is wholly unreasonable.

But the House bill will be equally disastrous elsewhere. For, instead of looking to a State's definition of minimum need, it looks to the amount which the State actually pays its public assistance recipients. Title XIX intended that medical indigency be defined at a level substantially in excess of a State's public assistance definition of minimum need. The House bill will in many States have the opposite effect, and is therefore, totally unrealistic.

For example, Mississippi, according to HEW figures, was paying 22.8 percent of minimum need to its ADC children in January of this year. When the 133⅓-percent limitation in the House bill goes into effect, the ceiling for medical assistance in Mississippi will be approximately 30 percent of its own definition of minimum need. The State of Ohio is another good example. In January of 1966 its definition of minimum need was $224 a month for a family of four. However, its ADC payments were actually $170 a month for a family of that size. When the 133⅓-percent limitation goes into effect, the ceiling on medical assistance for a family of four in Ohio will, therefore, be approximately $227 a month—an unacceptably low figure.

What is really involved even in the 150-percent limitation originally proposed is a failure of insight about the connection between ill health and dependency, a failure to realize that the provision of adequate health care to the poor depends upon an infusion of funds of the magnitude which title XIX as originally enacted was intended to supply.

If we cut into title XIX, we cut into the possibilities of better health care for the poor. It seems to me, Mr. Chairman, that we must not do that.

Let me suggest, however, that the committee might well allow for variations in eligibility levels within a State. The services provided under a title XIX plan appropriately begin to allow variations in eligibility based on differences in the cost-of-living within the State.

Mr. Chairman, the suggestions I have made to change the social security provisions of this bill are neither radical when viewed in light

of the clear needs of the Nation's elderly, nor are they a revolutionary departure from past social security theory. Rather, I believe they are the beginning of reform, the steps we can take now—they are fiscally sound changes in an inadequate structure.

By increasing benefits we can provide a more secure future for millions of elderly Americans. By raising the contribution base we distribute more equitably the cost of these benefits. And, by turning toward general revenue financing, we insure that the noncontributory aspects of social security will be financed out of the progressive income tax rather than the regressive payroll tax, easing the burden on middle and lower income wage earners.

The unsatisfactory and regressive features of the House welfare provisions should be manifest. It is unfortunate that we must retrace our steps to correct these errors. But, it seems to me, we ought not hesitate.

We must act now to reform the archaic structure of rules and conditions that impose penalties on the poor for their misfortune. We ought to assist people to lift themselves out of poverty, with training and jobs and income. But, it is a senseless ethic that punishes the poor, or disrupts family life, or tears children from their mother.

The frustration of poverty, the fury induced by want in the midst of affluence is not assuaged by foolish and debasing rules of eligibility. We must restore sense to this legislation so that we can restore hope to millions of people. That mandate should guide us in our deliberations.

The CHAIRMAN (presiding). Thank you for a very well thought out and comprehensive statement, Senator Kennedy. I think you perhaps know that some of the things you are advocating here are things that some of us on this committee have been advocating for years ourselves.

Senator KENNEDY. Yes.

The CHAIRMAN. A number of times I offered amendments to raise the minimum social security payment, looking hopefully toward something around about what $100 would be today. I see you have a figure here. As I recall your brother offered those amendments when he was in the Senate even before you joined us here.

Senator KENNEDY. Well, Mr. Chairman, you have done a great deal in this field. And really, together with Senator Douglas, other members of the committee, have led the fight to try to do something in this field. And, I just pass on my suggestions or ideas for your consideration and the consideration of the members.

The CHAIRMAN. Some of us here on the committee have been trying to provide that people on welfare could earn something to help themselves and keep it. We have made a little progress in that area. Not as much as I would like to see but we have made some headway, and we, I believe, will continue to move in that direction.

May I say that I believe I have had a lot of contact with this problem. I was born and reared in a working neighborhood and my recollection is that both with regard to the family of which I was a part and with regard to people among whom my father was raised in a rural community, great numbers were successful in moving ahead. Our family had the good fortune and tried, by looking at their problems, to help them make good use of the resources they had available to them. Sometimes Louisiana has been criticized for being the wel-

fare State because we did go so far in trying to take care of so many people who through no fault of their own, were very poor.

I do think that you would agree with the idea that we should not give handouts to people where work is available to them.

Senator KENNEDY. Absolutely, Mr. Chairman.

The CHAIRMAN. In other words, if you take it back to the old principle that existed many years ago, some fellow would come to the back door looking for food because he was hungry—as a matter of fact, my impression was that for many years back, if a fellow was hungry and needed some food he would have a better chance of getting some if he went to the back door of someone of moderate or poor means, than that of the rich family. They would obviously chase him away; somebody else would invite him in and try to help him. As often as not in the olden days the housewife would say, "Well, there is some wood out there that needs to be cut. If you chop that wood I will feed you." So the fellow went out and chopped some wood, and the lady of the house fried some country ham or fixed some grits and sat the fellow down to a plate of grits and red eye gravy. He had something to eat and he had done some work for it.

When my father started practicing law and running for public office, every fellow who was panhandling on the streets figured this fellow ought to be a great prospect. My dad worked out a deal to keep these people just from taking that money and spending it on something frivolous. He had an arrangement with a restaurant so that he could say, "You go in there and that fellow will feed you something and charge it to me." That man would clean out what was left in the kitchen and give it to this fellow and keep the cost very low. Insofar as the House is seeking to follow that principle, that a person ought to do something to help themselves if it is available to them, it would seem to me, that it does have some merit.

Now, I have supported programs the other way around where we do not demand or expect anything of these people, but I just wonder whether we are doing much good for them, and when a person is capable of doing some work and we fail to find something for him to do, now there is a lot of talk—you saw these cartoons in the Washington Post, very fine cartoons, may I say, by one of the best cartoonists in the world, Mr. Herblock, about these horrible slum conditions. I could not help but think half of those people there are living on welfare checks. As a condition of those checks why did not somebody require those people to clean those streets up. If you are paying them, why not get something for it even if it is only for their own good. We should be able to find ways that people can help themselves even if we have to create marginal or submarginal jobs, such as cleaning up the place, clean up the streets, clean up the highways. We could provide more income for them just by subsidizing them rather than simply having them live directly off the dole.

Now, you do not object to us trying to work out something on that?

Senator KENNEDY. No, Mr. Chairman. I have spoken a number of times about the welfare system over the period of the last year or so and I have been very critical. I think that it is creating an immense problem across the country. In the city of New York, which I can use for an example, it is $700 million a year. Over the period of the next

3 or 4 years, it is going to go up to probably $1.3 billion or $1.4 billion, and it is going to be very difficult for the city to be able to afford that kind of a program. The answer really, is basically finding people jobs, making them productive members of society rather than just living on welfare.

I do not think, if I may say so, though, the House bill will accomplish that objective. I think we have to insure that there are jobs available in the areas where people are presently on welfare. You have got them in rural areas in your State. We have them in the urban centers in our State. I think we have to develop a program which is going to make it possible to find jobs. Maybe for a period of time the Government is going to have to create those jobs. But, I would hope that after that we can induce the private enterprise system to be more actively involved in this.

The CHAIRMAN. Of course, we are going to have to stipulate that some of these people do something. There is the old story about the man who wanted to see the poverty conditions in Arkansas so he left his chamber of commerce job and set out on a tour through Arkansas. He found an old broken-down shack and a fellow lying on the ground out in the front yard. The roof was about to fall in and the windows were all broken. He said, "Don't tell me that you have lived your whole life here like this." The old fellow says, "Not yet." [Laughter.]

Senator KENNEDY. Well, I am sure there is some of that, Mr. Chairman. I have been around a great deal and, from my own studies, I think also that in many of these areas there are just not jobs available. When we visited northern Mississippi, in the delta area, there are not jobs available any more. The farmers have turned to mechanization and for a lot of these people, there are not jobs available.

Secondly, in the ghetto areas of our country there are just not jobs available. I think it is partially due to the fact that we have emphasized the welfare system for such a long period of time, over the last 30 years, that instead of providing jobs we thought we would keep the poor happy by giving them welfare. Now, we find the cost is too high to pay and too high a burden to carry, not just the financial cost but the cost in human misery because the welfare system also puts a premium on a broken home.

So, you have in Harlem Hospital, last year, for example, 50 percent of all the births were illegitimate, but at least a large part of this is because you do not get welfare unless the family is broken. If this man lives in the house, you do not get welfare any more. If the woman marries she does not get welfare any more.

So, I think that system, the way we have handled welfare, is wrong and I think the fact that we have relied solely on welfare instead of providing employment, is wrong. And I think it is wrong, the provision in this bill about compulsory work for welfare mothers. I am all in favor of men working, but I think we have to take some care if a women has children at home. It may well be better if she does not work, and in any event it is wrong to take her away from her children and start a job training program for a job that might not exist. So I think a good deal of care must be taken by this committee before that provision is accepted.

The CHAIRMAN. Well, now, here is a statement that the Secretary o Labor has before us. He will present this later on in the day. He say that: "There has been an unprecedented increase in the number of jobs available. The papers are full of help-wanted ads, and it is next to impossible to get appliances repaired or certain other kinds of work done."

Now, I inquired of it and my best information is that there are more than 50,000 jobs available on police forces alone where there is difficulty in securing enough applicants who can qualify for the job.

Senator KENNEDY. Well, now, Mr. Chairman, I will give you as an example the school system across the United States. If children are going to school in these areas, the ghetto areas, they have three out of 10 chances of finishing high school, and if a child finishes high school in a ghetto area, he has a 50–50 chance of having an eighth-grade education. The educational system does not prepare children for those jobs. There are vacancies in the health field, in the police force, for doctors and nurses and lawyers, but these people are not trained for those kinds of jobs. They cannot go in and get that kind of a job, Mr. Chairman. A man cannot get that kind of a job at the moment. So, what does he do? And what I say is that you have got to provide jobs for these people. There are just not jobs available in these areas of the United States at the moment.

And, I am all in favor of getting people off welfare. I think that is the only answer. We must take them off welfare and find them jobs and have them go to work and live their lives with their wives and with their children, but that is not the kind of society that we have created here in this country over the period of last several decades. We put the premium on welfare, the premium on the broken family, and we put a premium on neglecting the fact that the man should be head of the family and we put a premium on welfare rather than the provision of jobs and employing people.

The CHAIRMAN. Well, may I just say that the first responsibility for support of a child, I am sure you will agree, is on the parents. I find no fault with a mother who must apply for welfare assistance because the father of that child could but is not doing anything to help support that child, whether the child is legitimate or illegitimate. I have had the experience of trying to chase those poppas down as a young lawyer. A wife comes and wants to do something about it and about the time I think I have it all fixed up to get some support for the child, then poppa leaves town. It occurs to me that maybe we can help out in this area; maybe we can write up a tax on poppas, particularly those who leave town to avoid the necessity of supporting their children.

Senator KENNEDY. It seems to me, if I may say so, Mr. Chairman, that if we had jobs available for people, men could go to work and their wives would not have to go on welfare.

They had a job fair out in Oakland, Calif., just a short time ago, and 15,000 people showed up for jobs. They were able to find employment for 250 of them. You have got unemployment or substandard employment in the ghetto areas of the United States that ranges from 22 to 49 percent and averages 33 percent. Only two out of five Negro males in our ghetto areas make more than $60 a week. That is unsatis-

factory in this country at the moment. You have got to get people working, but there are no jobs. I have been to a lot of these areas.

The CHAIRMAN. I do not think we can provide all the answers to this.

Senator KENNEDY. I do not think the answer is, if I may say so, punishing the women or the children. That is my only point. I think that we should support and enact legislation which will find jobs for these people, putting them to work.

The CHAIRMAN. As I understand it, the House is seeking to move in the direction of providing jobs for people on welfare. Now, there are a lot of jobs that are available. You say those are not adequate and not enough of them. I agree that that is probably right.

Now, in many instances people can be trained to qualify. I think we can agree that we ought to have a training program to train them to qualify. If in addition to that we create a lot of jobs of a marginal nature or submarginal nature we could also help. At least the welfare recipient would be receiving more income than they would if they were simply living on welfare alone, and they would be earning it. But, I would hope that we could move in the direction of looking practically at these cases on the basis of saying, "Well, now, can this person do something for his own advantage, and if so, how can we best make use of the Federal money? The answer would be first, to find them a job if one is available. Second, to train them to a job that might be available. Third, to subsidize them for a job that we may even have to create, something that is useful--if nothing else, just picking up the beer cans off the side of the highway where they are very unsightly. But, I would hope that we can move in the direction of using effectively as much of this as we can.

I saw a poll awhile back that indicated by a 2 to 1 margin most people in this country seem to oppose further increases in social security that must be accompanied by tax increases to pay for it. I do not think anyone objects to the idea of making the best use of what we have or helping someone to qualify himself so that he can become a taxpayer instead of a tax consumer, and it seems to me, that if people think we are making the best use of this money as an investment to qualify people for the future so they will not be tax consumers but taxpayers instead, I think they would be much more inclined to go along with it.

Senator KENNEDY. I think that the problem is not just in our big cities. We can look at the great problem that our citizens face in the Appalachia area where I have seen a considerable amount of hunger. We can look at the delta area, as I mentioned, in the State of Mississippi, and look at the Indian reservations where the unemployment rate is up to 70 percent.

I think that when we are talking about social security and talking about welfare the emphasis has to be on training for jobs. The emphasis also must be on the providing of jobs if there are jobs available for a man so that he can support his family in dignity. I think that is the objective that we are all interested in.

The CHAIRMAN. I would be surprised if the delta area of Mississippi, though, made as poor a showing as the State of New York when you say that out of all these Puerto Ricans up there, only 37 of them ever reach college. My impression is that the delta area of Mississippi has that beat, even if you are only looking at the Negro area.

Senator KENNEDY. I emphasize the city so much and I talk about New York, Mr. Chairman, I did not want you to feel I was leaving out some other parts of the country. [Laughter.]

The CHAIRMAN. I did not think that you were necessarily saying the problem does not exist elsewhere, but——

Senator KENNEDY. We have tremendous problems in the city of New York and the other major cities of the country. My only point was that it is not unique and it is a national problem, not just a local problem, but, Mr. Chairman, we have tremendous problems——

The CHAIRMAN. Senator Anderson.

Senator KENNEDY (continuing). In my part of the country.

Senator ANDERSON. Well, Senator, I know the committee appreciates the fact that you paid some tribute to Senator Long who has year in and year out advocated higher social security benefits. I do not have many questions but on the top of page 3, third paragraph, you say:

> To finance this proposal, I suggest, first, that the contribution and benefits base be raised to $8,400 next January and $10,800 on January first, 1971.

In the original law back in 1935 the tax base was $3,000. Do you know how much the figure would be if we had to put that same level again now?

Senator KENNEDY. I am sorry.

Senator ANDERSON. About $14,000 perhaps would be the base. These are not exorbitant bases at all. That financing would be very worthwhile.

I have no further questions.

The CHAIRMAN. Senator Talmadge?

Senator Morton?

Senator MORTON. Senator, one point that you make, and I am glad you emphasized it, has disturbed me for many years and I know it has disturbed members of this committee. And that is that our present welfare program, whether we intend it to do so or not, really does not help the family life but stimulates broken families.

Senator KENNEDY. That is correct.

Senator MORTON. And as I get it from your study of the House-passed bill, you do not feel that it does anything or very much to improve what we agree has been one of the faults of this program.

Senator KENNEDY. Right. I think, if I may say so, I think it puts a premium on—emphasizes those provisions which have caused the breaking of the family rather than the family unit staying together and the head of the family unit going out and finding a job. Now you get paid much more money, you do much better financially, if you—if the family breaks up or the children are born illegitimate, and the man, the head of the house, does not work and does not stay at home. That is the way you are going to get money from the welfare system and that does not seem to me to make a great deal of sense.

Senator MORTON. Of course, our society has changed a lot in its complexity in the last 50 years but I can remember as a child that the family unit in the Negro community, be it rural or be it urban, was a very strong unit, and there was a great feeling of family responsibility. Their resources were extremely meager. This I admit. But it was a very cohesive unit.

Senator KENNEDY. Yes.

Senator MORTON. When old Aunt Minnie had to quit working and she was a widow, she was taken in by one of the nieces or nephews. Then came the great migrations to the cities. I think many of our programs have discouraged this family feeling that was so really outstanding among Negro families in the South and in the border States——

Senator KENNEDY. Yes.

Senator MORTON (continuing). During the early years of the century.

Senator KENNEDY. I would agree.

Senator MORTON. Especially prior to World War I.

Senator KENNEDY. I agree.

Senator MORTON. One other question, Senator, on the social security financing that you discussed in the first part of your statement. In 1961 I had a bill in the field of medicare which was financed entirely from general revenues. Now, we have a program which is partially financed from trust fund and partially from general revenues.

If we adopt a program such as you suggest so that ultimately 35 percent of social security benefits come from general revenue, are we not going to be under terrific pressure to do away with the trust fund entirely, put the whole burden on the general revenue, and will this not give us a tremendous tax problem?

Senator KENNEDY. Well, I would hope that we would not. I mean, I would be opposed to that myself. I think that when we go up to about 5 percent for the tax on salaries and 5 percent for the employer, we have gone almost as high as we can go on a regressive tax. I think the benefits are going to have to increase for the recipients of social security, just because of their cost of living, so it is going to be more costly and, I think, to a limited extent to go into general revenues, is going to be almost essential if we are going to have a social security that means anything in the years ahead.

But, I would be opposed to the general-revenue financing, Senator. The system should remain basically contributory. I think that what you point out is a danger. But, it seems to me, that if we look back at the history of the social security system and what it was intended to accomplish, we are not really meeting those objectives at the moment. I understand the great demands of the war in Vietnam. We cannot do all that we would like to do now, but it seems to me that for the future, we are going to have to get some of the funds out of general revenues because we cannot rely just on the payroll tax.

Senator MORTON. I think it is a matter that we have got to consider because I agree with you, that this is a regressive tax, and it is a tax that finds its way into the cost card of every industrialist, every manufacturer, whereas the income tax does not, and it was a distinguished member of this committee, former Secretary of Health, Education, and Welfare, Senator Ribicoff, who pointed out the fact that 10 percent—5 percent on the part of the employer and 5 on the employee—is just about all the economy can stand if we are to stay competitive.

Senator KENNEDY. Yes.

Senator MORTON. I remember my days in business and when I started in, the corporate income tax, I think, was 13 percent or less than that, and at the end it was 52 percent. We never changed the

price of our products when the income tax was raised, but if the price of our raw materials or our labor costs went up perceptibly, we had to raise our prices.

Senator KENNEDY. Yes.

Senator MORTON. And the social security tax is a wage tax and you grind this right into your cost card and, if you are competing with somebody in England or France for the South American market, it becomes a factor.

So, I think this problem that you brought up of ultimately having to transfer some to general funds certainly is something that someday we are going to have to study very carefully. It may not be this year.

Thank you for your statement. It certainly represents a lot of hard work and I think it is of benefit to these deliberations of the committee.

Senator KENNEDY. Thank you, Senator.

The CHAIRMAN. Senator Williams?

Senator WILLIAMS. No questions.

The CHAIRMAN. You will notice here that the House committee report on page 103 says:

> Our committee intends that a proper evaluation be made of the situation of all matters to ascertain the extent to which appropriate child care arrangements should be made available so the mother can go to work.
>
> Indeed, under the bill the states would be required to assure appropriate arrangements for the care and protection of children during the absence from the home of any relative performing work or receiving training.
>
> The Committee recognizes that in some instances where there are several small children, for example, the best plan for the family may be for the mother to stay at home. But, even these cases would be reviewed regularly to see if the situation had changed to the point where training or work is appropriate for the mother.

Now, I notice in their bill that the House provides $470 million for day care of children. I mentioned at a hearing prior to the time you came here, some of us have seen how the Russians handle their program where all mothers work and they do not have much illegitimacy. They usually have three little schools, one for the infants, where they care for them. Another for children about 2 to 4 and another for children let us say 4 to 6. I am not sure you observed it. I think you perhaps have visited over there, have you not?

Senator KENNEDY. Yes, I have.

The CHAIRMAN. That is one they did not have on the guided tour but it is something they do extremely well. Really, if I do say it, they are teaching those children a lot of family discipline that they might not have been learning in the home from some of the mothers we are supporting on welfare here. They really have a very good day care program.

Now, the best of our widows who are left with children to support and with no visible means of income do go to work rather than go on welfare, do they not? They find somebody to look after their child even though it might not be in the kind of day care schools and care centers that we provide here. But they do find someone to care for that child or have a kindergarten to put that child while the mothers are working.

Senator KENNEDY. When you say "the best" I suppose you are talking about ones who received an education. You are talking about women that received an education and can find jobs.

The CHAIRMAN. I would say of those that——

Senator KENNEDY. A lot do. To answer your question, a lot do.

The CHAIRMAN. Of those widow women that you would most admire, when their husband dies and they are left with some small children, they go to work and bring a lot more income to that family than they would receive on welfare.

Senator KENNEDY. I think that is not satisfactory. I do not think it is as satisfactory as it might be in any case. I have seen the Russian system and I would not want to introduce the Russian system here in the United States.

The CHAIRMAN. Well, let me say that as between two mothers, I am not the least bit embarrassed to say I regard that mother as a better one who goes to work and brings the family several hundred dollars a month income than one who simply sits there and draws welfare checks and continues to increase the brood, may I say, and asks for bigger and bigger welfare checks while the other is out there working and supporting those children to give them a better chance to live and also to provide better for the family.

Now, maybe you do not want to regard these as being better, but I do.

Senator KENNEDY. I am not against it, Mr. Chairman. No, it is difficult to say what should be done in a particular family group. I can understand where a mother would say that because of the particular problems that she might have at home that she does not want to leave her children. Or she might find that there are no child care centers that are satisfactory in the neighborhood, and I still would have a great deal of admiration for her even though she felt she had to go on welfare. I just do not know whether I want to break it down into a class of one group of people I admire more than the other. I think wherever we can, people should work. I have said that——

The CHAIRMAN. I know of some of those kinds of mothers whose children today are outstanding citizens of my State. Those mothers made tremendous sacrifices and worked hard to provide an opportunity for their children and it would seem to me as between two approaches, to help those mothers find a way to care for those children while they go to work is more efficient than simply to pay them more money, especially if they are the kind of mother who would just stay there and produce more and more children and ask for bigger and bigger welfare checks.

Senator KENNEDY. I am in favor of that in general terms. I think we have to then find out whether there is an adequate child care program and I am very much in favor of the program that has been suggested by the House of Representatives, but without the compulsory features that were tied to it. I think then we have to look at what jobs are going to be made available and I think that that creates other kinds of problems, whether the kind of employment that is being suggested to the mother is going to be a satisfactory kind of employment.

The CHAIRMAN. Well, we cannot put a mother in a job of a trained secretary if she cannot type and cannot take shorthand and does not even know how to answer the telephone, but you can start out by putting her in such jobs where she can qualify, if only keeping the office open during the noon hour while somebody who can do those

things takes off for lunch and pay her for the work she does during the noon hour.

Thank you very much, Senator Kennedy. You have made a very fine statement here. It is comprehensive, and it shows you have done your homework. I hope that all of us on this committee can say we have done as much on this. Thank you very much.

Senator KENNEDY. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Brooke was to be the next witness and he has to go make a speech. He will be back.

We are happy to have with us the Secretary of Labor, the Honorable W. Willard Wirtz.

Mr. Secretary, we are very pleased to have you here today and we urge you to proceed at your own pace.

STATEMENT OF HON. W. WILLARD WIRTZ, SECRETARY OF LABOR, ACCOMPANIED BY STANLEY H. RUTTENBERG, ASSISTANT SECRETARY OF LABOR FOR MANPOWER

Secretary WIRTZ. Thank you very much, Mr. Chairman and members of the committee. There is with me, Asssistant Secretary of Labor, Stanley Ruttenberg, Assistant Secretary for Manpower, who is also Manpower Administrator and under whose responsibility a good many of these programs fall.

I have a statement here of some length, Mr. Chairman, and I shall be glad to proceed in whatever way you suggest, either to read it or to file it with the committee with the request that it be included in the record as it is but then to summarize it quite briefly.

The CHAIRMAN. Mr. Secretary, I think it would be well if you read your statement. The information is something everyone of us on the committee should be thoroughly familiar with when we vote on this bill. I would appreciate it if you read it. We will go along with it.

Secretary WIRTZ. I started by noting some general matters involved and then just to give you the general outline of the testimony I have concentrated my remarks on the welfare provisions and most particularly on two points which are of general concern about them. I trust that the national interest in the social security amendments centers on the proposed increase in social security benefits and the extension of medicare. With respect to these points I join Secretary Gardner in urging support of the proposed 15-percent-benefit increase with a $70 minimum benefit as recommended by the President, a minimum benefit of $100 for persons who have worked 25 years or more in jobs covered by social security; full widow's benefits for disabled widows of any age; a contribution and benefit base of $7,800 in 1968, $9,000 in 1971, and $10,800 in 1974; and the inclusion of disabled social security beneficiaries under medicare. I simply stop that summary, Mr. Chairman, members of the committee, because to embellish it would be only to weaken it.

I would like to incorporate by reference everything secretary Gardner has said with respect to these matters. My own testimony is directed particularly at the basic set of issues presented by the proposed amendments to the welfare provisions of the Social Security Act, particularly as they involve—to which you have been directing

your attention—the interrelationship of the welfare program to opportunities for work and for training.

The coincidence of a large increase in the number of welfare beneficiaries with an unprecedented increase in the availability of jobs and at the same time with the development of an extensive manpower training program has given rise to increased interest in the responsibility of welfare recipients to accept available work and training opportunities.

Most people in this country earn their own way, and find the opportunity for doing it pretty good. There has been in the past, nevertheless, relatively full understanding of the incompleteness of this opportunity for others when there were not enough jobs for all in an economy that kept going up and down. This was particularly true under the sensed circumstance of the inexplicable denial of equal opportunity to minority groups. There has been a growing consciousness of common responsibility for the fact of human disadvantage which has led in the past to not pressing very hard on the issue of "whose fault it is."

But, there is a difference today.

The economy is in its seventh year of constant growth, and there is confidence for the future. There has been an unprecedented increase in the number of jobs available. The papers are full of help wanted ads, and it is next to impossible to get appliances repaired or certain other kinds of work done.

There are extensive training and work programs available.

Although the unemployment rates for minority groups remain intolerably high, as Senator Kennedy has just pointed out, the idea of equal employment opportunity has been written into the law and is now much nearer a reality. But the disadvantage of inadequate training is now a far more serious factor. Even if all discriminatory hiring practices disappeared tomorrow, and there were as many jobs available as persons who need and want them, all too many could not fill them because of lack of training.

To seem to suggest that there has been a full development of needed opportunities for either work or training would be wrong. There has not been. But the central elements in the situation are totally different from what they were in the thirties, when most of the formative thinking about "welfare" programing was done. And, there is now a new questioning of any practice which may seem to encourage anyone's staying "on the welfare"—when there are, or appear to be, unused work or training alternatives.

President Johnson's recommendations to the Congress, which are embodied in H.R. 5710, recognize the desirability of expanded efforts to increase the self-sufficiency of welfare recipients. H.R. 12080, adopted by the House, carries this idea forward: in some instances, I suggest respectfully, strongly, constructively, but in others to a fault.

I concur fully, and therefore, simply note it, in Secretary Gardner's testimony regarding the desirability of providing in this legislation:

> For the making of plans for each welfare family which include work and training where the circumstances warrant it;
>
> For the expansion of work and training opportunities for welfare recipients;

For expanded day-care facilities for the children of mothers who are or need to be working or taking training;

For the exemption, in determining offsets against welfare payments, of (i) the first $50 a month of earned income plus one-half of any additional earnings, and (ii) all earnings of AFDC children attending school full time (as provided in the House bill), and

For the restoration of the $20 incentive payment for those welfare recipients who accept work and training.

There are two other centrally important points here which warrant the most careful consideration, and on which I respectfully urge action different from that taken by the House.

H.R. 12080, if adopted by the House, would require that welfare assistance be denied to individuals if they fail or refuse to accept work or training opportunities unless they can show "good cause" for such failure or refusal.

This sounds good, and reflects an unquestionably desirable general principle. But in my judgment, such an absolute statutory conditioning of welfare payments on the acceptance of work or work training would be unwise and impractical.

Here again, Secretary Gardner has gone into this point so fully—and it involves considerations lying so much more within his province than within mine—that detailed comment would only burden the record. I should also like, Mr. Chairman, and members of the committee, to express the appreciation for the coincidence of the position which I am trying to propose here with the one Senator Kennedy has just advanced to the committee. It seems to me, it is a very constructive note.

I note in general, nevertheless, the lesson of experience from the administration of most of the existing work and work training programs. One of the hardest problems is getting through with these programs to those who need them most. This problem could well be aggravated rather than made easier by a general rule of compulsory training. There are facts of "alienation" although I am frank to say that is a word which has come to bother me because it seems to suggest a condoning of the distance and I do not mean that at all. I mean simply that there is a gap here which has got to be bridged, and there are facts, too, of difficulty of communication and lack of complete know-how involved here which will not be met by a threat of cutting off the individual's means of subsistence.

I do not mean to dismiss this point lightly. It bears directly today on much more than the administration of the welfare program. It is related—although in a strangely reverse sort of way—to the current proposals to create millions of new jobs to relieve the problems in the slums and ghettos—when there are already hundreds of thousands of jobs unfilled. It is a problem we face in administering the existing manpower programs, when we identify as we have the number of unfilled training slots today in some of these programs in some areas.

A century's accumulated mistakes are not going to be corrected by shortcut solutions. There is unquestionably going to have to be more responsibility assumed by everybody involved in this situation—by the indigent and unemployed to be sure—and also by employers, labor unions, civil rights organizations—and public agencies.

The right answers are unfortunately undramatic. They involve going after every single case of indigence or ignorance or unemployment or lack of qualifications to work in individual terms. They include much more training opportunity than is presently available; much more participation by private employers——

The CHAIRMAN. Mr. Secretary, can I suspend just a moment.

All right, please proceed, sir.

Secretary WIRTZ (continuing). Suggesting that the answers, undramatic as they are, do include the provision of more training opportunities, they include a matter of great importance, larger participation by private employers than have so far been worked out and a much larger acceptance by those who are disadvantaged of the training opportunities afforded them than they have so far shown. The right answers do not include sentiment and they do not include softness—but they do not include "off with their welfare" either.

Finally, as the intended point of primary emphasis in this testimony, I urge the adoption of the Senate of the provisions in H.R. 5710 for the administration of the work and training program for welfare recipients. I do not need to emphasize this point out of context of its importance but it involves a very important administrative matter which if it were left unnoted at this point, could result in very real trouble ahead.

H.R. 5710 would make this work and training program part of the broader work and training—or manpower—program presently in effect.

It would not make sense to proceed, as H.R. 12080 does, from the idea that welfare recipients should be moved as fully as possible out of the backwash of "welfare" and into the mainstream of training and employment, which seems to me, ought to then go on to the conclusion that welfare recipients' training and employment should be handled by the welfare agencies instead of by the regular training and employment agencies which seems to me, wrong.

There is today a manpower—work and training—program administered through the Manpower Administration in the Department of Labor in carefully worked out conjunction with other Federal, State, and local agencies. This present program embodies the present form of a system (i) developed slowly over the 30-year period following the enactment of the Wagner-Peyser Act in 1933, and (ii) has now, I think, accomplished an effective coordination and consolidation of the manpower programs enacted by the Congress during the past 5 years.

No one could be more acutely conscious than I am of two criticisms of the existing manpower program—compounded, in varying degrees, of earlier fact and prevailing fashion:

First, that the Federal-State employment system has become too old and tired and overinstitutionalized between 1933 and 1962 to ever be an effective agency in a war on poverty, a civil rights revolution, and now a modernization of the welfare program; that may have been earlier fact. I think it is only prevailing fashion. And second, that the manpower programs adopted during the past 5 years have been left sprawling across the landscape with the uncoordinated ineffectiveness of an octopus with brain damage.

I think that may have been earlier fact. I think today it is only fashion.

H.R. 12080 appears to reflect an acceptance of these criticisms to the extent that it would set up a new, competing and duplicating network of work and training facilities. It becomes relevant to provide the committee with the most accurate possible factual summary of the present national manpower program.

In the interest of time this listing may perhaps best be simply incorporated in the record, Mr. Chairman. It lists the eight or nine manpower programs which today are administered through the Manpower Administration of the Department of Labor, including the Federal-State Employment Service, unemployment insurance program, apprenticeship and training program, the manpower development and training program, the Neighborhood Youth Corps program, Operation Mainstream, the new careers program, the special impact adult work program and the program under title V of the Economic Opportunity Act, and I welcome the opportunity to note at this time to this committee the extent to which these programs have now been brought within a single administration.

The CHAIRMAN. Mr. Secretary, in line with what you are saying at that point, your people may have prepared some film of one sort or another to show just what these programs are and what they do, and it occurs to me that it might be well if you were to take the best visual aids you have—be it motion picture film or something else—and make it available to us, not necessarily during our regular hearing hour, but some time when we can see it and get a real basic and rather thorough understanding of just how your programs work. In fact, these television people ought to put some of them on the air to show unemployed people the kinds of opportunities that are available. I have found just ordinary fallen-down shacks seem to have television sets nowadays, and if people can be shown that there is a program right over here where they can go for job opportunities that we might be able to make even better use of what you are doing now.

Now, do you anticipate that if we make a concerted effort to try to screen these welfare cases to see the ones that could be put to work constructively, that you might make a concerted effort to get these people off of welfare insofar as possible and on the jobs?

Secretary WIRTZ. Yes. Your suggestion about our not having done enough descriptive is very well taken.

The CHAIRMAN. It may just be that I do not know enough about it.

Secretary WIRTZ. No; you are very right.

The CHAIRMAN. I have not been looking for a job. I am trying to keep the one I have. But for people who are looking for one, maybe there are ways to get to them and better inform them of what is available here.

Secretary WIRTZ. You are very right. To follow that up, I think I can, for the present purposes, meet your point most graphically by referring to a single recent development, and this is with respect both to the first part of your question and the second part, make just a passing reference to what we call the concentrated employment program.

Now, we may have made a mistake. I do not think we have wasted any steam on the whistle. I think it has all gone into the boiler. The

concentrated employment program is in lower case. We have kept even the capital letters out of it because we think the country is a little tired of acronyms that spell out words and there are lots of projects and operations, et cetera, that I would like to tell you in a moment what the concentrated employment program is. In 21 areas of the country, hopefully with the Congress approval of the President's recommendation of another $135 million, hopefully another 25 to 50 by the end of this fiscal year, we have developed this program. We set it up on a form which is entirely local. We make a single contract with a single local unit, although that local unit involves the local employers, the State and the local agencies, the civil rights groups, and so on and so forth. We make one contract with that group into which or through which we pass funds from five or six of these different programs.

Now, that is set up now with one contract covering five or six of these programs and in terms of the points you emphasize, the basic part of that program is first, that we are going after only the disadvantaged and then they come in and we work with them for 2 weeks on what we call an orientation 2 weeks during that period, figuring out whether they can go directly into jobs, and the private employers are cooperating with respect to that group, or whether they go into a neighborhood youth program or go into a manpower development and training program or whether they can go into an Operation Mainstream program or into a special impact program or new careers program.

Now, I have named six different statutes in that listing. I would hope that we can by television or otherwise describe that situation in a way in which it would get through. We are working to get that individual into a situation in which we can work with him—routing him into one or another of these various programs.

I think we have now a basis of experience which permits the full operation of that program in terms which would not require other statutory change beyond what was in 5710.

It would require—it would involve a stepping up of the concentrated employment program. Our programs today include about 60 to 65 percent of what we identify as the disadvantaged or hard core. This would mean another 200,000 to 400,000 people, as nearly as we can estimate it, coming into that grouping. So, it would represent, as far as our programs are concerned and to the extent that they are aimed at the disadvantaged, it would represent about 100-percent enlargement in that number.

It would require, in answer to your last question, changes in administrative practice, structural changes to some extent, no other statutory changes, would involve, in our judgment, the benefits of this debate both in the House and in the Senate, to the extent that it is suggested what I am sure, is a national agreement that there ought to be nobody on welfare without training who in the practical judgment of the country should get training, and we would count that a larger element than before because our manpower programs have included the other training for other than the disadvantaged.

I would like to say to you, but it would be too broad a statement, that everybody out of the 400,000 or 500,000 whom we would be train-

ing would be able to leave the welfare rolls. I think that goes beyond what I can assure as an administrative matter but I can assure you this, in the development of these programs, it would mean that we would proceed from what I understand to be the clearly accepted national agreement that everybody who in the public interest and in the individual's own interest ought to get training or jobs will surely have that opportunity and will have it pressed on him very, very strongly or on her.

The shorter answer to your question would be that it would not involve a basic change from the statutory standpoint. It would fit into the present program. If there is an administrative change, it would involve a larger emphasis on the clearly expressed idea that everybody ought to take training unless there are good reasons to the contrary.

And in what I have said, I have summarized quite a bit of what was left in my statement, and therefore, I will be glad to follow it in detail, simply noting the points I have already covered.

I have suggested on pages 9 and 10 of the document, which I would hope to be included in the original form, the reference to four illustrations of the complete coordination or relatively complete coordination now of these programs. They involve the developments by the Departments of Labor and Health, Education, and Welfare of arrangements under the MDTA. They involve the development by the U.S. Employment Service, the State employment service, the human resources development program which I think can be fairly said, Mr. Chairman, members of the committee, to have resulted in the last 3 or 4 years in a change in the role of the State employment service from being as it was before, simply a job referral point, to its being now as large as and strong an agency as this country has for the improvement of the position of the disadvantaged. It involves the development of the cooperative area manpower program system under which all Federal, State, and local manpower agencies are brought together to develop coordinated policies and programs for a particular area. Those initials do spell CAMPS, Mr. Chairman, and they got through without my recognizing it.

Then, they involve in the fourth place, the development of this concentrated employment programs. It is a conservative estimate that almost—and here I correct a figure in the printed statement, it ought to be 325,000 instead of 375—a conservative estimate is only 325,000 of the men and women, boys and girls, who are enrolled in training and work experience of one kind or another under the manpower administration programs are from the seriously disadvantaged group which is distinguishable only in details from the welfare group.

More than 60,000 of the 750,000 people who have received training in the MDTA programs during the past 4 years have been welfare recipents. Just in orientation and in answer to your question, that figure of 60,000 would be increased by 200,000 to 400,000 under this change. It would mean that that is a rough suggestion of the effects of the change.

Over a quarter of the 1,100,000 participants in the Neighborhood Youth Corps program (during the past 30 months) have been from welfare families.

It was understandable that when the community work and training program was added to the Social Security Act in 1962 it would

be included in the welfare agencies' responsibilities. It was at that point an experimental, voluntary program, and did not include Federal funds for training costs (with the result that only 12 States adopted community work and training programs).

That was before the development of an overall manpower program (the Manpower Development and Training Act had been passed only a few weeks before, with the appropriation of funds and the setting up of the administrative procedures for it being still in the future). The State employment services had not, at that time, gotten to any appreciable extent into the hard-core or disadvantaged worker area.

That was 2 years before the enactment of the Economic Opportunity Act and the establishment of the manpower programs under that act which relate so directly to the disadvantaged worker situation.

That was before the establishment of the Manpower Administration, and the development of the various procedures and programs which are aimed so largely at meeting the various different employment and training problems of those who, for one reason or another—good or bad—have been left out.

So far as the question is whether additional and more effective work and training programs are necessary to move welfare recipients onto an independent, self-sufficient basis—and to break the inheritance and the habit of living on welfare—the answer is that this is needed. Enlargement and increased program effectiveness of the national manpower training system which would come from an expansion of the work training program for welfare recipients contemplated in the Social Security Amendments of 1967 offers significant new encouragement for the development of this system.

But if the question is whether there should be another large-scale new system—separate and apart from the present system—to meet the work and training needs of those "on welfare," the answer is that this would reduce any future suggestion of "coordination" and efficiency to utter hypocrisy. Adding just one word, the proposal as the bill emerged from the House is for the setting up of a work training, working community training manpower program to be administered through the State welfare agencies which would be as large as or larger than the present system. I hope I need not express or disavow any feelings or suggestion of bureaucratic aggrandizement. It is just a deep belief after 2 or 3 and now 4 years, almost 5 of being charged with lack of coordination of the present program, of feeling that to set up another one would let me in the future never come before this group or any other group in the Congress to promise any coordination. It would be impossible.

To believe completely in the central idea of the proposed amendments—that the welfare recipient should be moved wherever possible out of that condition and into the mainstream of employment and self-sufficiency—requires the rejection as totally inconsistent with that purpose of the idea that his, or her, employment and training needs are to be met by welfare—instead of the established employment and training agencies.

I urge adoption by the committee and the Senate of the administrative provisions proposed in H.R. 5710 for the community work and training program, paralleling this part of my testimony with Sec-

retary Gardner's testimony. They place the responsibility for welfare activity with HEW, and manpower activity with the Department of Labor. They provide for coordinated effort, similar in nature to many other pieces of manpower legislation. At the local level, in particular, they eliminate overlapping and duplicating administrative functions and program operations.

Assistant Secretary Ruttenberg and I will welcome your questions, and welcome an opportunity, Mr. Chairman and members of the committee, to go further if it is your pleasure, into this matter of the relationship of the use of work opportunity and training opportunity to welfare entitlement, for I think it is a very large issue at present in the future development of the individual and the national structure in this country.

The CHAIRMAN. Senator Morton?

Senator MORTON. Mr. Chairman, I am sorry I have to leave. I have just one short question, Mr. Secretary. On page 1 of your statement—I ought to know the answer to this but I admit I do not—you say minimum benefits of $100 for persons who have worked for 25 years or more in jobs covered by social security. Does that mean that they would have to be in the covered job for the entire 25 years?

Secretary WIRTZ. It is my understanding that is true.

Senator MORTON. I was thinking about, for instance, domestic servants who came into the social security program less than 10 years ago although they worked as domestic servants for, perhaps, 40 years.

Secretary WIRTZ. This is outside my area but I will see that you get a specific answer to that. I do not know the details of the Social Security Act well enough to know the answer to that but we will get an answer to you and we will make it a part of the committee record and I will speak to the HEW people about it. I wish I knew more precisely.

(The following information was received from the Department of Labor:)

A check with HEW confirms Senator Morton's understanding: A special minimum benefit would be given for long-service workers. It would be equal to $4 multiplied by the number of years of coverage up to 25, so that a worker with 25 years or more of coverage will receive a benefit of at least $100 a month. For instance, a person who has worked in an occupation for 30 years with only 10 years of coverage, would receive a minimum payment of $40 (10 years × $4).

The CHAIRMAN. Senator Talmadge?

Senator TALMADGE. Mr. Secretary, I followed your statement with interest and, in general, I think I agree with most of it. How many different manpower training and work training programs does the Federal Government have now?

Secretary WIRTZ. There has been a discussion about that in the public print in the last several days about Under Secretary Cohen having said six or seven and with Senator Ribicoff having referred to 11. I have tried to analyze what figures they are using. It depends on what breakdown you take.

On page 8 of my statement, I have listed nine. That includes unemployment insurance. And those nine are administered in the Department, centrally in the Department of Labor. The only other programs which I think would come in any count, only other significant

programs, would be the vocational education program and I do not know whether you would count the vocational rehabilitation program as a training program. I would be inclined to. Those two, plus one under the Economic Opportunities Act, namely, Job Corps.

Senator TALMADGE. Do they work in conjunction with the Labor Department on their training program? It seems we have too much of a proliferation of these training programs now. I think they ought to be concentrated insofar as possible in one agency, the Labor Department, since it has experience and manpower in that field.

Now, I would not favor changing the vocational education program because they are doing an outstanding job and they have been in that field perhaps longer than the Labor Department has. Vocational rehabilitation is primarily a medical matter to a large extent and I would not favor changing that. But, it seems to me, that more of these work training programs ought to be concentrated in one general program instead of a proliferation of them. I think they offer a fertile field for examination and concentration. By and large, I think it has worked extremely well. If a person has the incentive to work, I think our Federal programs now give them the opportunity. And I know, particularly in Georgia, the vocational education program has done an outstanding job. Most of those students are snapped up before they ever finish their classwork and almost 100 percent of them get jobs at several times the highest earnings they have ever had prior thereto.

I agree with you that we ought not create a new training program under the Welfare Department which has had no experience in that field, no manpower, no expertise in the effort. I think this training program ought to be left in the Labor Department.

Secretary WIRTZ. Senator, I appreciate your question. It permits me to point out this. First, I should have included in my enumeration probably the work-study program. There is a work-study program which permits college students to take part-time work and which is administered by HEW and it would be my general feeling that everybody feels that that is the right place for that.

Senator TALMADGE. I would share that view.

Secretary WIRTZ. Then I should mention, too——

Senator TALMADGE. It is primarily an aid-to-education effort.

Secretary WIRTZ. That is right.

Senator TALMADGE. Instead of manpower training.

Secretary WIRTZ. That is right. I should include, too, this community work and training program under the social security amendments. Now, that has been in the welfare agency in the 12 States but the interesting thing is that the present situation parallels exactly your statement of what you think it ought to be except for the Job Corps which is presently in EOA. And my point is this, there continues to be a feeling that there has been no coordination of these programs when the point is that, when you set aside vocational education which, of course, we use, the whole MDTA program works, too, but when I set aside vocation education, social rehabilitation, the work studies for which you did not count, everything else is presently not only coordinated but most of it actually consolidated in the Manpower Administration.

Senator TALMADGE. What percentage of those people who have had those training programs have obtained gainful employment?

Secretary WIRTZ. The figures are these. A round figure first. About 75 percent.

Senator TALMADGE. About 75 percent. And what——

Secretary WIRTZ. Now, let me break it down. The on-the-job training program which is part of MDTA has a placement record right now of 89 to 90 percent. The MDTA institutional programs have a present placement record of about 75 percent plus or minus 2 or 3. The Neighborhood Youth Corps in-school program is for kids who are in school and the record there is not one of job placement, but the record of their not dropping out is one of the dramatic gain records in the whole thing. Then, you go to two very tough programs, the out-of-school Neighborhood Youth Corps program, that is the dropouts, no longer in school, and the Job Corps program. When you get to these really tough hard-core situations, the job placement record is between 40 and 50 percent.

Senator TALMADGE. What does it cost the Government per trainee on these manpower training programs?

Secretary WIRTZ. Institutional training program, the figure is between $800 or $900 per individual. No. On-the-job training programs is between $800 and $900 per individual. The institutional training is currently between $1,700 and $1,800. The Neighborhood Youth Corps averages between $200 and $400 on the in school, and around $1,500 on the out of school.

I should add that the figures are going up for a reason which is very relevant to the inquiry there. We are finding that, as we move into the hard-core areas there is more of the training needed of the kind that is involved here and we are, therefore, adding supportive services on these hard-core, basic education through HEW, and so forth. So, those figures are heading up some but those are the current figures.

Senator TALMADGE. Thank you, Mr. Secretary.

Secretary WIRTZ. I would like to add one thing to that. The rest of the arithmetic is that on the average the total cost is recovered in taxes alone on the average within 3 years. In addition to all the gain which comes to the individual and the community, in addition to getting people off the public's backs who would be on it the rest of their lives to the extent of $1,000 to $1,500 a year, it comes back in taxes between 3 and 5 years.

Senator TALMADGE. Thank you, Mr. Secretary. No further questions, Mr. Chairman.

The CHAIRMAN. Senator Curtis?

Senator CURTIS. Mr. Secretary, under the Manpower and Training Act and probably some of the other programs administered by your Department, you are permitted by law to enter into arrangements and utilize private schools that are operated for profit, are you not?

Secretary WIRTZ. There is a provision in the statute which provides that we shall use the public agencies where those services are available and can turn to private agencies where those services are not available or the private agencies can provide substantially equivalent training at comparable cost. You are talking about the vocational education training institution, I think.

Senator CURTIS. I have in mind some of our well-established—some of them are quite old—business and commercial schools to train secre-

taries. Many of them are privately owned and run for profit but have very fine records. Are they utilized?

Secretary WIRTZ. Very little. I should make it clear that the arrangement under MDTA is that all the institutional training we must contract for with HEW.

Senator CURTIS. But, you are the parent agency.

Secretary WIRTZ. HEW would not say that and I guess I would not either. The statute does provide that institutional training shall be supplied by HEW and the vocational education system, so when it comes to who provides the training, ours would not be a parent agency. But I think—I do not mean to fuzzy up the answer to your question. It is my impression—that regardless of whose decision it is, almost all of the MDTA institutional training is through the vocational education agencies. I would like to check with Mr. Ruttenberg to confirm that. I am advised that in calendar year 1966 there was a total of 163,000 enrollees in institutional training under title II of MDTA, 7,858 of whom were enrolled in private institutions. The statute does, however place priority emphasis on the vocational education system.

Senator CURTIS. Well, I have been hearing from some of these private schools and they are good institutions and I hope the time never comes in the United States when something that is run for profit is not worth considering. And it is their opinion that the existing law does permit them to participate and that some of the language in the House bill throws some doubt on it.

Secretary WIRTZ. Sir, I have no disagreement with that proposition, and under the experimental and demonstration provisions in title I of the MDTA, we have a larger license. As evidence of the support of the position which you have just suggested, we have, within the last 3 months, made training program contracts with private firms in nine cities. We are going along the line we are talking about. We are now experimenting with simply making a training contract directly with a private corporation. We let out what were in effect bids. About 46.

Senator CURTIS. Now, that is an employer corporation?

Secretary WIRTZ. No. It is a training corporation.

Senator CURTIS. In other words, a privately owned school. I think for the most part that they come under the on-the-job training.

Secretary WIRTZ. These contracts are experimental, to explore exactly the possibilities we are talking about here. They provide not only for institutional training but also include provisions for supportive services of one kind or another. I will supply for the record, a list of those contracting parties unless you have it, Mr. Ruttenberg.

There are nine of these experimental contracts with private firms.

(Pursuant to the above discussion the Department of Labor submitted the following material:)

[For release 10:30 a.m., Tuesday, June 27, 1967]

NEWS FROM U.S. DEPARTMENT OF LABOR, W. WILLARD WIRTZ, SECRETARY

UNIQUE PROGRAM WILL HELP 6,230 JOBLESS PERSONS IN 10 CITIES

Labor Secretary W. Willard Wirtz and heads of six private firms and a public school system today signed contracts to prepare 6,230 hard-core unemployed in 10 cities for full-time employment.

The 10 contracts mark the first time private companies will engage in a total effort to improve the employability of the hard-core jobless and disadvantaged under the Manpower Development and Training Act.

The cities, sponsoring agencies and the number of persons who will receive job assistance are:

Philadelphia, Philco Ford Corp., 800 trainees.
Kansas City, Training Corporation of America, Inc., 800 trainees.
Pittsburgh, Westinghouse Learning Corp., 720 trainees.
Atlanta, Atlanta Public Schools, 800 trainees.
Chicago, Brunswick Corp., 800 trainees.
Washington, D.C., Institute of Computer Technology, Inc., 360 trainees.
Houston Management Systems Co., 450 trainees.
Baltimore, Westinghouse Learning Corp., 600 trainees.
Detroit, Management Systems Co., 450 trainees.
Los Angeles, Management Systems Co., 450 trainees.

Secretary Wirtz said that the "central idea of the program is to use the innovative ability of private industry for solving, as effectively as possible, the myriad problems blocking the disadvantaged from productive employment."

In line with this aim, the 10 programs though all different in approach, will provide enrollees with counseling, testing, training, and follow-up services.

In addition, each program will:

Employ its own curriculum design, including the use of program learning and other advanced teaching techniques.

Allow for re-cycling an individual who might drop out. The purpose of this is to insure maximum success in reaching the hardest cases.

Seek out the most difficult of hard-core unemployed, in keeping with President Johnson's call to "help those with the greatest need."

Evaluate its own program so that the Labor Department will be able to weigh the relative merits of the different manpower approaches used by each project.

Contractors will also be required to enlist the cooperation of existing manpower programs in the city and assistance of the business community in opening up on-the-job training slots.

The State Employment Service will handle recruitment of enrollees, referring the "hardest of the hard-core disadvantaged" to the project.

The Department of Labor is providing $14.5 million for the 10 contracts which will run for 18 months. Here is a city-by-city breakdown of the funding:

Los Angeles, $1,294,840; Houston, $1,270,504; Washington, D.C., $749,500; Philadelphia, $1,502,851; Chicago, $2,425,506; Atlanta, $1,203,014; Kansas City, $2,396,660; Pittsburgh, $1,194,382; Baltimore, $1,185,068; and Detroit, $1,204,840.

The Department of Health, Education and Welfare participated in selecting the 10 projects and in setting up program guidelines.

Signing the contracts with Secretary Wirtz were: Robert Fickes, President, Philco-Ford Corp., and Vice President, Ford Motor Co., Donald H. McGannon, President, Westinghouse Learning Corp., Westinghouse Broadcasting Co.; W. A. Strauss, President, Northern Natural Gas and Management Systems Co.; John L. Hanigan, President, Brunswick Corp.; Albert Kreger, President, Institute of Computer Technology, Inc.; J. P. Chambers, President, Training Corp. of America; and Dr. John W. Letson, Superintendent, Atlanta Public Schools.

Also attending the ceremony were Assistant Secretary of Labor Stanley H. Ruttenberg; Administrator of the Bureau of Employment Security, Robert C. Goodwin; Bureau of Apprenticeship and Training Administrator, Hugh C. Murphy; members of the 4-member review team that selected the 10 projects: Cynthia Deuterman, HEW, and Ace Wilder, Merlin Taylor and Rita Dwyer, all of the Labor Department; and other representatives of the contracting organizations.

Senator CURTIS. Now, Mr. Secretary, you spoke at length about providing opportunities for the disadvantaged. I am aware that the anti-poverty programs are not under your jurisdiction, but I cannot resist this opportunity to call something to your attention because you are a member of the Cabinet and sit in the high councils of Government.

I believe we have a very serious problem in this country of poor people being let down and disappointed and disillusioned by promises or at least implied promises of the Government that are never fulfilled. I think one of the frustrations expressed is that programs are talked about but that is all that ever happens.

A year ago I called to the attention of the committee in a meeting here of a young lady in Washingon, a colored lady, of excellent character. Her mother and father had worked very hard to maintain the family. None of them has ever been engaged in rock-throwing or looting or being obnoxious. Excellent citizens. And, a year ago she went down to apply for some Government job that had been provided for people who needed it, people who need it very badly. She was advised in substance that she could not be considered because she was not a juvenile delinquent. This summer——

Secretary WIRTZ. That she could not get the job because she was not a juvenile delinquent?

Senator CURTIS. Yes.

Secretary WIRTZ. Thank you.

Senator CURTIS. Now, this summer she had completed 1 year of college. She went down to one of these agencies set up, spending a lot of the taxpayers' money, that is supposed to help people. She had an interview and she came away fully believing that she was to get a job as a teacher's aide in one of these temporary programs going on in Washington. Nothing happened.

I myself, not my staff, took the telephone. I called this office. I asked for the man who runs it. He was not available. I asked who I was talking to. They said it was his secretary. I gave the young lady's name. I told them of this promise and that she had not heard. I said will you please call her up. A promise was given that she would be called on the telephone.

Nobody ever called her. Weeks went by. So, some weeks later I made the second call to the same office, with the same story. Oh, yes, we will call her up. They never called her up at all and haven't to this day.

I am of the opinion that this Government is getting itself in a position with so many programs running in so many different directions that the taxpayers' funds are being consumed by overhead, plus appeasement of some people whose worthiness might be doubted, and that we are developing a very unfair situation to some of our citizens.

Now, I understand that you are not in charge of that program and I am not going to press you for comment but I could not resist this opportunity to tell a member of the Cabinet about this.

Secretary WIRTZ. Will you permit me to comment?

Senator CURTIS. Yes.

Secretary WIRTZ. My first inclination is, of course, surprise, but that is not the reaction I am going to express. With respect to the individual case, those facts could have only one answer and that is that they are completely unjustified and if any part of what you said happened, it should be redressed and I think immediately.

But, Senator Curtis, I would like to draw on your comments for a broader comment. You have cast your criticism in terms of the Government, I am replying the Federal Government, I think.

Senator CURTIS. Yes.

Secretary WIRTZ. I should rather turn it and say that I suspect that to whatever extent what you say, what you attribute to the Federal Government has been the fault of the whole country in the last 4 or 5 years, all of us have let down some people to whom we held out very high hopes and expectations. I suspect this girl was one of them. I

do not doubt what you say has happened in the Federal Government. I suspect it has happened in State governments. Beyond that I suspect it has happened on the part of private employers. I suspect it has happened on the part of labor unions. I suspect it has happened on the part of churches. I suspect it has happened on the part of schools. I suspect that the great national misfortune of the last 3 or 4 years is that there has been too much frustration of the promise that seemed to be carried.

I suspect that it is very important that for the very reasons you say, we do everything we can not to meet riots but to meet the frustrations and the hopes of the individuals who did not riot and about whom you are talking and therefore, Senator Curtis, instead of responding in antagonistic terms, I should like simply to suggest that I suspect that what you say has happened in the hearts and the minds and actions of too many people who have said we now believe in equality of opportunity but who have not yet practiced what they preach.

I do not believe it is the Federal Government alone. I think of the Government as a fairly faithful embodiment, from experience, embodiments of the strengths and the weaknesses of the country as a whole. I would hope that—I would like to take the moral of what you say as a national rather than a governmental moral. I do not believe in State rights and Federal responsibilities. I believe in national responsibilities. I think it is a pretty good moral for all of our guidance.

Senator CURTIS. I will not take the time of the committee to engage in debate. I can agree with you to a degree. I do not accept the premise that nobody is to blame but everybody is. That is even applied to cases where somebody murders the President. It is the theory that all people are to blame. I do not accept any such thing.

Secretary WIRTZ. If you found that in what I said——

Senator CURTIS. No, no. I said I agree with you to a degree, but I do not accept the premise that everybody is guilty but nobody in particular is responsible for their own acts.

Now, Mr. Chairman, I have a few questions here that were submitted by the minority leader, Mr. Dirksen. I will submit them after asking about one and that is the reason I am taking a little more time.

He has turned over to me a copy of a letter written by the Midwest Cement Pipe Lining Co., Inc., of Crossville, Ill. Mr. Henry J. Wallace, president, to Mr. Robert C. Goodwin, U.S. Employment Service, U.S. Department of Labor, Bureau of Employment Security, Washington, D.C.

DEAR MR. GOODWIN: Thought you might be interested in how the state of Illinois, "Employment Division" at Harrisburg, Illinois, handles calls for people to work.

We recently called for three or four men to help us through a bind and possible permanent employment. When we told the gentleman our starting wages, fringe benefits, etc., he grunted a bit and then frankly told us we did not pay enough to take his time to refer any men to us. He said: "Men can get more by drawing 'Unemployment Compensation' under the new laws than you are willing to start them out. I cannot ask men to make a sacrifice to work under such conditions." Just think—we employers are paying this department of bureaucracy to say this!

This is positive proof that welfarism is now an occupation—paid for by employers to allow men to become loafers while we must work and sweat and do without to pay their "loafing" bill. The pool halls, bars, and lodge halls are full

of them every day. No wonder the cities are having riots. Riots bring in more "loafing" money for more welfarism.

Why not try a work-in; instead of the sit-ins and riots?

HENRY J. WALLACE, *President.*

Here is Mr. Dirksen's first question, Mr. Secretary. The House of Representatives in approving H.R. 12080, included some new provisions that affected recipients of aid for dependent children. The purpose of these new provisions is to get more people off the welfare rolls and on employment rolls. In order to achieve this very worthwhile goal, the House imposed some stringent, but I believe necessary requirements. I say necessary because today these recipients could go to work but choose not to do so.

Mr. Dirksen's question is now, do you support the AFDC section of H.R. 12080? That means that as written by the House.

Secretary WIRTZ. My testimony is in opposition to that provision and it is in support, rather, of the provision in H.R. 5710. I think that the purposes which Senator Dirksen refers to, although not the correspondent whose views, I do not know, but I believe the purposes to which Senator Dirksen refers will be much more effectively met by provisions of H.R. 5710 than they would by 12080.

Senator CURTIS. Mr. Chairman, in deference to the other members here, Mr. Dirksen has submitted some questions about a number of items, including the amounts paid to trainees, how they arrive at number of unemployed, et cetera, and I ask that they be submitted to the Secretary and that the questions and answers be printed as though they were propounded.

The CHAIRMAN. Yes. Without objection.

I think that would assist us in getting on with the hearing.

(Questions of Senators submitted to the Department of Labor through the chairman, with answers supplied by the Department, appear at page 821.)

The CHAIRMAN. Mr. Secretary, most of the controversy I have heard about this bill seems to center around the House provision requiring that the welfare payment be reduced or denied where the individual involved refuses work or training without showing good cause.

Now, I find that this good cause provision is a part of the law now. It has been there since 1961. I am looking at compilation of social security laws, section 407 of the Social Security Act. This is "Benefits for Dependent Children of Unemployed Parent," and it requires that there be a provision in the State plan for denying aid to families with dependent children for as long as the unemployed parent refuses without good cause, to undergo retraining, or accept employment.

Now, that is in the law.

Secretary WIRTZ. Well——

The CHAIRMAN. It has been there since 1961.

Secretary WIRTZ. You see, and perhaps, Mr. Chairman, that is part of the basis on which I have just answered Senator Curtis, that I think the purposes can be much more fully achieved by a different approach than they were by that one. I do not mean to take advantage of that situation, though.

You see, that law in 1961 provided that the States could voluntarily set up programs of this kind. Very few of them did; only 12. I have checked to find that there are only between 12,000 or 14,000 people in training today under those community work-training programs. In short, my answer is that that did not work. That approach did not work. And I do not think it will work.

I think a much larger scale training program which is advanced with that same purpose in mind will prove much more effective than this situation.

The CHAIRMAN. Well, I note that the administration's bill—and this is one of the amendments Senator Williams asked the administration to come down with to show what the administration's recommendations are—has this provision. I am looking at page 201, line 22. It says——

Secretary WIRTZ. Page 10?

The CHAIRMAN. Page 201, line 22 of the bill before us. This is a committee print showing administration recommendations for amendments. This is an administration-recommended amendment. It provides for entering into agreement with the Secretary of Labor, et cetera, and goes on to say: "(b)"—line 22, page 201, line 22 of this print—"that such aid will not be denied by reason of such referral or by reason of refusal of such individuals to perform any such work if he has good cause for such refusal."

Now, that is putting it in somewhat different language, but I take that to mean the same thing, that if the person does not have good cause to refuse work, that he would—he will—be denied welfare aid or will only get a part of aid that would otherwise be available.

Now, does not that mean the same thing?

Secretary WIRTZ. Mr. Chairman, I am frank to say that I think the building up of a different, a basic difference, about this particular issue has done disservice to the common agreement or to the evidence of the common agreement which has developed. I do not believe there is really much basic difference among us about what ought to be done in these situations. I think when we come to the case of a mother of three children, the kind of mother who probably ought to be with those children rather than working, we would all come to pretty much the same agreement about what ought to be done in that case. When we come to another situation in which there is a loafer and the question is whether they ought to be given the hotfoot by insisting on training or work, I do not think we would resolve different cases the same way.

I think the objection, and in my judgment very well taken, is against what appears to be in 12080 simply a flat off-with-their-heads or off-with-the-welfare kind of approach as a general statutory insistence.

The difference—you are dead right—the difference between what different people feel about this, what the chairman of the House Ways and Means Committee has said, what you have said, what the rest of us have said, is a very minor difference. There is complete subscription today to the idea that with the economy going as it is, with the training programs available, with the jobs available, we have got to get out of this rut of inherited welfare. There is just complete agreement on that. And the disagreement comes down to a fairly fine point, as to whether there should be a flat statutory prohibition.

Now, I do not mean to give away objections that I have to the 12080. I think they have given the content—the language and content—of the 12080 items to a much flatter statutory prohibition than is a good thing, but I mean it in the best of good faith when I say to Senator Curtis in answer to Senator Dirksen's question, I think there will be more training done under the approach in the original House bill than the one in 12080.

The CHAIRMAN. Now, Senator Anderson was impressed by your statement here on page 12, that you believe completely in the central idea of the proposed amendments, that the welfare recipients should be moved wherever possible out of that condition and into the mainstream of employment and self-sufficiency, requiring the rejection, as totally inconsistent with that purpose, of the idea that his or her employment and training needs are to be met by welfare instead of the established employment and training agencies.

Now, his reaction was to ask, are you opposed to this bill? As it stands before us on balance? Are you against it, or, if not, will you submit amendments to meet your objections?

Secretary WIRTZ. Well, our objections would be met or our points served by the provisions of 5710, by the original provisions of 5710. In the form of 12080, those provisions would have to be adjusted and we would be glad to supply them. They would be the same in approach that 5710 provides. They would include the kind of language to which you have just referred there. They would embody this point which I have been making and I think the argument about the difference has been greatly exaggerated.

In answer to the question, we would be in favor of the provision relating to training and work and welfare as provided in 5710 which could be brought in here without basic readjustment.

The CHAIRMAN. Well, now if after considering your suggestion the committee and the Senate did not see fit to agree to it, would you be for or against the bill?

Secretary WIRTZ. That is making training compulsory?

The CHAIRMAN. As a key provision in the House——

Secretary WIRTZ. You ask——

The CHAIRMAN. This says only in "appropriate" cases. In that regard it says, "for development of a program for each appropriate relative and dependent child receiving aid under the plan and each appropriate individual living in the same home as the relative and child receiving aid."

Now, the administration bill itself provides for referral of all appropriate individuals who have attained the age of 16. They are talking about appropriate cases, just as you are. They aren't talking about cases that are not found to be appropriate for retraining or for jobs.

Would you be against that bill if your modification is not agreed to?

Secretary WIRTZ. The easy answer would be "no," but that isn't my answer. I think at this point in time, the development of the training program for about a million or a million and a half to 2 million individuals is put on the basis of you train or you don't get welfare. I think the reaction to it will be so negative in terms of the accomplishments of its purpose that I would recommend against the approval of that provision all the way. I don't believe it is necessary. I think it just is that serious.

May I offer one illustration of the importance of it and it ties in so closely with your questioning with Senator Kennedy. To tell these people they have to train or have to take work of one kind or another—we have seen their reactions. On the other hand, here in the District of Columbia when a group of some 1,100 boys, Negro boys, decided to spend the month of August in improving this situation, they did exactly the kind of work that you are talking about and when asked by a congressional committee, why do you do this kind of thing when you have rejected it as being the wrong kind of work, they said, it is because we are doing this ourselves under a program over which we have some control.

Mr. Chairman, those 1,100 boys would have refused to clean up alleys if they had been told, "You do this—or else." There is a very basic point, and they are doing it as part of a program which has a different spirit.

I would answer your question the hard way. I would be against the bill if it conditions all training on this approach as 12080 does.

The CHAIRMAN. Well, we are interested in getting the job done, Mr. Secretary, just as you are.

Secretary WIRTZ. Sure.

The CHAIRMAN. And, of course, this legislative process is such that you, at the executive level, recommend something and then the House committee studies it, and after they have heard what you recommend and ask some questions about it, they write what they think the law should be. If you don't like their idea, you get a second shot at them at the time it comes over here. You can say what you think of their idea. They have said what they thought of yours, and now you can say what you think of theirs. And we can take a good look at your arguments and theirs and work out which is the most effective.

Secretary WIRTZ. You know, I would not put the position in the form in which I did if it were not for the question which you put to me in the form in which you put it. But it is that important, Mr. Chairman.

The CHAIRMAN. Here is one thing. When we have someone who has no job and no one can find a job for him, and we find he has been trained the most that he can be but still can't find work, it appears to me we should try to find some way to subsidize him if need be to put that person on some job. Now, when we are providing submarginal jobs, do we really—are you so absolutely sold on this minimum wage and prevailing wage concept?

Do you really think we ought to insist on a prevailing wage and a minimum wage in a situation where we are actually subsidizing a person to put him on some job? What I have in mind is that after 20 years of the minimum wage, on these very marginal jobs, such as helping to keep the streets clean, beyond what the ordinary public services provide, and helping to keep the highways clean, as an example, helping to move some garbage that ordinarily wouldn't be moved, and a great number of other things that ordinarily you just can't find economic justification for, would you still insist that we have to provide a minimum wage for that type work?

Secretary WIRTZ. When you put it in the form of an exemption or whether you are covered by the minimum wage or not, you put it in a

very hard form for me to answer bluntly, but my longer answer will come out I think in the general area of your own position. I think it would be a great mistake for us to dilute the American standard of living by carving out large exceptions to the minimum wage law. That is the reason we have it. One of the reasons we have a higher standard of living in this country than in Japan, for example, is that there anybody is employed at any rates, and so forth and so on.

So that I would deal very, very gingerly with making any exceptions to the minimum wage.

I point out at the same time that physically and mentally handicapped persons, work at lower wages than the statutory minimum wage. People go to school at substantially less than the minimum wage, in fact, they are paying for it instead of the other way around.

I am coming, Mr. Chairman, to the point that I think there has got to be a recognition of the fact that there are some people who will not be employed at the minimum wage if it is applied to them, and that is a mistake. I think there are better ways of approaching their problem than to make exceptions to the minimum wage.

We are approaching it from the standpoint of on-the-job training, of a Government subsidy to cover that situation. That would have much to commend it as against, in my judgment, the exceptions to the minimum wage.

I think that it is incumbent on us, especially if this welfare program is moved along the lines that are proposed in 5710, it is incumbent upon us in connection with the training program to meet their problem in a way different from what we have before. Now we won't train anybody for a job which does not have a minimum wage prospect at the end. We would have to change that rule under your program to which you refer.

In short, Mr. Chairman, it seems to me we have got to recognize the fact that there are people who cannot perform in a private situation at a minimum with profit to an employer and that that situation has to be met, and I think it can be.

The CHAIRMAN. Well, here is just the type of situation that occurs to me. Let's assume that you have got some timber back here and only one road going to it. Here is an old settler with his humble home right on that road. Now let's assume that area is plagued by timber thieves. People go in there and they usually try to make it a point not to cut across the line on that Federal Government property because the Federal Government takes considerable pains to try to catch timber thieves on Federal property and hauls them 50 miles away from their home, where they may have relatives on the jury, to try them in a Federal court.

But they usually try to make a point of cutting over private property where this problem doesn't involve them, and it would seem to me that if you would just pay what you are going to pay in welfare to the sheriff and let him add something to it and just pay this person something, you can give him a responsibility just to watch for people going in there and inquire what their business is when they go back on this property and start hauling timber out of there.

Now, that person could earn something to supplement his welfare. He could actually be drawing pay and perhaps he might increase his

welfare by $30 or $40 a month. He is not doing anything most of the time, but he has responsibilities on that property back there.

Now, that type of thing, it would seem to me, wouldn't justify minimum wage but it would justify something more than he gets for just a welfare check.

Secretary WIRTZ. That case would not be covered today by a minimum wage law. There are a great many situations of that kind which would not be.

The CHAIRMAN. You aren't opposed to that type of thing.

Secretary WIRTZ. No, I am not. Especially at the end of a century like the last century which has created as much fallout of disadvantage as this one has, it would be sheer stupidity for us to take the position that nobody is to work on anything at less than $1.40 an hour and nobody is going to train at less than that. That is intolerable. I think it is essential that we find our answer to that in a way which does not undercut the sound principle of a standard of living which the minimum wage law brings in, but I am saying that I think that the meeting of this problem has got to take account of that situation and that need.

I think it can be done in better ways than exceptions to the minimum wage law. I think it can be done in your case by recognizing those situations which are outside the minimum wage law. I think it can be done in the case of those people who are training through a period, and that is the case that most of us like to think about, who are training through a period until they can earn a minimum wage. I think it can be done by on-the-job training, subsidies, because that is what they really are, picking up part of the cost of training, just as we do in the public schools.

Now, the hardest question of all is with respect to those people who will never make it above the point where they can be worth $1.40 or $1.60 I think we have got to recognize that, too.

The CHAIRMAN. As I understand the House committee report, the committee urges that the Secretary of Labor classify beneficiaries of this program as not being included under the Federal minimum wage law. They want you to classify certain types of work here out from under the minimum wage. Do you find any problem with regard to that suggestion?

Secretary WIRTZ. Oh, yes. I think that that would be as a statutory requirement exceedingly dangerous because what that would mean would be that there could be, then, a wholesale exception—if you take the on-the-job training situation—that would permit an employer to fill, at least as there are no exceptions there, permit an employer to fill all of his jobs with less than minimum wage people because of this during this on-the-job training period.

Now, if what we are talking about is the matter of making training programs, institutional training programs, fall outside the minimum wage law, they already are, Mr. Chairman. So that the principle again can be served, the flat requirement that all of the work-in-training programs be exceptions to the minimum wage law, would present us with difficulties. Administratively we can do that now. There is no restraint. So I would be opposed to a flat statutory requirement of that kind.

The CHAIRMAN. The sort of thing that has been suggested to me is that with regard to the people over 65, there are perhaps 200,000 people who might be made productive on a marginal or submarginal basis. I do not mean, for example, that he should be climbing on a rooftop nailing boards in the hot sun, but maybe he might be able to pass something up to somebody who is up on that rooftop, or cleaning up the streets, getting rid of the dead dogs off the highways, a few things of that sort.

Secretary WIRTZ. Mr. Chairman, what you just suggested, you would not think—your father and mine, neither of them is here—but the idea of their picking up dead rats and cats and cleaning up the streets after they are 65 at less than a minimum wage, we can't stand for that. I think we can put it in terms of older people to point up the poignancy which affects and should affect the matter.

You know, it is not just what they are doing. Oh, I must say the whole idea of finding the answer to the seriously disadvantaged in dirty work in some ways just cuts across my grain, dirty work at less than the minimum wage. We are compounding this problem as we go along.

Now, I think it can be met, but I think to put it in terms of the possibility of employing 200,000 older people gets both you and me into trouble with some of our principles. I don't think that is the answer. I think that work should be done, as a matter of fact, ought to be paid a lot more than the jobs some of us have because it is more unpleasant work, but the world isn't made up that way, and we know it.

I think a requirement which in its terms would mean that a person who is in the position he is—perhaps it is his own fault, perhaps it is mine, Senator Curtis perhaps notwithstanding—which is that he can't be a good employee, and to put him at cleaning up rats, dead rats, out of the streets at less than the minimum wage doesn't strike me as the compact that the people in this country made with each other.

The CHAIRMAN. Well, Mr. Secretary, from time to time I go walking in my neighborhood, just walking for exercise, and I don't like to see empty cans——

Secretary WIRTZ. I don't, either.

The CHAIRMAN (continuing). In a nice neighborhood, I pick them up and if I had—I guess it might look a little degrading for a U.S. Senator to carry a sack along, but as many as I can put in my pockets or carry in my own hands, I pick them up and carry them away to a trash can.

I was talking to one of the officials high in the same administration of which you are a part, and he tells me that he and his wife get out there and help clean up those streets in their spare time because they want the place to be clean.

Now, if a U.S. Senator and a member at sub-Cabinet level of this administration can do it, why is it so degrading for somebody living at public expense to do so?

Secretary WIRTZ. That is exactly what the 1,100 boys spent August doing, and my point is that it will be done, that it does provide perhaps a margin of error as far as these things are concerned, but to do it by way of simply providing a statute that you, because of your condi-

tion, are going to have to pick up dirt in the streets at less than $1.40 an hour, Mr. Chairman, I think that is the wrong approach to it. I think the reaction against that will defeat the purpose of the program, and I think—I was trying to suggest earlier a different approach taken to it will have a result which is illustrated by what the boys have done here in Washington in August, in the organization Pride.

The CHAIRMAN. The thing I am concerned about, Mr. Secretary, is this suggestion—and the people we are talking about in this bill the House sent us are all under 65—that, (a) they shouldn't do anything unless they want to do it, and (b) that they really wouldn't be but about $10 or $15 better off than they would be if they stayed in their home, where they didn't do so much as slap a mosquito. That really doesn't provide as much incentive as it would if you said, Look, we have got a job here for you.

Even if it is not a good paying job, if it is something that is well within your capabilities and we would expect you to do that before you do something else.

Now, you can talk all you want about dirty jobs. Somebody has to do it. I have done a lot of it myself just around the house or in the neighborhood, because I would rather do it myself than ask somebody else to do it. But when people want the taxpayers to support them, I would think they certainly ought to be willing to do something for it.

Secretary WIRTZ. I like the basis on which you put it, that there is an obligation on your part which you observe to pick up those beer cans when you see them. I would like to see a similar approach to the whole thing. The difference isn't whether people don't want to work, and it is not that I suggest these offers about dirty work or anything of that kind. It is just a question of whether you can get more people in this country who ought to be trained and employed, whether you can get them trained or employed by passing a statute which says, your children and you won't get any money on welfare unless you do this. That is one approach. Or whether you set up an approach to that same problem which emphasizes the necessity of administering it that way.

All I am saying is that the line is comparatively narrow as far as the difference in approach is concerned except for that fact of saying you are just not going to get it unless you clean up the streets at less than the minimum wage. If the Congress passes that law, it won't work.

The CHAIRMAN. Well, suppose we say at the minimum wage. Suppose we say at more than the minimum wage. Now, as I understand your suggestion, even at the minimum wage you are opposed to saying, well, now, you don't get the welfare check unless you are willing to help with this and you are well able and capable of doing it. You are opposed to that, too.

Secretary WIRTZ. Yes; that is right, but I would like to say, as far as I am concerned, the question is whether the job is most effectively done if you put the program to the welfare recipient that way.

Our question comes down to the question of judgment as to whether you get there best by providing for the training facilities and administration in the form of 5710 or whether you get there best by leaving yourself—ourselves in a position where they are doing it under threat of getting it cut off. That is the only difference there is. We are in favor of the same results and I don't even know whether there is a

difference of view about the question of whether more people will be trained and employed, one opposed to the other. I haven't heard anybody say they think more people will be trained and employed under the compulsory approach. I doubt that they would say that because I don't believe most people would believe it.

The CHAIRMAN. Well, the thought just occurs to me if you tell a person, here are a dozen different things that need to be done. Which one do you think you would be more interested in doing? Even if you have given them all the training that they can absorb, you still wind up with the proposition that you can't have good jobs for everybody. The best jobs usually are those that someone holds already. So you can't start them on the top on jobs. You have to start them in at what is left available after training.

Secretary WIRTZ. I agree on that.

The CHAIRMAN. Any further questions?

Thank you very much.

I have a number of questions I am going to submit to you, and I would appreciate it if you would answer them for the record. (See p. 821.)

(Secretary Wirtz' prepared statement, and the questions and answers referred to follow):

STATEMENT OF W. WILLARD WIRTZ, SECRETARY OF LABOR, BEFORE THE SENATE FINANCE COMMITTEE, ON COMMUNITY WORK AND TRAINING PROVISIONS OF THE SOCIAL SECURITY AMENDMENTS OF 1967 (H.R. 12080) AUGUST 29, 1967

Mr. Chairman and members of the committee, national interest in the Social Security Amendments of 1967 centers on the proposed increase in social security benefits and the extension of Medicare. I join Secretary Gardner in urging support of—

The proposed 15 percent benefit increase with a $70 minimum benefit, as recommended by the President;

A minimum benefit of $100 for persons who have worked 25 years or more in jobs covered by social security;

Full widow's benefits for disabled widows of any age;

A contribution and benefit base of $7,800 in 1968, $9,000 in 1971, and $10,800 in 1974; and

The inclusion of disabled social security beneficiaries under Medicare.

My testimony is directed particularly, however, at a basic set of issues presented by the proposed amendments to the *welfare* provisions of the Social Security Act, particularly as they involve the inter-relationship of the welfare programs to opportunities for work and for training.

The coincidence of a large increase in the number of welfare beneficiaries with an unprecedented increase in the availability of jobs and with the development of an extensive manpower training program has given rise to increased interest in the *responsibility* of welfare recipients to accept available work and training opportunities.

Most people in this country earn their own way, and find the opportunity for doing it comparatively satisfactory. There has been in the past, nevertheless, relatively full understanding of the incompleteness of this opportunity for others when there were not enough jobs for all in an economy that kept going up and down. This was particularly true under the sensed circumstances of the inexplicable denial of equal opportunity to minority groups. There has been a consciousness of common responsibility for the fact of human disadvantage which has led to not pressing very hard on the issue of "whose fault it is."

There is a difference today.

The economy is in its seventh year of constant growth, and there is confidence for the future. There has been an unprecedented increase in the number of jobs available. The papers are full of help wanted ads, and it is next to impossible to get appliances repaired or certain other kinds of work done.

There are extensive training and work programs available.

Although the unemployment rates for minority groups remain intolerably high, the idea of equal employment opportunity has been written into the law and is now much nearer a reality. But the disadvantage of inadequate training is now a far more serious factor. Even if all discriminatory hiring practices disappeared tomorrow, and there were as many jobs available as persons who need and want them, all too many could not fill them because of lack of training.

To seem to suggest that there has been a full development of needed opportunities for either work or training would be wrong. There hasn't been. But the central elements in the situation are totally different from what they were in the 30's, when most of the formative thinking about "welfare" programming was done. And there is new questioning of any practice which may seem to encourage anyone's staying "on the welfare"—when there are, or appear to be, unused work or training alternatives.

President Johnson's recommendations to the Congress, embodied in H.R. 5710, recognize the desirability of expanded efforts to increase the self-sufficiency of welfare recipients. H.R. 12080, adopted by the House, carries this idea forward: in some instances, I respectfully suggest, constructively, but in others to a fault.

I concur fully, and therefore simply note it, in Secretary Gardner's testimony regarding the desirability of providing in this legislation—

For the making of plans for each welfare family which include work and training where the circumstances warrant it;

For the expansion of work and training opportunities for welfare recipients;

For expanded day care facilities for the children of mothers who are or need to be working or taking training;

For the exemption, in determining offsets against welfare payments, of (i) the first $50 a month of earned income plus one-half of any additional earnings, and (ii) all earnings of AFDC children attending school full time (as provided in the House bill); and

For the restoration of the $20 incentive payment for those welfare recipients who accept work and training.

There are two other centrally important points here which warrant the most careful consideration and on which I respectfully urge action different from that taken by the House.

H.R. 12080 would require that welfare assistance be denied to individuals if they fail or refuse to accept work or training opportunities unless they can show "good cause" for such failure or refusal.

This sounds good, and reflects an unquestionably desirable general principle. But in my judgment, such an absolute statutory conditioning of welfare payments on the acceptance of work or work training would be unwise and impractical.

Here again, Secretary Gardner has gone into this point so fully—and it involves considerations lying so much more within his province than within mine—that detailed comment would only burden the record. I note, in general, nevertheless, the lesson of experience from the administration of most of the existing work and work training programs. One of the hardest problems is getting through with these programs to those who need them most. This problem could well be aggravated rather than made easier by a general rule of compulsory training. There are facts of "alienation" and difficulty of communication and lack of complete know-how involved here which will not be met by a threat of cutting off the individual's means of subsistence.

I don't mean to dismiss this point lightly. It bears directly today on much more than the administration of the welfare program. It is related—although in a strangely reverse sort of way—to the current proposals to create millions of new jobs to relieve the problems in the slums and ghettos—when there are already hundreds of thousands of jobs unfilled. It is a problem we face in administering the existing manpower programs, when we identify the number of unfilled training slots today in some of these programs in some areas.

A century's accumulated mistakes are not going to be corrected by shortcut solutions. There is unquestionably going to have to be more responsibility assumed by everybody involved in this situation—by the indigent and unemployed to be sure—and also by employers, labor unions, civil rights organizations—*and* public agencies.

The right answers are unfortunately undramatic. They involve going after every single case of indigence or ignorance or unemployment or lack of qualifications to work *in individual terms*. They include much more training opportunity

than is presently available; much more participation by private employers than has so far been worked out; and a much larger acceptance by those who are disadvantaged of the training opportunities afforded them than they have so far shown. The right answers don't include sentiment or softness—but they don't include "off with their welfare" either.

Finally, as the intended point of primary emphasis in this testimony, I urge the adoption by the Senate of the provisions in H.R. 5710 for the administration of the work and training program for welfare recipients.

This would make this work and training program part of the broader work and training—or manpower—program presently in effect.

It wouldn't make sense to proceed, as H.R. 12080 does, from the idea that welfare recipients should be moved as fully as possible out of the backwash of "welfare" and into the mainstream of training and employment, to the conclusion that welfare recipients' training and employment should be handled by the welfare agencies instead of by the regular training and employment agencies.

There is today a manpower—work and training—program administered through the Manpower Administration in the Department of Labor in carefully worked out conjunction with other Federal, State, and local agencies. It embodies the present form of a system which (i) developed slowly over the 30-year period following the enactment of the Wagner-Peyser Act in 1933, and (ii) has now accomplished an effective coordination and consolidation of the manpower programs enacted by the Congress during the past five years.

No one could be more acutely conscious that I am of two criticisms of the existing manpower program—compounded, in varying degrees, of earlier fact and prevailing fashion:

That the Federal-State Employment System has become too old and tired and over-institutionalized between 1933 and 1962 to be an effective agency in a war on poverty, a civil rights revolution, and now a modernization of the welfare program; and

That the manpower programs adopted during the past five years have been left sprawling across the landscape with the uncoordinated ineffectiveness of an octupus with brain damage.

H.R. 12080 appears to reflect an acceptance of these criticisms to the extent that it would set up a new, competing and duplicating network of work and training facilities. It becomes relevant to provide the Committee with the most accurate possible factual summary of the present national manpower program.

The following employment, unemployment insurance, occupational training, work experience and other manpower programs are today administered through the Manpower Administration in the Department of Labor (which is headed up by an Assistant Secretary for Manpower, a post established by the President in June, 1960):

The Federal-State employment service established in the Wagner-Peyser Act of 1933 (which includes, within the Department of Labor's Manpower Administration, the Bureau of Employment Security and its constituent services; and some 30,000 State Employment Service personnel in over 2,000 offices all over the country).

The Unemployment Insurance program established in the Social Security Act of 1935.

The Apprenticeship and Training program established by the Apprenticeship Act of 1937.

The Manpower Development and Training programs—institutional, on-the-job, and experimental and demonstration—set up under the Manpower Development and Training Act of 1962 and its amendments in 1963, 1965, and 1966.

The Neighborhood Youth Corps program established in the Economic Opportunity Act of 1964 (with full operational authority being delegated in 1964 by the Director of the Office of Economic Opportunity to the Secretary of Labor).

The Operation Mainstream (Nelson) adult work experience with rural emphasis program established by the Economic Opportunity Act Amendments of 1965 (with a similar delegation from OEO in March, 1967).

The New Careers (Scheuer) program (adult work experience in subprofessional jobs) established by the Economic Opportunity Act Amendments of 1966 (with a similar delegation from OEO).

The Special Impact (Kennedy-Javits) adult work experience and trainin program established in the 1966 EOA Amendments—also delegated by OEO—primarily for urban ghettos.

The manpower functions of the work experience and training program for welfare recipients and other needy persons under Title V of the EOA transferred from HEW to Labor by the EOA Amendments of 1966, effec tive July 1, 1967.

The administration of these programs involves an inevitably complex, bu now carefully developed, set of policy and operational relationships between (i the Department of Labor, the Department of Health, Education and Welfare the Office of Economic Opportunity—at the Federal level, (ii) the State emplo ment services and vocational education agencies, and (iii) local municipal "community action," educational, and private agencies.

There would be advantage and value in the Committee's broad inquiry int the development in the past five years of a series of inter-agency and inter governmental procedures which have had little public notice for the precis reason that they have worked so well; but which are relevant to the question o how the welfare work and training program should be fitted into the presen structure. I refer only illustratively to:

The development by the Departments of Labor and HEW of arrange ments under the MDTA by which the State employment services and th State vocational education agencies now conduct an institutional trainin program for some 162,000 enrollees a year, of which at least 50 percent with a goal of 65 percent, are from the seriously disadvantaged group.

The development by the U.S. Employment Service (in the Manpower Ad ministration) and the State employment services of a Human Resources Development Program. It has changed the role of the employment servic in the past two years from what was primarily a job referral agency to what is most significantly an agency for serving the disadvantaged job seeker. This program involves an active seeking out of the disadvantage from the slums and ghettos of the nation. It involves mobilizing services o the community to enable the individual to become employable—to surmount the barriers of poor health, poor education, and lack of skills. At the same time employers are encouraged and persuaded to hire the disadvantaged the poor, and the welfare recipient, for jobs with a future.

The development of the Cooperative Area Manpower Program System, under which all Federal, State, and local manpower agencies are brought together to develop coordinated policies and programs for a particular area.

The development of the "concentrated employment program" in 21 areas of heavy unemployment. Resources (currently totalling over $100 million) from six different manpower programs (MDTA institutional training, MDTA on-the-job training, EOA Neighborhood Youth Corps, EOA Special Impact, EOA New Careers, and EOA Operation Mainstream) are brought together in a *single contract* with a local unit. That unit ties together the activities of the various local agencies—public and private—in a program of recruiting, training (where necessary), and finding permanent employ ment for, the hard-core unemployed in that area. These are people whose unemployment problem is in most cases more a matter of personal disad vantage than a shortage of jobs.

It is a conservative estimate that almost 375,000 of the men and women, boys and girls, who are enrolled in training and work experience of one kind or another under the Manpower Administration programs are from the seriously disadvantaged group which is distinguishable only in details from the "welfare group":

More than 60,000 of the 750,000 people who have received training in the MDTA programs during the past four years have been welfare recipients.

Over a quarter of the 1,100,000 participants in the Neighborhood Youth Corps program (during the past 30 months) have been from welfare families.

It was understandable that when the community work and training program was added to the Social Security Act in 1962 it would be included in the welfare agencies' responsibilities. It was at that point an experimental, voluntary pro gram, and did not include Federal funds for training costs (with the result that only 12 States adopted community work and training programs).

That was before the development of an overall manpower program (the Manpower Development and Training Act had been passed only a few weeks before, with the appropriation of funds and the setting up of the administrative procedures for it being still in the future). The State employment services had not, at that time, gotten to any appreciable extent into the "hard-core" or "disadvantaged worker" area.

That was two years before the enactment of the Economic Opportunity Act and the establishment of the manpower programs under that Act which relate so directly to the disadvantaged worker situation.

That was before the establishment of the Manpower Administration, and the development of the various procedures and programs which are aimed so largely at meeting the various different employment and training problems of those who, for one reason or another—good or bad—have been left out.

So far as the question is whether additional and more effective work and training programs are necessary to move welfare recipients onto an independent, self-sufficient basis—and to break the inheritance and the habit of living on the welfare—the answer is that this *is* needed. Enlargement and increased program effectiveness of the national manpower training system which would come from an expansion of the work training program for welfare recipients contemplated in the Social Security Amendments of 1967 offers significant new encouragement for the development of this system.

But if the question is whether there should be another large scale new system—separate and apart from the present system—to meet the work and training needs of those "on welfare," the answer is that this would reduce any future suggestion of "coordination" and efficiency to utter hypocrisy.

To believe completely in the central idea of the proposed Amendments—that the welfare recipient should be moved wherever possible out of that condition and into the mainstream of employment and self-sufficiency—requires the rejection as totally inconsistent with that purpose of the idea that his, or her, employment and training needs are to be met by welfare—instead of the established employment and training—agencies.

I urge adoption by the Committee and the Senate of the administrative provisions proposed in H.R. 5710 for the community work and training program. They place the responsibility for welfare activity with HEW, and manpower activity with the Department of Labor. They provide for coördinated effort, similar in nature to many other pieces of manpower legislation. At the local level, in particular, they eliminate overlapping and duplicating administrative functions and program operations.

Assistant Secretary Ruttenberg and I will welcome your questions.

DEPARTMENT OF LABOR RESPONSE TO QUESTIONS OF SEPTEMBER 5, 1967, FROM THE COMMITTEE ON FINANCE, REGARDING THE WORK AND TRAINING AMENDMENTS TO THE SOCIAL SECURITY ACT

Question 1. Under the proposal supported by the Department of Labor, would you state specifically when the State would run the program and when will the Labor Department run the program?

Answer. Under H.R. 5710 the State welfare agencies would be required to operate a work and training program "only if the Secretary of Labor or his delegate does not maintain and operate any work and training program as authorized under section 410 in the State, and has certified that it is not practicable for him to maintain and operate such a program anywhere in the State."

Since over 2000 offices of the Federal-State Employment Service of the Department of Labor operate in all of the States and Territories, it is unlikely that there would be any State in which the Department of Labor through the Federal-State employment service system would be unable to operate a work and training program under H.R. 5710.

Question 2. When the Labor Department does set up programs in all States, will they do away with the existing State programs?

Answer. If H.R. 5710 is enacted, the program authority for State welfare agency-run community work and training programs under the present section 409 would expire. While the law would not prohibit State welfare agencies from continuing to run work and training programs, they would be unlikely to do so, since Federal funding would not be available.

As to the Community Work and Training programs which now exist in 12 States, the Department of Labor would consider funding them under section

410 of H.R. 5710 or providing an orderly transition to operation of such programs through the Federal-State employment service system if such a transfer appeared to further the purposes of the Act.

Question 3. In those instances where you have State administration under your proposal, won't those States be reporting to the Department of Health, Education, and Welfare as to these programs?

Answer. Yes, but see Answer to Question 1.

Question 4. Secretary Gardner's statement (page 14) indicates that the States would be required to have a community work and training program if "the Secretary of Labor does not and is unable to do so". On the other hand, Under-Secretary Cohen's statement says on page 18 that "if the Secretary of Labor does not operate a program, or finds it impractical to do so throughout a State, programs could be set up by the State welfare agency". Would you explain the mechanics of exactly how this would work?

Answer. The State welfare agency would be required to have a program only if the Secretary of Labor has no programs within a State and has found that it is impractical for him to establish any programs. See Answer to Question 1.

Question 5. (a) How would your proposal, which seems to authorize projects administered directly by the Department of Labor, or State-run projects through welfare agencies (which don't even report to the Labor Department) avoid duplicating existing programs in this area?

Answer. See Answer to Question 1. It is planned that the fullest possible use would be made of existing work experience and training opportunities under other statutes in order to avoid any unnecessary duplication of programs in the same geographical area.

(b) For example, what will happen to the work experience projects under Title V of the Poverty Act?

Answer. See Answer to Question 17.

Question 6. Recently, the Department of Labor indicated that the child should not be penalized by wrongs of the parents. Do you believe there are enough safeguards under H.R. 12080 to take care of the child but not reward the parent who refuses to undertake training?

Answer. I do not think it is possible to "take care" of the child and at the same time fail to provide any of the needs of the parent or other relative who is responsible for the child. Aside from food, clothing, and shelter, the primary need of the child is the tender, loving care of a parent. A welfare parent whose aid is cut off would almost always be forced to abandon his child. Even if he could keep the child, the malnutrition and inability to provide clothing and shelter for himself would reduce the child's existence to the barest animal level. The child's life cannot thus be so neatly separated from that of his parent's. In my view vendor and protective payments cannot "take care" of the child regardless how many "safeguards" are provided.

Question 7. As Secretary of Labor can you suggest any additional safeguards for the interests of the child? For instance, the House bill provides a State plan requirement which requires that vendor or protective payments should be used in "appropriate cases", p. 108, line 15. Is the case where a parent has had his payment stopped for refusal to participate in a work and training program an appropriate case? Shouldn't the State be required to use those protective payments or vendor mechanisms in this case?

Answer. H.R. 12080 provides (p. 132, line 9) that vendor or protective payments may be made in cases where a relative refuses without good cause to accept employment, and, in cases of such refusal, the House passed bill exempts such payments from the restrictions otherwise applicable to such payments. It seems clear to me that the House clearly intended that such payments were "appropriate" in cases where relatives refused without good cause to work. I think that it is better to require vendor and protective payments than to see the child denied assistance because the relative refuses to work. Let me make it clear, however, that I think vendor and protective payments visit a terrible penalty on the child for the refusal of the relative or parent. In practical terms, the child will almost never be able to continue living with his parent or relative when only the child's need is taken into consideration.

Question 8. Your Department will have a great deal to say about the type of training program that will be provided. I assume that there will be two types of programs, one for the mothers and one for the minors, 16 or over, who are out of school and out of work. Will you describe the type of training programs you have in mind?

Answer. The Department does not assume that there will be two types of programs distinguished by mothers on the one hand, and minors 16 and over on the other. Fathers will of course be involved when States have AFDC–UP laws.

The Department has provided work experience and training for over a quarter of a million youth ages 15 through 21 from welfare families. Many, if not most, of them might be termed young adults. In many instances these youth were mothers or fathers and were adult in attitudes and approaches to life.

Experience of the Department indicates that any training program for this disadvantaged group must necessarily be flexible enough to provide appropriate training according to (1) individual capabilities *and* (2) job possibilities. Experience also indicates that program differ as one moves from rural to urban situations. Job possibilities change, educational requirements differ. Motivation of individuals in the direction of employment vares.

Programs will be modeled on MDTA (institution and on-the-job), Neighborhood Youth Corps, and the adult work experience program administered by the Department of Labor. We expect to use these programs to the maximum extent to meet the needs of individuals and avoid the necessity of establishing separate and distinct programs for welfare recipients. To establish separate and distinct programs where they were not absolutely required would be a great mistake.

Question 9. Will the trainees be paid the minimum wage—$1.40 an hour—now, and $1.60 an hour next February 1, as they participate in these work-training programs?

Answer. Under both H.R. 5710 and H.R. 12080, the participant in the Community Work and Training program does not receive wages from his "employer." Rather, under H.R. 12080, he continues to receive his maintenance grant, and under H.R. 5710, his maintenance grant plus up to $20 a week incentive payment. This total payment, in either case, determines the amount of time he works, as stated in H.R. 5710:

"(4) the rates of pay for the time spent in work, when measured against the aid or assistance received by the participant in the program and the incentive payments paid to him under subsection (c), are not less than the minimum rate provided by law for the same type of work and are not less than the rates prevailing on similar work in the community."

The provision in H.R. 12080 dealing with rates of pay has the same result—

"(E) payments for such work are at rates not less than the minimum rate (if any) provided by or under applicable Federal or State law for the same type of work and not less than the rates prevailing for similar work in the community (except that in the case of work by individuals who under such law are considered learners or handicapped persons, payments may be at any special minimum rates established for them by or under such law).'

This payment in the form of credits against welfare benefits applies only to work experience as distinguished from training. It is our intent to move persons into cash wage paying on-the-job training and off of dependence on welfare assistance grants as quickly as possible.

Question 10. Will you be paying a mother $1.60 an hour to learn to do a job that may only pay $1.00 or $1.25 an hour?

Answer. No.

Question 11. A great many of these trainees will be teenagers. Do you have any estimate of what the total might be?

Answer. There are over 175,000 youth ages 16, 17, and 18, among the 3.7 million children now on welfare. Many work now. Many should be encouraged to return to school. During the past 30 months more than 250,000 participants in both in-school and out-of-school. Neighborhood Youth Corps projects have been from welfare families. We estimate that 75,000 youth might become involved in a Community Work and Training Program.

Question 12. How does your Department calculate the number of unemployed in the country today? Is the process related in any way to claims of unemployment compensation?

Answer. The number of unemployed is estimated from the results of a monthly survey conducted for the Department of Labor's Bureau of Labor Statistics, covering 52,000 households carefully distributed to represent the entire United States. Census Bureau enumerators ask about the work activity of all members of the household 16 years of age and over. Persons who are not working in the week before the survey, who had looked for work within the previous 4 weeks, and were still available for work are counted as unemployed.

The process is not related to claims for unemployment compensation although interpretation of changes in the unemployment situation is based upon examination of claims data as well as those from the survey. Many people counted as unemployed in the monthly labor force survey are not receiving unemployment benefits. This includes youth and women just starting to look for work who have not acquired unemployment coverage, workers who lost jobs in industries not covered by unemployment compensation, and workers who have been unemployed so long their unemployment compensation benefits are exhausted. In August 1967, for example, we estimated the total unemployed at 2,942,000 from the monthly survey, while the number of persons receiving unemployment compensation under State and Federal unemployment insurance programs was 1,108,000.

Question 13. How do you arrive at the rate of unemployment among the teenage group who have never held a job or never been eligible for unemployment compensation?

Answer. The rate of unemployment among the teenage group is estimated from the monthly survey. Persons who have never held a job and are not eligible for unemployment compensation, as well as those who have, are counted as unemployed if they meet the definition described above.

Question 14. The unemployed out-of-school youngster of 16 to 21 presents one of our biggest problems. What effect has the recent increase in minimum wages had and what effect will the increase to $1.60 an hour next February have upon their employment opportunities? Do you think that they are more likely to find work next year at $1.60 an hour when they cannot qualify now at $1.40 and were not worth $1.25 an hour to employers last year?

Answer. In the period since the $1.40 minimum wage rate went into effect—there has been a substantial increase in the number of employed youngsters 16 to 21 years of age. In February 1967, 8,062,000 persons in this age group were employed. In August 1967, the latest month for which data are available, the figure was 11,042,000. This represents an increase of almost 3 million. In large part, of course, this increase reflects summer jobs. However, even when we compare the number of young people employed in August of 1967 with the number at work in August 1966—it is still apparent that the minimum wage increase has not curtailed employment opportunities for youths. Actually 185,000 more youths were employed this August, six months after the change in the minimum wage law, than in August a year ago. The rate of youth unemployment is no higher this summer than last summer.

Generating additional jobs for youths still presents a major challenge. We do not believe this challenge can or should be met by lowering wage standards. We are convinced that it can best be accomplished within the framework of the present minimum wage law. Experience has already shown that youths can be trained for jobs which economically justify payment of the full minimum wage.

Question 15. There is one other area where minimum wages have had an adverse effect and that is with students who find it necessary to work part-time in order to get through college. They should be encouraged, but the private universities tell me that they simply cannot afford to continue many of these jobs at the new rates. Is there some Administrative action that you could take to exempt these students and the universities from minimum wage coverage so that they can continue to provide employment in these cases?

Answer. This question is not directly related to the proposed program since college students will not be enrolled. However, I am advised by the Administrator of the Wage and Hour and Public Contracts Divisions that many of the jobs in the private colleges available to students, such as waiters and waitresses, have been newly covered under the minimum wage law and that a rate of $1.00 an hour rather than $1.40 is applicable. There is little evidence to support the idea that students would take jobs at subminimum rates or that most colleges wish to pay such rates.

Question 16. You emphasized the training aspect of the Administration's proposal. What kind of work programs do you intend to set up for individuals with low-potential who have exhausted their training possibilities?

Answer. The Community Work and Training Program will provide greatly increased training for welfare recipients. Many of these individuals are considered to have "low potential" but their actual potential has not been carefully appraised or developed. We can approach this group with confidence since the Department of Labor is already using a number of program approaches which have successfully demonstrated that most so called "low potential" individuals

can be brought to the point where they can extend competitive employment and prove to be satisfactory employees.

In addition strenuous effort is being made to provide entry into career ladders within the private and public sector. "Job-engineering" relating to establishing sub-professional jobs will be the major focus of a working conference being held in November under the joint sponsorship of the Department of Labor and the Department of Health, Education, and Welfare. This conference is being called at the request of the Bureau of Work Programs of the Manpower Administration which is responsible for the New Careers program under the Economic Opportunity Act.

There are, of course, always those individuals who are at the "low end of the capability ladder." It is not safe to assume, however, that the majority of welfare recipients fall into this category. Welfare recipients have many other problems which must be faced and dealt with and which are currently keeping them from becoming effective members of the labor force.

With appropriate job-engineering, job development and job placement as well as a variety of training approaches, it is expected that a large percentage of welfare recipients can be brought into the labor force. Of course many persons will take longer to train or will need greater amounts of education. Those individuals who cannot enter the competitive labor market by virtue of their low potential or by virtue of the multitude of other problems must necessarily be dealt with on a case by case basis in the community in which they reside. Work roles for these must be individually tailored to meet the needs of the community and the needs of the individual.

We do not anticipate at this time the establishment of a separate work program for those with "low potential." Each situation will be handled in the context of the local project and of the individual needs.

Question 17. What specifically does the Administration plan for title V of the Economic Opportunity Act? If it is to be phased out will there be only one job and training program aimed at assistance recipients? If so, when will the title V program go completely out of existence?

Answer. The administration has requested $70 million for title V for FY–1968. This is a reduction of $30 million in the appropriation of FY–1967. For the present it is anticipated that title V of the Economic Opportunity Act will continue but with greater emphasis placed on its utilization as an experimental and demonstration program. Present Administration plans include some reduction in the size of the program but do not at this time anticipate its elimination.

Furthermore, since title V reaches "other needy persons" as well as assistance recipients it provides the basis for training male members of households in states where the law does not provide for assistance.

It is the intention of the Department of Labor to coordinate the activities of the Work and Training provisions of this bill with those of title V in such a fashion as to avoid duplication while providing the maximum service to individuals and communities. The Department of Labor is currently engaged in intimate coordination of its manpower functions under title V of the Economic Opportunity Act with the responsibilities of the Department of Health, Education, and Welfare. The responsibilities of the Department of Labor under title V of EOA and responsibilities under this Act will be handled by the same administrative unit in order to prevent duplication.

Question 18. In the report on the present Community Work and Training Program sent to the Congress earlier this year it was stated that only 8% of the assistance recipients in the program who got jobs got them through referral to the U.S. Employment Service. Why wasn't this proportion much higher? How many jobs have you gotten for all public assistance recipients over the last year?

Answer. Many Community Work and Training programs under the current Act have handled and developed their own job placement and referral systems. Thus a large number of participants were not referred to the U.S. Employment Service.

More importantly, however, the placement of a welfare recipient is not simply a matter of referral. If we are to place disadvantaged individuals including welfare recipients in jobs, extensive job engineering and job development services must begin at approximately the same time that the individual enters the project. Referral after training for this type of person is inadequate. Reasonable job placement can only be obtained when vocational counseling, employability planning, job development, and job referral are administratively

coordinated with the training being received. The Department of Labor has placed a substantial number of those public assistance recipients trained by it. For instance over 60,000 have been enrolled in MDTA training and a substantial majority of these have been placed in jobs. Reports indicate that 7 out of 8 of these achieved earnings in excess of the minimum wage and that nearly ⅓ were employed at a rate of $2.00 an hour or more. 54% of the men achieved earnings over $2.00 an hour.

Question 19. Under the provisions of the House bill do you feel that you would have the authority to contract with private business schools which are operated for a profit in order to provide adequate training facilities for the many thousands of welfare recipients?

Answer. The House bill (H.R. 12080) provides for a "work and training program administered or supervised" by the state welfare agencies and "maintained and operated by that agency or another public or non-profit agency." The Administration bill (H.R. 5710) provides that the Secretary of Labor may "make grants to, or enter into agreements with, public or private agencies or organization if he determines the program meets the requirements of this section."

The provisions of the Administration bill provide considerably greater flexibility in seeking out those agencies public or private which may be utilized in the provision of training.

Question 20. Do you think it would be productive in these work and work-training programs to make use of private job placement agencies—in addition to the State employment services? Wouldn't this provide a wider range of job opportunities?

Answer. The Department of Labor presently uses non-profit private agencies for some job-placement services. Use has not been made of private agencies which charge fees for their services.

The CHAIRMAN. I regret we were not in a position to hear you when you first arrived here, Senator Brooke. Senator Kennedy was testifying, and we appreciate your coming back. We are very happy to have you here. You have shown a great interest in the problems related to this social security bill, and we are aware of the fact that you are on the Commission appointed by the President to make a study with regard to these urban problems.

STATEMENT OF HON. EDWARD W. BROOKE, A U.S. SENATOR FROM THE STATE OF MASSACHUSETTS

Senator BROOKE. Thank you, Mr. Chairman.

Mr. Chairman, distinguished members of the Committee on Finance, I am grateful for this opportunity to testify on a matter of great concern.

We have recently seen dramatic and horrifying examples of violence and disruption which can occur when one segment of our population lives for too long in poverty and despair. Newark, Detroit, Watts, and Roxbury were primarily reactions to continuing, longstanding, and relentless economic deprivation. They were the outbursts of the totally frustrated, the hopeless, the "internal aliens" in our Nation for whom the community accepted a responsibility, those who had no other means of support: the blind, the aged, the disabled, the unemployed. This is still the principal purpose of public welfare.

But welfare, in and of itself, is not desirable. For those who can work, there is something about relief—permanent relief—that cripples the spirit and violates the recipient's sense of honor and self-respect. It is a negation of the American dream. And, perhaps, more telling, it does not work, if by "working" we mean offering some promise for

permanent solutions. Relief relieves desperate pressures, but it accomplishes little or nothing toward helping those who need it to escape from their unfortunate condition.

The elimination of this type of dependence on public welfare by those who are mentally and physically capable of becoming productive members of society is, I am sure, the objective of the legislation which you are considering today. The members of the House Ways and Means Committee have very wisely determined that the States and the local communities have, in all too many cases, confined their attentions to administering the relief rolls. Too little creative effort has been put into helping individuals on relief to break out of the cycle and to make their contribution to society. To correct this imbalance, the committee has seen fit to incorporate into the 1967 Social Security Amendments provisions requiring the States to make available, where appropriate, employment counseling, testing, and job training services for each adult and each child over 16 who is not attending school. The States would also be required to provide day care services for children whose mothers want to work to participate in job-training programs. Family planning services are to be made available by the States. Earning exemptions are to be granted by all States, to encourage individuals on welfare to become participants in the community without losing the opportunity to participate in welfare programs. All of these measures are good. They offer incentives to the States to provide the kinds of services without which the poor people of our country cannot begin to pull themselves out of the cycle of poverty.

I congratulate the authors of this legislation for including these provisions in H.R. 12080. But I ask you, what will we have accomplished if, in passing this legislation we help some of the poor while forcing others back into even greater poverty and despair.

In 1966, 3.2 million children received aid to families with dependent children. As of January 1, 1967, 84,000 of these were living in my own State of Massachusetts. In June 1967, the number of children on AFDC in Massachusetts was 91,500, an increase of 7,500, or close to 9 percent, in 6 months. Assuming a comparable rate of increase for the remainder of the year, the number of children receiving AFDC in Massachusetts by January 1, 1968, would be 99,735, or close to 100,000. Yet the bill presently under your consideration specifically states that (section 208, d):

> Notwithstanding any other provision of this Act, the number of dependent children who have been deprived of parental support or care by reason of the continued absence from the home of a parent with respect to whom payments under this section may be made to a State for any calendar quarter after 1967 shall not exceed the number which bears the same ratio to the total population of such State under the age of 21 on the first day of the year in which such quarter falls as the number of such dependent children with respect to whom payments under this section were made to such state for the calendar quarter beginning January 1, 1967, bore to the total population of such State under the age of 21 on that date.

Thus, as of January 1, 1968, allowing even for an increase in dependents as a percentage of the population increase, the number of children receiving AFDC in Massachusetts must once again revert to the neighborhood of 85,000, or 15,000 less than the anticipated number of children needing such assistance.

Let us assume that this bill passes the Congress by early October. Even if the States were to receive the funds for job training, counseling services, and day-care centers the very next day, and were to begin setting up such programs immediately, which of course we know they could not possibly do, it is inconceivable that a State like Massachusetts could find jobs for 15,000 untrained and undereducated youths and parents in a scant 2-month period. The result could only be that the burden of support would fall completely on the States and the local communities which operate on even tighter budgets than the Federal Government.

I therefore urge the committee to carefully reconsider this particular provision of the bill, and to either eliminate the ceiling entirely, or to at least extend it for a reasonable period, such as 2 or 3 years, to give the States and local communities time to develop the required programs.

One further point with regard to AFDC: The present bill provides that children who are between the ages of 16 and 21, but are going to school full time, may exempt their earnings in determining their eligibility for AFDC. Very few disadvantaged children in that particular age bracket are able to go to school full time. I believe the provision ought to be extended to include children who are attending school part time as well. If the objective of this legislation is to encourage the children of the poor to improve their conditions, then all initiatives ought to be welcomed and encouraged, not just those which can only be regarded as exceptional given the circumstances under which the children live.

There is another provision of the bill which I think merits further attention, not because I deem it unsound in principle, but because I believe it can, in practice, have serious consequences. This is the establishment of a low-income ceiling for recipients of medicaid. Perhaps it would have been advisable to include some ceiling, or a formula for establishing one, in the original bill. Perhaps in the interests of economy and sound fiscal practice, a ceiling needs to be established now. But I seriously question the wisdom of imposing a relatively low ceiling at a time when many States have programs covering families whose incomes are quite in excess of the limitation proposed.

When medicaid was first initiated in 1965, it was designed to meet the needs of those children whose parents were too poor to provide them with proper medical and dental care. Within 2 years, 25 States became participants in a program which presently helps to meet the hospital costs and doctors' expenses of 3.5 million children. Twenty-three additional States are expected to join in the program by 1968. Each State has so far been permitted to establish its own criteria for recipients of this combined Federal, State, and local assistance. Thus, in Massachusetts, for example, a father of two whose wife is not working becomes eligible for assistance if his income is less than $413 per month. This means a family becomes eligible for medicaid when its net income is approximately $100 per month per person, or a total family income of $4,956 per year for a family of four. This figure corresponds almost exactly to the poverty level established in the State of Massachusetts.

Yet under the present bill, the Federal Government would pay its share of the program only for those families whose income does not

exceed 133⅓ percent of the highest amount which would ordinarily be paid to a family of the same size under AFDC. A family of the same size receiving AFDC in Massachusetts is paid $226.70 per month; 133⅓ percent of this is $301.41 or $111.59 less than the $413 per month which is the maximum a family can presently receive and still be eligible for medicaid. I submit that there is a double penalty involved here. The States with the most effective programs are going to be most seriously hurt if the present limitation is passed into law. It has been estimated that the cost to the State of New York alone would be as high as $60 million per year. The cost to other States would be less only because the population is less. The percent of State budgets which would have to go to make up the difference would be quite similar.

The other alternative which the States have is to reduce the number of children eligible for medicaid to the level suggested by the limitations of the Federal Government. This would penalize most those families who are just beginning to better their economic conditions, and to have some reasonable hope that their children will know advantages and opportunities which they themselves were denied. I do not believe that this is the goal which the drafters of this legislation had in mind.

There are very few nations of the world which can even begin to approach the standard of living which we enjoy in the United States. Yet there are already 10 other nations which have a lower infant mortality rate than we do. Of all the countries of Western Europe only one, Greece, does not have a "family allowance" provided by the government. And even in Greece, the employer and employee together contribute to a fund to provide an allowance above and beyond the regular salary for workers with children. In all but two of these countries, France and Portugal, sickness and maternity benefits are provided by the government to all who need them. In many cases these benefits include not only hospitalization and medical costs for the patient, but a weekly allowance to his or her dependents as well.

How does the United States compare with these nations? At home, in the United States, more than 3.5 million poor children under the age of 5 who need medical help do not receive it under existing law. One million pregnant women each year receive little or no prenatal attention. Over a million American babies a year are born outside the hospital, at a time when most of the nations of Europe have been providing free maternity care for as much as six or seven decades.

It is inhumane to impose artificial ceilings on the number of children who are eligible for medical assistance. In fact, such assistance should be vastly expanded. Yet the present legislation would not only provide for a bare minimal increase in the amount to be spent for medicaid, and impose earnings limitations far below many present State levels for those eligible for the program. This bill would continue to make State participation optional, and would indirectly provide incentives to the States to substitute other programs for child medical care besides.

Section 224 of H.R. 12080 eliminates the requirement that the States must make available certain services, including inpatient and outpatient hospital services, laboratory and X-ray services, skilled nursing

home services, and physicians services on an equal basis to all those eligible. Under this bill, the States may as an alternative provide any seven of 14 services, including home health services, clinics, dental services, prescription drugs and eyeglasses, and the like.

It is only to be expected that, considering the increased burden on the States as a result of other provisions of the bill, not to mention the consequences of an ever-growing population, most State governments will choose to provide those services which are least costly. I do not believe that this is the time to encourage the States to reduce their medical services to needy children, or indeed, to any other segment of the population which is dependent upon them. Instead, the Federal Government should be offering incentives to the States through increased matching grants, to develop all of the various medical services and to make them available to all who need them.

In addition, Mr. Chairman, I would like to go on record as favoring the raising of the minimum payments to the elderly under social security beyond the increase provided in the bill, to a level more commensurate with the cost of living. H.R. 12080 provides that benefits would be increased by 12½ percent for persons now receiving social security, or a minimum of $50 per month per person. I think that this amount should be increased even further, to a minimum of $75 per month, if our elderly are to be enabled to enjoy the minimal advantages of a decent and dignified life.

I would also like to be recorded as favoring additional incentives offered to older persons on social security to enjoy gainful employment, without losing their right to their monthly pension. I personally favor elimination of the ceiling on earned incomes, but at least the ceiling could easily be raised, without increasing the cost of the Federal Government. Such elimination or substantial increase would be of immeasurable value to older persons who want to be self-supporting.

I would like to be further recorded as favoring welfare programs which would not penalize families. I am afraid that all too often the father, if he is unemployed or underemployed, feels obliged to leave his family, for he knows that they will be economically better off under AFDC and other similar welfare provisions than living on the income which he can provide. The provision in the current bill that if the father is collecting unemployment insurance, his children are not eligible for any AFDC assistance, only further undermines the ability of a family living in poverty to remain intact. Medicaid, food stamp programs, job training and counseling should all be geared much more to helping the father of the family. Family allowances might be examined as a possible way to encourage poverty stricken and marginally poor families to remain intact.

But my objective today is not to suggest new programs, but to work for the most careful and beneficial application of those programs already in existence. Assistance to the elderly has been increased under the present bill. I am confident that the Senate may yet modify the provisions regarding higher minimum payments and earnings exemptions. But the children of this country must be helped, and helped now.

If relief were the only, or the best, method of alleviating permanent distress, I would favor it, even if it meant, to take the most extreme

example, allotting lifetime subsidies to able-bodied but unemployed young men. For a society has an obligation to provide minimum welfare for those who cannot provide it for themselves. But in America, Mr. Chairman, relief is not the only way, nor even the best way. The best way is to help our people to help themselves to become a part of society, and to contribute their talents and energies to its betterment, not its destruction. As has been often said with regard to the civil disturbances in our major cities, to raise levels of expectation without providing corresponding opportunity can be psychologically devastating.

Mr. Chairman and members of the committee, I submit that the suggested changes in the pending legislation will help us to achieve our goal of a better life in the future for our Nation and for all her people.

I thank you.

The CHAIRMAN. Thank you very much for your statement, Senator Brooke. I believe it would be correct to say you are the first Republican Senator from Massachusetts to testify for this type of program.

Senator BROOKE. I think I am the only Republican Senator from Massachusetts, Mr. Chairman.

The CHAIRMAN. Well, there have been others before you. I served with several of them. And while they had some votes for some of these things, they never came before the committee to testify for it.

Senator BROOKE. I hope there is going to be a new day within the Republican Party, Mr. Chairman.

The CHAIRMAN. In years gone by I was one who offered some of these very suggestions, such as this increased minimum payment that you have. I have been offering amendments of that sort for almost 18 years, with some success, but more often without success. I can appreciate the suggestions that you have made here.

I believe we pretty much agree that in the main we ought to be providing for essential needs, and at the same time trying to see that we get the best possible results from Federal funds. If people can be helped more by finding ways to encourage them to help themselves, we should make the maximum effort to provide them with an incentive to improve their condition. We have a big program. This welfare program is about $8 billion a year now with almost $5 billion of Federal funds, and we ought to be working, I think, to try to improve and refine it.

Some of the suggestions you make I do think have very substantial merit with regard to some of those things that we must not neglect. You have made some very fine points. I appreciate your comparison with a number of these European countries.

May I ask where your source is for that information?

Senator BROOKE. I beg your pardon, sir?

The CHAIRMAN. Might I inquire of your source of the comparison you gave between this country and European nations with regard to family allowances?

Senator BROOKE. A competent research staff, Mr. Chairman.

The CHAIRMAN. Very interesting.

Senator BROOKE. I would be very pleased to get you citations on this if you wish.

The CHAIRMAN. It is interesting to see just how they are making out. I didn't realize the figure was quite as high as you indicate with

regard to pregnant women who receive practically no prenatal advice, I think that is something we ought to take a good look at.

Senator BROOKE. I would be very pleased to document all the statistics I have given.

(The material referred to follows:)

WELFARE BENEFITS IN EUROPE

Austria:

Family allowance: $6.50–$8.40 per month per child.
Birth allowance: $68.00.
Sickness: 50% of earnings.
Maternity: 100% of earnings for 12 weeks.

Belgium:

$11.18–$22.46 per month.
Birth allowance: $166.22.
Sickness & maternity: 60% of earnings (maternity, for 12 weeks).

Denmark:

Family allowance: $94.50–$102.00 per year per child.
Sickness & Maternity: $3.00 per day, plus $1.05 per dependent per day.

France:

$14.70–$22.77 per child per month.
Prenatal allowance: $14.70 per month for 9 months.
Birth grant: $138.00.
Sickness & Maternity: 50% of earnings; ⅔ of earnings after 30 days.

Germany:

Family allowance: $6.25–$17.50 per month per child.
Birth allowance: $25.00.
Sickness & maternity: 65% of earnings for 6 weeks; 75% of earnings thereafter. Maternity: 100% of earnings for 14 weeks.

Greece:

Family allowance: $3.90 per month per child.
Sickness & maternity: 50% of earnings; max.: $1.80 per day.

Ireland:

Family allowance: $1.40—$3.64 per month per child.
Sickness: $7.28 per week, plus $5.60 for each adult dependent and $1.82 for each child.
Maternity: $7.70 per week for 12 weeks.

Italy:

Family allowance:
$11.40 per month per child.
$8.32 per month for spouse.
$4.68 per month for dependent parents.
Sickness: 50% of earnings for first 20 days; ⅔ of earnings thereafter.
Maternity: 80% of earnings up to 21 weeks.

Luxembourg:

Family allowance: $10.90 per month to $17.40 per month per child. Birth grant: $73.74—$123.90 per birth.
Sickness: 50–70% of earnings.
Maternity: 70% of earnings for 12 weeks.

Netherlands:

$8.40–$16.00 per child per month.
Sickness: 80% of earnings.
Maternity: 100% of earnings for 12 weeks.

Norway:

Family allowance: $76.00—$200.00 per child per year.
Sickness: $.42–$2.66 per day, plus $.28 per day for dependents.
Maternity: same.

Portugal:

Family allowance: $1.20–$3.00 per month.
$.90–$1.20 per month for each eligible adult dependent.
Birth grant: $6.00
Sickness: 60% of earnings for first year.
Maternity: 100% of earnings up to 120 days.

Spain:

$90 maximum per month per child.
Sickness & Maternity: 75% of earnings.

Sweden:

$11.25 per child per month.
Sickness: $1.00 per day, plus supplement according to income.
Maternity: $.15–$6.00 per day up to 180 days.

Switzerland:

$4.60–$6.90 per month per child from Swiss government. $3.45–$6.90 per month per child from the Canton government.
Sickness & maternity: minimum of $.50 per day.

United Kingdom:

$1.12–$1.40 per week for each child after 2nd.
Sickness: $11.20 per week, plus $7.00 per week for wife, and lesser amounts for children.
Maternity: $61.60 grant.

Note: Most countries provide cash refund for part or all of medical expenses in addition to listed sickness & maternity benefits.

Source: Adapted from "Social Security Programs Throughout the World, 1967" published by HEW.

The CHAIRMAN. Senator Anderson had to leave while you were testifying. He told me he appreciated what you had to say and he read your statement.

Senator BROOKE. Mr. Chairman, while waiting, I overheard the colloquy between you and Senator Kennedy. You mentioned some 50,000 police jobs that were available. I have also seen that figure quoted. Very recently when I was on tour in New York as a member of this President's Advisory Commission on Civil Disturbances, I looked into some of the reasons why there were not more people seeking jobs with the police department in the city of New York, particularly in these poorer areas such as East Harlem, where we have had a civil disturbance and which is primarily inhabited by members of the Puerto Rican minority. The answer was given to me that some of the requirements for joining the police force were unreasonable. For example, in this particular area, the height requirement was a great deterrent to Puerto Ricans joining the police force.

I went into central Harlem. The same situation exists there. Of a police force of 28,000 in the city of New York, I think there were no more than 300 or 400 Puerto Ricans on the force and only 1,800 Negroes out of the 28,000. I asked whether there was a policy of discrimination, and the commissioner assured me that there was not. Why had not more sought to join the police force, which would certainly provide them with a livable wage? The requirements were simply too high.

For instance, suppose a young man had been convicted of a crime, say, when he was 16 years of age, maybe one crime, and then had gone off to war and fought in war and had come back, received some education and could qualify educationally for the police department.

He would never be able to join the police department, because of that one conviction when he was still a youth.

Now, there is a pretty large percentage of people who come from impoverished and disadvantaged homes with no opportunities. You would be amazed at the high statistics which were given me as to how many of these have been in violation of some law by the time they reach 21 years of age. I believe the figure was nine out of 10.

So you can see there are many, many factors that have to be taken into account in considering means of getting more people from the slums onto the police force.

The CHAIRMAN. It would be higher than nine out of 10 if you caught them for everything they did. I guess honest confession is good for the soul, and I can think of a number of things I did as a youngster, a teenager, or preteenage, that would have been a serious, perhaps disqualifying offense if I had been caught at it as a child.

Of course, as a kid both I and my friends could run pretty fast. I think we avoided some difficulties because of that very fact. Others, too.

Senator BROOKE. Mr. Chairman, you and I were fortunate. We were the lucky ones. We probably both had fathers who, if we did something wrong, let us know about it when we came home. But some of these children don't have any fathers at all. They know that when they get home the father is not concerned about their behavior outside the home. In fact, he might even, in some instances, encourage them to do wrong. And these are very serious problems which we have just got to come to grips on.

The CHAIRMAN. These qualifications you mentioned relate to some of the facts that exist in a great number of governments. Now, in this very bill we have a provision that hopefully could be a very great benefit to the State of Louisiana if we can work it out. But the State has so much bureaucratic conflict between various agencies of the State government itself that it presents a Gordian knot that we must try to untie to find out how the State can fully avail itself of what is provided in this bill.

I don't know if we can work it out or not. But that is not our fault. It is because the conflict among State agencies handling various aspects of the program is such that they can't resolve it, and we will try to work it out. Maybe we can, but maybe we can't.

Now, with regard to these police qualifications, it would seem to me that these police forces ought to be moving to modify this thing of requiring a certain height. How much height do they require of somebody to be on the police force?

Senator BROOKE. I think it is 5 feet, 8 inches.

The CHAIRMAN. My impression about the qualifications for a policeman is that the most important qualifications have to do with what is in his heart—the courage of the man to face danger. Here in Washington the physical requirements have been adjusted, reducing the requirement on eyes of from 20:20 to 20:40, correctable to 20:20 with glasses. The teeth requirements are reduced from a minimum of 16 natural teeth to proper-fitting dentures in good repair. And as recently as May 25, 1967, the height requirement had been lowered from a minimum of 5 feet, 8 inches to 5 feet, 7 inches.

Now, I regret to say it, but while I thought I was a pretty good naval officer—not that my commanders above me always thought that—I don't suppose I could have qualified, once I started wearing glasses, for the police force. And that is something that ought to be corrected. The fact that a man is 5 feet, 7 inches or 5 feet, 8 inches doesn't mean he couldn't qualify as a good policeman. Some races just are not as tall as other races, too. That probably applies to the Puerto Ricans.

Thank you very much for your statement.

Senator Talmadge?

Senator TALMADGE. No questions. I compliment you on your statement, Senator Brooke.

Senator BROOKE. Thank you, Senator Talmadge. Thank you, Mr. Chairman.

The CHAIRMAN. Our next witness is the Honorable Sam Caldwell, commissioner of the Georgia Department of Labor.

Senator TALMADGE. Mr. Chairman, it is my pleasure to welcome to our committee my friend and constituent, the distinguished labor commissioner of the State of Georgia.

The CHAIRMAN. I want to thank you very much, Senator Talmadge.

May I say, Mr. Caldwell, it is my impression that anybody from Georgia who comes recommended by Herman Talmadge has to be a very good citizen and good public official if he testifies in that capacity.

STATEMENT OF HON. SAM CALDWELL, COMMISSIONER OF LABOR, STATE OF GEORGIA

Mr. CALDWELL. Thank you, Mr. Chairman.

Mr. Chairman, distinguished members of the Senate Finance Committee, it is a great honor for me to have this opportunity to speak briefly to this committee of the Senate in regard to what I believe to be unsound provisions contained in H.R. 12080.

I address myself only to those provisions in the bill which relate to the manpower training programs in our Government.

Careful study of these provisions—even a cursory study—would reveal that they provide for one department of Government to take over a large part of the responsibility of another department of Government for which it is not fitted and for which the authority requested is inappropriate.

I speak to you as an elected commissioner of labor from Georgia, and one who has an overwhelming mandate from the people to insure realistic training programs and job placements.

It has been essential in our Government since its establishment that we should avoid excesses of power.

I believe it was George Washington who said that the Senate is like a saucer, where hot liquid is poured from the cup to be cooled.

Gentlemen, the manpower provisions of H.R. 12080, as passed by the House, should be allowed to cool here and, indeed, to die here.

Our forefathers realized that the acquisition of power creates the desire to obtain more and more power over the lives of individuals—and that having acquired, wrested, or assumed additional power leads to a demand for more and more and more power.

The Secretary of Health, Education, and Welfare now controls a broad spectrum in our Government and is, in truth, approaching what should be a ceiling on the extension of his domain.

Certainly, we should not let one Government agency have authority to plan and direct a program of activity, excluding another Government agency from such planning and direction, yet placing the responsibility for its success or failure on the department so excluded.

We are talking about training welfare recipients. We know at the outset that on a massive basis the success of such training as far as job placement is concerned will be limited.

We know, too, that it is an absolute necessity that this group of people be counseled frequently and on a continuous basis in order to motivate a desire for self-sufficiency and a better way of life.

Knowing of these barriers and having observed them over the years, we know as a fact, and as something that is daily evident, that surmounting these barriers will require herculean effort, staggering outlays of funds, and we feel that the percentage of success will be discouragingly low.

Nonetheless, we realize that the effort must be made and that we cannot treat any group of people as an island when we attempt to help them improve their lot in society. That is one of the great weaknesses in this House-passed version, in that it tries to set people receiving welfare assistance aside from their fellows in the population and to train them as a separate part of our society.

In reality, welfare recipients should have the opportunity of adequate training programs that will prepare them for gainful employment.

They should be made keenly aware that there is a better life and environment which can exist only through initiative and hard work.

We want no ghettos in America.

But, since we have them, we want training programs that can give hope and opportunity to those in ghettos.

In all areas, the fragmentation of manpower programs needs to be minimized if we are to provide those who need it most with adequate training and meaningful jobs.

Indeed, there is strong sentiment today for consolidating many of these programs which have been established outside of regular operating agencies, such as OEO, into one agency. Whenever the wisdom of this course is realized, much of the waste and duplication will be eliminated.

We should not throw out the window all of the experience and expertise gained by the Labor Department Manpower Administration in the successful operation of such programs.

In fact, the Manpower Administration is giving increasing priority to the chronically unemployed, including those on welfare. This is true in the State of Georgia. We have found that where the training has been sufficient and meaningful there is no difficulty in placing those who complete such training in good and lasting jobs.

And, we cannot lose sight of the fact that through the Manpower Development and Training Act programs, we are heading off many prospective welfare clients before they become dependent upon public assistance.

Gentlemen, to show you the absurdity of these duplicate programs we need only to compare the success of MDTA programs, where in Georgia we are placing 85 percent of those trained on useful jobs.

And yet, only 465 MDTA training slots are authorized for the Atlanta metropolitan area during the present fiscal year. We need a minimum of 5,000 and could successfully carry out a program embracing 10,000.

A proposal for utilization of 4,000 MDTA slots was submitted but could not be approved due to lack of funds—and yet, this bill calls for the expenditure of hundreds of millions of dollars for the doubtful and unproved.

We should expand MDTA program financing and bring the full impact of this program to all segments of the community, including substantial numbers of welfare recipients, potential welfare recipients, and other disadvantaged persons.

This is an approach where success has been proved.

This is a total approach—not one which is fragmented.

MDTA training courses in Georgia are jointly planned and operated by the department of labor and the department of education. The welfare agency in Georgia is not training-oriented and does not have qualified personnel in this field.

It is inconceivable that manpower and training functions such as those proposed in this bill would be placed under the Secretary of Health, Education, and Welfare, the result of which would be needless duplication of services already provided or which could be expanded under the Secretary of Labor.

Some of the specific recommendations contained in this section of H.R. 12080 provide:

1. That community work and training programs be established in those areas where the Secretary of Health, Education, and Welfare determines that a significant number of AFDC recipients are located.

2. That work and training programs be mandatory for all AFDC recipients who have attained the age of 16 and are not in school.

3. That such work is performed on projects which serve a useful public purpose and do not result in displacement of regular workers. This indicates that public works projects would be established under this plan, and no thought is given to permanent employment.

It provides for day care services and also that any recipients who refuse without good cause to register with local employment offices or to accept training or employment will be denied welfare benefits.

Gentlemen, the House Ways and Means Committee pointed out in their report that by 1970 this program would require some $200 million for day care services alone.

An additional $700 million would be required to establish the community work and training programs.

The Employment Service offices then would be placed in a position of having to certify those who refuse jobs and training, without the administrative authority to supervise that training.

A realistic and meaningful training program must include a determination as to what skills are needed and what job opportunities are available in the area in which the recipient is training.

Without job placement, training is an expensive exercise in futilty.

In the State of Georgia, there are 24,244 families now receiving AFDC payments. Of this number, 20,478 are unemployed mothers and only 3,766 are unemployed fathers. This clearly indicates that the proposed program is aimed at mothers who are heads of households. The great majority of these are not qualified for gainful employment. So, unless primary consideration is given as to whether jobs are available in every area where parents are trained, the training program becomes but another useless and greatly expensive experiment.

Certainly it is unlikely that any State is going to provide matching funds for this type of experiment.

It is my belief that the intent of the House Ways and Means Committee was to decrease welfare payments by placing more people on useful jobs. This intent was lost in a maze of unrealistic and impossible provisions which would result in a duplication of services and profound waste of dollars.

The original intent could be accomplished by placing the responsibility for training in the Department of Labor and including these provisions:

1. Require all AFDC recipients who are 16 or over, and not in school, to obtain from the local employment office a certification as to whether employment is available.

2. Require that those who refuse a job, without good cause, be ineligible for welfare benefits.

3. But do not require those recipients to go into a training program. For if it becomes mandatory for them to accept an available job, this will provide an incentive for them to train and upgrade their skills.

4. For those who accept employment, reduce their welfare payments by the amount of their salary or some reasonable percentage.

5. Expand MDTA programs and continue to train welfare recipients on a volunteer basis, in the same manner in which we are now doing.

This, gentlemen, is the only realistic approach, which takes into account the various complicated social conditions involved, shows a basis of proven success, and which is in accord with the traditional American principles of self-improvement.

Thank you, sir.

Senator TALMADGE (presiding). Mr. Caldwell, I congratulate you on your statement. I find myself in agreement with virtually everything you have stated here in your statement, particularly your six recommendations that you make to the committee on pages 7 and 8.

I notice in general that is substantially the same testimony that the distinguished Secretary of Labor, Mr. Wirtz, made this morning.

On page 4 of your statement, paragraph 3, you state that only 465 MDTA training slots were authorized for the Atlanta metropolitan area during the present year. Does that mean only 465 people will have the opportunity for training in this area?

Mr. CALDWELL. That is correct.

Senator TALMADGE. How many are getting the opportunity for the entire State?

Mr. CALDWELL. We have at the present in MDTA classes 1,050 throughout the entire State.

Senator TALMADGE. So really you are just kind of a drop in the ocean with what you are doing at the present time?

Mr. CALDWELL. That is right. And, as you will recall, the MDTA program was cut back in favor of some of these other programs that have been set up, and certainly with a program such as MDTA where we have proven success, these types of programs should be expanded.

Senator TALMADGE. Does the poverty program in their training program work with you? Do you have any jurisdiction in that field?

Mr. CALDWELL. We don't have any jurisdiction. Under OEO, when it was first created, I think we had a contract with them whereby we furnished personnel such as counselors in the neighborhood youth centers, and we were reimbursed from this agency. We still furnish those personnel, but at the present time we are not being reimbursed. So, in practically all of these training programs that have been set up outside of the Department of Labor and the vocational educational department, we have had to more or less supervise or furnish counselors for these training programs even though they were funded through other agencies.

Senator TALMADGE. Wouldn't it be a good idea if all those training programs were consolidated under one State agency?

Mr. CALDWELL. I think it would be a very good idea to consolidate them under one agency and, of course, the department of labor in Georgia works very closely with the department of vocational education in determining what skills should be trained for in these classes and also in determining whether or not jobs are available in these areas before we set up training programs.

Senator TALMADGE. On these training programs that you have, are you using to a large degree the area vocational training schools and the local vocational training schools or how is it implemented?

Mr. CALDWELL. Our vocational education department furnishes teachers to teach these classes, and then in many locations throughout the State we are using the facilities of the vocational education department. In other areas we have set up MDTA centers. I think we have some 15 in Georgia now. And, of course, it is coordinated very closely with the vocational education program.

Senator TALMADGE. How do you get your applicants for these training programs?

Mr. CALDWELL. We recruit them. Of course, we have a great many more people who are applying for these classes now than we are able to fill.

Senator TALMADGE. What is the ratio of applicants to vacancies that you have available?

Mr. CALDWELL. Well, in the Metropolitan Atlanta area, for example, we have some 5,000 that have applied for these training courses, and yet we only have 465 approved.

Senator TALMADGE. Are you urging them, in turn, when you don't have available slots, to go to the vocational training schools?

Mr. CALDWELL. Yes, sir; but, of course, with the vocational and educational schools, they are dealing with a little higher type personnel and also with people who might be in a better financial position. Most of those that we are training under MDTA are those who cannot afford to go to the vocational school and who must be provided some type of subsistence while they are going to these classes.

Senator TALMADGE. Yours, then, is some type of relief clientele?

Mr. CALDWELL. Yes, sir.

Senator TALMADGE. Thank you very much, Mr. Caldwell, for your very able and informative—one further question. How many AFDC recipients have you trained?

Mr. CALDWELL. At the present time we have 55 AFDC recipients enrolled out of 1,050 who are enrolled in MDTA classes. We don't have any statistics as yet because we have not been keeping them along this line as to what success we have had in training AFDC recipients and placing them on jobs. But overall, the program has been very successful and we are placing 85 percent of them that complete this training on jobs.

Senator TALMADGE. Did these AFDC recipients volunteer or did you have to recruit them?

Mr. CALDWELL. They volunteered.

Senator TALMADGE. Thank you very much. You made a very fine statement.

The committee will stand in recess until 10 a.m., tomorrow morning.

(Whereupon, at 1:25 p.m., the committee recessed, to reconvene at 10 a.m., Wednesday, Aug. 30, 1967.)

SOCIAL SECURITY AMENDMENTS OF 1967

WEDNESDAY, AUGUST 30, 1967

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

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

Present: Senators Long, Anderson, Gore, Talmadge, Ribicoff, Williams, Carlson, Bennett, and Curtis.

The CHAIRMAN. The hearing will come to order.

This is the third day of public witnesses testifying on the Social Security Amendments for 1967. Today our witness list is comprised primarily of persons who desire to speak to the medicare aspects of the House bill. Our first witness this morning is Dr. Donovan McCune, appearing on behalf of the Kaiser Foundation Health Plan.

Is Dr. McCune here?

Dr. McCune, I believe you have some assistants. Will you please take your seat there and identify your assistants and proceed, sir?

STATEMENT OF DR. DONOVAN McCUNE, ASSISTANT TO EXECUTIVE DIRECTOR, THE PERMANENTE MEDICAL GROUP; ACCOMPANIED BY SCOTT FLEMING, VICE PRESIDENT AND COUNSEL, KAISER FOUNDATION HEALTH PLAN

Dr. MCCUNE. Mr. Chairman, I am Dr. McCune of the Permanente Medical Group, which serves health plan members in the northern California region.

Before I proceed today I ask the indulgence of the committee to express my sorrow at the death a few days ago of Henry Kaiser, the original sponsor of the health plan which my associate and I represent.

The CHAIRMAN. May I say we all miss him. He was certainly a great American.

Dr. MCCUNE. He was indeed, sir.

He long maintained close personal associations with the physicians of the Permanente Medical Groups, first with Sidney Garfield, with whom he joined in founding the health plan, and later with many others, and hence his loss is felt deeply, not only by the administrators of the health plan, but also by the physicians in the various Permanente Medical Groups.

Referring to myself again, I was graduated from the Johns Hopkins University Medical School in 1928, and was a member of the Department of Pediatrics in Columbia University Medical School for about 20 years, until I joined the Permanente Medical Group in 1951.

During the last 16 years most of my efforts have been devoted to care for the prepaid members of the Kaiser Foundation Health Plan; I have also been involved in a good many administrative and managerial jobs with the medical group and have been continuously concerned with the effective use of our health care resources.

I am now assistant to the executive director of the Permanente Medical Group, which provides professional care to members of the Kaiser Foundation Health Plan.

With me is Mr. Scott Fleming, vice president and counsel for the Kaiser Foundation Health Plan. We are here at the request of the health plan to report on some observations concerning our experience with medicare, and with suggestions as to how the functioning of medicare for our members could be improved.

We wish in particular to voice our support for the provisions of section 402 concerning incentives for quality and efficiency in the provisions of health services. Representatives of Kaiser Foundation Health Plan have previously expressed our concern that the "reasonable cost" reimbursement approach not only fails to provide constructive incentives for the more effective organization and provision of health care services, but also tends to stifle innovation and potentially useful diversity.

The Kaiser Foundation medical care program is the largest of the group practice prepaid programs in the United States and now serves over 1.5 million persons residing in the Pacific Coast States and Hawaii. About 60,000 of these are eligible for medicare.

Similar programs under different sponsorship operate in other parts of the country. These plans differ fundamentally from health insurance and Blue Cross-Blue Shield plans which collect premiums from subscribers and utilize these funds to pay bills incurred for each covered service.

Group practice prepayment programs are not engaged in bill paying. On the contrary, they, and we, pool the funds collected from subscribers and use these funds to provide facilities and personnel required to serve the health-care needs of their subscribers.

This leads us to the fundamental concept which I wish to draw to your attention. Conventional medical and hospital care in the United States assumes responsibility for the treatment of single or repeated episodes of illness in individual patients. It is to this conventional method of providing and paying for health-care services that the basic medicare legislation is necessarily directed. However, a significantly broader assumption of responsibility is possible and we think desirable; namely, the assumption of responsibility not only to treat the single episodes of illness in individual patients, but also to promote the health of the population consisting of all enrolled individuals not only when they are ill, but when they are presumably well.

Our group practice prepayment health program—involving approximately 1,500 physicians and 10,000 nonphysician personnel, utilizing 18 hospital-based medical centers and 28 satellite medical offices—undertakes this responsibility. This program, that is to say these people, have accepted this assignment to serve the health-care needs of the aforementioned 1.5 million individuals including some 60,000 medicare beneficiaries who have individually elected to obtain their hospital

medical and related services primarily through the professional persons and facilities which constitute the program.

Physicians are associated with the program through the independent professional partnerships which contract with the Kaiser Foundation health plan. They are not paid on a fee-for-service basis under which earnings depend on fees charged and volume of services performed; rather, they receive steady incomes through prepayment unrelated to fees for individual services. Correspondingly, and except for the deviation necessary to conform to the requirements of medicare part A, the hospitals are not paid on a patient-day or other "piecework" basis in which a price or a cost is associated with an individual unit of service. Rather, the funds derived from the health plan membership are utilized to support the total staff and facilities required to serve this membership. Thus, the concept of responsibility for the comprehensive health care of a population is realized.

Under this economic structure there is no financial advantage to be gained by excessive or unnecessary hospitalization or by performing surgery or rendering other professional services which are not medically necessary. The healthy member is an asset and the sick patient a liability; to keep the member well becomes the most economical medical care. In this context financial incentives as well as professional responsibility are coordinated to encourage efficiency, economy, and effectiveness in the use of health-care resources, including preventive techniques and early detection of disease.

Admittedly, we have no private magic; and the health plan member cannot be kept free of illness, disability, or death.

Thus, we do not assert qualitative superiority for our program nor do we criticize more conventional approaches to the provisions of health care with respect to the elusive issue of medical quality. However, in the objectively measurable area of quantity of hospital service we do have utilization statistics, both before and after the effective date of medicare, to which I will refer for the purpose of informing this committee of the relatively low rates of hospital utilization which characterize our program.

The largest operating division of the Kaiser Foundation medical care program, the northern California region, with which I am directly concerned, now has a membership in excess of 770,000 persons, or nearly 15 percent of the total civilian population in the areas which we serve. In this region in 1957 when our northern California region membership was somewhat over 300,000 persons, the average rate of hospitalization for the entire health plan membership was about 650 days per 1,000 members per year; health plan members 65 years of age and over then utilized 2,240 days of hospital care per 1,000 members per year.

In a special analysis covering the 12 months ending June 1963, the average utilization rate for our total membership of approximately 450,000 in the same region was 600 days per 1,000 members and the corresponding rate for members 65 and over was 2,350 days per 1,000 members, again per annum.

By comparison, for the first full year of the medicare program—that is, the 12 months ending June 30, 1967—the average hospital utilization rate for our entire health plan membership of 725,000 in northern California was 500 days per 1,000 members per year, and the

corresponding figure for our 30,000 medicare members was 2,200 days per 1,000 members per year.

Thus it is clear that our hospital utilization for persons 65 and older did not increase after medicare. The average hospital utilization rates for the total health plan membership reported above are significantly below hospital utilization rates generally reported in claims-payment type of plans across the United States. These run from about 800 days per 1,000 persons per year in certain areas of relatively low utilization up to more than 1,000 days per 1,000 persons per year.

The CHAIRMAN. Could I stop you there to see if I understand the point you are making here? Do I understand that you have a much lower utilization ——

Dr. MCCUNE. Very much lower, sir.

The CHAIRMAN (continuing). Rate, than the national average for the medicare patients. Is that the comparison you are making?

Dr. MCCUNE. That is the substance of what I say, sir.

The CHAIRMAN. As I understand it, you are saying here that for those 65 and over, the rate was 2,350 days?

Dr. MCCUNE. They used about four times as many beds in rough figures as those under 65.

The CHAIRMAN. I see.

Dr. MCCUNE. This is well known in the health industry and other segments.

The CHAIRMAN. Yes.

Dr. MCCUNE. But we have had no increase of utilization in that segment of the population under medicare.

The CHAIRMAN. Yes, sir.

Dr. MCCUNE. May I proceed, sir?

The CHAIRMAN. Yes, sir, please.

Dr. MCCUNE. Comparison of per patient day cost in our hospitals shows somewhat lower costs than the average for California voluntary nonprofit hospitals. However, this difference is not nearly so dramatic as the difference in hospital utilization rates. Our experience—approximately 500 days of general hospital care per 1,000 members per year or a half a day per person per year—is as much as 40 percent lower than reported experience for the California general population and other California population groups.

A considerable amount of material is at hand regarding the ability of group-practice prepayment plans to achieve significant efficiency and economy in the provision of quality health care services. In view of time limitations and the complexity of cost comparisons I will not attempt to develop this aspect of the subject. The document which has been submitted includes an addendum which contains some pertinent references.

Just as group practice plans do not have any medical magic, likewise they do not possess any economic magic. Our costs for buildings, equipment, supplies, and personal services are largely, I would say, totally determined by the economic environment in which our plans exist. On the basis of my experience in the administration of our program I see these principal areas of economic advantage:

1. Incentives for the use of the medically most appropriate approach to diagnosis and treatment.
2. Optimum utilization of personnel.

3. Of primary importance is unremitting responsibile participation by physicians in promoting the economic efficiency of hospital operations.

To return to section 402, the purpose of this section is to——

The CHAIRMAN. Could I just ask a question here?

Dr. MCCUNE. Sir?

The CHAIRMAN. On point No. 3 there——

Dr. MCCUNE. Yes, sir.

The CHAIRMAN. How do you undertake to get this kind of responsible participation by your physicians?

Dr. MCCUNE. In brief, sir, we devote a great deal of energy and effort to seeing to it that the physician gains a thoroughgoing intellectual working knowledge of his responsibility in the field of medical economics. Our physicians are involved with the health plan, with the medical group and with the hospitals.

The CHAIRMAN. And they feel a real responsibility that they should keep those patients in the hospital no longer than necessary?

Dr. MCCUNE. They should not admit frivolously or for trivial reasons or merely in response to the patient's minor matter of convenience; not to give custodial care in the guise of acute hospital care. They should not keep the patient overlong because of administrative inefficiency or lack of proper preparation for discharging the patient, which involves several steps. They realize that the whole economy of practice in this operation is a very important point—not over the medical point, not over the medical necessities, but closely coordinated therewith.

The CHAIRMAN. I suspect if we could put that approach into effect in the State hospitals of Louisiana we would save about a third of what is being spent there. That is just the impression I gain because the average patient, the last time I looked at the figures, tends to stay about 50 percent longer when the State is paying for it than he does if he is paying for it himself. The human equation there seems to come into it.

Dr. MCCUNE. The human equation unquestionably enters, sir, and I have had some personal experience in both the administrative and the actual doing of these things. It isn't easy to get people out if they don't want to leave. It is an effort.

The CHAIRMAN. I am told that in your foundation hospitals you are discharging medicare patients after about 8 or 9 days although the national average is about 14 days.

Dr. MCCUNE. Mr. Fleming has the data on that.

The CHAIRMAN. Do you have that, Mr. Fleming?

Mr. FLEMING. Yes. I do not have the current data that is directly responsive to your question on our present experience with the medicare population. We can get that data and submit it as a supplement to the statement. I have some general utilization experience by age going back over 10 years. But I don't have anything that reflects currently the average length of stay of our medicare people.

The CHAIRMAN. Well, Mr. Constantine of our staff can help you get the figures from the Department and I would hope that you and he—he is beside me at the moment—I would hope that you would help

get those figures. I would like to see how your experience compares with the national average.

(The information referred to appears at p. A1.)

As I understand it, you are meeting HEW standards as far as care of patients and that sort of thing are concerned; is that correct?

Dr. McCUNE. Well, our standards are really those of the Joint Commission on Accreditation of Hospitals, Mr. Chairman. I am not aware that medicare has set up standards of therapeutic effort. This would be rather difficult.

The CHAIRMAN. Well, I would think that you have something that you could go by, the number of deaths per 1,000.

Dr. McCUNE. These data are, of course, available. But I again can't give you any documentary support, but I am morally confident that we are meeting any formal requirements of therapeutic quality in dealing with this segment of the population. We make no distinction, sir. Our physicians frequently don't know that their patient is a medicare patient. This doesn't interest our physicians at that point in time. They are treated as anyone else.

Mr. FLEMING. We are meeting all applicable legally established standards and all applicable standards established by professional and hospital organizations. There are studies on the general subject of the quality of service provided through our program, and we can also supplement this statement, if you wish, by some references to studies, by outside organizations on that issue.

The CHAIRMAN. I wish you would provide us as much as you can on that, because I know that you have taken a strong interest in these matters, to see how well you are doing with your program.

Now, I am rather concerned with these comparisons, and I am going to ask to get the figures for comparison. In the city of New Orleans, for example, we have the Ochsner Foundation Hospital which is one of the best in the world, and my impression is that patients who go there, who can afford to pay, are well able to pay, are waiting in line to go to that hospital. You are almost a priviliged person to get into it. Those who do go and who are able to pay their own way, if my impression is correct, they are out of there substantially sooner than when they go to our State hospitals, New Orleans Charity and others, where the medical attention is of high standard, but the patients stay a lot longer. The thought occurs to me that a great deal of money might be saved by trying to meet Ochsner standards at New Orleans Charity in terms of efficiency of treating a person and getting them out of there as soon as they can be discharged.

Dr. McCUNE. We agree with you, Senator Long.

Senator CARLSON. Mr. Chairman, just one question.

Dr. McCUNE. Yes.

Senator CARLSON. Do I understand that the patients that are treated by the Kaiser Foundation Health Plan are treated by physicians who are on a monthly or annual salary basis?

Dr. McCUNE. The Permanente Medical Groups generally employ physicians on a monthly salary basis for about 3 years. After that period most of the physicians become partners in the medical group in which they have been employed. As partners they are not technically on a salary but receive a regular drawing account and a share in the earnings of the partnership. This provides relatively steady

income and as such it is somewhat like a salaried type of employment. It is specifically not a fee-for-service method of compensation.

Senator CARLSON. That is the point I wanted to get.

In other words, they are not paid on a per diem basis when they treat patients?

Dr. MCCUNE. No, sir.

Senator CARLSON. All right, thanks very much.

Senator ANDERSON. Don't some of your own figures show that about 8 days is the average length of stay in your hospitals?

Dr. MCCUNE. That is probably approximately true, Senator Anderson. I don't know what figures——

Senator ANDERSON. I have a letter from your office that says "The length of stay in our acute general hospital for 1965 is 8 days."

Mr. FLEMING. Senator Anderson, I believe the letter you have there probably came from Dr. Sayward in Portland, and this is one of the four geographical regions in which we operate.

Senator ANDERSON. Is that figure there, 8 days?

Mr. FLEMING. Yes, that is the figure there.

Senator ANDERSON. Against 14?

Mr. FLEMING. Well, I think that a little bit of interpretation is necessary, and I would like the opportunity to submit this in writing after reviewing it with our director of medical economics because I am concerned that figures out of context may be misinterpreted. I can give the committee this information: The average length of stay for our total membership, not the medicare membership, but total membership, in 1957 was 7.1 days per stay. In 1960, it was 6.9 days per stay. In 1963, it was 6.7 days per stay. In 1965, 6.6 days, and 1966, 6.4 days. So for our total membership in our largest region, which is northern California, we have this pattern.

I am sorry that I do not have corresponding figures on what we call an age specific basis, that is the average length of stay for people in various age groups. I can get them, but I don't have them with me.

Senator ANDERSON. On your whole general program it is about 6.7 or 7 days?

Mr. FLEMING. It has varied during this period from slightly over 7 days down to about 6½ days.

Senator ANDERSON. Well 7 days might be an average. Is that general figure applicable to the country as a whole?

Mr. FLEMING. Oh, certainly not.

Senator ANDERSON. That is right, that is what I am trying to get to, certainly not.

Dr. MCCUNE. Certainly not.

Senator ANDERSON. There is generally a longer stay in hospitals other than the Kaiser plan. We have been discussing the Kaiser plan for a long time and it has been an inspiration for a great many people, but couldn't you give figures for other hospitals?

Dr. MCCUNE. Do you want average stays in other types of systems? These are readily available, Senator Anderson. We don't happen to have them here. I will not trust my memory, but we will reproduce them.

Senator ANDERSON. Send them to us.

Dr. MCCUNE. Yes.

(See p. 851.)

Senator ANDERSON. You know, average stays in other hospitals. Your hospitals come out to 7 days, others are 14 days and that is quite a difference.

Dr. MCCUNE. Right.

May I proceed, sir?

The CHAIRMAN. Please do.

Dr. MCCUNE. Section 402 has the purpose among others to provide the Social Security Administration with authority to experiment with various alternatives in purchasing and paying for medicare services so as to provide incentives for effectiveness—an idea that embodies quality, economy, and efficiency. The authority provided by section 402 certainly will be utilized in support of those concepts and innovations that appear to represent responsible and realistic alternatives. One approach of demonstrated effectiveness is the group-practice prepayment approach.

For section 402 to work effectively in support of this approach, payment should be made on an integrated basis in harmony with the system of payment customary in group-practice prepayment plans with respect to their nonmedicare subscribers. Section 402 should provide the Secretary with sufficiently flexible authority to achieve this result.

The method of payment generally employed by group-practice prepayment plans in collecting revenue from their subscribers is the "per capita" method—a specified level of payment per person per month. As a result of extensive and cooperative effort between representatives of the Social Security Administration and of group-practice prepayment plans it has been possible to arrive at a "per capita" method of payment for physician services under part B of medicare.

However, even though a "per capita" method of payment is expressly authorized in the definition of "reasonable costs" for part A services, this approach has not yet been implemented under part A for a variety of technical and administrative reasons. Our impression is that responsible administrators who have been working with this problem in the Department of Health, Education, and Welfare and the Social Security Administration recognize desirable incentives and administrative advantages possible through a combined part A–part B payment to group-practice prepayment plans covering all medicare services. It is our hope that section 402, supported by suitable expressions of intent by the congressional committees, will eliminate any remaining technical obstacles. In this connection there are two important points:

1. That payments may be made to an organization which assumes responsibility for putting together an integrated hospital and medical care program, whether or not such organization technically falls within the definition of "provider of service" as set forth in the basic medicare legislation.

2. That payment may be made to such an organization in a manner harmonious with the method of payment used by the nonmedicare membership in the organization. Under this concept the payments on behalf of medicare beneficiaries would contribute to the financial requirements of the organization in proportion to their use of the resources of the organization.

Because we are satisfied that the approach which we have just discussed best preserves and strengthens the desirable incentives inherent

in the group-practice prepayment system, we urge the committee's careful attention to this matter. If there be any doubt that the present language of section 402 permits this method of payment, we are submitting a suggested amendment which we believe would eliminate any remaining technical problem.

Thank you, gentlemen.

I have submitted here a much abbreviated version of the written statement, may I respectfully request the chairman to accept the original statement as previously submitted?

The CHAIRMAN. We will certainly do that, sir.

Dr. MCCUNE. Thank you, sir.

Mr. Fleming and I would be happy to try to answer any questions that you may have.

The CHAIRMAN. Thank you very much. Do you have any questions? Any questions?

Well, thank you very much, sir.

Dr. MCCUNE. Thank you.

(Dr. McCune's prepared statement follows:)

PREPARED STATEMENT OF DR. MCCUNE, SUBMITTED ON BEHALF OF KAISER FOUNDATION HEALTH PLAN, INC.

Gentlemen, I am Dr. Donovan McCune, graduated from the Johns Hopkins Medical School in 1928, Professor of Pediatrics in Columbia University Medical School for 10 years and a long-term member of the American Board of Pediatrics.

I have been associated with The Permanente Medical Group since 1951; during these 16 years most of my professional practice has been to care for prepaid members of the Kaiser Foundation Health Plan. I have held a number of administrative and managerial positions with The Permanente Medical Group and have been continuously concerned with the effective and efficient use of all health care resources associated with the Kaiser Foundation Medical Care Program—physicians, paramedical and administrative personnel, hospital and outpatient facilities, and equipment. At present I am an assistant to the Executive Director of The Permanente Medical Group which gives professional care to the members of the Kaiser Foundation Health Plan.

With me is Scott Fleming, Vice President and Counsel for the Kaiser Foundation Health Plan. I am here at the request of the Health Plan to present some observations on our experience with Medicare and to state why we believe the functioning of Medicare in the context of a group-practice prepayment medical care program can be improved within the scope of existing Medicare legislation, as amended by H. R. 12080.

In particular we wish to voice our support for the provisions of Section 402, Page 202, concerning incentives for quality and efficiency in the provisions of health services. Representatives of Kaiser Foundation Health Plan have previously expressed our concern that the uniform nation-wide "reasonable cost" reimbursement approach embodied in the basic Medicare legislation not only fails to provide constructive incentives for the more effective organization and provision of health care services, but also that the inflexibility of the "reasonable cost" method of payment tends to stifle innovation and potentially useful diversity.[1]

A brief description of the Kaiser Foundation Medical Care Program will help to illustrate a concept of basic importance in effectively implementing the authority for experimental methods of payment insofar as this authority may be utilized in payment arrangements for Medicare benefits provided through group-practice prepayment health care programs.

---

[1] Statement by Edgar F. Kaiser submitted to House Ways and Means Committee in support of the King-Anderson bill (H.R. 4222) in August 1961, Report of House Hearings, page 1964; Statement of Dr. Clifford H. Keene before House Ways and Means Committee on H.R. 1, February 3, 1965; Statement of Dr. Clifford H. Keene before Senate Finance Committee on H.R. 6675, May 7, 1965.

The Kaiser Foundation Medical Care Program, the largest of the group-practice prepayment programs in the United States, now serves over 1,500,000 persons residing in the Pacific Coast States and Hawaii, of whom about 60,000 are eligible for Medicare coverage. Similar programs under different sponsorship are operating in New York, Washington, D.C., Detroit, Cleveland, Seattle and a few other areas. These plans differ fundamentally from health insurance company plans and programs of the Blue-Cross-Blue Shield type which collect premiums from subscribers and utilize the funds to pay bills incurred for each covered service, a device which you know as indemnification. Group-practice prepayment programs are not engaged in bill-paying. On the contrary they pool the funds collected from subscribers and use these funds to provide facilities and personnel required to serve the health care needs of their subscribers.

This brings us to the fundamental concept which I wish to bring before this Committee—a concept involving the responsibility assumed by a physician or organization in the health care field. Conventional medical and hospital care in the United States involves assumption of responsibility for the treatment of single or repeated episodes of illness in individual patients. It is to this conventional method of providing and paying for health care services that the basic Medicare legislation is necessarily directed. However, a significantly broader assumption of responsibility is possible and, we think, desirable; namely, assumption of responsibility not only to treat the single episodes of illness of individual patients but also to promote the health of a population consisting of all enrolled individuals, not only when they are ill but when they are presumably well.

Our group-practice prepayment health care program, involving approximately 1,500 physicians and 10,000 nonphysician personnel, utilizing 18 hospital-based medical centers and 28 satellite medical office facilities, now undertakes this responsibility. This program—these people—have accepted this assignment to serve the health care needs of the 1.5 million individuals, including some 60,000 Medicare beneficiaries, who have individually elected to obtain their hospital, medical and related services primarily through the professional persons and the facilities which constitute the program.

Physicians are associated with the Program through the independent professional partnerships which contract with Kaiser Foundation Health Plan. They are not paid on a fee-for-service basis under which earnings depend on fees charged and volume of services performed; rather, they receive steady incomes through prepayment unrelated to fees for individual services. Correspondingly, and except for the deviation necessary to conform to the requirements of Medicare Part A, the hospitals are not paid on a patient day or other "piecework" basis in which a price or a cost is associated with an individual unit of service. Rather, the funds derived from the Health Plan membership are utilized to support the total staff and facilities required to serve this membership. Thus, the concept of responsibility for the comprehensive health care of a population is realized.

Under this economic structure there is no financial advantage to be gained by excessive or unnecessary hospitalization or by performing surgery or rendering other professional services which are not medically necessary. The healthy member is an asset and the sick patient a liability; to keep the member well becomes the most economical medical care. In this context financial incentives as well as professional responsibility are coordinated to encourage efficiency, economy and effectiveness in the use of health care resources, including preventive techniques and early detection of disease.

Admittedly, we have no private magic; and the Health Plan member cannot be kept free of illness, disability, or death. Indeed, the possibilities for better health which may be available through the more effective use of our Nation's large and rapidly developing health care technology have scarcely been appreciated. Extensive longitudinal research, particularly on the fruits of early detection of disease, in which our organization is actively engaged, will probably not produce results for some years to come.

Thus, we do not assert qualitative superiority for our program nor do we criticize more conventional approaches to the provision of health care with respect to the elusive issue of medical quality. However, in the objectively measurable area of quantity of hospital service we do have utilization statistics, both before and after the effective date of Medicare, to which I will refer for the purpose of informing this Committee of the relatively low rates of hospital utilization which characterize our program.

The largest operating division of the Kaiser Foundation Medical Care Program, the Northern California Region, with which I am directly concerned, now has a membership in excess of 770,000 persons, or nearly 15% of the total civilian population in the areas which we serve. In this Region we have made several special utilization studies:

In 1957 when our Northern California Region membership was somewhat over 300,000 persons, the average rate of hospitalization for the entire Health Plan membership was about 650 days per 1000 members per year; Health Plan members 65 years of age and over then utilized 2,240 days of hospital care per 1000 members per year.

In a special analysis covering the 12 months ending June 1963, the average utilization rate for our total membership of approximately 450,000 in the same Region was 600 days per 1000 members and the corresponding rate for members 65 and over was 2,350 days per 1000 members.

By comparison, for the first full year of the Medicare program—that is, the 12 months ending June 30, 1967—the average hospital utilization rate for our entire Health Plan membership of 725,000 in Northern California was 500 days per 1000 members per year, and the corresponding figure for our 30,000 Medicare members was 2,200 days per 1000 members per year.

Thus it is clear that our hospital utilization for persons 65 and older did not increase after Medicare. Indeed you will note from the foregoing figures that our utilization experience for this population group has been relatively stable over the last 10 years.

As this Committee no doubt appreciates, the average hospital utilization rates for the total Health Plan membership reported above—from ½ to about ⅔ of a hospital day per person per year on the average—are significantly below hospital utilization rates generally reported in claims-payment type of plans covering prepaid populations, in which utilization rates vary from about ⅞ of a day per person per year in some of the plans and in certain areas with relatively low utilization, to well in excess of one full day per person per year in other plans and other areas where utilization is comparatively high.

Comparisons of per patient day cost in our hospitals show somewhat lower costs than the average for California voluntary nonprofit hospitals (*e.g.*, patient day cost on the average was $56.06 for Kaiser Foundation Hospitals in the Northern California Region in 1965 as compared with an average of $63.48 for voluntary nonprofit hospitals in California). However, this difference is not nearly so dramatic as the difference in hospital utilization rates. Our experience—approximately 500 days of general hospital care per 1000 members per year or half a day person per year—is as much as 40% lower than reported experience for the California general population and other California population groups. This wide difference is also noted in published utilization rates for Federal Employee and their dependents in our plan as compared with the same group covered under the national plans available to the Federal Employees.

A considerable amount of material is at hand regarding the ability of group-practice prepayment plans to achieve significant efficiency and economy in the provision of quality health care services. In view of time limitations and the complexity of cost comparisons I will not attempt to develop this aspect of the subject. An addendum to this Statement includes some pertinent references.

Just as group-practice prepayment plans do not have any medical magic, likewise they do not possess any economic magic. Our costs for buildings, equipment, supplies and personal services are largely determined by the economic environment in which our plans exist. On the basis of my experience in the administration of our program I see these principal areas of economic advantage:

1. Incentives for the use of the medically most appropriate approach to diagnosis and treatment.
2. Optimum utilization of personnel.
3. Of primary importance is unremitting responsible participation by physicians in promoting the economic efficiency of hospital operations.

To return to Section 402, it appears that the purpose behind this Section is to provide the Social Security Administration with authority to experiment with various alternatives in purchasing and paying for Medicare services so as to provide incentives for effectiveness—an idea that embodies quality, economy and efficiency. Concerted effort, both governmental and private, is being devoted to developing improved approaches and methods for delivering health care. The authority provided by Section 402 certainly will be utilized in support of those concepts and innovations that appear to represent responsible and realistic alter-

natives. One approach of demonstrated effectiveness, and the only one with which I am thoroughly familiar, is the group-practice prepayment approach.

For the authority contained in Section 402 to be used effectively in support of this approach we believe it is important that payment be made on an integrated basis in harmony with the system of payment customary in group-practice prepayment plans with respect to their non-Medicare subscribers. Section 402 should provide the Secretary with sufficiently flexible authority to achieve this result if he finds it desirable.

The method of payment generally employed by group-practice prepayment plans in collecting revenue from their subscribers is the "per capita" method—a specified level of payment per person per month. As a result of extensive and cooperative effort between representatives of the Social Security Administration and of group-practice prepayment plans it has been possible to arrive at a "per capita" method of payment for physician services under Part B of Medicare. However, even though a "per capita" method of payment is expressly authorized in the definition of "reasonable costs" for Part A services, this approach has not yet been implemented under Part A for a variety of technical and administrative reasons. Our impression is that responsible administrators who have been working with this problem in the Department of Health, Education and Welfare and the Social Security Administration recognize desirable incentives and administrative advantages possible through a combined Part A–Part B payment to group-practice prepayment plans covering all Medicare services. It is our hope that Section 402, supported by suitable expressions of intent by the congressional committees, will eliminate any remaining technical obstacles. In this connection there are two important points:

1. That payments may be made to an organization which assumes responsibility for putting together an integrated hospital and medical care program, whether or not such organization technically falls within the definition of "provider of service" as set forth in the basic Medicare legislation.

2. That payment may be made to such an organization in a manner harmonious with the method of payment used by the non-Medicare membership in the organization. Under this concept the payments on behalf of Medicare beneficiaries would contribute to the financial requirements of the organization in proportion to their use of the resources of the organization.

Because we are concerned that there still may be technical obstacles to the full realization of these results, and because we are satisfied that the approach which we have just discussed best preserves and strengthens the desirable incentives inherent in the group-practice prepayment system, we urge the Committee's careful attention to this matter. If there be any doubt that the present language of Section 402, as interpreted in the Committee reports, permits the method of payment which we have discussed, we are submitting, as an addendum to this Statement, a suggested amendment which we believe would eliminate any remaining technical problem.

ADDENDUM No. I

COST-EFFECTIVENESS STUDIES CONCERNING GROUP PRACTICE PREPAYMENT PLANS

1. Williams, J. J., Project Administrator. School of Public Health and Administrative Medicine, Columbia University and the National Opinion Research Center, University of Chicago. *Family Medical Care Under Three Types of Health Insurance.* New York Foundation on Employee Health, Medical Care and Welfare, Inc., 1962.

2. Watts, H. S. M., Chairman. *A Special Report of the Medical and Hospital Advisory Council to the Board of Administration of the State Employees' Retirement System.* June 12, 1964.

3. *Special Study on the Medical Care Program for Steelworkers and Their Families: A Report by the Insurance, Pension, and Unemployment Benefits Department.* United Steelworkers of America. Tenth Constitutional Convention, Atlantic City. September, 1960. Pp. 96–98.

4. Wolfman, B. I. Comparison of Blue Cross and Kaiser Family Medical Expenditures Under a "Dual Choice" Collective Bargaining Agreement; Master's Thesis. University of California, Berkeley. June, 1961, P. 108.

5. Huntington, E. H. *Cost of Medical Care: The Expenditures for Medical* Care of 455 Families in the San Francisco Bay Area.
Care of 455 Families in the San Francisco Bay Area. 1947–1948. Berkeley and Los Angeles, California, University of California Press, 1951. Pp. 67–69.

6. Huntington, E. H., Chairman: The Heller Committee for Research in Social Economics of the University of California. *Quantity and Cost Budgets for Two Income Levels; Prices for the San Francisco Bay Area, 1960.* Berkeley, California. Regents of the University of California, 1961. P. 46.

ADDENDUM No. II

SUGGESTED AMENDMENT TO H.R. 12080

In Section 402, Subsection (b) on page 203, line 19, following words "or payment on the basis of reasonable cost" and preceding the semicolon insert the following:

"or to conformity with the definition of 'provider of services' in Title XVIII, Section 1861 (u)".

The CHAIRMAN. Our next witness will be Dr. Philip H. Jones, who is a practitioner of medicine in the city of New Orleans.

Dr. Jones, will you please take the witness stand?

He received a degree from two universities in 1920 and he was a Rhodes scholar to earn a Ph. D. at Oxford University. Following this he was on the Selection Committee for Rhodes Scholars for Louisiana.

Dr. Jones is a member of the College of Physicians, Board of Internal Medicine; the College of Cardiology, and he has represented Louisiana in the American Medical Association House of Delegates since 1955.

Dr. Jones is past president of the Orleans Parish Medical Society, of the Louisiana State Medical Society. He is professor emeritus of medicine at Tulane. We are very happy to have you here, Dr. Jones. We are pleased to see you here before our committee again.

STATEMENT OF DR. PHILIP H. JONES, PAST PRESIDENT, LOUISIANA STATE MEDICAL SOCIETY; ACCOMPANIED BY PAUL PERRET, STAFF, LOUISIANA STATE MEDICAL SOCIETY

Dr. JONES. Thank you, Senator, for your gratifying introduction.

Mr. Chairman, and members of the committee, I am Philip H. Jones, a practicing physician in New Orleans, La., past president of the Louisiana State Medical Society. Also I am currently and have been a delegate to the House of Delegates of the American Medical Association since 1955.

Speaking for myself and for the Louisiana State Medical Society, I wish to express my sincere appreciation for the opportunity to appear before you to discuss H.R. 12080, the "Social Security Amendments of 1967."

As a representative of the Louisiana physicians, I report that the physicians of Louisiana are vitally interested in all aspects of this broad subject. We are interested as physicians and also as citizens concerned with the health and welfare of our patients. However, I shall limit my discussion to matters relating primarily to titles 18 and 19, commonly referred to as "medicare" and "medicaid", respectively.

We firmly believe that government has an obligation to aid our citizens who are unable to provide adequate health care for themselves. However, we did oppose, and continue to oppose, the basic concept of the medicare program; that is, financing health care for all regardless of need just because they have reached a certain age in life.

Nevertheless, the Congress enacted the program into law, and as responsible citizens we are now endeavoring to make it operate with the minimum amount of interference between the physician and his patient and to eliminate much of the redtape. Our comments are directed to changes which we believe will materially assist in the operation of the program and at the same time permit the continuation of the very personal patient-doctor relationship.

The CHAIRMAN. Doctor, you know I agreed considerably with the philosophy that you express about medicare—that as many people as could should pay a substantial portion of their own medical expenses. But over a period of time these two Senators sitting to my right prevailed and when you don't have the vote why you have to do the best you can to accommodate yourself to a majority, and that is in effect what your association has done, and——

Dr. JONES. That is one reason——

The CHAIRMAN. I think that is one thing about democracy, when a majority wins fair and square why you have to adjust yourself to the thinking of the majority and that is what I am happy to say that you and your group have done.

Dr. JONES. And that is why we are still in there pitching because there may still come another day. [Laughter.]

Senator GORE. You accept what is done, but you don't accept it as permanent and irrevocable?

Dr. JONES. That is it exactly. [Laughter.]

An integral part of this relationship has been the historical arrangement that the physician shall look to his patients for reimbursement for his services. This arrangement was continued in medicare under title 18 by permitting the patient and physician alternatives, that is, allowing the patient to pay his physician directly, and permitting the physician to take an assignment from him. While title 18 recognized the traditional patient-physician relationship embodied in direct payment, the medicaid program, title 192, was interpreted as not allowing for this same kind of relationship. We are pleased to note that the House of Representatives in passing H.R. 12080 partly remedied this problem by making it optional for the States to allow the direct billing of the medically needy recipients who are not receiving cash assistance. We urge that your committee amend section 230 of H.R. 12080 so that the physician and patient can arrange for direct payment as is permitted under title 18, for all recipients under medicaid whether they be the medically needy or those receiving cash assistance.

As I have indicated, the physician has always looked to his patient for reimbursement of his services. If he looks to an indigent patient for compensation, he may suffer financially. But doctors prefer that risk to an involvement that may interfere with their personal relationship with their patients.

In connection with the authority to bill the patient directly, we urge that your committee retain the provisions contained in section 125 and to amend section 230 of H.R. 12080, to permit the patient to be reimbursed and to pay his doctor on the basis of an itemized statement of charges rather than on a receipted-bill basis.

The current requirement that a patient must have a paid receipted bill under medicare before he could receive reimbursement from the fiscal agent created an undue hardship on many patients. The ability to

pay on the basis of an itemized statement of charges will provide the patient an opportunity to secure the funds—80 percent of the bill—from the fiscal agent before paying the physician for his services.

Another very impotrant factor in the patient-doctor relationship is that the patient have a free choice as to which physician he wants for his personal doctor. This right is basic to all our concepts and we urge this committee to retain section 227 of H.R. 12080 which gives this free choice of physicians to all individuals eligible for assistance under the medicaid program.

Under the present medicare law, the term "physician" has been defined to mean a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such functions and a doctor of dentistry where he performs surgery relating to the jaw or the fracture and reduction of the jaw or any facial bone.

H.R. 12080 proposed that the definition of the term "physician" be broadened to include doctors of podiatry. We urge that the medicare program not be expanded in this area.

Also, the bill would authorize the Secretary of HEW to conduct a study of the need for including under part B the services of additional licensed practitioners. While we are not opposed to such a study, we would strenuously and vigorously oppose the inclusion of chiropractic at any time.

It is our position that chiropractic is an unscientific cult and that the practitioners of chiropractic lack the necessary training and background to diagnose and treat human disease. In our opinion, chiropractic constitutes a very great hazard to the health care of the people of this Nation.

Our opposition to this cult is based primarily upon the substandard and unscientific education of its practitioners and their adherence to an irrational and unscientific approach to disease causation. To understand our opposition one must understand what is chiropractic. In the recent case of *Jerry R. England* v. *Louisiana State Board of Medical Examiners*, a three-judge Federal district court in New Orleans, in its opinion defined chiropractic as follows:

> As broadly defined by its proponents, chiropractic is a healing art designed to relieve human ailments by manipulation and adjustment of the spine. It is chiropractic doctrine that most, if not all, human ailments result from a slight misalignment, or subluxation, of contiguous vertebrae. This subluxation tends to impinge on nerves emanating from the spinal cord through apertures in the vertebrae. As a result of the impingement, the innervation to the parts of the body served by the impinged nerve is abnormally altered, and such parts become diseased or predisposed to disease. The realignment of these subluxated vertebrae through manipulation of the spine by the chiropractor removes the impingement and restores the nerve function to the diseased parts of the body. Chiropractic science postulates that the commonly accepted causes of disease, such as viruses and germs, are merely secondary factors acting on parts of the body already predisposed to disease by nerve impingement. Thus disease results from lack of resistance to the viruses and germs which are always present in the body.

In this case, the chiropractors contended that the equal-protection clause of the 14th amendment of the U.S. Constitution bars the State of Louisiana from requiring chiropractors to have a medical school degree and that they meet the same educational standards required for medical practitioners. In its unanimous decision, the three-judge court

rejected the chiropractors' argument that their constitutional rights were violated. The judges found that:

> There has been no showing here that the state had done more than is necessary to protect the health of its citizens.

The district court also said:

> If the education obtained in chiropractic schools does not meet the standards of the American Chiropractic Association and the United States Office of Education, it may well be that the Legislature of Louisiana felt that in the public interest a diploma from an approved medical school should be required of a chiropractor before he is allowed to treat all the human ailments chiropractors contend can be cured by manipulation of the spine.

The Supreme Court of the United States on June 20, 1966, affirmed the judgment of the three-judge district court.

It was brought out during the testimony in the above case that chiropractic groups publicly have opposed immunization programs and community fluoridation programs, both of which are endorsed by the U.S. Public Health Service. In this same connection, the doctor of chiropractic degree is listed as "spurious" by the U.S. Office of Education in its publication of academic degrees. Also chiropractors cannot practice in any hospital accredited by the Joint Commission on the Accreditation of Hospitals, and they are not allowed to prescribe drugs or perform surgery in any State. Likewise, they are not used in the armed services as practitioners.

Much of the danger experienced by their patients is the delay of proper medical care caused by their opposition to the many scientific advances in modern medicine such as lifesaving vaccines and miracle drugs; and this delay often ends with tragic results.

We urge the committee to reject any suggestions for the inclusion of chiropractic.

The CHAIRMAN. May I say, Doctor, that I have been troubled with this problem and, of course, we hear from chiropractors as well. It does concern me when a person who has, let's say, cancer of the spine, goes to a chiropractor. Is a chiropractor competent to diagnose cancer of the spine? There is certainly such a thing.

Dr. JONES. There is certainly such a thing and his competence in that field we would regard to be so insufficient as to be negligible.

The CHAIRMAN. If that is what the ailment was and the chiropractor was working on the theory that he could give that person some relief by manipulating the spine, in your judgment, as a medical doctor, would that be good or bad for the person?

Dr. JONES. It would be particularly bad for his ultimate outlook and it would be bad immediately because of the amount of additional pain he would have from these so-called manipulations.

The CHAIRMAN. Yes, sir.

Senator Anderson?

Senator ANDERSON. Since you have dealt with the chiropractic matter, what about podiatry? Are you equally opposed to that?

Dr. JONES. The position on podiatry is this.

Senator ANDERSON. You mentioned it and I just wondered what your idea was.

Dr. JONES. It is better for the individual States to determine the competency and scope of what the podiatrist does.

If this federally operative law undertakes to state what the podiatrist should do and where he works it would be restrictive on what the States do. It is much better to keep it like all the other fields that practice medicine on a State-determinations basis.

The CHAIRMAN. The House bill, I believe, covers podiatry services to the extent that they are licensed by the State. I think that is the way they handle it.

Senator ANDERSON. If they are licensed by the State do you oppose the use of them?

Dr. JONES. We are not opposed to their doing what they are competent to do. That should be determined by the several State boards of medical examiners.

The CHAIRMAN. That is the way the law reads now. I believe it says that "only with respect to functions which he is legally authorized to perform as such by the State in which he performs them."

Dr. JONES. That is right.

The CHAIRMAN. As I interpret your answer you say that you don't quarrel with the podiatrist being paid for what the State authorizes him to do?

Dr. JONES. We want them to continue that, but we don't want them to get a blanket blessing to feel they can work everywhere.

The CHAIRMAN. I see.

Dr. JONES. We believe they should also be included in the study of the feasibility of certain additional services under part B of the bill.

It is gratifying to the membership of the Louisiana State Medical Society that the bill, H.R. 12080, did not make provision for the inclusion of those persons under 65 who are beneficiaries of the Social Security Act and who are totally disabled. The feeling is that the scope of title 18 should not be expanded and that provision for them is adequate under title 19.

It is our impression that the cost of providing for the million and one-half disabled would be several times the $225 million tentatively indicated as the cost of this inclusion.

The position of our society in regard to discussions of generic drugs and whether the prescribing should be limited to such is this:

We feel that there should be no restriction of any kind on the physician's judgment in prescribing drugs by brand names or by generic names. It is the province of the physician to use that remedy which in his judgment is best for that particular patient. Any bureaucratic restrictions would obstruct the free operation of the physician's judgment.

Senator ANDERSON. May I ask a question? Does that mean that you don't want to have a requirement about prescribing drugs? There has been argument about the costs of drugs when a doctor prescribes one certain drug which is very high priced and another drug is inexpensive.

Dr. JONES. We recognize those differences. It is our thought that operating over a period of years in the free market, the cost of the two types of drugs will be the same. Immediately after the presentation of a specialty drug, the price is going to be high. Over a period of years the two will approximate each other. In a routine survey in this area, it is found that the cost of the brand name and generic name drugs were approximately the same.

The CHAIRMAN. Could you provide us with a copy of that survey, Dr. Jones?

Dr. JONES. We can get it for you.

The CHAIRMAN. We would like to have it.

(Data referred to was received and made a part of the official files of the committee.)

The CHAIRMAN. Would you proceed, sir?

Dr. JONES. It is the further opinion of our society that bureaucratic control of quality and price would be administratively most difficult, would be professionally restrictive and costly beyond all present estimates.

In summary, the membership of the Louisiana State Medical Society is most anxious for the privilege of direct billing under title 19, for the privilege of submitting an itemized statement of charges instead of a receipted bill, for free choice of physician under title 19, for the exclusion now and at any other time of the chiropractic from the provisions of the bill, for the exclusion of the disabled below 65, and for the avoidance of compulsion in regard to the use of generic drugs.

The other features of title 18 and title 19 in general are gratifying to our membership.

The CHAIRMAN. Dr. Jones, if we go along with you on this direct billing under title 19, one problem that occurs to me is that we would feel that the burden would be on the doctors to treat those welfare patients even though on occasion they might not get paid for their service.

Now, there is no doubt about it, if the Government is responsible for payment for these people, once the doctor performs the service he will get paid. However, you don't want the doctor to do business directly with the Government. I spoke to your society and I indicated to them I thought I would go along with them on that suggestion and it was very warmly received.

Now, I do feel that if we do that, there is a very heavy responsibility on doctors to treat these people even though in some cases we will provide money to some aged persons with which to pay the doctor but these persons won't pay him. They might keep the money, and the doctor will have problems collecting. Some say that if that happens—patients do not pay the doctor—the doctor might not want to treat them again.

What is your reaction to that? Do you think we can be assured that these people will be treated even though in some instances they take the money and keep it rather than pay the doctor for the medical treatment?

Dr. JONES. It is our position first, that the conditions under which the doctors don't get paid are not new and, second, the type of patient who might fail to pay is the one who didn't pay anyway before this bill came into operation. The third thing is that the doctors would much rather take the risk of not being paid than to destroy what is an established and satisfactory patient-doctor relationship.

The CHAIRMAN. In other words, am I to understand that the doctor feels that he has the responsibility to treat those patients even though they do not pay; even though they are obligated to pay and don't pay?

Dr. JONES. You can only judge the future by the past. That has been

going along for a few hundred years and it probably will go by momentum until these adjustments are satisfactory to all.

The CHAIRMAN. Well, the thing that concerns me is that where we are trying to provide care and some of these people are not very intelligent and are not very responsible. Perhaps they don't pay for the care the first time but then they come back again looking for the doctor a second or third time and they have a bad record of not paying the doctor, even though they were provided with Federal money for that purpose. We still feel we have a responsibility toward those people to see that care is available to them.

Dr. JONES. He will treat them.

The CHAIRMAN. I believe that your associate there is making a note or two that he might want to add to your statement on that point.

Mr. PERRETT. Senator Long, the official position of our society is that the physician will treat the patient regardless. He is willing to accept this risk and responsibility.

The CHAIRMAN. Thank you very much.

Dr. JONES. Mr. Chairman, and members of the committee, thank you for giving me this opportunity to express the views of the Louisiana State Medical Society on this important legislation.

The CHAIRMAN. Senator Carlson?

Senator CARLSON. Just this, Dr. Jones: I appreciate very much your statement. We have some very outstanding physicians and surgeons in Kansas, and I know, based on past experience, they have treated these people who were unable to pay, and I know they are going to continue to do so, regardless of some of these programs, and, in fact, one of the very outstanding physicians in my State told me the other day that many of these people that he would treat and had treated in the past without any thought of collecting any fee are now being paid for by the Federal Government, and I have great faith in the future of the physicians and surgeons in our State.

The CHAIRMAN. May I say, Doctor, that in years gone by I have had a lot of free medical services. A cousin of mine who was once president of your society in Louisiana, Dr. Arthur Long, who passed away a few years ago, lived a couple of blocks down the street from me. I suppose I was the beneficiary of this free medical service because he practiced by the old fashioned idea that you treat your relatives free, and that you give away about one-third of your treatment to either people who can't pay or to relatives. You have to make the money on those who are not related to you and those who can afford to pay.

Dr. JONES. Arthur was very effective and helpful in the operation of our society. He got all the pleasure out of practicing medicine and doing a good job that any other physician gets.

The CHAIRMAN. In my judgment he was a very great American and I am sorry we lost him.

Senator ANDERSON. Do you oppose State vendor payments to doctors completely?

Dr. JONES. I beg your pardon?

Senator ANDERSON. If the States pay the doctor directly you oppose that; do you not?

Dr. JONES. It is much better that the patient pay the doctor.

Senator ANDERSON. How about the Kerr-Mills bill which the doctors supported almost solidly?

Dr. JONES. The Kerr-Mills bill has worked, but we still prefer the method by which the patient would pay the doctor. We are operating under the provision now in which the State does pay the doctor, but we prefer the situation in which the patient pays the doctor.

Senator ANDERSON. But you do recognize that they are now paid a great deal by the States; aren't they?

Dr. JONES. Where the doctor has an option between the two, the overwhelming majority of doctors would prefer that the patient pay the doctor.

Senator ANDERSON. I don't think there is a question of option. They do accept these payments in a great degree of practice.

Dr. JONES. He has an option under title 18.

Senator ANDERSON. For public assistance? He doesn't have that option, does he, under public assistance?

Dr. JONES. Under title 18 he can take an assignment or he can bill the patient.

The CHAIRMAN. Let me ask you one other thing, Dr. Jones.

Pardon me.

Senator ANDERSON. I am trying to find out what that attitude might be. I voted for the Kerr-Mills bill the first time it was presented because I thought it would do some good. I think it probably has benefited a great number and many people don't feel that it destroys the relationship between doctor and patient.

The CHAIRMAN. Doctor, let me just ask you about one other matter that we touched on with the witness for the Kaiser Foundation. Is it your impression in Louisiana and from your own experience and from the doctors with whom you associate that the average patient being provided care at State or Federal expense stays in the hospital longer than the person who is paying his own medical bill?

Dr. JONES. I can't speak from personal knowledge on the over-age-65 aspect of it. From the point of view of years of experience, there is no question but what the patient stays longer in a hospital like Charity or the Veterans than he does in a hospital like Baptist.

The CHAIRMAN. Would that same statement be true of Ochsner Foundation Hospital, that is in a private hospital, where the patient is paying, they tend to be out of there quicker?

Dr. JONES. He tends to get out quicker. The type of hospital that would be called a private hospital, the workday is longer. In the Charity-type hospital, the workday is much shorter.

The CHAIRMAN. Does that have something to do with it?

Dr. JONES. It has a bearing on how much is done in one unit of time.

The CHAIRMAN. Why is the workday shorter in the State-supported hospital?

Dr. JONES. The workday in the State-supported hospital is shorter because the pressure to get things done in a short time is not so constant. In the private hospital, there is a pressure to get the patient out because he is there at the expense of about $50 a day, which is coming out of somebody's pocket.

The CHAIRMAN. Is that largely a pressure of the patient himself trying to urge the doctor to keep the expenses down?

Dr. JONES. It is a composite; resulting from the anxiousness of the patient, the desire to get the patient properly cared for and, at the

same time, getting him out because there is somebody else waiting to come in.

The CHAIRMAN. You heard the statement of the witness for Kaiser testify that their patients stay only about two-thirds as long as the average in other hospitals. I just wondered if it might be possible one way or another to bring into the medicare program and the medicaid program some of that same cost consciousness that the Kaiser Foundation seems to inject into their doctors, in getting the job done and getting the patient out as soon as they can.

Dr. JONES. That should be possible, but it is a matter of administration. Suppose that the laboratories ran on Saturday afternoon and Sunday. Well, then, things would move more rapidly.

The CHAIRMAN. I see.

Thank you very much, Doctor.

Dr. JONES. Thank you, gentlemen.

The CHAIRMAN. Our next witness is Dr. Norman Sprague, director of the employment and retirement program of the National Council on the Aging.

Will you proceed, sir?

STATEMENT OF NORMAN SPRAGUE, DIRECTOR OF THE EMPLOYMENT AND RETIREMENT PROGRAM, THE NATIONAL COUNCIL ON THE AGING

Mr. SPRAGUE. Mr. Chairman, I am Norman Sprague, but I am not Dr. Norman Sprague. I am not going to read my testimony but I would like permission to have it included in the record in the hearing.

The CHAIRMAN. That will be printed in full.

Mr. SPRAGUE. I am from the National Council on the Aging which is a nonprofit voluntary organization concerned with all aspects of aging.

One of the problems with the House bill is that it has a great many negative aspects to it. The national voluntary organizations in the country are very concerned about this and I think you are going to hear from all of them on this; religious organizations, nonsectarian organizations, and the labor unions.

I would just like to point out one of the negatives that has been kind of in this woodpile of the House bill and that deals with the blood. Under the present Medicare Act a hospital patient who uses 1 unit of blood has to replace it with 3 pints of blood. Now, this is a special problem for the older person because after age 60 you are not allowed to give blood. It is considered a health hazard, so the person has to get it from his friends and that is usually difficult because they are usually in the same age group and this is definitely a problem to older people.

Under the House bill, this has been decreased from 3 pints of blood to 1 pint of blood. That is certainly a negative aspect of this bill.

I am not going to go in and read all the statistics on the social benefit levels and poverty and all that because everybody is familiar with that, but Monday just after I had gotten our testimony out of our printshop I got a call from a woman who asked about what the social security benefits would be and I explained to her it would be a

12½-percent increase over her present benefit and she said "would it bring my benefit to a $100 a month? I currently get $54 a month."

I explained it would be 12½ percent of $54 and she asked me how much that would be and I calculated it for her and it was $60.75 and she said would that be $60.75 a week and I said "No, $60.75 a month." How much would her benefits be? I told her it would be $60.75 and she grunted and said "you talk about fighting poverty."

I think it is difficult by an act of Congress to solve a lot of problems, difficult to solve the war in Vietnam by an act of Congress. Negro problems are going to take a complicated series of acts of Congress and a lot of other things. But we do have the administrative mechanism to solve poverty among the elderly by an act of Congress and we recommend that the retirement benefits for older people be raised where the minimum benefit for the aged be at or above the poverty level. That level for an individual is approximately $1,500 a year and that should be the minimum benefit for a single individual receiving retirement benefits under social security.

Senator ANDERSON. Are you blaming the Congress for poverty?

Mr. SPRAGUE. Beg your pardon, sir?

Senator ANDERSON. Are you blaming the Congress for poverty?

Mr. SPRAGUE. I am not blaming poverty on Congress. I am saying we have an administrative mechanism to pull the elderly poor out of poverty; there are 5 to 7 million people and we can do this by increasing social security benefits and lifting the entire poverty level out of it. It is much more difficult to pull other people out of poverty, but we do have a mechanism for doing this for the elderly poor. If this requires using general tax revenues then we would recommend that.

In my written testimony I make the points that we also endorse an escalation clause so that retirement benefits are kept up to, at least up to, the cost of living. We would see the escalation costs tied to the gross national product so that old people share in the growth of real productivity as well as growth of price raising.

We also recommend that the original provisions of covering farmers and agricultural labor as proposed by the administration and taken out by the House, be put back in by the Senate.

We also recommend that the administration proposal on medicare and medicaid which were taken out by the House be put back in.

Furthermore we recommend that the provisions of the Senate bill S. 1661 sponsored by Mr. Moss and others be included in the Senate bill on social security.

We also recommend that the Senate bill S. 1662 on the licensing of nursing home operators which was sponsored by, introduced by, Senator Kennedy of Massachusetts and others, be included in this bill.

In brief summary then we urge that the Senate provide higher benefit levels, a cost-living escalation formula, more inclusive medical benefits, more liberal benefits for rural residents, and improvement for long-term care.

Senator ANDERSON. Senator Carlson.

Senator CARLSON. No; I have no questions.

Senator GORE. I have no questions.

Senator ANDERSON. Thank you very much. We will print your statement in full in the record.

(The prepared statement of Mr. Sprague follows:)

STATEMENT OF NORMAN SPRAGUE, DIRECTOR, EMPLOYMENT AND RETIREMENT PROGRAM, THE NATIONAL COUNCIL ON THE AGING

The National Council on the Aging is a national, voluntary, non-profit organization dealing with all aspects of aging. It is a membership organization made up largely of persons who are professionally involved with aging. They come from industry, labor, education, social welfare, health and medicine, religious organizations, and government. Our organization is financially supported by foundations, company and union contributions, membership dues, and community funds.

We now have an official government definition of poverty, about $1,500 a year for an individual and $2,000 a year for a couple. By this definition, some 5 to 7 million retired people in this country live in poverty. At the present time, the average benefit for all retired workers is $85 a month, $1,020 a year. Under the President's proposal for a 15% increase, the average would have risen to $97.75 per month, $1,173 per year, still below the poverty level. The House has given us a 12½% increase, making the benefit $96.00 a month, $1,152 a year. Thus, do we fight a war on poverty on the one hand, and pass legislation bound to perpetuate it with the other hand.

The Bureau of Labor Statistics' budget for a retired couple over age 65 living in New York City in 1960 was $3,044. Between 1960–1967, the Consumers' Price Index has increased about 14.9%, which would make that budget, at the present time, about $3,500. At the present time, only 15% of the persons age 65 and over are receiving income from private pension plans. This will, of course, change in the future because so many workers are now covered by pension plans, but, at the present time, the overwhelming majority of persons age 65 and over have income primarily from Social Security. Therefore, instead of providing average retirement benefits that are below the povery level, we ought to aim for retirement benefits closer to the real needs, as established by the Bureau of Labor Statistics' budget.

Social Security benefits have to be looked at in relation to poverty, increases in the cost of living, and rising standards of living. People in retirement should share in the prosperity they helped to bring about. These views were confirmed at the NCOA Sixteenth Annual Meeting. At this meeting, held at the Hotel Plaza in New York, March 5–9, 1967, the participants were polled by questionnaire as to how they ranked in importance 30 issues of public policy affecting the aging.

The first three issues of priority importance, according to this survey of professionals working in the field of aging, are:

1. Gear Social Security retirement insurance benefits to an automatic escalation formula.
2. Generally extend the coverage of the Medicare program to include dental care, podiatry, eye care, drugs, hearing aids, etc.
3. Increase old age and disability insurance benefits of the Social Security Act.

Based on these priorities from its membership, the NCOA, in its testimony to the House Ways and Means Committee, urged that retirement benefits be linked to a formula based on growth in the national product that would increase retirement payments each year in proportion to the growth of the economy. For example, if the real GNP went up 3%, Social Security insurance benefits would be increased by 3%. Such a formula would account for both price rises and increased productivity, thus allowing a retired worker to share in the growth of the economy. We urge the Senate to look into higher cash benefits for retirees, as well as into an escalation clause.

COVERAGE OF FARMERS AND AGRICULTURAL LABOR

In rural areas where farms are small, the farmer over 50 is often occupationally disabled by no longer being needed in the labor market or the food market, and if he cannot be retained and re-employed, should be treated the same as the totally disabled under the Social Security Act. His plight is one of the major social problems of rural America.

For agricultural labor, the President's proposal reduced the annual cash wage test for Social Security coverage from the present $150 to $50. In addition, the time test would be reduced from 20 days a year to 10 days a year. The House bill did not include this provision. We urge that the Senate put it back.

MEDICARE

Under the President's proposal there was a provision for depreciation of plant and equipment included in "reasonable cost" for hospital reimbursement only as such amounts are used for either capital or non-capital purposes under conditions approved by State planning agencies. This was not included in the House bill and we recommend that it be put back in.

MEDICAID

Under the House passed bill, a state is no longer required to provide 5 services (inpatient hospital, outpatient hospital, laboratory and X-ray, skilled nursing home, physicians'), but only 7 of 14 services which might be only some or even none of the 5 now required. On the face of it, this would appear to be retrogressive.

PUBLIC ASSISTANCE—LONG-TERM CARE

The NCOA has for more than 15 years been concerned with standards of care in nursing homes and homes for the aging. We urge the inclusion in the 1967 Amendments to the Social Security Act of the provisions of Senate bill S. 1661, sponsored by Mr. Moss and others. This bill is designed to assure the quality of nursing home services rendered to patients under public assistance programs, and to assure the adequacy and safety of the facilities of which such services are rendered.

LICENSING OF NURSING HOME OPERATORS

NCOA urges that federal aid be provided to any state for the construction and operation of nursing homes, if there is in such state a state program providing for the licensing of all operators of nursing homes located within such state. A bill with such provisions has been introduced into the Senate by Mr. Kennedy of Massachusetts and others. (S. 1662).

CONCLUSIONS

We urge the Senate to provide higher benefit levels, a cost of living escalation formula, more inclusive medical benefits, more liberal benefits for rural residents, and improvements in long-term care.

While the NCOA is primarily concerned with older people, it is a national social agency with a responsibilility to be fair to the interests of younger people and their problems. NCOA is concerned with some of the implications of the House bill regarding Aid to Families with Dependent Children. There are punitive aspects of this legislation which encourage the use of sanctions to control behavior.

The harshest provisions of the House bill are designed to deal with illegitimacy and non-support among Negroes by punitive means and without apparent recognition of the real cause of these phenomena.

NCOA considers that the benefits under social insurance and social assistance programs be matters of right whether the costs of these benefits have been paid through pre-paid insurance or through general taxation.

Senator ANDERSON. Dr. Mowbray. I asked a question about podiatry earlier. You do represent that group now?

Dr. MOWBRAY. That is correct, sir.

Senator ANDERSON. We will be glad to hear your testimony.

STATEMENT OF DR. DOUGLAS T. MOWBRAY, RETIRING PRESIDENT, AMERICAN PODIATRY ASSOCIATION; ACCOMPANIED BY DR. SEWARD P. NYMAN, EXECUTIVE DIRECTOR, AMERICAN PODIATRY ASSOCIATION; AND WERNER STRUPP, GENERAL COUNSEL, AMERICAN PODIATRY ASSOCIATION

Dr. MOWBRAY. Mr. Chairman, and members of the committee, I am Douglas T. Mowbray, retiring president of the American Podiatry

Association and a doctor of podiatry in private practice in Waterloo, Iowa. The American Podiatry Association is a voluntary, nonprofit organization established in 1912 and is composed of 53 component societies, one in each State, the District of Columbia, Puerto Rico, and a society for podiatrists in Federal service.

I would like to interject here I have with me as research persons, Dr. Seward P. Nyman, executive director of the American Podiatry Association and Mr. Werner Strupp, counsel for the American Podiatry Association.

On March 13, I had the privilege of appearing before the House Ways and Means Committee to present the views of the American Podiatry Association regarding the proposed Social Security Amendments of 1967. Mr. Chairman, this detailed statement is included in the printed report of those hearings. To conserve your committee's time I will briefly summarize and reiterate the position of my association regarding this legislation as embodied in H.R. 12080 which is now being considered by your committee.

Section 127 of H.R. 12080 would make podiatrists' services available to medicare beneficiaries under title 18. In the language of H.R. 12080:

> The definition of a physician would be amended to include a Doctor of Podiatry with respect to the functions he is authorized to perform under the laws of the State in which he works. However, no payment would be made for routine foot care whether performed by a podiatrist or a medical doctor.

My association wishes to express its support for inclusion of podiatrists' services in the manner now detailed in section 127 of H.R. 12080.

It is fully in accord with the recommendations made by President Johnson. The President first called attention to this need in July 1965, when the plan was inaugurated, and recently in his message to the 90th Congress on aid to the aged, he observed that:

> Certain types of podiatry are important to the health of the elderly. Yet, these services are excluded under present law—I recommend that foot treatment, other than routine care, be covered under Medicare.

There are only four classes of practitioners in the medical arts who by training and by licensure treat by both medical and surgical means—doctors of medicine, doctors of osteopathy, doctors of dentistry, and doctors of podiatry. The Medicare Act as presently constituted includes all of the professions so licensed except the podiatrist. Section 127 of H.R. 12080 would correct this inequity by properly including the podiatrist under the amended definition of physician.

With "routine foot care" excluded, foot care would be included in the medicare program in a manner consistent with coverage under private insurance contracts and would not increase the cost of the program. The Health Insurance Association of America has stated:

> The cost of such an extension of the program should not require an increase in the Supplementary Medical Insurance premium.

Many studies have established that foot disability is widely prevalent in the aged. In fact, people over 65 have three times as many foot problems as younger people. To meet this health need effectively and to foster mobility and independence among older people, the Nation's podiatrists are actively engaged in cooperative educational and foot care programs with public health agencies and other health professions.

Inclusion of foot care in the medicare program would give tangible evidence of the concern of Congress that all aspects of health care for the elderly are covered.

Mr. Chairman, 2 years ago this committee and the Senate approved amendments to include podiatrists' services in the medicare program. I trust that on this occasion this committee will again lend its support to inclusion of podiatrists' services in the medicare program in the manner recommended by the House Ways and Means Committee, and passed by the House on August 17.

I appreciate this opportunity to appear before your committee to urge your support of section 127 of H.R. 12080. I will be pleased to answer any questions at this time.

The CHAIRMAN. Senator Anderson?

Senator ANDERSON. I have no questions. I just want to say to you that I checked very carefully on the previous recommendations. I think podiatry should be included and I so voted.

The CHAIRMAN. I would assume that the committee, having substantially the same members, would vote substantially the same as they voted last time.

Senator Carlson?

Senator Bennett?

Senator Curtis?

Senator CURTIS. As I understand it you are satisfied with the House bill?

Dr. MOWBRAY. Yes, sir; that is correct. We have had extensive conferences, as you know, with the House Ways and Means Committee and we are recommending that the Senate adopt the phraseology that has been adopted by the House.

Senator CURTIS. The definitions and other provisions regarding podiatrists are workable, in your opinion?

Dr. MOWBRAY. Yes; we feel that these are workable in their present form.

Senator CURTIS. No further questions.

The CHAIRMAN. What is your reaction to the suggestion that podiatrists be paid to the extent that they are licensed to practice under State laws? That is the law now, isn't it?

Dr. MOWBRAY. Well, sir, in response to your question, and I think I understand it correctly, it is that the license to practice and the nature and degree of the license to practice is the legislative prerogative reserved for the States. To that degree the bill properly includes the definition of podiatrist as licensed to practice in the State in which he performs such functions. This is roughly the language included. So this is self-leveling. This is a State legislative prerogative and not the prerogative of the Federal Government or the Federal agency.

The CHAIRMAN. Thank you very much, sir.

Dr. MOWBRAY. Thank you.

The CHAIRMAN. Dr. Grady Lake, vice president of the International Chiropractors Association.

Senator TALMADGE. Mr. Chairman, it is a great pleasure for me to welcome my friend and constituent from Georgia, Dr. Grady Lake.

STATEMENT OF DR. GRADY V. LAKE, VICE PRESIDENT, INTERNATIONAL CHIROPRACTORS ASSOCIATION; ACCOMPANIED BY JOSEPH P. ADAMS, WASHINGTON COUNSEL

Dr. LAKE. Thank you, Senator Talmadge and Mr. Chairman.

With me today is our Washington, D.C., representative, Gen. Joseph P. Adams, who represents the International Chiropractors Association of which I am a member and a vice president.

If it is within the committee's wishes, I would just like to submit my testimony here today that is in printed form, which you, I understand, have in your possession, and just touch the salient points of the International Chiropractors Association's position in the Medicare Act, H.R. 12080.

First of all we would urge the inclusion of chiropractic services in title XVIII, medicare, under social security.

We wish to urge that the people who are the beneficiaries of this legislation should have the freedom to choose the doctor and the method of health services; that those who are chiropractic patients should not be discriminated against.

The present section 1802 of medicare of the Social Security Act guarantees the patients' freedom of choice of health services.

It is respectfully submitted that this freedom is not complete nor available in fact unless the patient has the choice of the services of any and all of the healing arts.

Let it be made clear that the inclusion of doctors of chiropractic under a proper scope of practice, as we will urge here, should do no violence to the cost structure of the administration of this legislation as there are and will be no duplication of services.

In continuing this idea of possible cost, which we realize is quite a staggering sum under the present situation, we have here two booklets entitled exhibits A and B.

No. 1, No. A, is entitled "Back Injury," and it is a survey primarily of workmen's compensation cases, and it is a comparative cost study that was compiled by the International Chiropractors Association in comparing chiropractic, osteopathy, and medicine.

We have a booklet, exhibit B, which has been compiled by the Florida Chiropractic Association, and again it goes into cost comparison studies. These materials support our point of view that the cost of chiropractic care freely chosen and in lieu of other health services will not add to the overall costs of the medicare program.

(Exhibits A and B referred to appear in the official files of the committee.)

Furthermore, we recently ran a survey, or this survey was run by the Louisville local, United Rubber, Cork, Linoleum & Plastics Workers of America, which is a part of AFL-CIO, and they offered chiropractic care to its members and their indications of cost experience since institution of chiropractic care has been excellent.

These facts and figures are at this committee's disposal through our association.

I don't think we are here today to consider the relative merits of one system of healing versus another system of healing at all, and the legal recognition of chiropractic has already been given as evidenced

by all except the State of Louisiana. Our other 48 States license doctors of chiropractic.

I would like to mention that the workmen's compensation laws readily recognize and realize the importance of chiropractic in the field of the spine and the nerve system and their relationship to each other. I would also point out that the GI bill of rights, by Federal funds, has educated many of the doctors of chiropractic, including myself, and additionally title 19 of the present act entitled Medicaid, permits recognition of chiropractic services.

Members of the chiropractic profession in the United States now—now gentlemen, our name as International Chiropractors Association might be considered a misnomer in some instances as the majority of our membership are wtihin the confines of the 50 United States. However, we do have members in most all foreign countries with the exception of those in the Communist countries, and we do have a few there, but our communications are rather limited and have been for the last few years.

We have approximately 20,000 practitioners of chiropractic and we care for upward of 3 million patients a year. These patients are from all walks of life and most of these patients participate in some form of health insurance or the other.

Again let me point out that chiropractic is a separate and distinct science, and we provide a nonduplicating service. This service is confined to the care of the spine, consisting of spinal analysis and spinal adjustments to relieve normal nerve interferences due to vertebral subluxations or misalinements.

Again, I would like to say, gentlemen, we do not hold ourselves to be competent in any of the other fields of the healing arts, only chiropractic.

Therefore, we respectfully submit this terminology in the inclusion of chiropractic services under the supplementary medical insurance program.

We have listed the sections and the lines and the proper punctuation, and defined the chiropractic services.

We would also urge that under section 1867, pages 99 and following of this bill, that all health services be represented on the Health Insurance Benefits Advisory Council contemplated here.

An important point in your consideration of inclusion of chiropractic services in H.R. 12080 is how noninclusion can affect an outside industry such as that of insurance. As I have mentioned here previously, so many of our patients are covered under one form of health insurance or another they, of course, are delighted, in the main, these insurance people, with our services.

But one of the major carriers of insurance made this comment the other day. He said:

Although—

The name of his company—

has consistently been honoring the claims of chiropractors, they would find themselves in the very embarrassing position of not being able to reimburse for chiropractic care if they were to become one of the insurance carrier administrators of the medicare plan if it is passed in present form because the definition of a "physician" does not include chiropractic.

Even though the act states that the patient shall have a freedom of choice.

Now, this situation has been in existence now for 2 years. Because of this exclusion, we have been denied participation in medicare.

We feel that these suggested amendments to H.R. 12080 will bring the bill in line with the intent of the basic medicare legislation and truly give the patient his freedom of choice in the selection of his health care.

Now, Mr. Chairman, and members of the committee, 2 years ago this committee and the Senate approved an amendment to include chiropractic care, and I would urge that upon this occasion that this committee will again lend its support to the inclusion of chiropractic services to the benefit of our many millions of patients.

I would like to thank you for your time and ask if there are any questions I would answer them.

Senator ANDERSON. Thank you, Doctor, for your statement.

Senator TALMADGE. I want to commend the witness on his statement.

Senator BENNETT. Mr. Chairman, I have a letter from the Utah Chiropractic Association asking the same inclusion, and at this point in the record I would like to have this letter included.

Senator ANDERSON. Without objection it will be done. Thank you very much, Doctor, we are glad to have you here and have you present your point of view.

Dr. LAKE. Thank you, sir.

(The letter referred to by Senator Bennett, and the prepared statement of Dr. Lake, follow:)

UTAH CHIROPRACTIC ASSOCIATION, INC.,
Salt Lake City, Utah, May 23, 1967.

HON. WALLACE F. BENNETT,
U.S. Senator, Senate Office Building,
Washington, D.C.

DEAR SENATOR BENNETT: It has been resolved by the Utah Chiropractic Association that:

Whereas, the Federal Medicare Act, Title 18, included within its provisions, two basic provisions which stated: Prohibition against any Federal interference and free choice of patient guaranteed, and

Whereas, the Medicare act as presently written constitutes Federal interference with states rights in denying recognition to state licensed and regulated health care professions including chiropractic health care and also denies the free choice of the patient in selection of health care by refusing to provide for allied health care professions including chiropractic health care, and

Whereas, chiropractic health care inclusion in the Medicare bill will not require additional expenditures of funds in the Medicare program since health care under chiropractic is a substitute at lower cost for medical care.

Now therefore, this convention does hereby resolve that it decries the denial of freedom of choice imposed upon the senior citizens of the United States in the selection of the health care of their choice under the existing provisions of the Medicare Act and,

Be it further resolved that it urges the adoption of amendments to the Medicare Act which will include chiropractic as an optional health care and

Be it further resolved that copies of this resolution be forwarded to the Congressional delegation of this state with an appropriate letter urging the passage of amending legislation providing the inclusion of chiropractic health care in the Medicare Act.

Resolved this 20th day of May, 1967.

DR. THERIS P. ASTLE,
President.
DR. ROBERT B. SHELTON,
Vice President.
DR. GUNNAR T. SYVERSON,
Secretary.

STATEMENT OF GRADY V. LAKE, D.C., VICE PRESIDENT AND MEMBER, BOARD OF CONTROL, INTERNATIONAL CHIROPRACTORS ASSOCIATION

Chairman Long and Distinguished Members of the Senate Finance Committee:

I am Dr. Grady V. Lake of Atlanta, Georgia, a practicing doctor of Chiropractic, having practiced my profession in Atlanta for overy twenty years. I appear here today on behalf of Dr. Leonard W. Rutherford, President of the International Chiropractors Association, a non-profit professional association representing thousands of practicing chiropractors throughout the United States, with headquarters offices at 741 Brady Street, Davenport, Iowa. Accompanying me today is Brig. Gen. Joseph P. Adams, the ICA Washington, D.C. Counsel.

I wish to thank this Committee for making time available for us to urge inclusion of Chiropractic services in H.R. 12080, a bill to amend the present "medicare" provisions of the Social Security Act.

We wish to urge that the people who are to be the beneficiaries of this legislation should have the freedom to choose the doctor and the method of health services; that those who are chiropractic patients should not be discriminated against. Section 1802 of the present "medicare" provisions of the Social Security Act guarantees the patient's freedom of choice of health services. It is respectfully submitted that this freedom is not complete or available in fact unless the patient has the choice of services of all or any of the healing arts.

Let it be made clear that inclusion of doctors of chiropractic under a proper scope of practice as we will urge here should do no violence to the cost structure of the administration of this legislation as there would be no duplication of services. The patient would freely choose the services offered by the particular health service provided and no other, for any specific ailment eligible for care under the act.

It is well to note here that the Civil Service Commission has approved language for inclusion in some of the Federal Benefit Plans which, if properly administered, prevents duplication of services while providing freedom of choice of doctor and health care. An example of such language is contained in this statement in the portion urging inclusion of chiropractic as amendment to this bill.

Continuing our discussion of cost of chiropractic care, we are attaching a copy of a booklet, marked Exhibit A, titled "Back Injury" to our original statement, which booklet has been prepared by the International Chiropractors Association. Material in the booklet covers cases from insurance company files, workmen's compensation records and reports from field doctors. These materials support our point that the cost of chiropractic care, freely chosen, and in lieu of other health services, should not add to the cost of the "medicare" program. Along this same line, we attach a copy of a booklet produced by the Florida Chiropractic Association, marked exhibit B, which indicates favorable cost comparison for chiropractic care with other health services in workmen's compensation cases.

Furthermore, and quite recently, the Louisville Local of the United Rubber, Cork, Linoleum and Plastic Workers of America (AFL-CIO) offered chiropractic care to its members and indications of cost experience since institution of chiropractic care has been excellent.

We are not involved here with any considerations of the relative merits of one system of healing versus another system of healing. Legal recognition of chiropractic has already been given, as evidenced by the fact that 48 of our states, plus the District of Columbia and Puerto Rico, provide for the licensing of Chiropractors.

Today's doctor of chiropractic must have at least a high school education prior to entry into chiropractic college, and with only one or two exceptions, he must obtain four in-residence years of chiropractic education before making application to the State Board of his choice. Additionally, about one-half of the states today require one or two years of pre-professional college education in addition to high school and the four years of chiropractic education. Moreover, about one-half of the states require the prospective chiropractor to take the same basic science examinations given to prospective members of the other healing arts.

Most workmen's compensation laws recognize the chiropractor's services, and several hundred insurance companies recognize such services in their policies, or by administrative action. Moreover, many doctors of chiropractic obtained their chiropractic education as a direct result and benefit of participating under

the "GI Bill of Rights" education opportunities. It can also be noted that the federal tax laws permit chiropractic charges to be listed as deductions.

Additionally, Title 19 of the present act ("medicaid") already permits recognition of chiropractic services. Members of the chiropractic profession (the second largest healing art in the United States) number about 20,000, and care for upwards of 3,000,000 patients per year. These patients are from all walks of life and most participate in some form or forms of health insurance.

It should be pointed out that chiropractic is a separate and distinct health science providing a non-duplicating service. This service is confined to the care of the spine consisting of spinal analysis and spinal adjustments to relieve nerve interferences due to vertebral subluxations or misalignments.

Therefore, we respectfully submit for your favorable consideration the following amendments to H.R. 12080:

I. On page 51 between lines 2 and 3, insert the following heading:

INCLUSION OF CHIROPRACTORS' SERVICES UNDER THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

SEC. 127. (b) Section 1861(r) of the Social Security Act is amended—

(1) by adding at the end thereof the following "or (4) chiropractors' services".

II. Between lines 2 and 3 of page 51 and following the above proposed amendment, insert the following:

SEC. 127. (c) Section 1861(z) of the Social Security Act is amended—

"Chiropractors' Services

"The term 'chiropractors' services' means those services confined to the care of the spine, consisting of spinal analysis and spinal adjustments to relieve nerve interference due to vertebral subluxations or misalignments for the restoration and maintenance of health."

We would note that under Section 141 of this bill the Secretary is to make a study regarding inclusion of health services under the supplementary medical insurance program (part B of Title XVIII of the Social Security Act). International Chiropractors Association offers any assistance it can provide to such a study. We would also urge that under Section 1867 at pages 99 and following of this bill that all health services be represented on the Health Insurance Benefits Advisory Council contemplated there.

An important point in your considerations of inclusion of chiropractic services in H.R. 12080 is how non-inclusion can affect an outside industry, such as that of insurance.

Specifically, during the week of May 3, 1965, just prior to the passage of the original "medicare" provisions to the Social Security Act, an executive of a major insurance carrier advised International Chiropractors Association that:

"Although [company] has consistently been honoring the claims of chiropractors, they would find themselves in the very embarrassing position of not being able to reimburse for chiropractic care if they were to become one of the insurance carrier 'administrators' of the Medicare plan if it is passed in its present form because the definition of a 'physician' does not include chiropractic."

This objective statement from a potential insurance carrier participant is the best example that could be offered this Committee to indicate the dire results facing the chiropractic profession from the present discriminatory language contained in the definition of physician. It is assumed that this existing discrimination is inadvertent and arises from a failure to understand the legislative language needs of chiropractic to accomplish inclusion under Medicare and that such discriminatory language will be eliminated by the adoption of amendments proposed herein.

We feel that these suggested amendments to the present proposal will bring the bill into line with the intent of Section 1802 of the legislation, "Free Choice By Patient Guaranteed", and will afford the nation an example of general legislation in the health care field which will not be subject to charge of special interest legislation. Further, it will provide all who will come under the benefits of this legislation with the right to fully participate in its benefits, an objective shared by all who support the legislation.

We thank you very much for your interest and kind considerations.

Senator ANDERSON. Dr. Judd Chapman. Senator Smathers regrets that he cannot be here to introduce you this morning, Dr. Chapman,

but he has asked me to make the following introduction in his behalf (reading):

It is always a pleasure for me to introduce one of my constituents from the Great State of Florida as a witness before this Committee. It is gratifying to know so many Floridians share my interest in good legislation, and I find it reassuring that some of them will take the time and interest to come here and contribute in whatever way they can to supply information vital to the legislative process.

We have a gentleman from Tallahassee here to testify today on behalf of the American Optometric Association. This is an organization which has for nearly three-fourths of a century been a vital factor in improvement of human vision through better optometric education, more extensive eye research, the promotion of legislation to better protect the vision of Americans, and by constantly working to upgrade the professional standards of those practicing optometry.

Dr. W. Judd Chapman is a practicing optometrist in our capital city of Tallahassee. He is a native of the Sunshine State, and attended the University of Florida preparatory to his enrollment for graduate work at the Northern Illinois College of Optometry in Chicago, where he was awarded the doctor of optometry degree in 1949. I am sure that the Committee will benefit from his appearance before us.

STATEMENT OF DR. W. JUDD CHAPMAN, CHAIRMAN, COMMITTEE ON LEGISLATION, AMERICAN OPTOMETRIC ASSOCIATION; ACCOMPANIED BY WILLIAM P. McCRACKEN, JR., WASHINGTON COUNSEL

Dr. CHAPMAN. Mr. Chairman and members of the Senate Finance Committee, it is a pleasure to appear before you again. I am W. Judd Chapman from Tallahassee, Fla., and chairman of the American Optometric Association's committee on legislation.

I will be brief, but respectfully request that my full statement with attachments as printed be made a part of your records.

Senator ANDERSON. You mean the exhibits as well?

Dr. CHAPMAN. They are attached to the statement, Senator Anderson.

Senator ANDERSON. You want all of these included?

Dr. CHAPMAN. Yes, sir, I would appreciate it if they can be.

Senator BENNETT. Mr. Chairman, I suggest that these attachments be included in the committee's files. That this will greatly overbalance the record itself. In the file they are available to the committee.

Senator ANDERSON. I think so. I think this is too much.

Dr. CHAPMAN. All right, sir. We just want to have all the facts involved in the presentation and if it is in the committee files that would be adequate, I am sure.

Senator ANDERSON. Thank you very much.

(The attachments referred to are made a part of the official files of the committee.)

Dr. CHAPMAN. Joining me at the table, Senator Anderson, is the Washington counsel of the American Optometric Association, Mr. William P. McCracken, Jr. Mr. McCracken has been with me before and it is always comforting for me to have him here.

Senator ANDERSON. We welcome him again.

Mr. McCRACKEN. Thank you, Senator.

Dr. CHAPMAN. I am here to support the Carlson amendment which you adopted as section 409 of the Senate version of H.R. 6675 during

the 89th Congress. We again ask your support. We believe the need for this amendment is greater now than in 1965. We also ask you to adopt Senator Ribicoff's amendment introduced earlier this year as S. 804. Both amendments are attached to my full statement.

After H.R. 6675 became Public Law 89-97, Congressman Henry Helstoski of New Jersey requested that the Department of Health, Education, and Welfare tell him its position relating to optometry. He received a reply from Dr. Philip Lee, Assistant Secretary for Health and Medical Affairs on August 1, 1966, from which I quote:

> The profession of optometry is accepted by the Department as a legitimate and essential health profession which is performing highly useful functions in promoting solutions to the eye health needs of this Nation.
>
> The Department agrees that the American public should continue to have freedom of choice in the selection of a practitioner to care for vision problems.

It appears that neither the U.S. Welfare Administration nor the Social Security Administration share its Department's views.

The only guidelines issued to States relating to vision care we have seen were contained in a 1963 Welfare Administration booklet titled "Medical Care in Public Assistance—Optical Services." Although subsequently rescinded, the guidelines have not been replaced. Our experience indicates that these guidelines still prevail. Here are a few quotations which illustrate optometry's problem in providing welfare program services—use of the term "optical services," by the way, is an easy way to avoid the term "optometry"—

> Optical services provided or authorized by the state agency should be based upon the findings of a thorough eye examination performed by an ophthalmologist.
>
> In fulfilling a physician's recommendations, the eyeglasses, other vision aids, ocular prostheses, etc., should be provided by a supplier licensed to assume such responsibilities.

There is more of this, but I will not take the time to read it. The point is simply: optometrists' services are ignored by the Welfare Administration unless expressly stated in the law. The State supervising ophthalmologist is supreme and his "supervising" services are reimbursed principally from Federal funds, which my colleagues and I help provide as taxpaying citizens.

The Social Security Commissioner recently wrote the House Ways and Means Committee assistant counsel the following:

> In addition, as medical doctors, ophthalmologists bear along with all other physicians certain additional responsibilities under the Medicare program which are related to their legal status and professional competence . . . To include optometrists within the term "physician" would, therefore, have the effect on the one hand of extending to optometrists the right to receive reimbursement for their services or services they might prescribe without the authorization of a medical doctor, and on the other hand, of extending to optometrists certain functions and responsibilities which they cannot now perform and which would exceed their professional competence.

Dr. Milford O. Rouse, the American Medical Association's president, who spoke to you last Monday, said, among other things, this:

> We are concerned lest there be ascertained an unwarranted and unproved need for expansion of the program. We are concerned lest the door be opened to permit, under the guise of necessary health care, services which may do injury to the health of the very people who need competent medical care.
>
> The services of optometry and podiatry, both of which had been considered for inclusion in this category, are useful within the limitations of their competence. But we would recommend against their inclusion and urge that the Medicare program not be expanded in this area.

Dr. Rouse's statement complies with AMA policies such as its Resolution No. 77 (June 1955) which:

> Provides that association between doctors of medicine and optometrists are unethical . . . that physicians faithful to the ancient tenets of the medical profession, are ever cognizant of the fact that they are trustees of medical knowledge and skill . . . and that they must dispense the benefits of their special attainments in medicine to all who need them; that it is a futile gesture to consult on a professional level with one who does not possess the same knowledge, training, experience and ideals as the doctor of medicine.

Mr. Chairman, we believe the only real opposition to optometry's participation in the Social Security Act stems from one source, the American Medical Association. The language of its testimony here is strikingly similar to that of the Social Security Administration. The AMA said "The services of optometry * * * are useful within the limitations of their competence."

The Social Security Commissioner said "to include optometrists within the term 'physician' * * * would exceed their professional competence."

Resolution No. 77 states the AMA belief that no discipline—dentistry, podiatry, or optometry—is "competent" unless it possesses "the same knowledge, training, experience and ideals as the doctors of medicine."

Optometrists are "competent" to engage in their field of health care. Each State certifies their competence before allowing them to practice.

Senator Ribicoff's amendment to which Mr. Ball referred, states that optometric services are limited to those acts legally authorized by the States in which they are performed.

There is no question as to the "competence" or legal authorization of optometrists, as Mr. Ball and the AMA infer.

Optometrists receive 4 years of professional training to earn the doctor of optometry degree. Dentists receive 4 years of professional training for their doctor of dentistry degree. Podiatrists receive 4 years of professional training to obtain their doctor of podiatry degree.

Medical doctors likewise need only 4 years of professional training to obtain their doctor of medicine degree. All of the health disciplines named, except medicine, devote 4 years of study concentrated in a specialized area of health care. The doctor of medicine during his 4 years must obtain knowledge in all areas of health. Who, then, is better trained to immediately engage in specialized practice? Logic rejects the conclusion that 4 years of general training would be superior to 4 years of specialized training.

Dr. Rouse said:

> We are concerned lest there be an unwarranted and unproved need for expansion of the program.

Neither the amendment proposed by Senator Ribicoff nor the amendment of Senator Carlson expands social security programs. These amendments provide that the beneficiary will be free to select either an optometrist or a doctor of medicine for eligible eye care services.

Dr. Rouse further said:

> We are concerned lest the door be opened to permit, under the guise of necessary health care, services which may do injury to the health of the very people who need competent medical care.

All States have promulgated laws regulating the practice of optometry to protect the public from injury to their health.

Commissioner Ball's letter makes two conclusions: (1) To include optometrists within the term "physician" would, therefore, have the effect on the one hand of extending to optometrists the right to receive reimbursement for their services or services that they might prescribe without the authorization of a medical doctor, and (2) on the other hand of extending to optometrists certain functions and responsibilities which they cannot now perform and which would exceed their professional competence.

No other State or Federal law requires authorization of a medical doctor before a patient can be reimbursed for services an optometrist performs.

As to Mr. Ball's second conclusion: Senator Ribicoff's amendment clearly restricts the services of an optometrist by the modifying clause "but only with respect to functions which he is legally authorized to perform by the State in which he performs them." In no way could optometrists "exceed their professional competence."

The need for optometrists' services is substantiated by the Welfare Administration's own figures released in 1963. Here are a few of them:

> As many as 58 percent of the population require some form of vision care. About 9,800,000 children need eye care; a large number of these children should be wearing glasses.

In his statement to the House Ways and Means Committee on this bill, HEW Secretary Gardner said:

> Many preschool children who are poor and need treatment for eye difficulties do not see a doctor; 1 million poor children need glasses . . . with this program we would dramatically reduce handicapping conditions among poor children. Congenital handicaps would be reduced by at least 30 percent, uncorrected vision problems by at least 40 percent.

We commend Secretary Gardner for his efforts to initiate new and more effective ways to deliver comprehensive health care. We believe the term "comprehensive health care" must include optometrists' services to be comprehensive. Our belief appears not to be shared by all HEW officials.

In the various title V grants which deal with comprehensive health care of needy preschool and schoolchildren, not one provides for the services of optometrists. The policies and procedures manual distributed by HEW titled, "Grants for Comprehensive Health Services for Children and Youth," contains a long list of the professional personnel to be used—including dentists, nurses, nutritionists, medical social workers, speech and hearing specialists, occupational therapists, and administrative officers—but not one word about optometrists.

Our members have spent months developing ways to assist programs for crippled, handicapped, and economically disadvantaged children; they have tried every conceivable method to get approval for optometric participation in these programs to no avail. They are told that since the law makes no mention of optometrists, optometrists' services are not covered by the terms "medical care" or "comprehensive health care."

Additionally, we believe there should be hearings on a bill intro-

duced by the very able former HEW Secretary, now a member of your committee, Senator Abraham Ribicoff.

His proposed Child Health Census Act, S. 590, is a good effort in the proper direction.

There is no new information regarding optometry which could result from a study by the advisory body established by section 141 of H.R. 12080. The beneficiary who prefers services from an optometrist is forced to wait until January 1969 to learn if this advisory group might recommend inclusion of optometrists' services under medicare. Until Congress takes further action, a beneficiary must bear the entire cost of eligible services he chooses to obtain from an optometrist or he must forgo such care entirely. This is grossly unfair.

The basic questions before you are these: Are services which can legally be performed by optometrists available to social security beneficiaries? Are optometrists qualified to perform these services? We believe State laws have fully answered these questions. State optometry licensing laws expressly permit optometrists to use any objective or subjective means for examination of the human eye.

You would have to bar the use of the ophthalmoscope by every type of practitioner in order to completely exclude optometrists. The ophthalmoscope is used for examining the interior of the eye, and is necessary to properly investigate a majority of human disease.

The optometrist would violate his code of professional ethics should he charge a profit from the materials he supplies to his patient.

Under H.R. 12080, payment is made for the retail price of phosthetic devices. Any services provided are covered by the markup over wholesale cost.

The optometrist is now paid for refraction services and dispensing services necessary to fit an aphakic lens following cataract surgery. If H.R. 12080 were enacted, payment for these services would be eliminated. Likewise, payment could not be made for fitting an artificial eye.

H.R. 12080 stipulates that reimbursement for any eye care service can be made only for services rendered by a practitioner defined as a physician under title XVIII. The ethical optometrist is excluded from participation in this program. State legislative and judicial actions verify the optometrist's qualifications to furnish eye care. H.R. 12080 attempts to question the optometrist's qualifications.

To further substantiate the position of optometrists and optometric patients, I would like members of this committee to study the documents which are attached to the full statement, which we discussed at the beginning of my presentation that we hoped could be made a part of the record but I understand will be part of the committee files. And they include the following:

(1) A list of optometric schools and colleges giving location and university affiliation.

(2) A catalog from one of the optometry schools outlining the training an optometrist receives.

(3) A list of State optometric laws and the dates they were enacted.

(4) A list of States which have enacted provisions similar to the Carlson amendment you adopted in 1965, with the language of those provisions.

(5) A booklet on "Military Optometry," the second page of which reprints a letter from President Lyndon B. Johnson in which he said:

The American Optometrist is this nation's home front defender of one of our most prized human possessions—the gift of sight. His battles are many and often severe. But his victories sustain and improve the health and fiber of our society.

(6) A list of eligible optometric services available to title XVIII beneficiaries under present law.

(7) A copy of page 18 of the "Medicare Handbook" which states that optometrists' services are not covered.

(8) A copy of a legitimate claim by medicare beneficiary F. H. Bauerfield of Yates Center, Kans., not reimbursed solely because the services were provided by an optometrist. There are many similar rejected claims should you care to see them.

(9) A reference to the Army's recent draft order to optometrists.

(10) A copy of a 1966 letter from the Social Security Administration which states that payment can be made for a prosthetic lens regardless of whether it is furnished by an ophthalmologist, an optometrist, or an optician.

(11) Copies of amendments proposed by Senator Ribicoff and Senator Carlson.

Gentlemen, all we ask is that you confirm by law what the U.S. Department of Health, Education, and Welfare has already stated in Dr. Philip Lee's letter to Congressman Helstoski in which he said:

The profession of optometry is accepted by the Department as a legitimate and essential health profession which is performing highly useful functions in promoting solutions to the eye health needs of this nation.

The Department agrees that the American public should continue to have freedom of choice in the selection of a practitioner to care for vision problems.

Thank you for this opportunity to again be with you. If you have any questions either Mr. McCracken or I will be happy to attempt to answer them.

Senator CARLSON. Mr. Chairman.

Senator ANDERSON. Senator Carlson.

Senator CARLSON. Mr. Chairman, I would like to read into the record language of a proposed amendment that will be available for consideration from the executive session, and the language would read this way:

SECTION 404. Notwithstanding any other provisions of the Social Security Act whenever payment is authorized for services which an optometrist is licensed to perform the beneficiary shall have the freedom to obtain such services from either a physician skilled in disease of the eyes or an optometrist, whichever he may select.

I write that into the hearing record so that it will be available with other proposed amendments such as we have been dealing with podiatry and chiropractic services and others.

I would like to ask one or two questions of Dr. Chapman. How many ophthalmologists and how many optometrists are practicing in the United States today?

Dr CHAPMAN. There are approximately 17,000 optometrists practicing, Senator Carlson.

Senator CARLSON. Pardon me, I didn't get that.

Dr. CHAPMAN. 17,000 optometrists and approximately 4,500 ophthalmologists.

Senator CARLSON. Well now, are these services generally available everywhere or what is the area?

Dr. CHAPMAN. No, sir, quite frequently they are not. The optometrists are located throughout many of the smaller communities and areas of this country, whereas the concentration of ophthalmologists is in the more urban areas, because of the need for pathological and surgical treatment of the eyes and the proximity of large hospitals where such treatment is given.

Senator CARLSON. Coming from a rural area I have noticed that there are many sections in our State where people have to go to considerable distances to get treatment for eye trouble and for that reason I think we ought to give some special consideration to this.

Dr. CHAPMAN. In my own State of Florida, as a matter of fact, our State legislature has provided funds for the training of optometrists so that certain rural counties in our State and smaller communities which do not now have optometrists will have adequate manpower. We are very pleased about that action of our State legislature.

Senator CARLSON. Thank you very much.

Senator ANDERSON. Senator Bennett?

Senator BENNETT. No questions.

Senator CURTIS. From the standpoint of the optometrists, within what limits do you define the area of practice permitted under State law as contrasted to the ophthalmologists?

Dr. CHAPMAN. Senator Curtis, perhaps the simplest and quickest way to answer that would be to say that because the great majority of people of this Nation first see an optometrist for vision care, approximately 70 percent of them, in fact, the optometrist must be trained and qualified to adequately determine the health of this eye before any device or any prosthetic instrument would be used for the correction of some vision problem.

Therefore, his training is such that he makes this determination at the outset of his examination. If this proves to be clear, and does not require additional referral, then the optometrist will proceed to use all of the many techniques and systems by which he can determine the full capability of the person visually to perform.

The optometrist may stop at that point. The investigation of the eye might well determine the need for a general practioner's care or an ophthalmologist or some other specialty.

The optometrist does not prescribe medicine for the human eye. His assignment is to recognize the need for additional professional help and to refer it if that is necessary. So the basic distinction between the two is in that field.

Senator CURTIS. It is in treating the disease.

Dr. CHAPMAN. Basically, yes, sir, that is correct, and the optometrist does not perform surgery.

Senator CURTIS. What testing devices, if any, do ophthalmologists use that optometrists do not?

Dr. CHAPMAN. Senator Curtis, I don't know of any device in the analysis procedure that the ophthalmologist would use that an optometrist does not use. There might be—well, Mr. McCracken was saying that there are forms of tonometers which ophthalmologists use which we do not.

Senator CURTIS. What are they?

Dr. CHAPMAN. But we use tonometers.

Senator CURTIS. They test pressure?

Dr. CHAPMAN. They test pressure. One particular type requires that an agent be instilled into the eye so that it is deadened and, therefore, the pressure plate of the tonometer can be placed upon the eye. The optometrist uses tonometers and uses one which does not require the use of any installation of drops in the eye. This is known as the electronic tonometer.

Senator CURTIS. What does that test show, the presence or absence of what?

Dr. CHAPMAN. This test indicates the absence or presence of increased pressure. The electronic tonometer upon its application registers upon a graph. It actually makes a very accurate determination of existing pressure within the eye which is a symptom of glaucoma. I didn't mention——

Senator CURTIS. What did you say about glaucoma?

Dr. CHAPMAN. Which is the symptom primarily.

Senator CURTIS. What is?

Dr. CHAPMAN. Increased pressure within the eye.

Senator CURTIS. Oh, yes, I am aware of that.

In the ordinary course of things is a referral by an optometrist to an ophthalmologist frequent?

Dr. CHAPMAN. Yes. I don't recall the figures but a study was made several years ago of the numbers and they were in the millions. I don't recall the exact number.

Senator CURTIS. That is all, Mr. Chairman.

Senator ANDERSON. Thank you very much.

(Dr. Chapman's prepared statement follows:)

PREPARED STATEMENT OF DR. W. JUDD CHAPMAN, REPRESENTING THE AMERICAN OPTOMETRIC ASSOCIATION

Mr. Chairman and members of the Senate Finance Committee. It is indeed a pleasure for me to again appear before you on behalf of the American Optometric Association. I feel that I am back home again visiting old friends.

For purposes of the record, I am Dr. W. Judd Chapman, a privately-practicing optometrist from Tallahassee, Florida. In my appearance before you today I speak as Chairman of the American Optometric Association's Committee on Legislation.

The last time you heard me testify, we, the optometrists of America, were requesting your support for the Carlson Amendment, which you subsequently passed as Section 409 of the Senate version of H.R. 6675. We greatly appreciated your unanimous action for that amendment and ask you again to adopt it. We were disappointed, as many of you were, that the House of Representatives conferees were not willing to accept your version of the bill in 1965. We ask that you make the effort once again. We believe the need for the Carlson Amendment is greater now than it was in 1965, and, we believe the amendment proposed by Senator Ribicoff and a number of other Senators, is a necessary addition to H.R. 12080. I will refer to Senator Ribicoff's amendment later in this statement.

Senator Herman Talmadge best described what took place in 1965. With your permission I would like to quote what he said in the December 16, 1965 issue of "The Optometric Weekly."

"When the Senate Finance Committee received and began consideration of the House-passed Medicare Plan, I immediately noticed its lack of clarification regarding the status of optometrists. As incredible as it seemed, I could only interpret its provisions as having excluded optometrists.

"Such an omission was clearly inconsistent with past pronouncements of the Congress in legislation dealing with areas that extended to the optometric profession.

"Public Law 88–654, passed by the Congress last year, recognized the need for greater professional manpower in the field of optometry by providing loans to optometry students. With over 90 million Americans relying on optometrists for their visual requirements, it was imperative that the government assist by providing educational inducements to meet the increasing demands made by the American public on this group of specialists.

"Failure to have included optometrists in the Medicare Health Program would have virtually nullified the accomplishments of Public Law 88–654.

"Since there were certain sections in the House-passed bill which treated ophthalmologists and optometrists alike, I was led to believe that the House Ways and Means Committee had inadvertently excluded optometrists from the basic and supplemental health plans. For example, under "Definition of Services," payment was authorized for glasses prescribed by an optometrist as well as an ophthalmologist, whichever the individual selected. Another section provided "that in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye, *or by an optometrist*, whichever the individual may select.

"However, in all other cases of eye care, it was not made clear whether the beneficiary could elect to be treated by an optometrist as well as an ophthalmologist.

"Since 75 percent of all Americans who need eye care go to an optometrist, while only 25 percent go to a physician skilled in diseases of the eye, I could find no reason for excluding optometrists. Furthermore, it had obviously been overlooked that there are certain areas of visual training and corrective instruction in eye diseases that are performed almost exclusively by optometrists. Of course, physicians are by statute privileged to practice optometry, but that does not mean that optometric vision care and medical vision care are identical. Both are performed in a highly specialized and skillful manner and require the utmost in professional experience and expertise. Since one complements the other, and lends symmetry to the scope of professional eye care, it was inconceivable that either should be excluded from the Medicare basic or supplemental health plan.

"When this matter was brought up for discussion in executive session, the proposal to amend the bill so as to accord optometrists the same standing as ophthalmologists was widely and energetically received. I was gratified by this response and felt reassured that no serious objections would, or could be raised against our action.

"As it turned out, the bill, as amended (Carlson Amendment) to include optometrists passed the Senate, but was defeated in the Conference between House and Senate committee members."

The optometrists shared Senator Talmadge's belief that there could be no serious objections to your action. After the Senate-House Conference, some believed that the Social Security Administration was against your Section 409 which resulted in its disapproval. After H.R. 6675 became law, a member of the New Jersey Congressional delegation, the Honorable Henry Helstoski, wrote to the Secretary of Health, Education and Welfare for an explanation of that Department's attitude towards the profession of optometry. On August 1, 1966, he received a reply from Dr. Philip R. Lee, HEW's Assistant Secretary for Health and Scientific Affairs, which led us to believe that such suspicions were unfounded. I will attach the complete letter to this statement but would like to read to you the pertinent sections of Dr. Lee's letter:

"I have reviewed the brief prepared by the American Optometric Association and in this letter will deal with the conclusions contained in the brief.

A. *Recommendation that the Department, and its member agencies avoid discrimination against the profession of optometry.* This conclusion pertains to the

American Medical Association Resolution Number 77 (June 1955): ". . . provides that association between doctors of medicine and optometrists are unethical . . . that physicians faithful to the ancient tenets of the medical profession, are ever cognizant of the fact that they are trustees of medical knowledge and skill and that they must dispense the benefits of their special attainments in medicine to all who need them; that it is a futile gesture to consult on a professional level with one who does not possess the same knowledge, training, experience and ideals as the doctor of medicine.

"The American Medical Association is an independent organization and does not request Departmental consultation on its actions. Resolutions passed by the American Medical Association are not binding upon either the Department or its employees.

"Since 1950 the provisions of Title X of the Social Security Act authorizing grants to States for aid to the blind have required that State plans for this program provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select. The Public Welfare Amendments of 1962 established Title XVI of the Social Security Act authorizing grants to States for aid to the aged, blind, or disabled, or for such aid and medical assistance for the aged. Identical language with that contained in Title X is included in this new title. The Social Security Amendments of 1965 included a new Title XIX of the Social Security Act authorizing grants to States for medical assistance programs. Section 1905, which defines the term "medical assistance" includes the language "eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may elect."

Thus, in the determination of blindness as a factor of eligibility for public assistance payments and in the prescription of eyeglasses under the new medical assistance programs, the Federal law requires States to give an individual his free choice of an optometrist or a doctor of medicine. While such a requirement does not exist with respect to other aspects of public welfare programs, the silence of the Federal statute in no way limits the freedom of States to use optometrists in such other ways as they may find appropriate.

B. *Freedom of choice in selection of a practitioner.*—The Department agrees that the American public should continue to have freedom of choice in the selection of a practitioner to care for vision problems."

We were especially pleased by the concluding paragraph of Dr. Lee's letter in which he stated:

"The profession of optometry is accepted by the Department as a legitimate and essential health profession which is performing highly useful functions in promoting solutions to the eye health needs of this Nation."

Unfortunately, we find that the Social Security Administration and the former Welfare Administration, which came out of Social Security, are not as well-informed or agreeable about optometry and its services.

A 1963 Welfare Administration booklet, subsequently rescinded, set out guides and recommended standards for "Medical Care in Public Assistance—Optical Services." Here are only a few quotations from that booklet which illustrate our problem:

"As previously mentioned, optical services provided or authorized by the State agency should be based *upon the findings of a thorough eye examination performed by an ophthalmologist.* This examination would establish the recipient's particular eye pathology, his visual acuity (both near and distance), visual field, and ocular need. It would also show how well, if at all, this visual acuity can be aided by either the usual refractive devices or more specialized optical or vision aids . . ." (italic supplied).

"Optical services are generally paid through the vendor method, although the State has the option of including costs in its money payments to recipients. Certain of these services may be covered by health insurance policies or similar health entitlements and thus would not be assumed by the State agency. In some places, all or part of such expenses are paid by specialized voluntary programs or other public agencies to whom the State agency refers qualifying clients.

"When expensive aids and devices are under consideration, it is recommended that their purchase or replacement be reviewed *by the State Supervising Ophthalmologist or an eye care specialist whom he designates.*" (Italic supplied.)

"In general, *a medical eye examination should precede decisions to replace or alter visual aid or devices* . . ." (Italic supplied.)

"The possible services of an optometrist were contained in the section which stated:

". . . In fulfilling a physician's recommendations, the eyeglasses, other vision aids, ocular prostheses, etc., should be provided by a *supplier licensed* to assume such responsibilities." (Italic supplied.)

Although, as I stated earlier, this booklet was rescinded, the Welfare Administration has issued no subsequent instructions to States. We optometrists remain "licensed suppliers" under these programs. States are still guided by guided by similar advice from Federal offices. The State Supervising Ophthalmologist is supreme and "supervising" services are principally reimbursed by Federal funds.

The quotations I have just read come from the Welfare Administration. Robert M. Ball, Commissioner of Social Security, expressed a similar attitude in the last paragraph of an April 27, 1967 letter addressed to John M. Martin, Assistant Chief Counsel of the House Ways and Means Committee:

"In addition, as medical doctors, ophthalmologists bear along with all other physicians certain additional responsibilities under the medicare program which are related to their legal status and professional competence. Thus, the medicare program provides that the determination as to the need for medical service is a decision to be made by a medical doctor, i.e., a physician in the language of the statute, and that such services are to be provided either by the physician or in accordance with his authorization or prescription. To include optometrists within the term physician would, therefore, have the effect on the one hand of extending to optometrists the right to receive reimbursement for their services or services that they might prescribe without the authorization of a medical doctor, and on the other hand of extending to optometrists certain functions and responsibilities which they cannot now perform and which would exceed their professional competence."

It appears that both the U.S. Welfare and Social Security have accepted the AMA concept that since a doctor of medicine can legally perform all services and do all things in the health field; the total field of health is the practice of medicine and no other health discipline can be allowed to operate in independent practice. This line of reasoning is completely contrary to the will of the people as expressed in every State law which licenses for independent health practice the disciplines of dentistry, podiatry, and more germane to my point--optometry.

The U.S. Office of Education recognizes and accepts the accreditation of optometric educational processes leading to the doctorate degree, and subsequent licensing.

The U.S. Bureau of Health Manpower provides scholarships to optometric students so they can pursue their training. It provides loans to build and rebuild the schools in which optometrists receive their training. Yet, the Welfare and Social Security Administrations recognize neither the scope of the optometric license nor the competence of our independent practitioners.

The U.S. Public Health Service commissions optometrists. The U.S. Army drafts optometrists to serve its visual requirements. By Executive Order, the President of the United States has deferred from the regular draft optometry students together with medical and dental students. The Health Professions Educational Assistance Act amendments provide for the forgiveness of student loans to graduates who establish practices in areas deemed critically short of physicians, dentists *and* optometrists.

It appears that optometrists are considered to be critically needed except in the social welfare systems of our Federal institutions.

Let's look at some of the statistics on the need for vision care compiled by the U.S. Welfare Administration. In 1963 it reported (in the same booklet I referred to earlier):

"Of the 6.5 million persons served by the State-Federal public assistance programs, almost 3 million are elderly, disabled, or legally blind. Even if they are not financially independent they could be expected to need some medical care, including optical services. Almost 3 million are children, whose health may have been threatened by poor diet, inadequate housing, and parental ignorance or apathy.

Unmet health needs, including visual problems, may handicap them at school and at home.

"The following figures may serve as some index of the need for optical services in the general population:

An estimated 100 million people in the United States—as many as 58 percent of the population—require some form of vision care (correction by glasses, visual training, or other treatment.)

About 9,800,000 children need eye care; a large number of these children should be wearing glasses.

About 350,000 persons are legally blind.

Some 1,500,000 persons are blind in one eye. An estimated 2,600,000 Americans have, or have had to some degree, a crossed eye. This condition has caused about 1 million persons to have reduced vision in one eye.

"Visual impairment exists in full proportion among public assistance clients. Opportunity to benefit from optical services may both enable these persons to move toward greater independence and prevent more severe visual problems."

Mr. Chairman, I submit that even the use of the term "optical services" completely ignores optometric services.

In my home state of Florida, optometry is briefly defined in state law, as it is similarly in your states, and all others, as:

"Florida Chapter 463.01. The practice of optometry is declared a profession, and, for the purpose of this chapter, is defined as follows, viz: to be the diagnosis of the human eye and its appendages, and the prescribing and employment of lenses, prisms, frames, mountings, orthoptic exercises, light frequencies and any other means or methods for the correction, remedy or relief of any insufficiencies or abnormal conditions of the human eyes and their appendages. An optometrist is one who practices optometry in accordance with the provisions of this chapter."

In his presentation to the House Ways and Means Committee, Secretary John W. Gardner, in the early part of his statement on the Child Health Provisions of this proposed Act, reported:

"Many preschool children who are poor and who need treatment for eye difficulties do not see a doctor; 1 million poor children who need glasses today do not have them." Later, in the same section of his testimony, he said: "We estimate that with this program we would dramatically reduce handicapping conditions among poor children: congenital handicaps would be reduced by at least 30 percent, uncorrected vision problems by at least 40 percent, uncorrected hearing disorders by at least 25 percent, and other physically handicapping conditions by at least 20 percent."

The American Optometric Association congratulates Secretary Gardner on his desire to demonstrate new and effective ways for bringing comprehensive health care to people suffering from lack of services. We believe, however, that the term "comprehensive health care" is intended to include optometrists' services. This belief does not appear to be shared by all officials of his Department.

In the various Title V grants which deal with comprehensive health care of needy preschool and school children, not one provides for the services of optometrists. The policies and procedures manual distributed by HEW titled, "Grants for Comprehensive Health Services for Children and Youth," contains a long list of the professional personnel to be used—including dentists, nurses, nutritionists, medical social workers, speech and hearing specialists, occupational therapists, and administrative officers—but not one word about optometrists.

Our members have spent months developing ways to assist programs for crippled, handicapped and economically disadvantaged children; they have tried every conceivable method to get approval for optometric participation in these programs to no avail. They are told that since the law makes no mention of optometrists, optometrists' services are not covered by the terms "medical care" or "comprehensive health care."

These disheartening experiences have occurred despite assurances made in a letter dated July 15, 1965, from the then HEW Secretary Celebrezze to Senator Harrison Williams of New Jersey:

"The section 532 relating to special project grants for low-income children of school and preschool age, as you indicate, does not refer explicitly to either eye-care or to optometrists. It does require that projects must be comprehensive in

nature. This would certainly include eyecare. There is no doubt that the recipients of grants under section 532 of Title V would have the authority to include the services of optometrists in providing eyecare. And it would seem certain that a great many, probably a substantial majority of the eye examinations of children would be made by optometrists."

Optometrists, across this country, have quoted this letter to Federal, state and local officials until they are blue in the face. All to no avail. The plain facts are that optometrists will continue to be excluded from these Federal programs until Congress makes it clear in the law that optometrists are to be utilized.

Mr. Chairman, in America today, there are only some 21,000 to 22,000 health practitioners who can be said to be fully qualified to provide vision care for our visually needed citizens. There are some 4,500 certified ophthalmologists and 17,000 optometrists practicing full time. Our nation's population is nearly 200 million people. If the need for surgery and treatment of eye pathology were as extensive as our medical colleagues tell us, ophthalmologists should be working overtime exclusively treating eye disease and performing eye surgery.

There simply are not enough practitioners to take care of all of our health problems. The facts show that the visual impairments described by Secretary Gardner cannot be adequately corrected without the full use of all practitioners trained in the art and science of vision care.

Our services are readily accepted when we volunteer them at no cost to Federal programs such as Project Headstart of the War Against Poverty. Led by our charming Chairwoman, Mrs. Patrick Nugent, optometric volunteers checked the vision of hundreds of thousands of poverty-stricken children. We full well know their vision needs.

Mrs. Nugent and Dr. Julius Richmond, Health Director for the Office of Economic Opportunity, appeared before our AOA House of Delegates assembled in Boston and challenged the optometric profession to find ways to provide the vision care needed by the 58,800,000 children and youth of our nation, whether they be rich or poor. We have been attempting to do just that; it is one of the reasons we appear here today.

Along this line we believe there should be hearings on a bill introduced by the very able former HEW Secretary now a member of your Committee, Senator Abraham Ribicoff. His proposed "Child Health Census Act," S. 590, is a good effort in the right direction.

Now I wish to take up another bill introduced by Senator Ribicoff, S. 804. Under its provisions, optometrists would be defined as physicians for purposes of Title XVIII of the Social Security Act. Attached to this statement is a page from the Congressional Record containing Senator Ribicoff's views when he introduced his bill, together with Senators Cotton, Hollings, Long of Missouri, Pell and Williams of New Jersey.

As Senator Ribicoff reported, his amendment simply smooths out an inequitable wrinkle in the Social Security Act. It adds no new benefits to the program and the only possible additional cost would be that beneficiaries would have more convenient and ready access to vision care practitioners. Beneficiaries who select optometrists for their vision care services must pay for optometric services out-of-pocket, even though the Act now authorizes reimbursement for these services.

The House Ways and Means Committee considered an amendment identical to that proposed by Senator Ribicoff contained in the following House bills:

H.R. 216 by Bates (Mass.); H.R. 719, Hosmer (Calif.); H.R. 737, Ichord (Mo.); H.R. 1261, Sisk (Calif.); H.R. 1417, Utt (Calif.); H.R. 1465, Wyman (N.H.); H.R. 2141, Roybal (Calif.); H.R. 2302, Clark (Pa.); H.R. 2587, Thomson (Wis.); H.R. 3292, Edwards (Calif.); H.R. 4104, Corman (Calif.); H.R. 4123, McFall (Calif.); H.R. 4243, Hull (Mo.); H.R. 4875, Johnson (Calif.); H.R. 5621, Holifield (Calif.); H.R. 5885, McDade (Pa.); H.R. 5889, O'Neill (Mass.); H.R. 6366, Helstoski (N.J.); H.R. 6789, Fuqua (Fla.); H.R. 6807, Howard (N.J.); H.R. 6808, Joelson (N.J.); H.R. 6826, Teague (Calif.); H.R. 6903, Clancy (Ohio); H.R. 8230, Thompson (N.J.); H.R. 8723, Patten (N.J.); H.R. 8972, Montgomery (Miss.); and H.R. 10073, St Germain (R.I.).

Early in their executive session deliberations, Ways and Means Committee members decided that "Optometrists will be paid for services they perform that are also performed by M.D.'s but restrict so that there will be no payment for refractive services for any practitioners." This unanimous agreement among Com-

mittee members was subsequently broken into two parts and now appears in H.R. 12080 as follows:

Page 51, line 23 reads . . .

"SEC. 128. Section 1862(a)(7) of the Social Security Act is amended by inserting after 'changing eyeglasses,' the following: 'procedures performed (during the course of any eye examination) to determine the refractive state of the eyes,'."

Page 68, line 10 reads:

"SEC. 141. The Secretary shall make a study relating to the inclusion under the supplementary medical insurance program (part B of Title XVIII of the Social Security Act) of services of additional types of licensed practitioners performing health services in independent practice. The Secretary shall make a report to the Congress prior to January 1, 1969, of his findings with respect to the need for covering, under the supplemental medical insurance program, any of the various types of services such practitioners perform and the costs to such programs of covering such additional services, and shall make recommendations as to the priority and method for covering these services and the measures that should be adopted to protect the health and safety of the individuals to whom such services would be furnished."

We believe it is grossly unjust to ask the thousands of older Americans who are optometrists' patients to wait for a year and a half for a recommendation from this advisory body. Presumably, if that group finds it feasible to consider inclusion of optometrists under the supplementary medical insurance program, the Congress could, in 1969, consider amendments to re-instate optometry to its present status under the law.

This brings up the question of what "additional types" of practitioners the House had in mind when this bill was passed, and I'd like to explore this with you for just a moment.

In its interpretation of Public Law 89-97, the Social Security Administration has omitted the optometrist from any direct participation, particularly under Title 18. This is illustrated by the Administration's form #1510 where the following "facilities and services provided" are listed as: "Nursing, physical therapy, occupational therapy, speech therapy, social services, recreational activities, pharmacy, clinical laboratory, diagnostic X-ray, examination and treatment room, dentistry, podiatry, ophthalmology, and other. Please note that even though the present law does not exclude optometrists, this HEW-Social Security form makes the exclusion.

Another HEW publication may help you to determine what may be the "additional types of practitioners" referred to in Section 141. Publication #1509, printed for the Public Health Service and titled "Health Resources Statistics" lists 10 health occupations for which a license is required in all 50 states and the District of Columbia. Among these 10 are: dental hygienists, environmental health engineers, pharmacists, practical nurses, professional nurses, and veterinarians. None of these fit the description of "health practitioners in independent practice", since they do not examine and prescribe, or are under the direction or supervision of physicians, or are not dealing in human health care. The remaining health occupations listed are the only health professions, licensed in all 50 states, which are legally and traditionally in independent practice. They are physicians, dentists, (MD & DO), podiatrists, and optometrists.

Optometrists are the only independent health professionals not defined as physicians under Title 18 of H.R. 12080, which are listed.

This omission is so glaring that it appears to be more than an oversight.

The optometrist's fate, according to this proposed section, is to rest with a Department which has never appointed an optometrist to an advisory committee related to either the U.S. Welfare Administration or the Social Security Administration. The optometric profession's services, as defined by all State laws, are to be questioned by an Administration which knows little or nothing about the scope of the profession which it has ignored in these important social and welfare programs.

Whenever a question arises about the profession of optometry, the Administration seeks advice from one of its ophthalmological consultants (a doctor of medicine); which occurred during House Ways and Means Committee deliberations of this bill. An ophthalmological consultant was sent by HEW into Committee executive sessions, apparently by invitation, the day before this section

was adopted. His reason for being present was to tell the Committee about the scope of optometric practice. You can see the results in H.R. 12080.

An obvious problem for optometric patients exists under this Act.

Are services which optometrists are licensed to perform available to Social Security beneficiaries? Are optometrists competent to perform them? These are the two questions which need to be answered. We feel State laws have answered these questions. The various State laws expressly provide that optometrists may use any objective and subjective means to examine the human eye.

You would have to prohibit the use of the ophthalmoscope, used to examine the interior of the eye by every single doctor of medicine in the United States, in order to completely exclude state-defined optometric services under Title XVIII. The ophthalmoscope is absolutely essential to proper investigation of nearly all known ills and diseases of the human body.

By prohibiting reimbursement for refractions under Title XVIII, the bill before you requires the optometrist to violate the code of ethics he has accepted as a mode of professional practice. Under this bill, the only way an optometrist can realize any income from his professional services, is to mark up the cost of materials supplied to his patient.

It is unethical for a member of the American Optometric Association to add a mark-up or to make a profit from any materials he supplies to his patient. The Social Security Administration, recognizing this factor, currently pays the optometrist for refraction following surgery for cataracts. It also reimburses him what he pays to the wholesale laboratory for the cataract lenses and frames supplied. The same procedure holds true when an optometrist furnishes and fits an artificial eye. Cataract lenses and spectacles and artificial eyes are considered prosthetic devices by the Administration.

Under the House-passed version of H.R. 12080, expenses incurred for the "medical" eye examination and retail cost of a device will be reimbursed. A beneficiary can be reimbursed for the majority of his expenses for medical services and optical services, but only if he goes to a doctor of medicine or osteopathy and a retail optical outlet.

If a beneficiary obtains his initial examination from an optometrist, surgery from a physician and returns to the optometrist for subsequent refraction and needed device, the beneficiary will be reimbursed for the surgical expenses, he will not be reimbursed for the refraction. The ethical optometrist can charge the patient only the laboratory cost of materials furnished which can be reimbursed. The optometrist's services for fitting the device, however, cannot be considered eligible expenses because optometrists' services are not eligible for benefits. Part of the mark-up on materials sold by retail optical stores, however, covers the services used in fitting the device and thereby is reimbursable.

We do not believe the quantity of services optometrists might provide under this Act should be the guiding factor in your decision. If only one small service an optometrist performs is eligible for benefits under title XVIII, we believe the optometrist's patient should be reimbursed. The principle of justice and equity should prevail regardless of the size of the problem. We have faith that you will recognize the laws of every state in viewing the scope of the practice of optometry accorded those holding an optometric license. These are privileges accorded by the citizens in every state when they elected their representatives who passed the state optometric laws in those states.

Optometry is not among those health professions whose qualifications can be questioned. The last optometry law was enacted decades ago. For countless years optometry's educational curricula and schools have been recognized by the U.S. Office of Education. To now place optometry's qualifications in question by this section of H.R. 12080 is regressive and contrary to the public welfare.

To further substantiate the position of optometrists and optometric patients, I would like members of this Committee to study the documents attached to this statement which I hope can be made a part of the record of this hearing, Mr. Chairman.

(The documents referred to were made a part of the official files of the committee:)

(1) A list of optometric schools and colleges giving location and University affiliation.

(2) A catalogue from one of the optometry schools outlining the training an optometrist receives.
(3) A list of state optometric laws and the dates they were enacted.
(4) A list of states which have enacted provisions similar to the Carlson Amendment you adopted in 1965, with the language of those provisions.
(5) a booklet on Military Optometry, the second page of which reprints a letter from President Lyndon B. Johnson in which he said:
"The American Optometrist is this nation's home front defender of one of our most prized human possessions—the gift of sight. His battles are many and often severe. But his victories sustain and improve the health and fiber of our society."
(6) A list of eligible optometric services available to Title XVIII beneficiaries under present law.
(7) A copy of page 18 of the "Medical Handbook" which states that optometrists' services are not covered.
(8) A copy of a legitimate claim by Medicare beneficiary F. H. Bauerfield of Yates Center, Kansas, not reimbursed solely because the services were provided by an optometrist. There are many similar rejected claims should you care to see them.
(9) a reference to the Army's recent draft order for optometrists.
(10) a copy of a 1966 letter from the Social Security Administration which states that payment can be made for a prosthetic lens regardless of whether it is furnished by an ophthalmologist, an optometrist, or an optician.
(11) Copies of amendments proposed by Senator Ribicoff and Senator Carlson.
All we ask is that you confirm by law what the U.S. Department of Health, Education and Welfare has already stated in Dr. Philip Lee's letter to Congressman Helstoski in which he said:
"The profession of optometry is accepted by the Department as a legitimate and essential health profession which is performing highly useful functions in promoting solutions to the eye health needs of this nation.
"The Department agrees that the American public should continue to have freedom of choice in the selection of a practitioner to care for vision problems."
Thank you for this opportunity to again be with you. If you have any questions I will be happy to attempt to answer them.

Senator RIBICOFF. Mr. Chairman, on Monday, August 28, Mrs. Gertrude A. McCall, Mrs. Magdalena Ostapiuk, and Mr. Neal Mosher visited my office with a petition regarding H.R. 12080, now before this committee. I ask that this material be placed in the record of these hearings for the committee's consideration.

ADDRESS TO CONNECTICUT SENATORS AND CONGRESSMAN DADDARIO

I have been sent here to speak by the Hartford Branch of this Convention. I wish to speak about this Social Security Amendment, as well as for all the people represented here today.
I wish to present these signatures of endorsement to my petition.
We, as your people, most strongly urge your support in changing this Bill, so all poor people everywhere, can, and should live decently within their means, and not like animals.
I ask for all here present, and represented, to let us give our children a better life, as all children, should and can have, to be free people.
I have also been a representative before our Governor's Conference and State Legislature, asking for these same things. We have even published a book called "Like It Is". This evidence was accepted (as Sen. Ribicoff knows) as part of their Proposal of Action. We are still waiting, for many of these promises.
We have tried to be heard, to make a change now, and now we need your help, here and now.
Respectfully submitted.

Mrs. GERTRUDE A. MCCALL,
Connecticut Delegate, and Hartford Chairman.

PETITION TO CONGRESSMAN DADDARIO, SENATOR RIBICOFF, SENATOR DODD

The National Social Security Act decides if welfare can or can't be adequate in Connecticut.

Congress will soon be changing the Social Security Act.

I want my representatives to vote—

For: Allowing welfare recipients to work and earn without their welfare checks being completely reduced, so they can get ahead financially by working, and so their income level will be at least as high as the highest U.S. Government defined poverty level. ($4,000/yr. family of 4.)

Against: Forcing adults and not-in-school 16–21-year-olds to go into work or training, or else lose their assistance. Such force ignores respect for people and further, is *unnecessary*, since those who won't work, will be found to have their own good physical, emotional or other reasons, and those who can work *will*, if they can get ahead financially and if adequate child care facilities are provided.

Charles Dickson
George Diamond
Daniel Marquis
Pauline Bentley
Stanley Osya
Michael Kiecrunean
Louis W. Cybulski
Howard Lewis
Joseph Urbanski
Donald Breny
Richard F. Collier
Donald T. Perkins
Daniel F. Lunseif
Joseph M. Maddalena
Dr. R. L. Damuth
Daniel J. Harris
George Salisby
Morrill N. Smith
Mrs. Mary Fiser
Ida Davidson
Josephine J. Perry
Jean Gleba
Carmelo Dias
Gloria Lopez
Marcial Sanchez
Carmen Torres
Alartis Stewart
Roosevelt Chavis
Mrs. Michele Young
Rose H. Morais
Sherri Morais
Mrs. Rolanda Wallen
Mrs. Magdalena Ashasink
Harry Rose
Laura Thomas
Katy Forbes
Doris Hill
Majd. O'Brien
Miss Edwards
Miss Edward Hotchiss
Brenda Rose
Richard Rose
Mrs. Flo Chapman
Mrs. Anna Mitchell
Mrs. Mary Ann Benerado
Mrs. Linda Franco
Glen Wallen
Mrs. and Mr. Ficth
Josefa Wellrank
Mrs. Mary Spruill
Rocco Bove
Emily Lafrazier
Arlene Henry
Ruby Miller
Mary Ann Stewart
Linda Lafrazier
Anderson Atkinson
Joseph Harris
Henry Jefferson
Alice Mattison
Ruth N. Taylor
Anne L. Pesapane
Robert O'Brien
E. W. Pritzker
Miss Matti Rut Williams
Mrs. Mary M. Moody
Ethel G. Drovin
Mrs. Rose Rigo
Mrs. Joan Caruso
Mrs. S. Printz
Mrs. Mary Hothan
Mrs. Kathryn South
Lillie B. Campbell
Henry Lewis
Joyce Lewis
Patricia Williams
Eunice Goran
Effie Paine
Merline Nails
Barbara Goode
Pearl Patterson
Carol Dyson
Sandra Rattman
Joe Roberts
Ella Mae Beryaut
Hattie Brown
Thelma Mankins
Horace Green
Philip Govan
Ronald E. Ferguson
Mrs. Winifred Daigle
Charles Farley
John Wilson
Daniel Bailey
John Henry Nelson
Miglul Martin Baez
Alfredo Rivos
Hattie Lucas
May Jan Bingham
Joe Lacora
Mrs. Elsie Wilsen
Blakie Deleston
Rosa Gonzales
William Corl
Carmen Maysonet
Andrea Riviera
Virginia Campbell
Michelle Smith
Arline Baynes
Gloria Smith
Diana Smith
Sylvia Govan
Marlina Halloway
Sherrell Bell
Patricia Weaver
James Price
Jimmie Campbell
Carrie Roberts
Shirley Walls
Carol Caston
Bernice Roberts
Mary Williams
Elina Jones
Mary Wattman
Shirley Grice
Joan Smith
Shirley Campbell
Margie Blake
Edith Doering
Alice Nixon
Beth Scott
Kay Wilson
Barbara Childers
Thomas Ehrlich

This is to inform you that the National Welfare Rights Organization convention has adopted Connecticut's petition with full, unanimous support. This vote was taken today, August 27, 1967.

MRS. JOHNNY TILLMAN,
Chairman, National Welfare Rights Organization.

Senator ANDERSON. That concludes today's hearing. We will meet again at 10 a.m. tomorrow morning.

(Whereupon, at 12 noon, the hearing was recessed, to reconvene Thursday, August 31, 1967, at 10 a.m.)

SOCIAL SECURITY AMENDMENTS OF 1967

THURSDAY, AUGUST 31, 1967

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

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

Present: Senators Long, Gore, and Williams.

The CHAIRMAN. The meeting will come to order.

We are pleased to have with us this morning the distinguished Senator from Utah, the Honorable Frank E. Moss.

Senator Moss, we are very pleased to hear your statement and your views in regard to this legislation we are considering. I am sorry that we are short on members this morning. I think you understand why that is the case. But on the Republican side of the aisle, while the party is short on members, they are not short on quality. I believe that the ranking member can speak for most of his side of the aisle.

We will be privileged to have your views on this matter.

STATEMENT OF HON. FRANK E. MOSS, A U.S. SENATOR FROM THE STATE OF UTAH

Senator MOSS. Thank you, Mr. Chairman.

I agree with you, we are long on quality if not numerically in the committee and I appreciate the chance to appear here and present my proposal, two amendments to H.R. 12080, and since I have a text I will try to stay with it and probably be able to move along more swiftly than if I ad libbed. I have seen the peril of ad libbing when oftentimes you wind up by taking twice as long.

Mr. Chairman, I am here today to propose two amendments to H.R. 12080, the social security amendments passed by the House of Representatives, and to support strongly the concept found in both the administration and House version of the social security amendments that there should be an expanded community work and training program to prepare welfare recipients for the independence of a decent job.

First, I should like to discuss my amendment No. 293 which would provide an across-the-board benefit increase of 15 percent with a $60 minimum benefit, rather than the 12½ percent increase with a $50 minimum provided in the House bill. This amendment would make two additional changes. First, a three-step increase in the amount of annual earnings counted for contribution and benefit purposes: to $7,800 in 1968, to $9,000 in 1971, and to $10,800 in 1974, rather than a single increase to $7,000 recommended by the House. Second, a

change in the retirement test that would permit a beneficiary to earn up to $1,800 in a year, instead of $1,680, and still get his full benefits.

Social security benefits are not adequate. They have not kept up with the increases in prices and wages that have occurred in the past 12 years. For example, the 7-percent increase in 1965 fell slightly short of restoring 1958 purchasing power and the 1958 increase of about 7½ percent also fell slightly short of restoring the 1954 level. This means that those getting benefits throughout this period have seen the value of their benefits decline. While the 12½-percent benefit increase provided in the House bill does go further than merely restoring the purchasing power that the benefits have lost since the last increase, I believe an even higher benefit increase should be provided to give our older citizens, the disabled, widows, and orphans a few more dollars with which to build a better life.

The benefit increase and the change in the retirement test that I proposed would be financed by the three-step increase to $10,800 in the amount of earnings that count toward a person's benefit protection. H.R. 5710, the bill containing President Johnson's recommendations for improvements in the social security program, included this proposal. In my opinion, it is soundor to increase the base to get needed benefits than it is to increase the contribution rate because the people who pay more are the ones who get more protection. And since the matching employer contributions are more than sufficient to pay for the improved protection when combined with the new employee contributions, they are available to improve benefits throughout the system.

Without an increase in the earnings base the cost of improvements in the program would have to be met in some other way, perhaps by a greater increase in the contribution rates paid by all workers, including the lowest paid. Thus, an increase in the earnings base provides a more progressive financial basis of the program.

In spite of the fact that the base has been increased from time to time over the years, it has not been increased enough to keep up with a rising earnings level. When the amount of annual earnings counted toward a worker's social security benefit protection do not keep pace with the earnings levels, more and more workers have earnings above the creditable amount and these workers have insurance protection related to a smaller and smaller part of their earnings.

When the social security program began, the $3,000 base in effect then covered the full earnings of 94 percent of regularly employed men, who then, as now, are the principal support of the family. As earnings levels rose the number of workers who had earnings above the $3,000 base increased until by 1950, only 43 percent of regularly employed men had their full earnings covered under the base. Even at the present time, with a base of $6,600, only a little over one-half of the regularly employed men get social security credit for their full earnings. Under my amendment, a much larger percentage would be provided full protection. It is estimated that in 1968 the $7,800 base would cover the full earnings of 68 percent of regularly employed men, in 1971 the $9,000 base would cover the full earnings of 78 percent of regularly employed men, and in 1974 the $10,800 base would cover the full earnings of 82 percent of this same group. In contrast the $7,600 base provided under the House bill, would cover the full earnings of about 64 percent of regularly employed men when it would

become effective in 1968, and this proportion can be expected to decline from year to year as earnings rise. It is projected that by 1974, only about half of the regularly employed men would have their full earnings covered under a $7,600 base. The increase I recommend, of course, would not fully restore the basic idea of the original Social Security Act, which was to cover the full earnings of all but the highest earners, but it would be a significant step in this direction.

The most important aspect of this three-step increase, however, is that it would improve social security protection for those whose earnings are somewhat above the average. These people would pay higher dollar amounts of contributions as a result of the increased base but would, at the same time, earn substantially greater benefit protection. For example, if a worker aged 35 in 1967 with annual earnings of $10,800 dies in 1977, his widow and child would get a monthly benefit of $310.60—$78 more than is provided now, and $33.80 more than would be provided under the House bill. His widow at age 62 would get a monthly benefit of $170.80—$42.90 a month more than under present law; $18.50 more than under the House bill. If the worker became disabled in 1977, he would bet a monthly disability benefit of $207, an increase of $52 a month over the amount he would get under present law and $22.50 more than under H.R. 12080.

I am also recommending a greater liberalization in the amount a beneficiary may earn annually and still get full retirement benefits—generally referred to as the retirement test. The House bill would increase this amount from $1,500 to $1,680, but my amendment would allow a person to earn as much as $1,800 in a year before any benefits would be withheld. This is, in my opinion, an important and significant change.

We encourage our elderly to be self-sufficient, and then we limit the amount they can earn to contribute to pitifully small retirement benefits. And we do this at a time when the cost of living is spiraling, and when many of them are having a very difficult time to make ends meet. This does not make sense to me.

My amendment would reduce somewhat more than does H.R. 12080 the adverse affect that the retirement test has on incentives to work. For example, a worker reaching age 65 and retiring in January 1968 who has had maximum earnings in all years would be eligible for a monthly benefit of $158.70—$1,904.40 for the year; he could earn $4,000 a year and, under my amendment, still get $304.40 in social security benefits for the year. If he were married, he and his wife would get monthly benefits of $348.10—$2,857.10 for the year; he could earn $4,000 a year and they, as a couple, would get over $1,200 ($1,257.20) in benefits for the year. This provision will enable our older citizens to increase their income without having any social security benefits withheld and thus have a more comfortable life.

My second amendment, No. 294, deals with long-term care, particularly nursing home care, provided to the aged under title XIX of the Social Security Act. The need for it has become apparent in hearings I have held as chairman of the Subcommittee on Long-Term Care of the Senate Special Committee on Aging and in other studies done by and for the subcommittee.

Mr. Chairman, the Federal Government is the largest purchaser of nursing home services in the Nation. Approximately 60 percent of the patients in nursing homes today are recipients of care under OAA,

medical assistance for the aged, or medical assistance under title XIX. Last year over half a billion dollars of the taxpayers' funds were paid to nursing homes for the care of welfare patients. Almost $300 million were appropriated Federal funds. The Congress has both a right and responsibility, in my opinion, to assure that the taxpayers receive full value for their huge expenditures. My amendment seeks to do this by amending the provisions of title XIX of the Social Security Act, since ultimately all State public assistance medical care programs will come under this title.

The first major provision of my amendment would require that State plans under title XIX which provide nursing home care also provide home health services. Section 1902 of the Social Security Act enumerates 14 health services which may be included in State plans and requires the provision of services numbered 1 through 5. Nursing home care is one of these mandatory services. Section 223 of the bill now before you would add the option of providing any seven of the 14 enumerated services. My amendment would alter this language to require that State offering service numbered 4 in the act, nursing home services, must also offer the service numbered 7, home health services.

My subcommittee has heard considerable testimony to the effect that there are many patients in nursing homes who do not need to be there, and many patients are now being sent to nursing homes who need services which could be as well provided in their homes if home health services were available.

We do not know how many patients out of roughly 400,000 who are in nursing homes under public assistance programs who should not be institutionalized. This has never been measured. Our subcommittee has heard estimates that as many as one-third of these patients do not really require continuous skilled nursing home service. Many of them are there because they need services which can be provided and paid for by public assistance programs only if they are admitted to nursing homes since no other mechanism is available for payment. This is bad economically and it is bad for the patient. My amendment would not solve this problem entirely of course, but it would provide one major alternative to institutionalization for patients with minimal needs.

My amendment also adds to the State plan requirements provision for a periodic medical review of the utilization of nursing home care by public assistance patients. Too often patients entering nursing homes are simply left there for the rest of their days. Months and years pass without reevaluation of a patient's condition to determine if the services of the home are adequate to the patient's needs, or if they are still appropriate and needed. The State health department is concerned with standards in the nursing home itself and not with the care of an individual patient. The welfare department is concerned with the individual patient but primarily with his eligibility and social casework problems. Rarely is a welfare department equipped to review and evaluate the medical care the patient is receiving. Each patient has a physician responsible for his care, but witnesses before my subcommittee testified almost without exception that physician visits to welfare patients are infrequent and often perfunctory. An independent medical review will help to assure the quality and appropriateness of services in relation to the current needs of the patients.

Under the provisions of my amendment the State plan requirements also would include agreements with providers of service under which records, prescribed by the State, will be maintained on services provided and the cost of such services. The providers of service also would agree to make these records available to appropriate State agencies and to reresentatives of the Department of Health, Education, and Welfare and the Comptroller General. Investigations by the General Accounting Office in California and Ohio have found inadequacies in the controls over payments for services to welfare patients and have disclosed the possibility that serious abuses are occurring in such matters as billing for drugs and physician visits. The Department of Health, Education, and Welfare is responsible for assuring itself through administrative reviews and audits of the soundness of State administration of the programs. However, at the present time the Department is hampered in its efforts to audit the propriety of expenditures under the program by lack of authority to examine pertinent records of the providers of service.

Mr. Chairman, amendment No. 294 which I am urging this committee to consider also calls upon States using title XIX to establish certain basic requirements for nursing homes in their jurisdictions. I would like to comment briefly on the need for some of these provisions which participating States would be obliged to include in their nursing home regulatory programs.

First, full disclosure of ownership. It seems to me that basic to any successful regulatory program is disclosure of the identity of the persons responsible for meeting the regulations. The subcommittee has been informed that sometimes the apparent owners of nursing homes are not in fact the owners or may have only a minor interest. Licensing officials tell us that it is very difficult to obtain the correction of violations or the improvement of substandard conditions when they cannot identify and deal with the person who actually makes the business decisions for the institution. Moreover, when some of these hidden owners are identified they sometimes have been found to have interlocking interests with such related businesses as suppliers, as drugstores, wholesale grocery outlets, and linen services. This should be out in the open.

Nursing home owners also would be required to inform the licensing agency of the amounts, terms and conditions of loans made to the home with the exception of operating capital loans obtained from commercial banks. This addresses itself to another problem which was brought before the subcommittee by witnesses who testified that some nursing home operators become loaded with debt at very high interest rates, and services to patients are cut to the bone in an effort to meet the large payments on these debts. Some homes, unable to obtain credit through normal banking channels, have become victims of unscrupulous money lenders and have actually been forced into bankruptcy. In such situations the patients are certain to suffer neglect and deprivation of needed services during the long slow process of business failure. My amendment would not prevent this from occurring, but would enable the State licensing agencies to be informed if the amount and terms of debt threaten the solvency of the nursing home.

The remaining standards are quite similar to those recommended by the Welfare Administration for skilled nursing home care under title XIX in its State letter No. 845 issued shortly after enactment

of title XIX. These are not minimum standards, but are basic standards. They represent, in my opinion, the distinguishing characteristics of the skilled nursing home which is capable of playing a part in a medical care program. Title XIX is a medical care program and employs the language "skilled nursing home" to describe the service intended to be covered.

The amendment also defines a home health agency for purposes of the home health service which my amendment would make mandatory. The characteristics of a qualified home health agency are quite similar to those in title XVIII which established the standards for home health services under medicare.

Title XIX as now written provides that hospitals be paid on the basis of reasonable cost. No other type of provider of service is required to be paid on that basis. My amendment would require reasonable cost reimbursement to nursing homes and home health agencies. Mr. Chairman, we must acknowledge that in many States the payment to nursing homes for care of welfare patients has not been adequate to purchase high quality care and the basis for reimbursement has not been equitable.

A majority of States establish, through negotiation or through administrative or legislative action, a single rate of rembursement for the care of public assistance nursing home patients in the State. It seems to me that this system is inherently incapable of producing equitable results despite the best intentions of its administrators. If an effort is made to relate the rate determination to cost of care, there is a tendency for it to be predicated upon a median level of care among the homes in the State, and for some the rate will be inadequate and for others it may be too high. Furthermore, incentives to poor care are built into this system since the home which cuts corners thereby increases its monetary rewards, while the home which gives full measure may just barely get by or may even lose money on publicly assisted patients.

Some States classify patients according to the care they require and establish different rates for patients needing maximum care, intermediate care, and minimum care. This does not solve the basic problem associated with a fixed rate and creates a still worse problem. It establishes a monetary incentive to keeping patients in a maximum care state. The home with an active program of rehabilitation and training in self-care may actually be working against its own financial interest.

In short, our present approaches to payment for care tend to discourage initiative and promote passivity in patient care, to penalize excellence, and to assure the continuance of marginal and even substandard homes by giving them a relative financial advantage.

It seems to me that we must adopt the principle of payment of full costs for services actually provided to our publicly assisted nursing home patients. By using the phrase "reasonable cost," however, I do not wish to imply that I would like to see simply the adoption of the principles of reimbursement now developed for title XVIII. I am not in a position to make a detailed critique of these principles of reimbursement, but I am aware that neither the providers of service nor the administrators of the program are entirely satisfied with them. I am particularly concerned that the 2 percent-plus factor, or 1½ percent in the case of proprietary nursing homes, may operate as a dis-

incentive to economical operation and cost reduction. However, I believe we should establish the principle of paying the full cost of care actually rendered, and I think it would be desirable to allow some experimentation under the title XIX program with different methods of determining reasonable cost.

Mr. Chairman, the last provision of my amendment would prohibit the use of Federal funds as matching for public assistance nursing home care under any title of the Social Security Act in nursing homes which do not meet State requirements for licensure. It might seem almost unnecessary to enact such a provision of law. One might assume that if a home were in violation of State law it simply would not be permitted to operate. But that is not the case. Nursing homes which do not conform to State law do continue to operate, and while one department in the State is trying to close them another department is patronizing them by placing welfare patients in them.

For example, my subcommittee was told in California that two-thirds of the homes in that State are in violation of the code. We are paying for welfare patients in most of them. Why does this occur? State licensing agencies generally have no sanctions available to them for enforcement except revocation of a license. This requires lengthy and elaborate procedures, a heavily documented case, and a hearing. The decision may then be appealed to the courts. It may take years to succeed in closing a nursing home while the patients continue to suffer neglect and improper care and while we continue to pay public funds to maintain them in the home. I have mentioned California but the same is true of the other States we have visited and I am sure the same kind of problem exists throughout the country.

Mr. Chairman, no part of my amendment is designed to diminish the authority of the States over the nursing homes within its borders. Nursing home licensing and regulation is a State function and if my amendment is adopted the States will continue to perform that function. We are not in any sense talking about Federal licensing and Federal regulation. However, it seems to me perfectly proper for the Federal Government to establish reasonable specifications for services purchased in large part with Federal funds. Federal funds must not be used to buy services of poor quality, and Federal funds must not be used to maintain aging citizens in surroundings that endanger their very lives. This amendment seeks to establish a system for paying fully and equitably for services and at the same time assuring that the aged citizens whom we seek to serve actually get what we are paying for.

In conclusion, I would like to say a brief word on the expanding community work and training program to prepare welfare recipients to take jobs.

On the basis of the situation in Utah, I feel that the appropriate agency to administer such a program is the Department of Labor as recommended by Secretary Gardner and the Administration rather than the Department of Health, Education, and Welfare as recommended by the House bill.

I have been heartened by the degree to which the Utah Department of Employment Security has worked to place welfare recipients in jobs where possible and otherwise in programs to prepare them for jobs. In many cases the Welfare office has been a prime source for Neighborhood Youth Corps, Job Corps, and other poverty work programs recruitment.

The Department of Employment Security, as the State arm of the Department of Labor, is now able to refer welfare recipients to a broad range of training and work-experience programs. Certainly, the efficient manner in which to prepare welfare recipients for employability is to make use of the existing structure within the Department of Employment Security rather than to establish a duplicate structure within the Welfare Department. Accordingly, I urge the committee to place responsibility for the community work and training program within the Department of Labor where it belongs.

Thank you for your courtesy in listening to this rather lengthy statement this morning.

The CHAIRMAN. Can you tell us, Senator Moss, how much your amendment on nursing homes would cost. It sounds like a pretty good idea.

Senator Moss. Well, I do not have an exact assessment of this, Mr. Chairman. Exact data for such an estimate are not available. But the cost increases—and there would be some—would be two: One, the reasonable cost reimbursement in those States which now pay low rates, and two, matching the State payments for new home health service programs.

Some 17 States now pay nursing homes on a reasonable cost basis or pay fixed rates in excess of $11.50 a day. My amendment would have little effect on payments in these States. Nursing home payments undoubtedly would be increased in the remaining States.

However, if the total program is properly administered there should be substantial offsets through the moving out or not admitting patients who should not be in nursing homes. In addition, the medical review and improved controls and auditing should effect some substantial savings in payments for unnecessary drugs and supplies, for services not actually rendered, and so forth. But we cannot put a dollar figure on these abuses. However, it seems to me the net cost effect over a period of years would be slight.

The CHAIRMAN. In other words, on balance, you don't think it would cost any great amount of money?

Senator Moss. No; I do not think it would greatly increase it. As I say, there would have to be some adjustments but there would be some offsetting factors that I think might bring it fairly close to balance.

The CHAIRMAN. There is one other item you mention in your statement that has a great deal of appeal to it. It might be well to point out the problem from the point of view of those who have to vote on it. You want to increase the amount that people can earn and still draw their full social security benefits. It is a very popular thing and has a great deal of merit to recommend it.

But, the problem is, it greatly increases the cost of the program. It is just a question of how far you can go in doing this or something else that is also desirable.

In other words, it is argued that it would be well to completely remove this earnings ceiling, but the difficulty there if we do that, that would cost 0.7 percent of payroll.

Now for the same amount of money we could increase benefits across the board by 7 percent, and it raises a question as between other things that you could do such as providing for a great number of

people who are just not able to work at all. The problem that faces us is whether it would be more desirable to provide a 7-percent increase in all benefits or to liberalize this earnings test to let people keep all of what they earn when they are drawing their social security retirement. May I say I don't think any of us on this committee are out of sympathy with the idea of increasing it. Your proposal, as I see it, would be that we would increase the earnings from the present $1,500 or $1,680 recommended by the House up to $1,800. This is $150 a month that they could earn without any deduction.

Senator Moss. That is true, Mr. Chairman. That is rather a modest increase in the ceiling amounts.

It seems to me that when social security was first adopted as a policy, one of the factors that was considered was whether or not these people drawing social security would also soak up jobs, and employment was a real problem.

At the present time unemployment is down to a minimal amount and if the economy continues to function well, will not be a problem. Under those circumstances, I see nothing wrong with letting people who are able to work and make a contribution get into the labor market. Actually in some places we have a shortage of labor, and our economy is stifled a bit because we do not have enough labor.

Now, the types of things that these beneficiaries would do, of course, would vary but many of them are very highly skilled people and it may be—it might be—a wise thing if you would have the watchmaker continue to do his trade after he is 65 and not penalize him by reason of the fact that he begins to draw social security.

The CHAIRMAN. You are going to have to help us with the responsibility. You and others are going to have to cooperate in helping to meet this problem of a shifting population. We have a higher percentage of aged people now than we had because people are living longer. That is good. But in doing so we need more and more to set aside the things that they can do. Initially it was thought that people ought to retire and do nothing. We found they were not as happy, that they really don't live as long or maintain as good health as they would if they could feel that they are doing something constructive, something worthwhile.

Senator Moss. This is true.

The CHAIRMAN. We run into these difficulties with these labor contracts. A labor union makes a contract with a company that they won't—they will retire workers rather than put them on work that is less strenuous, less demanding, less hours, such as manning a gate for the plant or providing—looking after matters that are much easier to do than some of the more strenuous and demanding jobs.

But, labor, I think, needs to cooperate with us, to, in some of these contracts they have with management.

They need to take a new look with regard to things that have been done. Management, too. Contracts and policies adopted years ago may not make too much sense today. I am happy to see that you are looking to the future with these things, Senator Moss.

Senator Moss. I appreciate your comments on that, Mr. Chairman.

One of the things that our Special Committee on Aging is looking into is this whole area of retirement. What does the individual do? As the chairman suggests, just to compel a man to stop work and go home

and sit in a rocking chair is cruel and unusual punishment in a way. He needs to still have his identity. He needs to have a feeling of being needed. He needs to have things to do.

Now, continuing on a job is one of the things, one very important thing. If he is not able to continue on the job he needs some other direction to make his life meaningful because it doesn't do any good to medically be able to prolong the life of our citizens if we simply put them on a shelf and leave them there for those extra years.

I think you are entirely right.

Senator Williams?

Senator WILLIAMS. No questions.

The CHAIRMAN. Thank you very much, Senator Moss.

Senator MOSS. Thank you.

The CHAIRMAN. Our next witness is the Senator from Massachusetts, Senator Edward M. Kennedy. Senator Kennedy, we are happy to have you here before this committee. We know of your great interest in this legislation, and we are aware of some of your suggestions with regard to it. We hopefully feel at home here because we enjoy knowing your views and your suggestions as to how we might improve on the program that we have.

STATEMENT OF HON. EDWARD M. KENNEDY, U.S. SENATOR FROM THE STATE OF MASSACHUSETTS

Senator KENNEDY. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, first of all, I want to extend my congratulations to you and particularly to your chairman for the splendid set of hearings you have been embarked upon now for 2 weeks, and which you will continue after the recess. It demonstrates your great concern, and I think all of us in the Senate are deeply in your debt.

Mr. Chairman, just——

The CHAIRMAN. I know you made a tour through the poverty area of Washington, D.C. yesterday, and I commend you for it. Perhaps you will be able to bring us a little bit more information and better contact with what the problem is today than some of the others who have been here.

Senator KENNEDY. Thank you very much, Mr. Chairman.

Mr. Chairman, I have a rather extensive statement. I would like to ask if it would be possible to include it in its entirety in the record?

The CHAIRMAN. We will do that.

Senator KENNEDY. In that case, I would like to cover the first part of it in some detail, and then skip over a little better than a third of it, summarizing very briefly, and then just touch on the last part. Many of the points in my statement have been commented on by other Senators who have appeared before you, and rather than take the time of the committee, I would appreciate it if I could proceed in the manner I have described.

The CHAIRMAN. Yes.

Senator KENNEDY. Although I refer to it in the course of my testimony, I would like to mention here the questions which were addressed to the distinguished Senator from Utah, Senator Moss, in reference to eliminating the restrictions on earned income, in order that those who

are receiving or are eligible for social security benefits would not be penalized by working.

I realize from estimates I have seen, that if we did have an elimination of the restrictions on earned income, it could cost perhaps as much as $2 billion. I think it is rather unfortunate that those who are working and are interested should be the ones who are penalized, really, for their efforts. Granted, we have the responsibility of seeing the system as a whole but it does seem unfortunate that those who work are forced to accept lower benefits than those who do not.

Further on this point, one of the things I find very distressing is the fact that unearned income is not considered "earnings," and not figured in to reduce the benefits that one would receive from the social security system.

So, therefore, those who sit back and clip coupons are not within this category, but those who go out and work are—and are penalized. Certainly this is an inequity, and I think should be eliminated. I don't see any reason why those who are receiving unearned income from stocks, bonds, annuities, or pension funds should be given special consideration, while those who are receiving earned income and are actually working are penalized.

I would hope that on this particular point, we could have some kind of adjustment in the bill to be sent to the floor of the Senate.

The CHAIRMAN. I believe you know when it first started the idea was that there was a lot of unemployment and it was felt that we ought to find some way to prod people to retire. I think that that was part of the philosophy of saying that at age 65 or thereafter they ought to retire.

Senator KENNEDY. That is right.

The CHAIRMAN. Or if not at 65, 66, or 70 and that they draw their benefits when they retired. I think that is one of the reasons for the distinction, perhaps the main reason for it.

Senator KENNEDY. I recognize that as the historical background. I do feel, however, that given the labor market, the trends of employment in evidence today, the wide coverage of retirement funds, the observations that were made by the chairman with regard to many of our senior citizens who are interested in continuing some kind of productive involvement in their own life—I do feel that this penalty obviously works to the disadvantage of those without unearned income, while working to the advantage of those who do have sources of unearned income.

So, in sum, I think there is a basic inequity here, and I am hopeful that this point could be reviewed by the members of the committee and by the staff to see if some adjustment could be made in the legislation.

Senator WILLIAMS. If I might suggest, this committee has been most sympathetic to this suggestion that they be allowed to earn more.

Senator KENNEDY. Yes.

Senator WILLIAMS. In fact a couple of years ago, the amendment passed the Senate raising this to $1,800 and it was compromised in the House to $1,500.

As the chairman indicates, to eliminate the ceiling entirely it would require 0.7-percent increase in the payroll tax or if we followed the other method of financing it through general revenue it would require a 2-percent surtax.

Senator KENNEDY. Which comes to about $2 billion, as I understand it.

Senator WILLIAMS. Yes; $2 billion.

If it were removed in its entirety, as has been suggested, which procedure would you recommend that we follow, 0.7-percent payroll tax or 2-percent increase in the surtax?

Senator KENNEDY. As I have said, this is an extremely sizable amount of money, and when we have only limited funds, it is even more difficult. Recognizing the political problems which are suggested, as well as the economic strains, I would hope that at a bare minimum we could have a clear presentation of the alternatives available to us, as I think this unequal treatment of earned and unearned income is one which both bothers and concerns people.

My suggestion would be in the alternative: that we either eliminate the ceiling, or if not, then at least we treat earned and unearned income the same way. Thus, if we were to retain the ceilings on income, then both earned and unearned income should be included in the computation.

I think that is the equitable way of handling it. I know this committee has to balance and evaluate the various interests, and see what can be done, but I would hope that at least in the alternative that we could have both the earned and unearned treated the same.

Senator WILLIAMS. Thank you.

Senator KENNEDY. Mr. Chairman, the legislation presently before you—the proposed Social Security Amendments of 1967—is as important a piece of legislation as is before the Congress this year. The social security system touches the life of virtually every American, be he one of the 23 million persons who will receive benefits under its provisions, or one of nearly 78 million wage earners who pays a payroll tax. I consider the revision in the system this year absolutely critical, if we are to finish building the structure which was begun in 1935. President Roosevelt termed the 1935 act only the "cornerstone," and we have, over the years, been slowly piling stone on stone in our efforts to complete the structure.

The recommendations that I have, Mr. Chairman, on the amendments to the social security system, are many. First of all, however, is minimum benefits. The House bill raises the minimum benefits to $50 a month, or $600 a year. This is utterly unrealistic, particularly in the case of those individuals whose entire retirement earnings are social security benefits. I urge that instead, minimum benefits be set at $100 a month for individuals and $150 a month for couples. This is, in my judgment, a bare minimum. I would couple this rise in minimum benefits with an across-the-board increase of 20 percent, instead of the 12½-percent increase in the House bill.

Second, financing the increased benefit levels. Payroll taxes are regressive, as every member of this committee knows. The higher they are raised, without a sliding scale comparable to the progresive income taxation rates, the more, on a proportionate basis, those at the lower end of the wage scale are forced to pay.

The founders of social security did not intend the system to become as regressive as postwar administrations and Congress have permitted it to. In 1937, for example, the tax applied to wages and salaries up to $3,000, while the median wage or salary income was $1,112. If the

maximum salary or wage to which the contributory tax was applicable, bore the same relation now to the median salary or wage as it did in the late 1930's, the tax would now apply to wages and salaries up to $14,740. H.R. 12080 would, by way of contrast, raise the level of earnings subject to tax to $7,600, or to slightly half of what it would be as envisioned by the architects of the social security system.

Raising this contribution base could finance nearly the entire cost of the raise in benefits I have proposed. The administration has, in fact, recommended a gradual increase in the contributions base, but H.R. 12080 accepted only a small part of this recommendation.

Third, earnings limitation. This discourages workers still able and willing to work from doing so, and is an arbitrary, inequitable, unjust and unreasonable restriction.

It applies, as now written, as I have said, only to earned income. Thus those individuals with unearned incomes, as from stocks and bonds, pensions, annuities and the like, can have incomes of up to almost any amount and still draw down the full amount of social security benefits. The man or woman actually earning wages, however, is not so fortunate. When he works, he loses his benefits, and therefore, I would hope that this point would be adjusted and corrected.

Fourth, the cost of living. There should be an automatic cost-of-living adjustment in benefits. Twice in the last 10 years the Congress has increased benefits, both times by 7 percent. But this has still left the purchasing power of benefits actually lower than they were in 1954, due to increases in the cost of living. Another dramatic illustration of what happens when the cost of living is ignored is that 80 percent of the 12½-percent increase in benefits in H.R. 12080 would be used simply to restore the 1954 purchasing power, despite the belief held by some people that we have steadily improved our social security benefit structure. Cost-of-living figures are frequently published and readily available, and it would be a simple matter to adjust benefits accordingly. This should, in the interest of equity, be made a basic principle of our social security laws.

Fifth, State public assistance payments. Two aspects of State public assistance payments should be changed. State payments should not be reduced when social security benefits are raised, and State welfare payments should be raised to the level the State itself sets as the minimum for subsistence. These two proposals, acting in concert, would assure that State actions would not cancel out actions on the Federal level, to the disadvantage of those whom the programs are designed to help.

Sixth, Advisory Council on Social Security. Under present laws, the Secretary of Health, Education, and Welfare appoints 12 members to the Advisory Council on Social Security. I would recommend that this committee give serious consideration to requiring that at least one member of this council be a recipient of social security or welfare benefits. I think the concept that we have generally seen working in the Poverty Program is that many of the people who are actually recipients have these ideas, suggestions and recommendations, and I think it would strengthen the Advisory Council.

These six suggestions for revisions in the social security part of H.R. 12080 are, Mr. Chairman, the minimum we should make consistent with the desire I know we all share to bring meaning and fulfillment

to retirement years. They reflect a juxtaposition of the standards of living we want for older Americans, with the best advice of persons closely familiar with the social security system.

I urge their acceptance.

Following the structure of H.R. 12080, Mr. Chairman, I want now to turn to title XVIII of the Social Security Act, or medicare.

We have lived with medicare for over a year now, and we know that, as President Kennedy said many times, it has indeed heralded a new era for those who needlessly suffered because they could not afford proper health care. President Johnson, in his January 23 message on aid to the aged, termed medicare an "unqualified success." And it certainly has been just that.

But there are both improvements which need to be made, and shortcomings to be corrected, if medicare is to reach its full promise.

First, disabled Americans under 65. The President recommended that medicare be extended to the 1.5 million disabled Americans under 65 now covered by social security and railroad retirement, but the House did not accept this recommendation, calling instead for a study of it. Mr. Chairman, those disabled Americans under 65 who receive social security or railroad retirement benefits find themselves in much the same position as those over 65—they cannot work, are dependent upon social security benefits, are plagued by high medical expenses, and have difficulty finding adequate and reasonable insurance protection. It is my belief that they should be covered, and covered immediately.

Second, cost of prescription drugs. I commend you, Mr. Chairman, for the work you have done in trying to see that the generic name drugs are used, and your efforts working with HEW in this matter. I find myself completely in accord, and I hope this bill as reported to the Senate will reflect the position of the chairman.

Thirdly, chronic illness coverage. We have, under present law, imposed artificial limits on coverage for those individuals whose stays in health care facilities are of long duration. I can testify, Mr. Chairman, from my own personal experience with the sickness that my own father has had for many, many years, and can understand the extraordinary problems long-term illness causes to many people in many families throughout this country. I think particularly in the cases of terminal cancer and others that the expiration of the medical benefits comes at a time when these benefits are needed most. I am hopeful that we can broaden our limits on coverage for chronic illness, which would then mean that medicare is doing the job we expected of it.

Next is medicaid, Mr. Chairman. As title XIX of the Social Security Act becomes operational, we are only beginning to learn of its ramifications. Thirty States now have programs in operation, and eight more States will soon begin their programs. The House dealt quite extensively with medicaid, imposing certain restrictions on the operation of certain State programs, with an eye to insuring, in the words of the committee report, that "title XIX would afford better medical care and services to persons unable to pay for adequate care."

I have introduced an amendment, No. 298, to H.R. 12080, which would help guarantee the high quality of medical care as administered in nursing homes. This amendment is similar in effect to S. 1662, which I introduced on May 2 of this year.

In my prepared statement, I review the need for and the effect of this amendment in some detail. Let me just say that what this amend-

ment would do is to require States which include nursing home care as a component of their State plan, to require licensing of nursing home operators. If these operators were not licensed, then the Secretary of HEW, after 1970, would not be able to certify the State plan, thus rendering it disqualified for assistance. In my prepared statement, I review what the results of our hearings have been, in the Special Committee on Aging, with regard to licensing. From the hearings and from my own study in the area, I am aware of some of the abuses, as well as some of the strengths of nursing homes, and I do think there must be some kind of licensing provision made. I am hopeful that it can be incorporated in this legislation. It is complementary and supplementary to the suggestions Senator Moss has made, and I have discussed this with him at length and we are in accord on it.

Now, Mr. Chairman, I would like to turn to the public welfare provisions: if there can be said to be a consensus on anything within the ambit of H.R. 12080, it is that our present American welfare system is sadly inadequate. The President, Members of Congress, the Secretary of HEW, the American Public Welfare Association, the President's Advisory Council on Public Welfare, all have attacked our present system.

The House bill makes major changes in existing law. I have reviewed the testimony before this committee of Secretary John Gardner of Health, Education, and Welfare, and Under Secretary Wilbur Cohen regarding these changes, and I find myself in close agreement with them. I will, consequently, forgo extensive comments on them, with two exceptions. The first deals with limits on aid to dependent children. I would consider it a grievous mistake if the Senate were to accept the House provision limiting Federal participation in the aid to families with dependent children. I know the formula that has been reached in the House of Representatives and I think it is utterly unrealistic. We hear the comments of urbanologists, such as Dr. Patrick Moynihan and others, who discuss what is happening in many of our cities. Unfortunately, there is a startling growth in the numbers of illegitimate children. To try to set a rigid formula limitation, such as has been established in the House bill, is unrealistic. Certainly, we do not want to encourage illegitimacy. But this is, as others have stated here on other occasions, illogical and cruel to take out on the children themselves. So I am hopeful that this particular aspect of it can be carefully reviewed, and perhaps revised extensively by this committee.

Secondly, work training. I think it would be truly an archaic law which required all mothers to accept work or training, as a prerequisite to receiving welfare benefits. I think there should be an optional policy. It could be some kind of flexible policy. I am not prepared today to make detailed comments on how it should be established and regulated. I know you have Mr. Mitchell Ginsberg here and others from other welfare departments who will comment in detail, and perhaps then we can work out some kind of discretionary provision for welfare departments, so this is not mandatory. I think it would be helpful to have some kind of discretion in the welfare department, so they could take into consideration extenuating circumstances on these provisions.

The last area is child health. Few things are so poignant as a sick child, crippled or lethargic, unable to comprehend the nature of his illness or to understand why he is sick.

It is for this reason that I consider title III of H.R. 12080, improvements in child health, so important.

The figures are well known. Some 40,000 American children die each year who would live if our infant mortality rate were as low as Sweden's. More than 1 million crippled children, each year, are left without even the most rudimentary medical assistance. More than 125,000 infants are born each year mentally retarded, many of whom are retarded only because of inadequate prenatal care. I will say, Mr. Chairman, that as a result of the very extensive studies of the Kennedy Foundation, on the question of mental retardation, we find that this prenatal care is absolutely essential for mothers. There is a direct correlation between the incidence of mental retardation and also the lack of prenatal care. The provisions which have been incorporated in the House bill, I think, move us along in a very positive and constructive direction, and I am hopeful that we can certainly support these and will strengthen them.

In conclusion, Mr. Chairman, I think it useful, when we contemplate the estimated welfare costs of about $7.5 billion in 1968, to put this in a perspective. In 1940, total assistance expenditures represented 1.07 percent of the gross national product. In 1960, they represented 0.84 percent, and in 1966, 0.85 percent. We have, then, despite the absolute rise in the amount of public assistance expenditures, only kept even as a percent of GNP. Consequently, I do not think we should let ourselves be sidetracked by the large sums involved in H.R. 12080.

Rather, we should concentrate on what this actually does for the poor people of America.

We do not do our traditions and heritage well when we tolerate rules and conditions which force dignity out of the lives of those to whom dignity is vitally important.

We do not do our intelligence and abilities well when we tolerate an archaic patchwork of unintelligible and overlapping laws through which assistance is channeled to the poor.

We do not do our poor well when we hold out promises of increased assistance, only to fall far short of our promise.

What we can do, and what we must do, is to act firmly and with clear resolve. President Roosevelt, in his last public message, said that "the only limit to our realization of tomorrow will be our doubts of today."

Let us act, now, to make tomorrow, for the poor, not a life of punishment or scorn for being poor. Rather, let us construct enlightened structure designed to help in the realization of self-sufficiency.

The proposals I have made today can help in this realization, and I urge their acceptance.

The CHAIRMAN. Let me thank you for a very thoughtful and comprehensive statement, Senator Kennedy. There are some of us on this committee who made a very determined effort to try to provide that these health care benefits would continue as long as a person was really seriously ill and needed them.

I saw in the press the other day where a relatively young person died. He would not be covered under medicare, but this person had been in a coma for more than 2 years. Now when someone is really ill, and really sick, the idea of terminating the benefits, terminating the hospitalization and the care for them because they are still sick after a year or after 18 months is just pathetically ridiculous in my

mind. There are a small percentage of cases where that is true but some of us felt, and I still feel, and I think we both feel that way, that we certainly should extend the benefits of medicare to a person who is desperately ill and simply has not recovered, but is still ill. I think you made a fine suggestion there and that is how many of us voted when we voted on medicare previously.

I appreciate what you said about this problem about the drugs. We believe that we would save about $100 million and even provide a better quality of drugs than people are getting now if we heavy up on the testing and buy these drugs on a competitive basis rather than simply let someone charge a big price for it because he puts a fancy name on it.

Now, I appreciate what you have said, but I am inclined to think that there is a substantial amount of disagreement with what the House is probably trying to achieve in what appears to be sort of a get tough attitude toward this dependent children problem.

The law already states that these children would not draw benefits if their unemployed parents have work available to them and don't take it.

Now, it is recognized by the House committee and by the law that in instances where a mother has a number of children, that the money would best be spent simply to pay the mother to stay in the home. The House committee says that. They say that in some instances where there are several small children, for example, the best plan for a family may be for the mother to stay home. But even those cases should be reviewed regularly to see if the situation had changed to the point where training or work is appropriate for the mother.

Now, in a case of that sort perhaps that is the best answer. I do know that it has been my privilege on occasion to have a number of mothers working either in my office or working in my home from time to time who had children at home, and they were good employees, too. Because of the unfortunate death of the father, some of these mothers have done just a magnificant job in providing family income and giving their children a chance in life, a better chance than they would have had otherwise. I don't think we disagree about that sort of thing nor that the House proposal to help provide day care and schools for small children as well as the children of kindergarten age, to help mothers with that problem where they find it desirable to work.

Part of this seems to be because the Labor Department has had the responsibility of finding the jobs, and another department has had the responsibility of handing out the checks. Where the Labor Department has had the entire responsibility, such as the unemployment insurance program, you got exactly the same provision that those people shouldn't be drawing that money for unemployment insurance if there is work available for them, and the Labor Department in that area, I think, has done a pretty good job of handling there where they find someone has been drawing the benefits, drawing unemployment insurance with a job available to them over there, and they said, "We will have to cut off this unemployment insurance because here is a job right here that you could be holding at this very time."

It seems to me that what the House is trying to say is that they mean business when in their law they say that you shouldn't be drawing benefits if you have work available to you. It seems to me that is what

the House is striking at. Maybe this phrase may not be the way to do it, but I think we all agree that where someone could be working constructively and care for the children is provided while the mother works, that is probably a better answer. I also think that when one talks about the discrimination in favor of a husband who doesn't support his children we ought to eliminate that by finding that husband and seeing that he contributes something to the support of those children. I have been thinking about the possibility of suggesting a tax on fathers who don't support their children as one way to get at some of that.

I have experienced the frustration of being a young practitioner of law trying to chase down some of these truant parents. It is very difficult to do. So maybe we can do it at this level, the Federal level. Thank you very much.

Senator GORE. I want to thank Senator Kennedy for his statement.

I would like, myself, to make a brief comment about a related matter. I have long been an advocate of a full-employment policy which, as you realize, this country adopted as a national policy right after World War II. We seemed promptly to forget it as soon as we adopted it. I have long advocated implementation of the policy. It has been a matter of encouragement to me that the Labor Committee has now reported a bill which makes a vigorous approach to the accomplishment of this goal in our municipalities.

I note that some, both within and without the Administration, on the one hand, criticize the House bill requiring work with respect to welfare, and, at the same time, criticize the recommendation in the bill reported out by the Labor Committee. I expect to support that latter bill. It may not be comprehensive enough, but at least it is a vigorous step toward giving life and meaning to the full employment policy that was nationally adopted long ago, but never implemented. Would you mind responding to that?

Senator KENNEDY. If my memory serves me correctly, the full employment policy was enunciated in the Full Employment Act of 1946, and has been interpreted by subsequent administrations to be utilization of monetary and fiscal policy to bring about full employment. But the legislative history, as I remember it from the development of that act, suggests that the Federal Government should be the employer of last resort, which I think are actually the words used in the Full Employment Act. This is, consequently, something that has long been talked about and considered.

As the distinguished Senator from Tennessee has pointed out, to some extent the bill introduced by Senator Clark, of which I am a cosponsor, is the first sort of massive program designed to reach that issue. I voted for it in the committee, and I will support it on the floor.

The question, of course, comes down to whether the program can be strengthened. Senator Clark has indicated so, as, for examples, as to how incentives can be provided to the private sector to achieve the purposes outlined in his bill. I am sure there are other ways of strengthening it but the concept itself, I think, is worthy and I think it is something that should be recognized. I certainly support it.

Senator GORE. Many of us think that self-reliance, self-respect, industry on the part of the individual are inherent in, and necessary

for the vitality of, our way of life. I know few who would disagree with that. But whether the Government offers an opportunity for employment as the first or last resort, to the fellow who is desperately in need of a job, this may matter but little.

I strongly believe that our society, being as complex and as large and as interdependent as it is, owes to every able-bodied citizen who is willing to work an opportunity for a job at a decent wage.

This is a belief to which I am willing to pay more than lipservice. I wish to join you in support of this Labor Committee bill.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Williams?

Senator WILLIAMS. No questions.

Senator KENNEDY. Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator.

(Senator Kennedy's prepared statement follows:)

STATEMENT OF SENATOR EDWARD M. KENNEDY, U.S. SENATOR FROM THE STATE OF MASSACHUSETTS

Mr. Chairman, I appreciate this opportunity to appear before you and the other distinguished members of the Committee on Finance.

The legislation presently before you—the proposed Social Security Amendments of 1967—is as important a piece of legislation as is before the Congress this year. The Social Security System touches the life of virtually every American, be he one of the 23 million persons who will receive benefits under its provisions, or one of nearly 78 million wage earners who pays a payroll tax. I consider the revisions in the system this year absolutely critical, if we are to finish building the structure which was begun in 1935. President Roosevelt termed the 1935 Act only the "cornerstone"; and we have, over the years, been slowly piling stone on stone in our efforts to complete the structure.

But we have by no means finished building. Of the twenty-three million Americans now receiving benefits under the system, 5 million, or more than 20%, live in poverty. Retirement years for these Americans are not years of fulfillment, as they should be—they are years of despair, of frustration, and of pain.

The public welfare provisions of the social security laws, the complement to the retirement assistance provisions, are seriously in need of major revision. Last year, the Advisory Council on Public Welfare, appointed by President Johnson, cited in an extensive report that the "legislative mandate and financial resources" of the public assistance provisions "desparately handicapped" the operation of the system. The House-passed bill would work many major revisions in the public welfare provisions of the social security laws, but there are many Americans who believe these changes, in part, are a step backward rather than a step forward.

Events of this year have proven graphically that our assistance provisions have not kept pace with what the American electorate expects. I think that it is in this context that we should view the provisions in the bill before this Committee, and that we should bend our oars to move forward, not backward.

Mr. Chairman, H.R. 12080 contains a vast number of provisions. The Report of the House Committee on Ways and Means, for example, lists about 153 separate changes to existing law. While I would like to comment on a large number of them, it is virtually impossible within the time available to us this morning. What I would like to do, instead, is to comment briefly on a few matters and more extensively on a few others.

SOCIAL SECURITY

First, benefit levels. The House bill raises minimum benefits to $50 a month, or $600 a year. This is utterly unrealistic, particularly in the case of those individuals whose entire retirement earnings are social security benefits. I urge that instead, minimum benefits be set at $100 a month for individuals and $150 a month for couples. This is, in my judgment, a bare minimum. I would couple this rise in minimum benefits with an across-the-board increase of 20%, instead of the 12½% increase in the House bill. This would have the almost

immediate effect of raising the 5 million older Americans now living at poverty levels up and out of their abject living conditions. With one stroke, this Committee and the Senate could virtually eliminate severe poverty among older Americans, should this proposal be accepted.

Second, financing the increased benefit levels. Payroll taxes are regressive, as every member of this Committee knows. The higher they are raised, without a sliding scale comparable to the progressive income taxation rates, the more, on a proportionate basis, those at the lower end of the wage scale are forced to pay.

The founders of Social Security did not intend the system to become as regressive as postwar Administrations and Congress have permitted it to. In 1937, for example, the tax applied to wages and salaries up to $3,000, while the median wage or salary income was $1,112. If the maximum salary or wage to which the contributory tax was applicable, bore the same relation now to the median salary or wage as it did in the late 1930's, the tax would now apply to wages and salaries up to $14,740. H.R. 12080 would, by way of contrast, raise the level of earnings subject to tax to $7,600, or to slightly half of what it would be as envisioned by the architects of the Social Security System.

Raising this contribution base could finance nearly the entire cost of the raise in benefits I have proposed. The Administration has, in fact, recommended a gradual increase in the contributions base, but H.R. 12080 accepted only a small part of this recommendation.

The other, and critical, element of financing the social security benefits is through infusion of general tax revenues. We can never meet the needs of our senior citizens so long as benefits are tied solely to payroll contributions—and we must not forget that it is the needs of people, not some accounting standards, which should be in the forefront of our minds.

This Committee has been presented with a number of specific proposals for the infusion of general revenues, and I do not want to dwell on the particulars. But I do want to urge the members of the Committee to give all possible attention to this possibility.

Third, earnings limitation. Present law limits the incomes retired workers can earn and still receive benefits. This discourages workers still able and willing to work from doing so, and is an arbitrary, inequitable, unjust and unreasonable restriction.

It applies, as now written, only to earned income. Thus those individuals with unearned incomes, as from stocks and bonds, pensions, annuities and the like, can have incomes of up to almost any amount and still draw down the full amount of social security benefits. The man or woman actually earning wages, however, is not so fortunate. When he works, he loses his benefits.

Officials of the Social Security Administration have reported to me that elimination of the earnings limitation would be expensive, requiring perhaps as much as $2 billion more for benefits than under present law. But this misses the point: we are now, in effect, penalizing individuals over 65 who work, while not penalizing those with unearned incomes who do not work. If the cost of removing this inequity is high, then we should perhaps find another way of doing it—as, perhaps, subjecting all income, earned or unearned, to the same limitation.

But in any case, I consider it incumbent upon us, this year, in this bill, to correct this disturbing discrimination against the working man.

Fourth, cost of living. There should be an automatic cost of living adjustment in benefits. Twice in the last ten years the Congress has increased benefits, both times by 7%. But this has still left the purchasing power of benefits actually *lower* than they were in 1954, due to increases in the cost of living. Another dramatic illustration of what happens when the cost of living is ignored is that 80% of the 12½% increase in benefits in H.R. 12080 would be used simply to restore the 1954 purchasing power, despite the belief held by some people that we have steadily improved our social security benefit structure. Cost of living figures are frequently published and readily available, and it would be a simple matter to adjust benefits accordingly. This should, in the interest of equity, be made a basic principle of our social security laws.

Fifth, State public assistance payments. Two aspects of State public assistance payments should be changed. State payments should not be reduced when social security benefits are raised, and State welfare payments should be raised to the level the State itself sets as the minimum for subsistence. These two proposals, acting in concert, would assure that State actions would not cancel out actions on the Federal level, to the disadvantage of those whom the programs are designed to help.

Sixth, Advisory Council on Social Security. Under present law, the Secretary of Health, Education and Welfare appoints 12 members to the Advisory Council on Social Security. I would recommend that this Committee give serious consideration to requiring that at least one member of this Council be a recipient of social security or welfare benefits. One criticism of the administration of our present system is the lack of contact the policy makers have with those at whom the system is aimed: the old, the poor and the disabled. I can think of no better way for the voice of the recipient to be heard in the policy-making councils than for a beneficiary or recipient to be a full-fledged member of the Advisory Council.

These six suggestions for revisions in the social security part of H.R. 12080 are, Mr. Chairman, the minimum we should make consistent with the desire I know we all share to bring meaning and fulfillment to retirement years. They reflect a juxtaposition of the goals we have for older Americans with the advice of persons closely familiar with the Social Security System. I urge their acceptance.

MEDICARE

Following the form of H.R. 12080, Mr. Chairman, I want now to turn to Title XVIII, of the Social Security Act, or Medicare.

We have lived with Medicare for over a year now, and we know that, as President Kennedy said many times, it has indeed heralded a new era for those who needlessly suffered because they could not afford proper health care. President Johnson, in his January 23 message on Aid to the Aged, termed Medicare an "unqualified success." And it certainly has been just that.

But there are both needed improvements and shortcomings to be corrected, if Medicare is to reach its full promise.

First, disabled Americans under 65. The President recommended that Medicare be extended to the 1.5 disabled Americans under 65 now covered by social security and railroad retirement, but the House did not accept this recommendation, calling instead for a study of it. Mr. Chairman, those disabled Americans under 65 who receive social security or railroad retirement benefits find themselves in much the same position as those over 65—they cannot work, are dependent upon social security benefits, are plagued by high medical expenses, and have difficulty finding adequate and reasonable insurance protection. It is my belief that they should be covered, and covered immediately.

Second, cost of prescription drugs. The cost of prescription drugs administered outside of hospitals or other health care facilities should be covered under Part B of Medicare. It can hardly be denied that the cost of drugs prescribed by a physician, whether taken inside or outside of a hospital, are a part of the cost of being sick. Yet they are not included under Medicare I think we should include them, and do so immediately.

Mr. Chairman, I have noticed with great interest, in this regard, your efforts to have the Secretary of H.E.W. prepare a list of drugs by their generic names, as opposed to their brand names, and to limit Medicare payments to the price of the generic drugs. I quite agree with you that this would bring great savings, by encouraging use of generics, and I support your far-sighted efforts.

Third, chronic illness coverage. We have, under present law, imposed artificial limits on coverage for those individuals whose stays in health care facilities are of long duration. Yet it is exactly these illnesses of long duration which prove most disastrous, financially, to those whose ability to pay is limited. We must broaden our limits on coverage for chronic illness, if we are to claim that Medicare is doing the job we expect of it.

MEDICAID

As Title XIX—Medicaid—of the Social Security Act becomes operational, we are only beginning to learn of its ramifications. Thirty States now have programs in operation, and 8 more States will soon begin their programs. The House dealt quite extensively with Medicaid, imposing certain restrictions on the operation of certain State programs, with an eye to ensuring, in the words of the Committee Report, that "Title XIX would afford better medical care and services to persons unable to pay for adequate care."

I have introduced an amendment, 298, to H.R. 12080, which would help guarantee the high quality of medical care as administered in nursing homes. This Amendment is similar in effect to S. 1662, which I introduced on May 2 of this year.

It would require States which included a nursing home care component in their State plans to provide for a State licensing system of nursing home opera-

tors. If these operators were not licensed, then after 1970 the Secretary of H.E.W. would not be able to certify the State plan to qualify it for Title XIX assistance.

Denial of Federal funds for nursing home care is a drastic step. I urge such a drastic step because of information elicited in an important series of hearings in 1965 held by the Subcommittee on Long-Term Care of the Special Committee on Aging, because of information developed by my staff and the staff of that Committee, and because of my own personal visits to many nursing homes.

This information has convinced me that the operator or administrator of a nursing home is the key person in assuring that the care received by nursing home patients is of a very high quality. The operator is, after all, the man who hires and fires the staff, the man who orders the food, the man who schedules visits by physicians, and, in general, the man who sets the standards by which each individual nursing home operates.

The care nursing home patients require is considerable, since they are in nursing homes only because they cannot take care of themselves. The typical nursing home patient is 80 years old. More than half of such patients require assistance in walking or are bed-ridden. Nearly half of the patients are senile or mentally confused at least part of the time. Many patients are permanently disabled and cannot be rehabilitated to a degree at which they could live independently outside the nursing home. The average length of stay in a nursing home is a year or more.

The care of patients in a nursing home is, then, a very large responsibility. The man who must oversee the discharge of this responsibility—the operator or administrator—must be a man of dedication, skill or experience. The hearings I have participated in, the studies which have been undertaken, and visits I have made have convinced me that, by and large, nursing home operators meet these standards and are conscientious in their efforts to bring the best care and comfort to their patients.

But, unfortunately, not all nursing home operators are so motivated. A survey of nursing and rest home administrators recently conducted in Massachusetts by Dr. Samuel Levy indicated why many members of the medical professions are concerned about the qualifications of nursing home operators. Only 41 per cent—428 persons—responded to Dr. Levy's questionnaire. Only 18 per cent had completed college; 20 per cent were school drop-outs; 10 per cent had no formal education at all; and of those who had not completed college only 18 per cent could cite any special training in their profession. And I draw the unhappy conclusion that had the other 59 per cent responded, the statistics would be even more discouraging. While these figures combine rest and nursing homes, the results would not be significantly different if nursing homes were separated out.

I want to make it clear, Mr. Chairman, what my amendment would and would not do. All States presently require the licensing of nursing homes, and pursuant to this requirement, periodic inspections of nursing home facilities are made, usually by personnel of State health departments. But this requirement alone is insufficient to ensure that patients receive the care and treatment the inspectors are led to believe they receive. I have evidence, for example, of an operator who kept meat in a freezer to show the State inspectors, but the meat was never fed to the patients—they were fed spaghetti, spam, and so forth. It is this type of unscrupulous taking advantage of old, sick people at which my bill is aimed.

It would require States to establish a board of individuals representative of the professions, occupations, and institutions directly concerned with the care and treatment of the chronically ill or infirm elderly, as well as of the public. This State board would develop, impose and enforce standards which must be met by operators of nursing homes before they could be licensed by the State. If the State did not have a licensing program in effect by July 1, 1970, then a nursing home component of a State program for Title XIX asistance would not be able to be certified by H.E.W. The standards to be developed by the State boards are designed to ensure that nursing home operators are individuals well-qualified by experience, training and character to operate nursing homes. The amendment would establish a small program of matching grants to States for training nursing home operators.

States presently require the licensing of doctors, of dentists, of lawyers, of architects, of engineers, and of other professionals as well. This licensing process enures that the public interest in receiving services meeting some minimum requirements of quality are met. Since nursing home operators are directly responsible for assuring, day-to-day, that their patients receive the medical care

they need, it is my firm belief that the operators should be licensed by the States much as doctors, dentists or lawyers are.

The Department of Health, Education, and Welfare estimates that there are approximately 20,000 homes with 850,000 beds providing nursing and residential care in the United States, an average of about 43 beds per institution. Approximately 85 percent of the institutions and 75 per cent of the beds are owned by proprietary nursing home organizations, which is a sharp contrast to the ownership patterns of the hospital industry, where the great majority of institutions are publicly-owned. The national health expenditure for nursing home care was $1.2 billion in 1964, the public share of which was over $400 million. The Veteran's Administration, the Department of H.E.W., and the Department of Housing and Urban Development all finance, in various ways, various costs of nursing homes.

Nursing homes are a big business in the United States today, and public funds are heavily involved, as these figures indicate. Licensing of operators of nursing homes is one element in guaranteeing the best possible care to our elderly citizens who are patients in nursing homes. It is an important element, as the hearings in the Subcommittee on Long-Term Care indicated, and as it is framed in the amendment I have offered, it dovetails with the amendments introduced by the Chairman of that Subcommittee, the distinguished Senator from Utah, Mr. Moss, which cover other aspects of problems associated with nursing homes. The Senator from Utah has, by the hearings he chaired in 1965, performed a valuable service to our senior citizens who must be confined to nursing homes, because he brought these problems out for public scrutiny.

The bills introduced as a result of these hearings were carefully drawn to bring patients in nursing homes a higher order of care than they presently receive. My own amendment would do it by focussing on the qualifications of the operators of the homes. A recent poll conducted by the periodical NURSING HOME ADMINISTRATOR shows that a majority of respondents approve of the licensing of operators. They do so, I think, because the profession wants to rid itself of the small minority of unprofessional operators whose activities detract from the dedication to excellence of the majority of the members of the profession.

PUBLIC WELFARE

If there can be said to be a consensus on anything within the ambit of H.R. 12080, it is that our present American Welfare System is sadly inadequate. The President, members of Congress, the Secretary of H.E.W., the American Public Welfare Association, the President's Advisory Council on Public Welfare—all have attacked our present system.

The House bill makes major changes in existing law. I have reviewed the testimony of H.E.W. Secretary John Gardner and Undersecretary Wilbur Cohen, before this Committee regarding these changes, find myself in close agreement with them. I will, consequently, forego extensive comments on them, with two exceptions.

First, ADC limits. I would consider it a grievous mistake if the Senate were to accept the House provision limiting Federal participation in the Aid to Families with Dependent Children Program (ADC), based on the existing proportion of the child population which received aid because of the absence of a parent as of last January. This is a plain, arbitrary freeze on the number of children who can receive payments under the ADC program, and attempts a solution by ignoring the problem.

We must all be concerned at the rising number of children receiving ADC, a number which has risen so that now fully 4.9% of all children under 18 are receiving payments. But this means, for these children, food and clothes, and we simply cannot ignore what the effect of freezing the number of recipients at a number *already exceeded* will be. This unduly harsh provision goes completely against the grain of the rest of the House provisions, which are in general aimed at moving families toward financial independence.

Second, work training. It would be truly an archaic law which *required* all mothers to accept work or training, as a prerequisite to receiving welfare benefits. This would be so even with an adequate system of day care centers, which, of course, we do not have and will not have, even under the House bill, for some time to come. If part of our concern is the reestablishment of the family as a viable unit, then what we should not do is require mothers to leave their children.

There is considerable merit in requiring States to establish work training programs, but none in requiring mothers to leave their children. I would urge

this Committee to rewrite the House provision, making participation by ADC mothers in work training programs voluntary instead of mandatory.

There are, Mr. Chairman, many good and constructive public welfare proposals in the House bill, such as the day care centers, the work incentives for those on welfare, the program designed to reduce the incidence of illegitimate births, and the college grants for training social workers. These provisions, and others, should be retained.

But the two I have discussed in detail must, if we are not to be considered as punishing people for being poor or illegitimate, be deleted.

CHILD HEALTH

Few things are so poignant as a sick child, crippled or lethargic, unable to comprehend the nature of his illness or to understand why he is sick.

It is for this reason that I consider Title III of H.R. 12080, Improvements in Child Health, so important.

Forty thousand American children die each year who would live if our infant mortality rate were as low as Sweden's. More than 1,000,000 crippled children, each year, are left without even the most rudimentary medical assistance. More than 125,000 infants are born each year mentally retarded, many of whom are retarded only because of inadequate pre-natal care. Poor children have 5 times more diseased teeth than more fortunate children.

These are cruel statistics.

The House bill, in response to these distinct needs, has consolidated existing maternal and child health programs, and has provided for the establishment of a few new ones. In particular, the House bill; (a) expands the maternal health care program to state explicity that a major purpose is the reduction of infant and child mortality; (b) authorizes grants for the support of hospital intensive care units for high-risk newborn infants; and (c) authorizes support of projects to provide comprehensive dental health services for children, and for studying various methods of organizing community dental health programs.

Mr. Chairman, these provisions must be retained, for they go far towards solving what many have called a national shame—that we have not, with all our vast resources, been a world leader in child heath, but have instead trailed much of the rest of the world.

CONCLUSION

I think it useful, Mr. Chairman, when we contemplate the estimated welfare costs of about $7.5 billion in 1968, to put this in a perspective. In 1940, total assistance expenditures represented 1.07% of the gross national product. In 1960, they represented 0.84%, and in 1966, 0.85%. We have, then, despite the absolute rise in the amount of public assistance expenditures, only kept even as a percent of GNP. Consequently, I do not think we should let ourselves be sidetracked by the large sume involved in H.R. 12080.

Rather, we should concentrate on what this actually does for the poor people of America.

We do not do our traditions and heritage well when we tolerate rules and conditions which force dignity out of the lives of those to whom dignity is vitally important.

We do not do our intelligence and abilities well when we tolerate an archaic patchwork of unintelligible and overlapping laws through which assistance is channelled to the poor.

We do not do our poor well when we hold out promises of increased assistance, only to fall far short of our promises.

What we can do, and what we must do, is to act firmly and with clear resolve. President Roosevelt, in his last public message, said that "The only limit to our realization of tomorrow will be our doubts of today."

Let us act now to realize that tomorrow, for the poor, is not punishment or scorn for being so. It is rather, an enlightened structure designed to show the way to self-sufficiency.

The proposals I have made today can help in this realization, and I urge their acceptance.

The CHAIRMAN. Our next witness is Mr. James M. Ensign, vice president of the Blue Cross Association.

Mr. McNerney has a rather formidable statement here, and I am going to ask that we print this entirely in the record. I understand

you intend to summarize it. Then we will ask a few questions based on the statement.

STATEMENT OF JAMES M. ENSIGN, VICE PRESIDENT, BLUE CROSS ASSOCIATION

Mr. ENSIGN. Thank you, Mr. Chairman.

Unfortunately, Mr. McNerney, who was to have appeared before you today, is ill in bed here in Washington and, therefore, will be unable to be here today.

My name is James M. Ensign. I am vice president of Blue Cross Association, and we have, as you mentioned, a prepared statement of Mr. McNerney which we would like to submit for the record. In the interest of time, and with your permission, Mr. Chairman, I would like to summarize for you the key points from that statement.

Collectively, the Blue Cross system is the largest voluntary health care financing agency in the world.

Eliminating the overlaps, we serve nearly half the total U.S. population in some capacity, including an estimated 18.6 million elderly beneficiaries under the medicare program in areas where providers have selected Blue Cross as intermediary under part A.

Our concern here today lies primarily with those individual beneficiaries and with the services they receive. The health insurance for the aged program enacted under Public Law 89-97 is a large and complex undertaking. Our comments relate to benefit design, administration, reimbursement to providers and administrative cost.

In many of these areas we have been working closely with the staff of the Department of Health, Education, and Welfare, and expect to continue to do so, primarily through a Bureau of Health Insurance of the Social Security Administration. But there are some highly desirable results which these agencies cannot accomplish, except with legislative sanction or encouragement from the Congress, and I would like to address myself first to these.

A common theme running through newspaper reports on the first year of medicare is one of confusion or uncertainty among beneficiaries. Many elderly persons do not understand the basic elements of the benefits package, parts A and B, much less the details. They do not know what they may have to pay themselves, starting with the $50 part B deductible, or to whom they may have to pay it; they are concerned about requests to pay, which they had not anticipated.

They are apt not to understand about a "spell of illness" under part A and how that fits in with a "calendar year" under part B, to say nothing of the "carry over" provisions involving year-end benefits.

We do not believe that "education" of beneficiaries can be exepcted to cure this situation. Anyone spending a quiet morning in the lobby of a Blue Cross plan, or a Blue Shield plan serving under part B, or a Social Security district office, cannot help but be impressed with the serious effort of beneficiaries to find out what they need to know to understand their situation regarding costs of health care—and the frustratingly difficult task faced by sympathetic and trained beneficiary relations personnel in trying to get the needed detail across.

The only successful course, in our opinion, is to move deliberately toward simplification of the process. Every proposal for legislative

change should be examined to determine whether it eases or adds to the burden on comprehension by elderly beneficiaries and by providers of care who must deliver the benefits.

All other problems aside, the clearest lesson of Medicare Year One, in our opinion, is this one. New changes should be aimed at eliminating confusing detail, and concentrating responsibility for quick and clear explanation as close as possible to the point at which care is rendered, that is, the hospital, the physician's office, or the intermediary-carrier to which each is asked to report when benefits are provided.

Some of the provisions of H.R. 12080 do, in our opinion, contribute to this simplification, while others do not. Some changes which we have recommended previously have not been incorporated into the bill before you, and we should like to reiterate our major emphasis on these.

The need for simplification extends also to administration by providers and physicians, and to firm controls of administrative cost by all involved. The present program is too complex to administer without excessive paperwork, time and cost. Some of the proposals in H.R. 12080 improve this situation. It is the failure of many factors to mesh well with each other or with the existing system for providing health care which creates the greatest problem, in our opinion.

An insistence on merging statistical reporting with case administration has contributed heavily to the problems involving providers. Every encouragement should be given by Congress to the establishment of administrative procedures by the Social Security Administration which will contribute to rapid, effective and inexepensive case handling related to benefit determination and provider reimbursement, with full fiscal controls, but with statistical and research needs fulfilled on a sample basis or by separately obtained summary data rather than on a case-by-case data delivery. Intrusion of research needs into claims processing has not facilitated either beneficiary handling or provider effectiveness, and has tended to increase administrative cost.

Similarly, adoption of rather inflexible and highly complex concepts of reimbursement right from the start of the program has tended to add to costs of administration and to burden the program with detail that might better have been developed slowly on the basis of experience rather than imposed as an untried system.

It is in the light of these concerns for beneficiary understanding, provider effectiveness and administrative cost reduction that I offer the following comments.

Simplification as it relates to H.R. 12080:

H.R. 12080 provides desirable modifications of certain procedural aspects of the program. Under the heading of "simplification of Reimbursement to Hospitals," the bill moves toward simplification of one segment of the program which can produce the greatest amount of confusion, that is, services provided in the hospital setting which invlove reimbursement from both the part A and part B funds. The bill does not, in our opinion, go far enough in this direction.

In addition, modifications are suggested with respect to (1) certain in-patient services provided by physicians, (2) consolidation of out-patient services under part B, and (3) simplicity in the collection, by the hospital, of out-patient charges below a stated maximum. Viewed separately, each proposal has merit. However, all three share a common interrelationship and administrative burden which arises from the annual $50 deductible under part B.

The intent of Medicare is to provide coverage in the service-benefit context, and so hospitals are paid directly and physicians are urged to accept assignments. However, the imposition of a "first dollar" $50 annual deductible is incompatible with this intent. The provider of care does not know the extent of the patient's liabilities at the point of rendering care, a central record of the deductible status must be maintained, and each provider must query the master record through an intermediary or carrier each time service is provided in order to make this determination. This adds administrative complexity and cost to the confusion and frustration of both the provider and the beneficiary.

Further complexities result because (1) the deductible can be fulfilled by charges submitted to a variety of intermediaries and carriers by a variety of providers, physicians or beneficiaries; (2) the provider does not have adequate knowledge of the status of the deductible when small and short-term benefits are involved, as in outpatient services; and (3) the requirement that expenses incurred in the fourth calendar quarter of a year and applicable to that year's deductible are also "carried over" and made applicable to the following year's deductible in an effort to achieve greater equity among beneficiaries.

With this basic complication in mind, let me now comment on some of the proposed modifications.

Concerning radiological and pathological services furnished to hospital inpatients, H.R. 12080 would permit combined billing for hospital services and the services of a radiologist or pathologist. This partially simplifies the billing problem. Unfortunately, this method of billing is not extended to all hospital-based physicians such as cardiologists, neurologists, physiatrists, pulmonary physiologists, anetesiologists, and others.

While arrangements between these specialists and hospitals may not be as prevalent as in the case with radiologists and pathologists, where such arrangements do exist the hospitals' billing problems would not be helped by the provisions of H.R. 12080. Moreover, this proposal adds another type of billing for physicians' services, because no deductible applies to radiology and pathology. They must be identified separately in billing while at the same time the services of other hospital-based physicians remain subject to the $50 deductible. Add to this the existing separate rules for billing for interns and residents in approved as distinguished from nonapproved training programs, and the result is four distinct methods of billing for professional care rendered in hospitals, some of which are subject to the deductible while others are not.

Our recommendation:

In those cases where the hospital would normally bill for services, we urge your consideration of a uniform method of combination billing through part A for all inpatient services—hospital and professional—and a periodic adjustment between part A and part B trust funds for the professional component. This would greatly improve beneficiary understanding and satisfaction, and further simplify the administrative burden and cost. Those physicians who choose to bill independently would continue to do so.

Concerning services to hospital outpatients, we recommend that there be a substitute for the $50 deductible, and that that substitute be a copayment requirement under which the patient will always pay a prescribed portion of each charge incurred. This would eliminate

the confusion attendant on the deductible status, and thereby contribute to the understanding and satisfaction of the patient. It would also reduce the administrative cost at all points in the system—provider, intermediary and SSA.

With respect to simplified reimbursement of outpatient hospital services, we would urge that in line with our general administrative recommendations for separation of statistical and payment reporting, limit the provider claim procedure to a simple reporting of charges and collections which would permit listing of cases rather than individual claims for relatively small amounts; and further, we would urge adoption of our previously stated recommendation for a copay provision instead of a deductible. This would have the combined effort of greater beneficiary understanding and satisfaction, and reduction of administrative cost across the board.

Incentive for lowering costs while maintaining quality in the provision of health. This is the provision of the bill giving authority to the Secretary to experiment with alternative methods of reimbursing hospitals under medicare, medicaid and child health programs which is of great interest to us. We have previously noted that the current system of reimbursement under title XVIII, known as the RCCAC concept, is costly to administer, has required additional employees among providers and among intermediaries to audit more extensive data, and it poses difficult questions for providers who have so-called all-inclusive rates.

We salute this provision in the bill as an indication of the flexibility needed to arrive at adequate reimbursement to providers where variable circumstances require such flexibility. We also look to this provision as a means for exploring the validity and reliability of a variety of possible reimbursement methods.

Senator GORE. Mr. Chairman, could I interrupt to ask a question?

The CHAIRMAN. Yes.

Senator GORE. May I ask a question of the witness? I suppose you are concerned with the inflation of costs, and certainly the members of this committee are. Do you have any evidence that parts A and B of medicare are operating to inflate the costs of health care for the total population, and if so, what can you recommend to this committee that we do to control this kind of inflation?

Mr. ENSIGN. Well, Senator Gore, on your first question, "Do we have evidence that the establishment of a part A and part B has inflated the cost?" With respect to the separate identification of a professional component which has caused a number of hospital-based specialists to move away from a system whereby the hospital had billed for care for that physician, and toward a system where the physician separately bills, we have some evidence which suggests that the total cost of that service now—now that the physician has departed from his old practice of billing through the hospital, or rather accepting an arrangement with the hospital—has in fact, in some parts of the country, inflated costs for Blue Cross and Blue Shield subscribers. We have not measured it on the medicare side.

Senator GORE. It is no good now to recall it except for a little personal satisfaction, but Senator Douglas and I sponsored amendments in 1965 that would have forestalled this, or so we thought.

Now that we have the situation, do you think some amendment would be appropriate, or do you have a better suggestion to make?

Mr. ENSIGN. Well, sir, we have just covered in our testimony what I think would be a major step toward simplification and the reduction of expense for the program, namely, to fold in or allow the folding in of all hospital-based professionals into a billing arrangement which would allow the hospital to bill for the services of these physicians. This would not require a separate identification of professional components until the end of the year when this would be done through a simple adjustment of A and B trust funds.

Senator GORE. Well, I think your suggestion is a progressive step. At least, it has a good deal of merit, in my view. If you or other witnesses have additional suggestions on this point, I would welcome them because the medicare program, for which I take some small responsibility for bringing into being, is an enormously important one. It is a great step in social progress.

Nevertheless, we must husband our resources, guard the program, to prevent the kind of promoted inflation which you have been describing.

Thank you, Mr. Chairman.

Mr. ENSIGN. With respect to incentives for lowering costs while maintaining quality in the provision of health service, I covered some comments about our concern with the current system of reimbursement under title XVIII, known as the RCCAC, and we certainly salute the provision in the bill which allows flexibility needed to arrive at adequate reimbursement to providers where variable circumstances require such flexibility. We look to this provision as a means for exploring the validity and reliability of a variety of possible reimbursement methods. This was also mentioned by Senator Moss in his previous testimony. As fiscal intermediary for hospitals under medicare and medicaid, Blue Cross offers its experience to the Secretary under agreement to conduct such experiments on incentive reimbursement.

On additional days of hospital care, we note the expansion of benefits by providing an additional 30 days of care during a "spell of illness" in an effort to meet the problem faced by a beneficiary who requires long-term care in an extended-care facility. The problem is only slightly eased by the proposal. The difficulty arises because present law does not authorize any distinction between a beneficiary who is receiving skilled nursing care and other services in an extended care facility and one who resides in a nursing home, which may or may not be an "extended care facility" which provides skilled nursing services to some patients. Once the resident who is domiciled in such a nursing home has used up his presently authorized 90 days of inpatient hospital care and his presently authorized 100 days of extended-care facility benefits, he cannot start a new spell of illness and become entitled to further care unless he moves his residence for at least 60 days to one which does not provide skilled nursing care to anyone.

In addition, it should be noted that the provision of an additional 30 days of inpatient care with a co-pay requirement equal to 50 percent of the inpatient hospital deductible would be to add another complexity to the benefit structure, and require the beneficiary to understand the difference between days with no co-pay requirement—after the initial $40—days with a 25-percent co-pay requirement, and days with a 50-percent co-pay requirement. Because these days usually are not all received in sequence in a single hospital admission, understanding of where one starts counting in successive admissions can be difficult for the beneficiary.

The CHAIRMAN. If you would permit me to do so, I want to ask you a few questions based on your statement.

Mr. ENSIGN. Yes, sir.

The CHAIRMAN. We will study it, and I am going to go into it in much greater depth because you have some very constructive suggestions here, and I think some of them definitely ought to be a part of this bill.

Mr. ENSIGN. Thank you, sir.

The CHAIRMAN. So I am going to ask you a few questions that we are particularly concerned with that you might be able to help us on.

We will print this whole statement in the record at this point, and we will study it. As a matter of fact, I am going to take it along with me on the airplane and study it until I am thoroughly familiar with it. I won't read it once, but two or three times, because you have some very good information we need here.

I want to ask you about that.

(The prepared statement of Mr. McNerny, submitted by James M. Ensign, follows:)

STATEMENT BY WALTER J. MCNERNEY, PRESIDENT, BLUE CROSS ASSOCIATION

Mr. Chairman: My name is Walter J. McNerney. I am president of the Blue Cross Association, the national organization of Blue Cross service Plans, and I appear here today as a representative of those Plans. Collectively, the Blue Cross system is the largest voluntary health care financing agency in the world. We provide benefits to approximately 64 million subscribers in the United States, including more than 4 million Federal employees and dependents. In the Medicare program, in addition, Blue Cross acts as intermediary chosen by more than 92 per cent of the participating hospitals, 83 per cent of the home health agencies and 57 per cent of the participating extended care facilities. In 25 states Blue Cross serves in a variety of ways under welfare health programs, including 12 states in which Plans perform comprehensive administrative functions under Title XIX programs. Blue Cross administers benefits in 33 states under the Civilian Health and Medical Program of the Uniformed Services, and it has accepted certain administrative responsibilities under the VISTA program.

Eliminating the overlaps, we serve nearly half the total U.S. population in some capacity, including an estimated 18.6 million elderly beneficiaries under the Medicare program in areas where providers have selected Blue Cross as intermediary under Part A.

Our concern here today lies primarily with those individual beneficiaries and with the services they receive. The health insurance for the aged program enacted under Public Law 89-97 is a large and complex undertaking. Our comments will relate to benefit design, administration, reimbursement to providers and administrative cost. In many of these areas we have been working closely with the staff of the Department of Health, Education and Welfare, and expect to continue to do so, primarily through the Bureau of Health Insurance of the Social Security Administration. But there are some highly desirable results which these agencies cannot accomplish, except with legislative sanction or encouragement from the Congress, and I would like to address myself first to these.

A common theme running through newspaper reports on the first year of Medicare is one of confusion or uncertainty among beneficiaries. Many elderly persons do not understand the basic elements of the benefit package, Parts A and B, much less the details. They do not know what to expect that they may have to pay themselves, starting with the $50 Part B deductible, or to whom they may have to pay it; they are concerned about requests to pay, which they had not anticipated. They are apt not to understand about a "spell of illness" under Part A and how that fits in with a "calendar year" under Part B, to say nothing of the "carry over" provisions involving year-end benefits. Welfare patients reportedly are continuing to go to county clinics rather than try to cope with Medicare's complexity. The delays in processing claims, both by intermediaries and carriers, and recording them on SSA computer tapes, have often stretched out the time period during which elderly beneficiaries have had to worry about

the status of their health affairs, and their own obligation for eventual partial payment out of limited resources.

We do not believe that "education" of beneficiaries can be expected to cure this situation. Anyone spending a quiet morning in the lobby of a Blue Cross Plan, or a Blue Shield Plan serving under Part B, or a Social Security District Office, cannot help but be impressed with the serious effort of beneficiaries to find out what they need to know to understand their situation regarding costs of health care—and the frustratingly difficult task faced by sympathetic and trained beneficiary relations personnel in trying to get the needed detail across. Confusion is apt to be heightened by necessary explanation of private coverage bought to fill the uncovered valleys of Medicare benefits.

We should face the fact that people often don't understand details of their insurance coverage, particularly elderly persons, and particularly in regard to such personal and frequently recurring benefits as those derived from health insurance. When one deals with death or fire or other infrequent casualties, one's concern is normally to be satisfied in advance that adequate protection has been obtained within fairly common parameters. In health insurance, even the professionals may have difficulty. In Medicare, there is being created one of the most complex health insurance relationships ever designed, one which is becoming more instead of less detailed as time goes on and interpretations are added to regulations. Accountants, physicians, hospital administrators, health care plan executives, and other experts have difficulty in coming to clear conclusions on many details. It is too much to expect the elderly beneficiaries, no matter how much "information" is given them, to do so.

The only successful course, in our opinion, is to move deliberately towards simplification of the process. Every proposal for legislative change should be examined objectively to determine whether it eases or adds to the burden on comprehension by elderly beneficiaries and by providers of care who must deliver the benefits. All other problems aside, the clearest lesson of Medicare Year One, in our opinion, is this one. New changes should be aimed at eliminating confusing detail, and concentrating responsibility for quick and clear explanation as close as possible to the point at which care is rendered, i.e., the hospital, the physician's office, or the intermediary-carrier to which each is asked to report when benefits are provided. The greatest possible concentration of point-of-contact will facilitate this, and the logical point at which to aim is the intermediary-carrier which works directly with providers and those who render covered health services, and who also are part of the private industry which provides complementary benefits.

Some of the provisions of H.R. 12080 do, in our opinion, contribute to this simplification, while others do not. Some changes which we have recommended previously have not been incorporated into the bill before you, and we should like to reiterate our major emphasis on these.

The need for simplification extends also to administration by providers and physicians, and to firm controls of administrative cost by all involved. The present program is too complex to administer without excessive paperwork, time and cost. Some of the proposals in H.R. 12080 improve this situation. It is the failure of many factors to mesh well with each other or with the existing system for providing health care which creates the greatest problem. An insistence on merging statistical reporting with case administration has contributed heavily to the problems involving providers. Every encouragement should be given by the Congress to the establishment of administrative procedures by the Social Security Administration which will contribute to rapid, effective and inexpensive case handling related to benefit determination and provider reimbursement, with full fiscal controls, but with statistical and research needs fulfilled on a sample basis or by separately obtained summary data rather than on a case-by-case data delivery. Intrusion of research needs into claims processing has not facilitated either beneficiary handling or provider effectiveness, and has tended to increase administrative cost.

Similarly, adoption of rather inflexible and highly complex concepts of reimbursement right from the start of the program has tended to add to costs of administration and to burden the program with detail that might better have been developed slowly on the basis of experience rather than imposed as an untried system.

It is in the light of these concerns for beneficiary understanding, provider effectiveness and administrative cost reduction that I offer the following more detailed comments. Some of them could involve benefit cost increases, but con-

tribute toward simplification, and we urge your serious consideration of them nonetheless.

Simplification as it relates to H.R. 12080

H.R. 12080 provides desirable modifications of certain procedural aspects of the program. Under the heading of "Simplification of Reimbursement to Hospitals," the bill moves toward simplification of one segment of the program which can produce the greatest amount of confusion, i.e. services provided in the hospital setting which involve reimbursement from both the Part A and Part B funds. The bill does not, in our opinion, go far enough in this direction.

In addition, modifications are suggested with respect to (1) certain in-patient services provided by physicians, (2) consolidation of out-patient services under Part B and (3) simplicity in the collection, by the hospital, of out-patient charges below a stated maximum. Viewed separately, each proposal has merit. However, all three share a common complicity and administrative burden which arises from the annual $50 deductible under Part B.

The basic complication arises from the fact that Part B, of the present program, attempts to blend the indemnity major medical concept of first dollar deductible with the service benefit concept of providing reimbursement directly to the provider of care. The two concepts do not mesh well. The service benefit concept is directed essentially toward providing assurance of reimbursement to the provider of care at the time care is rendered. The usual major medical benefit which entails the imposition of a deductible comes into play only after the basic service benefit has been exhausted. Also, the deductible is in the form of a "corridor" between the two benefits, and is unrelated to a specific time period. The beneficiary is charged with the accumulation of his expenses until the deductible amount is met, and only then is a claim filed.

The intent of Medicare is to provide coverage in the service benefit context, and so hospitals are paid directly and physicians are urged to accept assignments. However, the imposition of a "first dollar" $50 annual deductible is incompatible with this intent. The provider of care does not know the extent of the patient's liabilities at the pont of rendering care, a central record of the deductible status must be maintained, and each provider must query the master record through an intermediary or carrier each time service is provided in order to make this determination. This adds administrative compexity and cost to the confusion and frustration of both the provider and the beneficiary.

Further complexities result because (1) the deductible can be fulfilled by charges submitted to a variety of intermediaries and carriers by a variety of providers, physicians or beneficiaries; (2) the provider does not have adequate knowledge of the status of the deductble when small and short-term benefits are involved, as in out-patient services; and (3) the requirement that expenses incurred in the fourth calendar quarter of a year and applicable to that year's deductible are also "carried over" and made applicable to the following year's deductible in an effort to achieve greater equity among beneficiaries.

With this basic complication in mind, let me now comment on some of the proposed modifications. For ease of reference, paragraph identifications which follow are those used in the General Discussion of the Bill contained in the Report of the Committee on Ways and Means on H.R. 12080, part 6, beginning on page 37 of the Report.

Radiological and Pathological Services Furnished to Hospital In-patients (Paragraph 6(d)(1) Page 39)

Over the years there have evolved various arrangements whereby physicians work under a contract with a hospital. These arrangements must be mutually acceptable to the hospital and physician involved. Often, the services of such physicians are considered a part of hospital costs and as such are invariably paid for by private organizations like Blue Cross. If the charge were rendered by a physician, the bill would be paid, for example, by Blue Shield. Thus, over the years, the cost of such services has been treated as a hospital cost or as a physician cost depending upon the source of the bill, and the whole billing and prepayment system is geared to that procedure.

H.R. 12080 goes part way toward capitalizing on this tested and acceptable prepayment system. It would permit combined billing for hospital services, and the services of a radiologist or pathologist. This partially simplifies the billing problem. Unfortunately, this method of billing is not extended to all hospital-based physicians such as cardiologists, neurologists, physiatrists, pulmonary

physiologists, anesthesiologists and others. While arrangements between these specialists and hospitals may not be as prevalent as is the case with radiologists and pathologists, where such arrangements do exist the hospitals' billing problems would not be helped by the provisions of H.R. 12080. Moreover, this proposal adds another type of billing for physicians' services, because no deductible applies to radiology and pathology. They must be identified separately in billing while at the same time the services of other hospital-based physicians remain subject to the $50 deductible. Add to this the existing separate rules for billing for interns and residents in approved as distinguished from non-approved training programs, and the result is four distinct methods of billing for professional care rendered in hospitals, some of which are subject to the deductible while others are not.

RECOMMENDATION

(1) In those cases where the hospital would normally bill for services, we urge your consideration of a uniform method of combination billing through Part A for *all* in-patient services, (hospital and professional) and a periodic adjustment between Part A and Part B trust funds for the professional component. This would greatly improve beneficiary understanding and satisfaction, and further simplify the administrative burden and cost. Those physicians who choose to bill independently would continue to do so.

Services to hospital outpatients (paragraph 6(d)(2) page 41)

One of the basic problems facing providers in the administration of the program has been the requirement to identify separately out-patient diagnostic and therapeutic services. Added to this was the third form of dollar deductible and benefit period ($20 for a 20-day diagnostic study period), plus the application of the $20 deductible toward the $50 deductible. H.R. 12080 would eliminate most of the problems related to out-patient care, but again, would not solve the entire problem.

There would still remain the necessity for completing a billing form for each episode, the decision to collect from the patient (and how much to collect), the query to the master file to ascertain deductible status, the communication to the provider as to patient and program liability, and the resulting adjusments for under or overpayments on the part of the beneficiary. If the patient and provider could know precisely the patient liability and program liability at the point of service, most, if not all, of the confusion could be eliminated for both the patient and provider, and administrative costs reduced.

A further administrative consideration is the requirement that the hospital describe the services provided to out-patients on the billing form for use in statistical analysis and research. At best, this description is imprecise, and in our opinion inadequate for the intended purpose. An alternate method of obtaining this type of data (e.g. post sampling) would further simplify the billing operation, and tend to speed up reimbursement.

RECOMMENDATION

(2) Substitute for the $50 deductible a co-payment requirement under which the patient will always pay a prescribed portion of each charge incurred. This would eliminate the confusion attendant on the deductible status, and thereby contribute to the understanding and satisfaction of the patient. It would also reduce the administrative cost at all points in the system (provider, intermediary and SSA).

(3) In line with our general administrative recommendations for separation of statistical and payment reporting, limit the provider claim procedure to a simple reporting of charges and collections, which would permit listing of cases rather than individual claims for relatively small amounts.

Simplified reimbursement of out-patient hospital services (paragraph 6(d)(3) page 42)

Yet another problem with out-patient cases has been the frustration related to the billing and collection process for small bills which resulted in no program liability—which could be ascertained, however, only after the multiple processing steps recited earlier.

H.R. 12080 alleviates this problem by permitting the hospital to collect its charges on certain cases directly from the patient, and eliminate the need for preparation of a billing form. The Secretary would issue regulations prescribing

the conditions for use of this procedure and in no event could the provider collect more than $50 from the patient. While this provision does eliminate some of the paper work problems of hospitals, it tends to increase the burden on the patient who must pay in full and seek reimbursement from the program. It would still require the handling of a request for payment by the intermediary, the query to the master file, etc. It could also add to the beneficiary's confusion in terms of what coverage he has. In short, it does not go to the heart of the problem, which is the $50 deductible.

RECOMMENDATION

(4) We urge adoption of our previously stated recommendation for a co-pay provision instead of a deductible. This would have the combined effect of greater beneficiary understanding and satisfaction, and reduction of administrative cost across the board.

This recommendation would or would not require more money, depending upon the size of the co-pay provision. However, even if the contributions from the government and the beneficiary have to be raised we think it would be worth doing so in order to make the program work better, and be more comprehensible to the elderly.

Incentive for lowering costs while maintaining quality in the provision of health service (paragraph 6(e) page 43)

The provision in the bill giving authority to the Secretary to experiment with alternative methods of reimbursing hospitals under Medicare, Medicaid and Child Health programs is of great interest to us. We have previously noted that the current system of reimbursement under Title XVIII known as the RCOAC concept is costly to administer, has required additional employees among Providers and among intermediaries to audit more extensive data, and it poses difficult questions for providers who have so-called all-inclusive rates.

We salute this provision in the bill as an indication of the flexibility needed to arrive at adequate reimbursement to providers where variable circumstances require such flexibility. We also look to this provision as a means for exploring the validity and reliability of a variety of possible reimbursement methods. As fiscal intermediary for hospitals under Medicare and Medicaid Blue Cross offers its experience to the Secretary under agreement to conduct such experiments on incentive reimbursement.

Additional days of hospital care (paragraph 6(f) page 44)

We note the expansion of benefits by providing an additional 30 days of care during a "spell of illness" in an effort to meet the problem faced by a beneficiary who requires long term care in an extended care facility. The problem is only slightly eased by the proposal. The difficulty arises because present law does not authorize any distinction between a beneficiary who is receiving skilled nursing care and other services in an extended care facility and one who *resides* in a nursing home (which may or may not be an "extended care facility") which provides skilled nursing services to some patients. Once the resident who is domiciled in such a nursing home has used up his presently-authorized 90 days of in-patient hospital care and his presently authorized 100 days of extended care facility benefits, he cannot start a new spell of illness and become entitled to further care unless he moves his residence for at least 60 days to one which does not provide skilled nursing care to anyone. This is required even though he is not currently receiving any skilled nursing care. Even should emergency in-patient hospital care be needed by such a nursing home resident, under existing law, he cannot obtain it as a Medicare benefit. This appears to be inequitable to the elderly person whose permanent domicile is such a nursing home.

The proposed addition of 30 days of in-patient eligibility would only lengthen a "spell of illness" somewhat but would leave this beneficiary in the same ultimate position after those additional days were used up. No future benefits would be available to him unless he moves.

We believe that this inequity should be cured by regulation.

It should be noted that the provision of an additional 30 days of in-patient care with a co-pay requirement equal to 50 per cent of the in-patient hospital deductible would be to add another complexity to the benefit structure, and require the beneficiary to understand the difference between days with no co-pay requirements (after the initial $40), days with a 25 per cent co-pay requirement, and days with a 50 per cent co-pay requirement. Because these days usually

are not all received in sequence in a single hospital admission, understanding of where one starts counting in successive admissions can be difficult for the beneficiary.

RECOMMENDATION

(5) We urge that there be established by regulation a method for counting days so that days of residence in a domiciliary facility during which no skilled nursing care services are received by the beneficiary do not serve to prolong a spell of illness. If statement of Congressional intent is needed to authorize such a regulation, we urge that it be given in the context of H.R. 12080.

Payments for certain portable X-ray services (paragraph 6(k) page 47)

The provision in the bill for including portable X-ray services in the home is a welcome additional benefit but could be better qualified to meet home health needs. As the provision is written, these portable X-ray services to beneficiaries in their homes does not require that they be in the context of a home health plan, nor that the X-ray service be hospital based, and would only be available for bedridden patients or those unable to provide transportation.

One of the fundamental purposes of the home health benefit in the present law is to provide a meaningful alternative to institutional services where these services can be provided within the home environment. Under present law X-ray services are not included as a home health benefit.

RECOMMENDATION

(6) We suggest that this provision require that home X-ray services be included as a home health benefit within the framework of an approved home health agency plan ordered by a physician and also that these services be made available under arrangement with a hospital either in the patient's home or by the patient going to the hospital out-patient department.

Blood deductibles (Paragraph 6(m) page 48)

We also note the provision in the bill concerning blood deductibles designed to provide an incentive for blood replacement. We concur in the need to develop incentives for blood replacement but note that the many administrative problems connected with the blood deductible under the present law will be further complicated by this provision.

RECOMMENDATION

(7) We again urge that blood be excluded as a benefit. This would be consistent with the nearly universal exclusion of blood as a benefit in private prepayment programs and would assure incentive for blood replacement. It would eliminate the very cumbersome administrative methods set up to handle the deductible and would be a legitimate cost saving to the program which could help offset any additional costs in connection with our recommendation on the hospital out-patient deductible.

Other provisions

We note finally that the bill has other provisions for simplification, extension of benefits and removal of inequities on the beneficiaries' behalf. In this context we cite the elimination of the requirement for physician certification of the medical necessity for hospital in-patient and out-patient services. (Paragraph 6(b) Page 37). This will serve to strengthen and make more meaningful the recertification and utilization review provision of the present law.

Also, we support the provision for payment for the purchase of durable medical equipment where this will serve as an economical alternative to present coverage (Paragraph 6(i) Page 46).

The provision for payment for hospital physical therapy services furnished to beneficiaries in their homes (Paragraph 6(j) Page 46) will make this valuable service available where home health agency services are not available or where hospital-based home health services have not as yet developed.

We also wish to recognize the provision in this bill to remove the inequity in the carry-over provision of the present law which bars payment for general hospital services to patients who are in long term psychiatric or tuberculosis hospitals prior to first eligibility. As we understand it, this provision of the bill will now make services in general hospitals available to long term psychiatric or tuberculosis hospital in-patients when such patients suffer an illness requiring medical or surgical care. We endorse this change.

CONCLUSION

In conclusion, Mr. Chairman, I would feel remiss if I did not take cognizance of the need within the health care system for continuing improvements in administrative efficiency, for increased evaluation by non-profit prepayment Plans, among others, of the cost of services for which they pay, and for greater emphasis on the need to participate actively in area-wide planning and other programs designed to enhance the provider system as well as the individual provider.

We in Blue Cross are gearing ourselves as a system to further these objectives within the private market as well as under our assignments from various levels of government. We are firm in our determination to take those steps which will improve both our own performance and that of the health care industry within which we function. Efforts to improve productivity within our health care system are essential for the welfare of the beneficiaries of private and governmental programs, from the standpoint of clarifying the scope of benefits which can be provided through the various public and private programs and extending it to the full range of services which the system is now capable of offering beneficiaries.

There is a limit to the amount of the gross national product that can be devoted to health care, although the total amount allocated to health is still rising steadily and the limit is not visible as yet. As we approach it, however, the desire of the population for services will be translated increasingly into getting more service out of whatever limited resources are available. We in Blue Cross are prepared to assist in achieving this objective. We anticipate full support from the providers who have selected us to represent them under Medicare, to whom we pay for benefits in the private market, and without whose wholehearted public service dedication these private and governmental programs would not have worked. Thank you, Mr. Chairman, for this opportunity to present some of the viewpoints of Blue Cross.

The CHAIRMAN. You testified before the Ways and Means Committee that there would be a rise in hospital costs of about 12 percent in calendar 1967, 10 percent in 1968, and 8 percent in 1969. I say, you testified—Mr. McNerney testified to that.

Now, based on your extensive experience in actual reimbursement of hospitals, do you still hold to those estimates?

Mr. ENSIGN. At this point in time, Mr. Chairman, when all of the facts are yet to come in on 1967 and 1968, we do not have evidence that would cause us to change our projections from those which were provided in the detailed analysis, following up on our testimony before the Ways and Means Committee.

The CHAIRMAN. How extensive a study are you undertaking to develop these cost projections?

Mr. ENSIGN. It is difficult for me to answer that question, Senator, because I did not participate fully in them. But judging the number of hours that were devoted to the analysis and, perhaps, even more importantly, devoted to the assumptions regarding what will happen during the years 1967 and 1968, I would say that it was a fairly thorough analysis.

The CHAIRMAN. Now, the American Hospital Association, in their testimony before that same committee, projected increases of 15 percent annually for the next 3 to 5 years.

How do you account for the large differential between your estimate and theirs?

Mr. ENSIGN. Senator, I believe the differential exists because of differences in assumptions made about certain components of the hospital cost picture, differences in assumptions made, for example, about the increase in salaries and wages within certain groups in the hospital setting.

The basic data from which these projections were developed are consistent. It is the assumptions made about what will happen in individual cost components within the hospital that differ.

The CHAIRMAN. Well, can you give me just one example to illustrate the point?

Mr. ENSIGN. If my recollection serves me—one of the differences—in addition to the cost rise for nursing personnel—was the question of what would follow within the hospital outside of the nursing personnell area once substantial increases were made in that area, such as other professionals, other ancilliary personnel, housekeeping personnel, laundry personnel, et cetera.

The CHAIRMAN. If we accept the AHA assumptions of cost increases at a rate of 15 percent a year, aren't we telling hospitals that increases of that magnitude are accepted—this was the American Hospital Association—that they were accepted and they are tolerable if they stay, if they are 15 percent a year; and would not this reduce whatever incentive hospitals might have to keep their costs below that figure?

Mr. ENSIGN. Well, I have a feeling, Senator Long, that even if you did accept the 15 percent per year as a reasonable projection, there are other factors which are at work within the hospital setting which would tend to limit increases: Such things as reviews of hospital management practices by hospitals; scarcity of personnel; and a whole host of things that are at work, partially because of medicare, to view the hospital setting, make comparisons among departmental costs and things of that kind which, I think, would have an effect that would, perhaps, tend to limit cost increases.

The CHAIRMAN. Well, there is a significant effort being made by the Office of Economic Opportunity and, perhaps, others to train more nurses and provide more help. That ought to help keep the costs down, should it not, if you have more competent people to help operate these hospitals and do the job.

Do you think that the Congress can reasonably accept your estimate as its basis for financing part of medicare, that is, the hospital part of it?

Mr. ENSIGN. It is my opinion, Senator Long, that our estimates remain reliable, and until such time as we have evidence to the contrary, I would say, yes.

The CHAIRMAN. A witness for the Kaiser Foundation indicated ways that they go about keeping the number of hospital days below the average under medicare, mainly being a matter of making their doctors cost conscious, and we have had some testimony about the extent to which it is possible to find ways that you should use to operate hospitals more efficiently.

Do you agree that there is a potential here for a substantial reduction of costs by improving the efficiency of treatment and service in the hospitals?

Mr. ENSIGN. Well, Senator Long, in all organizations and industries and activities, I would suspect that there is a potential for increases in efficiency, and the health care setting is certainly no exception.

The CHAIRMAN. Would you be so kind as to provide us with a detailed analysis of the differences between your assumptions and your

cost data and the assumptions and cost data of the American Hospital Association so that we can take a look at the two and see whether we think we might be able within the costs that you anticipate?

Mr. ENSIGN. For the Blue Cross Association, I would be happy to submit to you an analysis of our assumptions; yes, sir.

The CHAIRMAN. Well, I would appreciate it if you would take a look at theirs also, so as to help to point up the differences between the two, so we know what difference we are going to move.

As a matter of fact, there is a difference of several hundreds of millions of dollars there, and that has something to do with how much additional benefits we can provide within the funds available under the program.

Senator Gore.

Senator GORE. No questions.

The CHAIRMAN. Thank you very much, sir.

Mr. ENSIGN. Thank you, sir. I appreciated the opportunity.

(Pursuant to the above discussion the following information was received by the committee:)

BLUE CROSS ASSOCIATION,
Chicago, Ill., September 7, 1967.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance,
U.S. Senate,
New Senate Office Building,
Washington, D.C.

DEAR MR. CHAIRMAN: During my appearance before your committee on August 31, 1967, you requested that we submit an analysis of the differences between our assumptions and cost data relating to projected hospital costs for 1967 and 1968, and those of the American Hospital Association. Subsequent to this request, a member of our staff, Mr. Joseph Nagelschmidt, received a request from Mr. Constantine asking that we have this information in your committee's hands no later than Friday, September 8. In order for us to be responsive to this deadline, we have attached to this letter a copy of the issue of *Blue Cross Reports* dated May–June, 1967, titled "Hospital Cost Trends." This document contains a full exploration of short-term general hospital cost trends to 1970, and contains a detailed description of the assumptions used in projecting these cost trends.

(*The document referred to was made a part of the official files of the committee.*)

Also, we have attached a brief recap of those assumptions.

In addition, we have attached a summarization of the American Hospital Association cost estimates and assumptions contained in an AHA staff memo dated November 17, 1966, which will demonstrate the differences in assumptions made concerning hospital costs and their trends for a two-year period from October 1, 1965 to September 30, 1967.

We trust that this information will be of use to your committee in its deliberations. It should be noted, however, that the cost data in making these projections and the projections themselves relate not to "Medicare hospital costs" but to short-term general hospital costs for the total U.S. population.

We should also report to you that a similar analysis of hospital costs will be undertaken by our research staff during the month of November, so that our trend lines and cost projections may be appropriately adjusted with the most recent data available.

Again, sir, we appreciated the opportunity to present our comments and suggestions concerning H.R. 12080 to you and members of your committee. We believe that our suggestions would add considerably to the simplification of the Medicare program for beneficiaries, providers of care, intermediaries, carriers, federal agencies, and the public in general.

Sincerely yours,

JAMES M. ENSIGN, *Vice President.*

BASIS FOR ASSUMPTIONS USED BY BLUE CROSS ASSOCIATION IN PROJECTING HOSPITAL COST TRENDS

Population: Population projection used was that prepared by the Department of Commerce, Bureau of the Census, Series P-25, No. 320, March 10, 1966. The Series B projection results in the population estimate of 207,127,000 by 1970.

UTILIZATION

Admission Rate: The projected admission rate for 1070 of 147.7 annual admissions per 1,000 population was based on the 1954–1965 trend for short-term general hospitals. ("Guide Issue" Hospitals Magazine)

Length of Stay: The 1970 projected length of stay is assumed to be the same as that experienced by short-term general hospitals in 1965. ("Guide Issue" Hospitals Magazine)

Days per 1,000 Population: The projected 1070 days per 1,000 population of 1,128 is the product of the projected admission rate and length of stay.

HOSPITAL COST PER DAY

Blue Cross Reports, Vol. 5, No. 2, May–June, 1967 presented a series of these projections. Four of six were long-term projections primarily designed to predict hospital costs by 1970. They are based upon trends using the following base periods:

1. 1950–1965
2. 1950–1966
3. 1961–1965
4. 1961–1966

The other two projections addressed themselves to the recent changes in hospital costs. These two projections assumed the increases after 1967 would tend to follow the 1961–1965, 1950–1965 trends. The additional assumptions were that:

1. Nurses would get general increase to the magnitude of 20%.
2. That other nursing personnel would get increases of 13%.
3. And that all other personnel would get salary increases of 10%.

This increase would be in addition to the normal trend in hospital costs.

EXCERPTS FROM AN AMERICAN HOSPITAL ASSOCIATION STAFF MEMO DATED NOVEMBER 17, 1966

The following assumptions were used in a hospital cost projection made by the American Hospital Association:

1. Nurses salaries increased 30 per cent from October 1965 to September 1967.
2. Other salaries increased 25 per cent from October 1965 to September 1967.
3. Other expenses increased 11 per cent from October 1, 1966 to September 30, 1967.
4. Full time equivalent employees increased 5.1 per cent from October 1, 1966 to September 30, 1967.
5. Average daily census increased 3.4 per cent from October 1, 1966 to September 30, 1967.

Based upon these assumptions, the attached schedule will show that total expense per patient day increased 9.8 per cent for the period October 1, 1965 to September 30, 1966 and we anticipate it will increase 18.6 per cent by September 30, 1967. For the two year period from October 1, 1965 to September 30, 1967 the total expense per patient day would increase 30.2 per cent. The attached table will show detail figures.

FORECAST

	Yearend Sept. 30, 1965	Yearend Sept. 30, 1966	Yearend Sept. 30, 1967
Total full-time-equivalent employees	1,388,000	1,466,000	1,541,000
Total staff nurses	277,000	293,000	308,000
Total other personnel	1,109,000	1,173,000	1,233,000
Average salary—all personnel	$4,072	$4,382	$5,140
Average daily census	563,000	569,000	588,000
Other expense/P.D.	$17.12	$18.95	$21.03
Salary expense/P.D.	$27.44	$29.88	$36.90
Total expense/P.D.	$44.48	$48.83	$57.93
Percent		9.8	18.6
Do			30.2

The CHAIRMAN. The next witness is Mr. Mitchell Ginsberg, Chairman, Division on Social Policy and Action of the National Association of Social Workers, and Commissioner of Welfare of New York City.

Mr. Ginsberg, we hope that you can summarize your statement to us in 10 minutes. We can read it faster than you can read it aloud to us; then let us ask some questions based on the points that you want to highlight.

STATEMENT OF MITCHELL I. GINSBERG, CHAIRMAN, DIVISION ON SOCIAL POLICY AND ACTION, NATIONAL ASSOCIATION OF SOCIAL WORKERS, ACCOMPANIED BY DR. DANIEL THURSZ, CHAIRMAN, COMMISSION ON SOCIAL ACTION, NATIONAL ASSOCIATION OF SOCIAL WORKERS

Mr. GINSBERG. We will certainly try to do that, Mr. Chairman.

The CHAIRMAN. We will print the entire statement in the record.

Mr. GINSBERG. I am Mitchell Ginsberg, the chairman of the Division on Social Policy and Action of the National Association of Social Workers, and I am commissioner of the Department of Social Services of the city of New York.

With me is Dr. Daniel Thursz, who is chairman of our association's Commission on Social Action, and dean of the School of Social Work at the University of Maryland.

I think, as you know, our association is an organization with about 50,000 members who work in every State of the Union, and with every aspect of the social security law.

I am going to ask Dr. Thursz to talk briefly, with your permission, on the social security, social work education aspects of the bill; then I would like to comment briefly on the public and child welfare and medicaid problem.

Dr. THURSZ. Mr. Chairman, I will try to limit my comments to a brief discussion, of title 2 of the social security part of the bill, a comment about medicare, and then a comment about social work legislation, and I hope to get through in a couple of minutes.

Mr. Chairman, we believe in the National Association of Social Workers that title 2, the social security part of the bill, is the keystone of any program to eliminate the poverty of over 30 million Americans today.

We believe that welfare rolls must be reduced, and that eventually welfare must become a minimum, emergency-type of program or, as the Vice President has put it, a disaster relief program, and these are the goals to which we have addressed ourselves.

Now, today there are a million persons who are covered by social security with payments so inadequate that they must turn to welfare departments, plead total poverty, claim to be destitute, and then they will receive support through two arms of the Government.

One arm is that which has been developed under social security, which provides a safe, efficient, low-cost, dignified way of helping senior Americans live their years in retirement, and the other arm, the welfare system, provides help only as a person accepts a means test; it requires a pauper's oath. It requires investigations, and at enormous administrative costs when compared to social security.

We believe that it is patently; I was going to say absurd, for one government to use two bureaucracies to provide what eventually turned out to be inadequate support for a senior citizen.

Therefore, we feel that one of the steps that can be taken and that ought to be taken by this Congress is the enlargement, the broadening, of the social security part of the bill, to raise social security benefits, so that at least a million persons can be removed from welfare rolls, and several million persons can be removed from that poverty population of 30 million we have been talking about.

Now, the administration bill, Mr. Chairman, would have removed about 2 million people from the ranks of the poor to an increase in social security benefits.

The House bill reduces that number to much less than half, only about 800,000. We recommend that the bill be broadened to give an average of 50-percent increase in benefits, and that you raise the minimums to $100 for a single individual and to $150 per couple.

This is not luxury, but this would permit persons to at least survive without having to go on welfare rolls.

We recommend that the revenue for such an increase—well within the capacity of our Nation, be obtained from general revenues, and by increasing the wage base over the next several years to $15,000, permitting future retirees to obtain a higher level of benefits.

The use of general revenues for social security has been consistently recommended by experts since the creation of the social security system.

On the second item, the item of medicare, we support the administration's proposal to provide medicare to the disabled which was denied by the House.

The Congress has already recognized that the disabled, the victims of disaster, of occupational accidents, of genetic accidents, have dim prospects for entering the labor force, and need to be helped to secure a dignified life. This is why the Congress saw to it that they were granted social security benefits.

For the same reason, they ought to be granted additional protections of hospital and doctor coverage.

The association believes that the health coverage ought to be extended to all OSDI beneficiaries, including the primary beneficiary, his dependents and survivors, and the spouses of retired workers at any age.

And finally, Mr. Chairman, I wish to comment on that part of the bill that provides some aid to social worker education.

We endorse strongly this part of the bill, but urge that the annual ceiling of $5 million imposed by the House be eliminated except for the first year. We are spending more than $15 billion a year on a variety of public assistance, public child welfare and voluntary welfare agency programs, and we have never had sufficiently trained staff to handle these programs.

In addition today, trained personnel are being eagerly sought by new programs, private industry, et cetera.

Mr. Chairman, I submit that no program can be successful, no matter how well designed, unless it is manned by persons who have skills, who identify with the public good, who understand and can use themselves to help people, can cope with the demands of the jobs, and can provide efficient administration.

We know very well, based on all of our experience, that we need better equipped personnel, and this part of the bill is a small but significant step in the right direction.

Thank you, Mr. Chairman.

Mr. GINSBERG. Mr. Chairman, I would like to comment on public welfare, child welfare, and medicaid.

Our association shares the concern that you and the House and all others, I think, now have about the public welfare program and the way it is working.

The evidence is quite clear there are very serious limitations. Money standards are low and uneven. Too much dependency has been encouraged by constant investigation; too often the great portion of the worker's time is spent on forms, on investigations, and he is prevented thereby from giving the kind of assistance that he is supposedly on the job for.

We all know the goals of providing a minimum standard of living and opportunity for self-support have not even been reasonably achieved. The evidence is overwhelming, and yet what does that bill do? Many features of the House bill simply continue these methods, and even go further in the same direction.

There are some positive features in the bill, the day care, the homemaker service, and so forth. But we believe that they will not work because the overwhelming intent of the bill is in the opposite direction, and the experience is very clear that this kind of coercion and compulsion simply defeats even good provisions.

What will be the result of this? Even if the freeze were to work, and we believe it will not, do you intend to penalize the children who are going to be cut off welfare? The children, of course, have no responsibility for the fact that they are in that situation, and it would require far more foster homes than are currently available—many times as expensive as the care of the child in his own home—and you would be shifting economic burden from the Federal Government to the States and localities, which would have to find some way of providing assistance, because nobody would be in favor of allowing these people to starve.

The quota that has been set up is harsh and punitive. If the positive provisions of this bill would work, there is no need for a quota. If it does not work, what are we doing but penalizing the children and shifting the burden from the unit of government most able to bear the costs, to the unit least able.

With respect to the AFDC problem—unemployed fathers—this legislation was designed some years ago to remedy a major defect in the whole public welfare system, which would be the objective of strengthening family life, which actually forced fathers to desert their families so that the mothers and their kids could get some assistance.

The enactment of this provision was a step forward, although fortunately it was not made mandatory. The approach of H.R. 12080 to the families of unemployed fathers penalizes a substantial group. We estimate in New York City alone that up to half the group that is now receiving assistance under this category would be forced out of the category, and they would face, again the fathers would face, the alternative of staying home and preventing their family from getting assistance, or deserting their family so they could get some support.

With respect to community support and training programs, we believe emphasis on work and training is a very sound one, but much more can be done than has been done up to now.

The experience over the years is overwhelming that you cannot do this in an atmosphere of compulsion. You cannot say to a mother, "You will have to go to work," and then expect that these kinds of programs will work. It just has not worked in the past and there is not the faintest indication that it will work in the future.

The notion that guidelines to be developed by HEW will prevent abuse simply does not add up. What it does do is provide discretion to each individual worker in each community and in each agency, and will undoubtedly, in our judgment, lead to a whole variety of abuses.

Senator Gore mentioned the fact that people opposed to compulsion very generally opposed the notion of full employment. That is not true in our case at all. While we are strongly opposed to the compulsion feature, we support wholeheartedly the notion of full employment, and would, indeed, go beyond that and would support the notion of guaranteed employment, where the Government is the employer of last resort, and that there should even be a subsidy of industry for those people who are not productive at this stage of the game.

We do favor, as originally suggested by the administration, the assignment to the Department of Labor of the responsibility for running these programs. HEW should be in a support position and should be in position to help, and its experience should be drawn upon, but we should have one department to work on it, and we believe that the Department of Labor is the logical one.

We support the notion of employment incentive that is in this bill. We think it is a step forward toward the notion of getting away from what actually at the present time is a 100-percent tax on the welfare recipient who finds employment.

But we must say that the bill's proposal of a $30-a-month incentive, plus one-third of income above that simply is inadequate, and we very much fear going in that direction will not produce any productive results. This is a concept which well deserves to be tested and tried out and will in our judgment work if given a fair chance at an adequate level.

We support strongly the OEO's position of $85 per month plus one-half on income above that. Tomorrow will be beginning in New York City an experiment which exempts the first $85 per month, and then 30 percent of the rest of the family income.

We support the notion of Federal support for child welfare. We think it is important to assist all children. The bill's provisions for day care, homemaker services, and foster care are real steps forward together with substantially increased Federal support. This is long overdue.

We would urge that the bill not go in the direction of requiring that services and income maintenance be kept together. The notion of separating these two out is long overdue, and the fact is that HEW has just in the last week or so reorganized its facilities and its structure in order to make that possible.

Yet this bill moves in just the opposite direction of the new administration of that organization.

With respect to medicaid, the ceilings that are suggested here will penalize the States that provide the most and the most comprehensive

programs. In the case of the State of New York, for a family of four, it reduces the eligibility level from $6,000 to $3,900, well below what the State's program was even before medicaid came into effect. We have built up certain expectations in people and now we are saying "You are not eligible for this program." They have had the program for a year, and now we are saying to them, "After having a year of this care we are going to take it away from you."

Let me just close by saying that overwhelmingly, aside from the questions of morals and humanitarian factors, and so forth, we think that you have to take into consideration that, in our judgment, this program will simply not work.

For 30 years we have gone down this route of feeling that by adding compulsion and adding investigations, and so forth, we would somehow solve the problem. It has not worked in the past and it is not likely to work any better in the future.

We would urge support and adoption of the positive features in this kind of bill, such as the child welfare, the day care, the homemaker.

We would urge the improvement of the incentive program. We would urge that you consider restoration of some proposals that were suggested by the administration but not included, such as the requirement that States meet at least their own definition of needs. We would strongly urge the elimination of some of those that we feel are coercive, harsh, and self-defeating, such as the freeze and the compulsory features.

For too long, it seems to me, Mr. Chairman, and to our association, we have thought of programs designed to meet conditions of 30 years ago. These conditions have changed very drastically. We ought to be looking forward to programs like guaranteed employment, like some form of children's allowance, like a drastic revision and reduction of the public assistance program and a significant expansion of public social services.

We ought to be thinking in those terms rather than, by and large restrictive approaches. Public welfare has not done its job over 30 years for reasons not inherent in the people who have staffed it, but it goes beyond that.

Any other business—and public welfare is a big business—which has had a record of 30 years of lack of success would certainly consider what could be done to change it, rather than to go on doing more of the same, and that is the direction we would urge that the Senate move. Thank you.

The CHAIRMAN. Let me just submit the problem to you because I think I understand what the House is trying to do with the bill. I am not sure that I will vote to keep it the way they sent it to us, but at the same time, I think I understand what the objecive of he House is in this area.

You are aware of the success of the unemployment insurance program in getting people back to work who, let us say, have been displaced from a job because they are no longer needed, that skill is no longer needed, but when some job opens up and becomes available to them, they either take the job or they lose the unemployment insurance benefits.

Now, do you find some sympathy for the House position that that same general philosophy ought to apply in areas where fathers and mothers find it necessary to pay taxes to support someone else's chil-

dren where those people could work but simply prefer to live on welfare payments?

Do you find some sympathy with the House feeling that well, they doubt that the effort is really being made to encourage people to gain productive employment. They think we ought to provide more help to help look after those children in day-care centers while those people are working, and simply in an effort—that is what they mean by that "freeze"—to press the administrators and the State governments to really make the present law effective.

You are aware of the fact that the law presently requires that these people on welfare accept employment in appropriate cases where there is work that they can do, that they accept employment?

Mr. GINSBERG. Mr. Chairman, let me say on several aspects of it, we support wholeheartedly the provisions on day care, and so forth. We think they are essential and no program will work without them.

We are also very much aware that the present law requires, under certain safeguards, fathers to accept employment where it is available and appropriate. The law does not require that mothers should accept such employment. In fact, the whole notion of the ADC program was that in a sense the mothers were encouraged under that program to stay home and take care of their children.

I happen to think, Mr. Chairman, that was overdone. I think there are many mothers who want to, and can, find employment if they are given training, and so forth, but there is a difference between giving them an opportunity and training for employment, and forcing the mother to work.

The CHAIRMAN. Let me say, the law says, "Parent." It makes no distinction between mothers and fathers. Where is that language? It says—the title is "Dependent Children of Unemployed Parent." And it requires that there be provision in the State plans for denying aid to families with dependent children to any such child or relative if and for as long as the unemployed parents—it does not say "father," the word "parents" obviously means to include the mother—"refuses without good cause to undergo any such retraining."

Now, there is an affirmative provision that these people should not—and that is the existing law—should not be receiving this assistance if they can do something.

Here is the administration's proposal, sent down by the administration, and you were in support of this when it came down. It says that "such aid will not be denied by reason of such referral or by reason of the refusal of such individual to perform any such work if he has good cause for such refusal." That is just saying the same thing the other way around, by saying that if they do not have a good ground to refuse such work that they would be denied these benefits.

Now, doesn't that amount to an affirmative provision in both the existing law and the administration bill, which was supported by the departments, to the effect that if there is work available to these mothers that they should either take the training, take the work, or they should not be given the welfare payments?

Mr. GINSBERG. No; I think not, Mr. Chairman. I think along with the wording of those specific provisions, one has to look at what was the intent of Congress when they passed the other bill and when they considered this one. I think if you examine that, the intent under

the ADC program, to the extent, as I say, beyond what I would have gone, was to make it possible for mothers to stay home. As I said we have gone too far in that direction.

If you study the discussion that went on in the committee on this particular bill you will find that the intent could not be more crystal clear, which is to require, to force mothers, fathers, and I think children, as I recall, of 16, to go to work. Those are two quite different approaches to this particular kind of problem, and again I think you have to look at not only what it says, but what is going to happen, what is going to be the effect of this bill.

I would simply suggest to you that this kind of approach, which we think is completely inappropriate on humanitarian and humane grounds, is also not going to work.

The CHAIRMAN. May I say to you, sir, that I am well aware of a number of cases—and I won't embarass the people by calling their names, although they are very fine people—of mothers who experienced the loss of the breadwinner of the family. Some of them were working prior to that time, and some of them had never worked before in their lives in any type of employment outside their own home. Those mothers went to work and earned substantial income and provided opportunities for those children.

I know of cases where some of those children have become outstanding lawyers, outstanding newspaper reporters, writers, professional people in other categories, and I would just submit that it does not seem quite fair that those type mothers would have to pay taxes for those who just prefer to lay at home and cash welfare checks and fill up the whole house with more children rather than go to work.

Now, how can you justify taxing the mothers who actually go out and provide an inspiration and an incentive, and a much higher standard of living for their children, to pay for those who have jobs available to them to go to work but prefer just to stay there at home and produce more children?

Mr. GINSBERG. Mr. Chairman, I do not justify that for a moment and, of course, there are thousands of mothers who do as you say, and there are thousands and thousands of mothers who would be glad to do this if they had the opportunity, if there were the employment and training, and if there were also places to take care of their children.

Our experience in our city demonstrates that again and again, and we want them to have every opportunity. But I would say again there is a difference between those ladies you are talking about, and I doubt very much they took that because somebody stood over them and said, "You have to take it."

They took it because they realized it is a better way of life for them and their children.

I might suggest, if my colleague and I are incorrect here, that the wording you are reading, given to you by a member of the staff, did not come from the ADC legislation, but from AFDC–UP, which is quite different, because if you look at the wording of ADC, the ADC program, it talks a good deal about strengthening family life and making it possible for the mother to stay in the home.

The CHAIRMAN. The law refers to unemployed parents.

Mr. GINSBERG. But that is a different provision in the law.

The CHAIRMAN. The House bill makes reference to unemployed fathers.

Mr. GINSBERG. I think you will find if you look at——

The CHAIRMAN. But the unemployed father provisions you are talking about in the law, it says, "unemployed parents." It makes no distinction.

Mr. GINSBERG. Yes. But——

The CHAIRMAN. May I say also I know of some of the frustrating experiences which you refer to—I made reference to it previously during these hearings—of trying to gain some support from a father who really, from the morality point of view, just is not worth the powder it takes to blow him up. He has children, he owes support for those children, he leaves town, even leaves the State, rather than contributing to the support of those children.

But I am going to tell you that, as a lawyer who has tried to pursue some of those people across State boundaries with legal process, and knowing the frustrations of a young lawyer, perhaps at the Federal level, we can find some ways to gain support for that mother of his children.

Wouldn't it seem to you that if that man is making $4 or $5 an hour somewhere, we ought to find some way to reach him, even if it takes the long arm of the Federal law to reach him, rather than tax someone who is supporting his own children to support this child if that fellow takes off for the tall timber?

Mr. GINSBERG. Absolutely. If you did not find him, we would not want to penalize the mother and the children if you did not find him. And that is what this proposed law or bill does.

The CHAIRMAN. It seems to me it is fair to ask the mother to cooperate in seeking support for those children from a father who owes it.

My understanding is that this House bill does not provide that the aid be cut off from the children, but only to the extent that mothers or others decline to take advantage of the opportunities available to them.

Dr. THURSZ. Senator Long, I think the basic position of our association is that some value must be given, at least the possibility of value of having a mother devote herself to the task of bringing up her children at home; that there are mothers who need to go to work and will go to work if they are provided the opportunity for training and the opportunity for employment.

But the act initially was designed, if I may quote from section 401:

> For the purpose of encouraging the care of dependent children in their own homes and in the homes of relatives by enabling each State to furnish financial assistance * * *

And so on and so forth.

We think the purpose of the aid to dependent children in 1935 is still valid today; namely, to afford to mothers a choice, a choice based on all the counseling and all the help she can get, but a choice between deciding to devote herself to the upbringing of her children at home or a choice—provided adequate day care is available, as this bill proposes, and go to work.

Our objection is to a situation where the choice disappears, and when they can only be coerced, "You must go to work," because it seems to me that those who created the Social Security Act were fully aware of the value of a mother's devotion to bringing up her own children and try-

ing to break the cycle of poverty by the sort of home that makes it possible for children to grow up as responsible citizens.

We are not ready to give this up yet.

The CHAIRMAN. If you will just permit me to say it, I happened to write the welfare program of Louisiana, and in some respects ours have been more liberal than yours, at least in some areas. Maybe the payments were not as high, but the qualifications were easier to get it.

It seems to me that we have gone far in providing money to assist people who could show some need of it, and we have been liberal with it.

However, we have also desired that people should work and help themselves where they can. The idea here is to help people who, through no fault of their own, require assistance.

Now, I am trying to say that I gain the impression that we have called upon our welfare administrators to dispense aid and provide assistance to these people and we really have not placed any great emphasis on trying to see to it that every effort was made to make these people independent of a requirement of State support.

Now, I say that as one who helped put our program into effect. When we started out with our aged program in Louisiana, we were trying to get everybody on there, just trying to find ways to bypass these Federal requirements if we could, and that is one reason why we have a higher percentage of aged people drawing assistance now than any other State.

We actually started out with the hope, in fact, back in the time when we did not have as many aged people as we have now, we tried to get them all on, and we went to a needs requirements because the Federal law forced us to. We tried it the other way around but being such a tremendous cost we could not do it with State funds.

In all these cities you have got page after page of help-wanted ads for people who have jobs available; all sorts of people tell me, young people say, that they really cannot afford to hire anyone to do domestic work in their homes for them. The cost is too great, and they cannot find the people if they tried to get occasional work in their homes. That is just one example.

There are lots of jobs available, and it just seems to me that what the House is trying to say is that they mean business, and that we ought to see to it now that we insist on providing care for the children while parents work, and if the parents can work they ought to work.

You have a lot of them who cannot work, and we have, too. But I view this as a case of the House saying that every effort should be made to put these people to work where they can work, and to care for those children. I would not be surprised to find that in many instances those children would be better cared for and learn more in some of these day care centers than they would in some homes.

Now, with regard to these absentee fathers, it occurs to this Senator that there is another area where, perhaps, we ought to do more.

For a great many years, a great number of years, the Department of Health, Education, and Welfare would know where that father was and would not provide that information so that legal process could be filed against that man to provide for his children. Now they are willing to cooperate. Maybe we could go a step beyond that and do something even more effective to require the fathers to do something to help support their children.

Mr. GINSBERG. May I say, Mr. Chairman, the issue is not whether parents, mothers particularly, because that is the great bulk—we have some 700,000 people on welfare in New York City, and 21,000 of them are adult males, half of them functionally illiterate, so you are talking here in the big cities, particularly of the mothers. The issue is not to encourage them to work, the issue is whether the children would be better off.

I think overwhelmingly they would probably be better off. But the issue is, how are you going to achieve this objective by forcing the mother, saying, "Go to work or we will take the money away."

But I say, Mr. Chairman, it is not going to work, and a year from now, or 2 years from now, or whenever this committee will be considering the legislation, you will be back here with a bigger problem than you had before, because it is true there are some jobs available, but they are generally the less attractive jobs in the community.

When you say to a person, "You have to go out and take that job regardless of what it is, and when you take that job we are going to submit you to 100 percent tax on your earnings," because that is what the law requires, 100 percent tax, and when they do not do it, then we say there is something the matter with them; I would suggest to you that the thing that is the matter is primarily the regulations, the laws, and the way they have been carried out, rather than the people who are affected by it.

The CHAIRMAN. Well, the House bill has an earnings exemption in it, and maybe we ought to go beyond what they provide.

Dr. THURSZ. We support that part of the bill.

Mr. GINSBERG. Yes. We think the idea is a good one, but we ought to go beyond it.

The CHAIRMAN. I offered amendments myself, and Senator Douglas has offered amendments, to permit people who are drawing public assistance to earn a certain amount of money and keep that, and the House now, having found it difficult to get them to enact any of it, are now sending us a bill which goes beyond what the law presently provides.

Someone told me that that House bill in that respect is based on New York law, by the way.

Mr. GINSBERG. Well, Mr. Chairman, all I can say is we do have a program going into effect tomorrow, literally September 1, in New York City, which for this same group provides an exemption of the first $85 a month, and then 30 percent of the rest up to a family income of $4,890. It may not be the best figure, but we worked it up, and we think it is much better than the one provided in the House.

The CHAIRMAN. May I say, when I sat on the Committee on Foreign Relations over a great number of years, I kept insisting that we should not be giving anybody anything. If those people were capable of doing it for themselves, we should not be making a grant if a loan would do the job. And there is no point in even making a loan if by guaranteeing someone else's loan you could get the job done. You should not be doing any of it if free enterprise would do it for you, if you would simply protect their investment when they did, and I must say I was very frustrated over a great number of years in trying to advocate those principles.

But I am happy to say that they seem to have caught on now, and the majority of the committee comes out now with bills proposing about that sort of approach.

I think we have a much better program because we have adopted those concepts, and I would hope that within this area that we could be thinking in certain simple terms, one of them being that everybody ought to be encouraged to develop his full potential, and that we ought to try to get them to do something, rather than doing nothing when we are paying them public money. We ought to try to put them in the most constructive job we can put them in.

I was in the Navy operating a little amphibious craft. I am not sure we were real Navy at all, some called us the Hooligan Navy or some such thing as that. It was generally regarded that if a fellow on those small ships—they would not expect a man working on that ship or fighting on that ship to do anything that that officer would not do, and in many cases the officer would go and do some of the most unpleasant tasks, sometimes to the extent of even being embarrassed about the thing. For instance, putting on dungarees, and getting out there and painting, and have some other officer come up and start ordering him around.

But the concept that I believe the House is working toward is something I think would be very constructive.

There are a great number of people drawing public assistance who could be doing something more, and we ought to be affirmatively moving those people to doing the best things that we can put them to, even if that is nothing more than helping to get rid of the rats, or to get the garbage out of the place. It is still better than leaving the rats around and having the place smelling.

It would be better, as I see it, to have some in-between status where we are, in effect, subsidizing someone to take a marginal job than it would be to simply have that person just 100 percent on public assistance.

Mr. GINSBERG. Absolutely. That is why, Mr. Chairman, if I may say again, we have urged this guaranteed employment which we think will do the thing that you are saying, and if necessary, subsidizing private industry until the person becomes fully productive.

We just think that is a sounder way of achieving the very thing you are talking about.

The CHAIRMAN. Thank you very much. I will study this statement in detail.

Mr. GINSBERG. Thank you.

(The prepared statements of Dr. Thursz and Mr. Ginsberg follow:)

PREPARED STATEMENT OF DR. DANIEL THURSZ

As Mr. Ginsberg indicated, our Association considers Title II—OASDI of the Social Security Act—a keystone in any program to provide a floor of income for Americans and to eliminate the poverty of over 30 million Americans. We welcome, therefore, the opportunity to present to the Senate Finance Committee what we believe are the basic elements of such a program. While the House-passed bill—H.R. 12080—does provide the largest single cash benefit increase in the history of the legislation, it is our conviction that this increase is decidedly insufficient. The House bill, for example, will remove only about 800,000 from poverty in contrast to the Administration's more generous proposal which would affect about 2,000,000 people.

Our association's position on income assurance

In April of this year, our Delegate Assembly, the top governing body of our Association, representing our membership from all over the United States adopted a policy statement on income maintenance which urged the implementation of programs "that would insure income as a matter of right in amounts sufficient to maintain all persons throughout the nation at a uniformly adequate level of living." But, we went further than this, and with aid of extensive consultation with experts in and out of the government in a thorough discussion of these matters, outlined the following broad objectives which include:

First, we hold firmly that work will continue to constitute the major source of income for most American families in the forseeable future. We believe it essential that a job be available for everybody willing and able to work. In this pattern we see the government as a provider of employment for those individuals for whom there are no opportunities in the private areas. These jobs, whether available through private effort or government, should pay adequate wages. Our first position, therefore, is for an adequate assured income through assured employment.

Second, for the retired, the disabled, and for children of the deceased breadwinner, we want adequate social insurance benefits and provisions for health care.

Third, for those persons not in the labor force or those whose work experience is so insubstantial as not to enable them to qualify for adequate social insurance benefits, we believe consideration needs to be given to programs that provide income as a matter of right through devices such as a federally administered system of family allowances or negative income tax.

In this connection, we note with interest that the President in his 1967 Economic Report recommended the appointment of a Presidential Commission to study "the many proposals that have been put forward (for guaranteeing income), reviewing their merits and disadvantages and reporting in two years, to me and to the American people".

Fourth, regardless of how well the above income providing systems may work, a public assistance program—much diminished undoubtedly from today's program—based on Federally enforceable minimum standards and with need the sole criterion for eligibility, will be needed as the ultimate guarantor against deprivation.

Higher minimums and an average 50% benefit increase are required for social security to fulfill its role

If we are to remove people from poverty, eliminate the necessity for over a million OASDI beneficiaries to receive supplementary Old Age Assistance and shrink our welfare rolls to a minimum emergency type of program, to what the Vice President Hubert Humphrey called "disaster relief", the House bill—H.R. 12080—and the Administration's original proposal—H.R. 5710—make only a modest beginning.

Under the House bill and the Administration's proposal a large number of beneficiaries, dependent primarily upon their Social Security benefits, will still be receiving benefits which place them below the poverty line as established by the Social Security Administration and other analysts—$1,540 per year for an individual living alone, $1,850 for an aged couple, $3,130 for a family of four. We understand that these statistical measures of poverty are based on what is absolutely needed for minimum nutrition for a temporary period only. Although the maximum amounts to which some people might be eligible in the future will be above the present poverty floor, the average payment will be below the poverty floor in most cases. We are not suggesting at this time what should be an adequate level but we are certain that it must be well above the poverty level and take into account rises in the cost of living, rising wages and our productive level as well as recognize that we started in the early stages of Social Security with a very inadequate benefit base. Although subsequent increases have kept up generally with the increased cost of living, we have not made up the distance necessary to overcome the inadequate start.

If Social Security is to be the central core of our income maintenance program, and its beneficiaries are to share in the Nation's growing prosperity, we need to consider a very substantial increase in Social Security benefits. As a possible, and we believe practical, goal, although we recognize that this still will not provide an adequate level of living, we suggest a minimum of $100 a month for a single individual living alone, a minimum of $150 a month for a

couple and an average increase of 50% for all those above the minimum. We believe we can afford this goal and note that practically every other industrial country including our neighbor to the North—Canada—devotes a larger share of its national income to social security purposes than we do.

To achieve this goal, and we are convinced it is urgent that we do so, a contribution from the general revenues will be required, particularly for persons already retired and who should be receiving benefits, or if they are already receiving benefits, should be receiving increased benefits. As you are aware, I am sure, the Committee on Economic Security which developed the Social Security Act 33 years ago in 1934 made such a recommendation and most of the Social Security Advisory Councils since that time have likewise recommended the use of general revenues. More recently, two governmental advisory bodies have made similiar recommendations. The Advisory Council on Public Welfare established by the Ways and Means Committee in the 1962 Public Welfare Amendments and on which several members of the National Association of Social Workers served, after noting that "unless social insurance benefits are substantially increased, a much larger proportion of social insurance beneficiaries will require public assistance to meet their needs" then stated that "consideration must be given to a substantial contribution from the general revenues".

The National Commission on Technology, Automation and Economic Progress, composed of representatives of business, labor and the public generally, in its February 1966 Report to the President and the Congress after noting "that a better integrated and comprehensive system of social insurance and income maintenance is both necessary and feasible at this stage in our history," recommended that "Congress undertake a detailed review of the entire system including both its coverage and financing. There is danger, in our view, that reliance on a narrow payroll tax base makes the system more and more regressive as incomes rise and other taxes are reduced."

Increases can be financed through general revenues and an updated wage base

As we indicated, we believe the average 50% increase we propose can be financed out of general revenues for those already retired—at a present cost of about $3 billion a year—and increasing the wage base over the next several years to $15,000 permitting future retirees to attain a higher level of benefits by having an increasing portion of their wages subject to the Social Security tax. This would enable persons in the higher income brackets to provide more adequately for their retirement and at the same time assist in strengthening the financing aspects of the system.

We see this tri-partite system of social security moving toward a pattern of financing that would provide one-third of the income from payroll taxes on the individual, one-third on the employer and one-third from the general revenues.

While not citing specific figures, the 1965 Report of the Advisory Council on Social Security noted as the aim of an increase in the taxable limit the following:

> "The maximum amount of annual earnings taxable and creditable toward benefits needs to be substantially increased to maintain the wage-related character of the benefits, to restore a broader financial base of the program and to apportion the cost of the system among low-paid and high-paid workers in the most desirable way."

Provision of medicare for the disabled

We support the Administration proposal for providing Medicare to the Disabled which was denied by the House. We see no good reason why these individuals, whose prospects of entering the labor force on the average is little better than the aged and who are generally in a low income category, should not be granted the additional protections of hospital and doctor coverage.

As a matter of fact, our Association position favors the extension of health coverage to all OASDI beneficiaries including the prime beneficiary, his dependents and survivors, and spouses of retired workers at any age.

If in fact the disabled worker requires participation in the public program to meet his medical needs, it should be self-evident that the same situation would prevail for his dependents and survivors. Furthermore, an inequity exists with regard to retired worker beneficiaries for many of them have spouses below the age of 65 and the purposes of the Medicare program are particularly thwarted by the need for the elderly person still to provide for his wife's medical care at the escalating open market rates, since if she is below 65, she is not now covered by the program.

We share the President's deep concern at the lack of medical care services for needy children as expressed in his message on the welfare of children and urge as part of the approach to this problem the inclusion of mothers and children now receiving survivor benefits into Medicare.

Finally, we have some further recommendations with respect to Medicare which we are including in an appendix to this statement.

SOCIAL WORK EDUCATION

We welcome the inclusion in H.R. 12080 of a general aid to the social work education program, but urge strongly that the annual ceiling of $5 million imposed by the House be eliminated, except for the first year.

We support the provision in the bill for funds for undergraduate as well as graduate education in social work and accept the House's provisions that half the funds go to undergraduate education with the proviso indicated that, accordingly, the ceiling of $5 million be removed.

We are concerned, and it is not too strong language to say alarmed, at the increasing shortage of trained personnel to man the various public and voluntary welfare programs in this country. I doubt if there is another field of community endeavor that has as large a shortage of adequate personnel.

We are spending (exclusive of all types of social insurance programs) more than $15 billion a year in a variety of public assistance, public child welfare, and voluntary welfare agency programs. In addition, trained social welfare personnel are now being eagerly sought by private industry; the expansion of Medicare and Medicaid as well as the development of community mental health centers and other expansions in the mental health field, the development of a variety of local and state anti-poverty programs stimulated by the Office of Economic Opportunity's efforts to make an impact on poverty in America; the increased use of welfare personnel in public housing and urban renewal programs—these are merely indicative of the new demands for better equipped personnel.

This social work education proposal is essentially similar to the legislation introduced last year by Senator Abraham Ribicoff of this Committee. Members will recall the strong support registered for that proposal, not only by social workers and schools of social work, but by a wide range of voluntary agencies and their citizen boards. This proposal may not solve the problem immediately, but it will be a step in the right direction. In many states, which have no facilities for training for such personnel, this proposal will permit the initiation of planning for training facilities, while in other states existing programs will be strengthened.

Mr. Ginsberg will now present our point of view with respect to various proposals affecting public welfare, child welfare and Medicaid.

PUBLIC WELFARE

PREPARED STATEMENT OF MR. MITCHELL GINSBERG

The concern for the nation's public assistance program that is expressed in H.R. 12080, is a concern we all share. The Congress, the taxpayers, the social work profession and the poor themselves have witnessed the weaknesses of the program over the past 30 years.

The public assistance program was designed to provide basic financial support for the destitute, as well as services to encourage self-support where possible. On both counts, it has clearly not succeeded. Support payments in most states are too low to sustain even a minimal, decent standard of living; the method by which these payments are delivered encourages feelings of worthlessness that lock recipients into dependency; and the complex administrative structure prevents an investment in the time and skill required to offer constructive help.

As a result, there has been a growing consensus that what is required is not more of the same, but new approaches. It has been demonstrated amply over the years we think, that more investigations of eligibility are not the answer, that forced work is not the answer, that removing children from their homes is not the answer, that denying Federal assistance to intact families is not the answer, that arbitrary caseload ceilings are not the answer, that increasing the stigma of welfare is not the answer, that welding services and income maintenance is not the answer.

The nation has 30 years of experience with these devices and the results are plain: they have not succeeded in controlling the caseload and they have not helped people. It is equally evident that some of the provisions in H.R. 12080—adhering as they do to the familiar route of control and threat—will fail. Aside from the morality of penalizing children with the proposed ceiling on the AFDC

caseload, removing children from parents who decline to work and forcing mothers into work and training that may not be appropriate—there are also questions of practicality and effect.

It is our contention that these devices will not work to the end that H.R. 12080 envisions: a reduction in the number of Americans in need of public assistance. I am confident that the enactment of provisions for an AFDC ceiling, mandatory work and training and restrictions in the AFDC–UP program will increase the number of hearings and court challenges, aggravate tension in ghetto areas with a high proportion of welfare recipients, further cripple the administration of public assistance by multiplying areas of discretion, penalize the children who are already penalized by their families' reduced circumstances, and place intolerable financial burdens on states and localities that try to maintain their programs.

At a time when we are agreed that the problems of the urban communities pose the greatest challenge to our domestic policies, we are in danger, through this bill, of striking at the very group most involved. The admirable programs now under discussion in the areas of employment opportunities, better housing, improved police protection, revitalized education, and more accessible health programs could in large measure be vitiated by a return to more restrictive, coercive methods of public assistance.

The Report of the House Ways and Means Committee has estimated that the House-passed bill will reduce the AFDC rolls by about 300,000 persons from its present total of nearly 5 million. Since we have found that forced work, coercive paternity searches and other restrictive measures do not, in fact, lead to independence from public aid, the attainment of this reduction is highly unlikely.

But even if the bill's restrictive provisions were to be effective in reducing the number of recipients of AFDC, these are likely to be the results:

1. The removal of children from parents who decline to participate in community work and training would merely shift the financial responsibility for their care to another part of the program, at a higher cost. Foster care, whether it be in an institution or a foster family, is far more expensive than AFDC.

2. The removal of federal participation from post-freeze AFDC cases would open up a series of undesirable alternatives: the financial burden for the care of destitute children would be shifted to the states and localities that can least afford it; states with well-developed programs and commitments to their poor residents would be penalized for continuing to help; poorer states would be forced to reduce their payments and develop even more punitive and restrictive relations with applicants than they have now; and persons who were unable to conform with the requirements for AFDC—since they cannot be left to starve in 20th century America—will have to be absorbed into other programs.

3. The strengthening of the union of services and income maintenance and the multiplication of areas in which investigation will be emphasized invites coercion and abuse, builds even more complexity into already cumbersome administrative controls, emphasizes the second-class status of welfare recipients and consolidates the role of social workers in the program as investigators rather than as instruments of encouragement, self-respect and family strength.

4. The children who remain covered by the AFDC program would be penalized, as well as those who are unqualified merely by virtue of their numbers. The effect of disqualifying children who exceed the required numbers would be to reduce an entire family's grant. For example, a mother with three children may today receive $200 a month, or $50 per person. When a fourth child is born and exceeds the number to be covered, the effect would be to reduce each grant to $40, thereby penalizing the other children. The effect would be the same in cases where the adult was removed from assistance because of noncompliance with the work-training requirement. Although the Committee Report declares that it would be the adult who would be dropped from the rolls while the children continued, the effect would certainly be to reduce the amount available for each family member.

5. The multiplication of areas of discretion in the delivery of public assistance and the added sanctions on individuals will most certainly aggravate tension in ghetto communities where residents are just beginning to organize in their own behalf. The experience of most urban anti-poverty programs has been that a high percentage of time and effort is spent in defending the poor against unreasonable, arbitrary public welfare policies. There has been

overwhelming evidence that welfare clients, far from abusing their entitlements, are often deprived of their legal rights as recipients and their civil rights as citizens. Responsible segments of society have viewed community concern with welfare policies as a positive development. Even segments of the conservative press have demonstrated growing concern with the abuse of clients by welfare policies, as much as the abuse by clients of welfare policies.

It is true that there are many positive and helpful provisions in H.R. 12080 that I would urge the Senate to support. I wish that we could encourage your support without qualification. But it must be said that even the forward-looking provisions are in danger of being adversely affected by the over-all attitude of the bill. The Report of the House Ways and Means Committee makes it plain that such progressive contributions as Federal support for day care, training and employment programs, foster care, family planning and family counselling are included in the bill only as specific devices for reducing the AFDC rolls, not as methods for encouraging states to grapple with the massive social problems that face our urban communities.

The attitude of disapproval that emanates from the regressive provisions permeates all the others in such a way as to intensify the stigma, the second-class citizenship, the helplessness and dependency of welfare recipients. One of the primary battles that welfare administrators have had to fight is the battle against the stigma of welfare. Its prevalence in the community has infected welfare clients themselves, set them apart from other citizens, crippled their self esteem, confirmed their hopelessness and rendered them the most difficult portion of the population to rehabilitate. The first step in moving welfare families toward self support is to build up their sense of dignity, self-respect and confidence. Only then can programs of family planning, training and preparation for employment really work. The attitude toward poverty, illegitimacy and desertion expressed in H.R. 12080 militates against the positive work we have been able to do in this area and would constitute a severe handicap in the future.

To offer a mother the right to training and employment, and to provide her with counselling, encouragement and child-care facilities, has a possibility of success. To require her enrollment in training and the placement of her children—regardless of family circumstances—encourages subterfuge and feelings of helplessness on the part of the client and coercion on the part of the agency.

There is no doubt that employment and training programs, family planning advice and day care facilities are desirable, and that aggressive efforts to educate low-income families to their values are crucial. But to require, rather than to make available, these resources as a condition for continued financial assistance opens such wide areas of discretion that it constitutes an open invitation to abuse.

It violates the basic premise on which Congress based the Economic Opportunity Act: that if the opportunity to choose a better way of life exists, and if the government fulfills its obligation to provide opportunity and the chance for self-determination, then Americans will embrace those opportunities.

I urge the Senate to adopt the positive features of H.R. 12080, to extend the provisions that are progressive in nature, to restore some of the excellent provisions proposed by the original Administration bill and to strike out the punitive, coercive measures that will move us even further down the road that is now clearly labelled as a dead end. To remove the coercive provisions would result not only in a bill that could positively encourage states to develop alternatives to welfare for their poor residents, but would also avoid contaminating the positive features with the atmosphere of threats and punishment.

I would also urge the Senate to strengthen the public assistance provisions by restoring H.R. 5710's requirement that states meet their own minimum standards, by adding measures to simplify the determination of eligibility for public assistance and by separating the two functions of social service and income maintenance. This will enable social workers to spend all their efforts to "strengthen family life, assist family members to attain or retain capability for maximum self-support and personal independence," to use the words of the House Ways and Means Committee Report itself. The retrogressive provisions of H.R. 12080, on the contrary, would lock social workers even further into the investigator's role—a role that has proven both futile and wasteful both of public funds and professional skill.

I would like now briefly to review some of the specific provisions of H.R. 12080 and comment on what, in my view, would be their effects.

Limitation on Federal assistance to broken families

This proposal to limit the number of one-parent children on AFDC to their proportion of a state's entire child population in January 1967 is an excessively harsh measure. Even now, only about 4 million of the nation's 15-million poverty-stricken children are covered by AFDC. It might be more appropriate to be concerned with the program's failure to help more needy youngsters rather than with its meager record of success.

The Committee Report defines the "freeze" as a device to encourage states to implement the bill's other, more positive, provisions. But the facts are that a decrease in the number of broken families and dependent children is not something a state can achieve through employment, day care and family planning programs, no matter how effective they might be. Through the increase in Federal support for these programs, states and localities that have no such resources will be able to develop them. But that will take years. And in the meantime, children who began receiving Federal assistance this year—before these measures were conceived—will either be cut off the rolls or will be consigned to an even lower level of support than before. And new babies will suffer even more than they do today for the difficulties of their parents.

We are all familiar with the national movement from rural to urban areas resulting from automation in agriculture and the attraction of jobs and social opportunities in the cities. If a better life is possible for Americans anywhere in the national economy, are we to deny them access? Are we to say to states and localities that have been most imaginative, most successful in creating a good life for their residents that we will penalize them for producing an environment in which striving families wish to live?

The "freeze" would confront states with an impossible decision: to take over the financial burdens of public assistance themselves or to impose even more stringent eligibility requirements that would deny aid to those in need. I would hate to have to defend either decision.

Limitation on aid to families with an unemployed parent

The AFDC-UP program, initiated in the 1962 amendments, was one of the most progressive steps to be taken in the public assistance program since its inception. It sought to remedy one of the greatest abuses in the federal assistance program—the implicit encouragement for economically insecure fathers to desert their families to make them eligible for ADFC. Not all states have General Assistance programs for intact families and even when they do, the non-federally-aided grants are even lower than AFDC.

We have strongly supported provisions to make this program permanent and would have been pleased to see that H.R. 12080 did so, except for the fact that the requirements for the program are so changed as to reduce its effectiveness sharply. The requirement that an unemployed father to be eligible for AFDC-UP must have had a recent connection with the labor force and be receiving no Unemployment Insurance, no matter how small, defeats the purpose of the program.

In New York City, we estimate that about 50 percent of the families now receiving AFDC-UP would become ineligible under H.R. 12080. And these are the families most in need of help. If a man has had some work experience in the past 18 months, the likelihood of his being able to resume supporting his family himself is much greater than if he is one of the long-term unemployed. Our greatest efforts should be devoted to keeping these most deprived families together and helping them succeed.

In a program designed to strengthen family life, we should not further extend the self-defeating approach that discriminates against intact families.

Community work and training

Certainly the effort to move people toward self-support must be one of the highest priorities of public social service programs. We have strongly favored such programs as the Nelson-Scheuer amendments to the Economic Opportunity Act, Senator Clark's proposed amendments to the same Act, expansion of its Title V provisions and a much greater emphasis on training and employment programs directed specifically at welfare recipients.

We subscribe fully to a recommendation of the Emergency Convocation of the Urban Coalition held in Washington August 24th, that as a first goal we should put "at least one million of the presently unemployed into productive work at the earliest possible moment." This Convocation, in which our Association participated, was comprised of the top leadership of business, labor, church and civil

rights groups. It urged the development of programs "to end once and for all the shame of poverty amid general affluence" and recommended as one measure an emergency work program to provide jobs and training opportunities.

However, the compulsory nature of the work and training provisions in H.R. 12080 make them impractical, coercive, possibly unconstitutional and most likely ineffective.

Our experience has been that persons who take training or employment merely because it is required as a condition for assistance are so un-motivated that they never really become self-supporting. They leave the job after a few days and are unable to stick with training. The social worker is unable to help them build positive attitudes because he is seen by the client only as an investigator.

It is vital, we believe, to handle the employment potential of each client on an individual basis, in terms of each family's needs and capacities. It would be equally unsound to mandate that no mother on welfare should work—the traditional approach. It is important, rather, to provide a choice and an opportunity.

If a parent feels strongly that her place is at home with her children—and the public welfare agency disagrees—what are the alternatives? The adult could be dropped from assistance, the children could be removed from the home by court order and placed in foster care, or assistance could be given only in the form of voucher payments.

Obviously, these are all undesirable alternatives. Removing the family or the adult from assistance will only penalize the children whom we are pledged to protect. Placing the children unnecessarily in foster care is not only cruel to the family and more expensive for the government, but highly impractical; we already know how difficult it is to find foster homes for the number of truly abandoned children we now have, without adding gratuitously to the homeless. And the final alternative, a return to the worn-out system of voucher and protective payments, was proven ineffective long ago. You cannot ever expect persons to become independent if you treat them as if they were incompetent children.

In addition to its ineffectiveness and disrespect for individual differences, the Community Work and Training provisions would, I feel, be difficult and demoralizing to administer. The key objective of professionals in income maintenance programs has been to reduce the discretion of individual departments and workers, so as to limit the opportunities for abuse.

H.R. 12080 would multiply these opportunities—by making possible a wide variety of definitions of the "good cause" for which a welfare mother might refuse training or work, by legitimizing the threat of withdrawal of assistance for a fatherless child, by encouraging welfare departments to spend much of their time and personnel on investigations, searches and other violations of civil rights.

There are other abuses that could well grow from this provision—the employment of welfare recipients in the 75-cents-an-hour learners' wages and the assignment of recipients to training and work for which they are unfitted merely because no appropriate programs exist.

We also do not favor assigning direct responsibility for work and training programs to the Department of Health, Education and Welfare. The public assistance program should be assigned to supporting role of referral, counselling and preparation of recipients to accept and follow through on employment programs. But the administration of these programs should appropriately be assigned to the Department of Labor, which has primary responsibility for developing and implementing the national manpower effort.

In New York, for example, we have found that the duplication of manpower development efforts by many different agencies has been wasteful and inefficient. We are, therefore, consolidating the efforts of the Department of Social Services and the Manpower and Career Development Agency so that an over-all attack can be made on the City's manpower programs. We have assigned the highest priority in these programs to welfare recipients, but feel that the training itself can best be administered centrally, under the aegis of the Department of Labor.

Child welfare services

As we said in testifying earlier this year on H.R. 5710, we feel that the provisions in the Burke bill—which would provide full federal support for child welfare services for all children in need, not just those eligible for AFDC—would provide the best protection for our children.

However, the child welfare provisions in H.R. 12080 do move in the right direction and we would support most of them, especially the requirement for a court order to remove a child from his family. It must be emphasized, however, that if increased Federal participation in child welfare services is used by states as the rationale for removing more and more children from their homes, the purpose of this program will be destroyed.

Employment incentives

We endorse the provision that states be required to provide earnings exemptions for AFDC families, but strongly urge that the exemption be substantially increased over that proposed by H.R. 12080. An exemption of $30 a month and one-third of the rest is inadequate to serve as a real incentive to employment. Studies have shown that incentives are ineffective unless they provide a substantial income supplement if the incentive is too low and therefore proves ineffective it may endanger the entire concept, which deserves a fairer test. Even the Administration's proposal for an exemption of $50 a month plus one-half of the remainder does not go far enough. We favor, instead, an exemption similar to that available to persons employed by OEO-sponsored projects—$85 a month and half of the remainder.

The welding of services and eligibility for assistance

We object particularly to the way H.R. 12080 ties services into eligibility for assistance. Our association supports strongly a complete separation of income programs from social services and urges that persons applying for assistance not have the receipt of assistance conditional to the provision of services.

There is a very substantial number of persons at low incomes who might avail themselves of family and child welfare, family planning and day care services, but who will not do so if this means they must apply for financial assistance to be eligible. The provision of such services might in very many instances prevent the later necessity for applying for assistance.

Conversely, we maintain that there are some families who need only financial assistance for a certain period of time, and should not be forced to accept other services that may infringe on their civil rights, damage their self-esteem and reduce their capacity to return to self support.

We have ample evidence that people will avail themselves of preventive social services if they are easily accessible through a neighborhood center and if appropriate incentives are afforded. We also have evidence that these services are not beneficial if they are based on coercion.

Medical assistance for needy persons (title XIX)

The restrictive provisions in H.R. 12080 as they relate to the state's Title XIX programs would have a negative effect similar to that of some of the public assistance provisions—the frustration and denial of rising expectations.

The House Ways and Means Committee report makes no attempt to disguise its intention to penalize New York State specifically for the liberality and comprehensiveness of its program. The Title XIX legislation required all states to reach a certain point in developing its medical assistance programs by 1970. Now New York is to be penalized for having advanced so far so fast. The question must be raised, then, about what will happen to the program as other states implement this, the most significant piece of social legislation in 30 years? Will the medically indigent population of every state—encouraged, recruited, enrolled and then offered quality medical services—be told eventually that they must give up the protection they just began to receive?

The original legislation declared the intent of Congress to protect a large proportion of the population from potential destitution by guaranteeing high-quality medical care. It acknowledged the connection between ill health and poverty, recognized the disastrous consequences for a modest budget of high medical expenses, and pledged to make health care available as a matter of right to all citizens.

Both the definition of the issues and the intent of Congress are as valid today as they were when the bill was passed in 1965. We believe that the States should be given the opportunity to experiment with different formulas for eligibility and urge the Congress not to impose arbitrary ceilings.

If New York's experience is representative, and I think it is, we have not seen a rush to enroll by what the House Ways and Means Committee called "the middle class." Only about 4 percent of the 1.5 million persons presently enrolled in New York City are in families earning in excess of $4,500 a year.

What we have seen, however—and I think this, too, is representative—are low-income families receiving dental treatment that they never received before; heads of families receiving the best treatment for debilitating ailments that had threatened to take them out of labor market; mothers getting regular care for conditions that would otherwise have prevented them from caring for their children. We cannot tell these people, who have been begun to enjoy the kind of health care that should be available in an affluent society, that this care is no longer available. Perhaps in some of the richer states, part of the financial burden will be taken over by the state and localities. But in the poorer states, persons now receiving services will no longer receive them. As with other provisions of H.R. 12080, this will force us to frustrate the legitimate expectations of our citizens. The consequences are inevitable.

Conclusion

Our main goal here today has been to indicate that aside from the philosophy of H.R. 12080 with respect to public welfare—which is contrary to our growing understanding of the roots of poverty and its remedies—the bill's punitive and compulsory provisions simply will not work. They represent just more of the same thing that we have been trying for 30 years to little avail.

While these provisions will be costly and burdensome for the states and local communities, they will *not* achieve the goals of providing a minimum standard of living for all Americans and the opportunity for self-support for those who are able.

We do recognize that there are major problems with both the human and financial costs of the welfare program in the nation today. We have long urged the necessity of basic, fundamental changes. I had the opportunity, as Chairman of our Association's Division on Social Policy and Action, to present and defend the proposals on income assurance that Dr. Thursz referred to as having been adopted at our 1967 Delegate Assembly.

We also recognize that such changes as guaranteed employment, the inclusion of the aged and disabled in Social Security, family allowances, a revised and reduced public assistance program and an expanded system of public social services cannot be accomplished immediately. But we feel strongly that it is time for Congress and the public to begin discussing some of these approaches rather than turning back, again and again, to the methods that have failed us in the past.

We have been wasting both money and lives in this program for 30 years. Now let us begin to consider seriously new approaches that have some chance of meeting the needs of the 60's and 70's.

We appreciate this opportunity to present the views of the National Association of Social Workers on H.R. 12080.

FURTHER RECOMMENDATIONS WITH RESPECT TO TITLE XIX—MEDICARE

We cannot accept the Administration's argument, and essentially that of H.R. 12080, that it is too early to correct admitted deficiencies or lacks in the Medicare program. We believe, as we shall demonstrate, that the imposition of deductibles and co insurance have not only deterred older people from health care, but are administratively burdensome, while the lack of provision for the cost of prescription drugs further denies the full range of health care for the aged.

Advisory council on personal health services

We propose that the enlarged Health Benefits Advisory Council which is to assume the duties of the National Medical Review Committee as recommended in H.R. 12080 be merged with the Advisory Council on Medical Assistance recommended in the bill and that there be substituted therefor a provision for an Advisory Council on Personal Health Services.

We see such a Council as providing for a central concern for services to children, people on public welfare, to the aged, regardless of which segment of the Department that is administering them and which section of the Act applies. The emphasis on such an Advisory Council should be on the individual who is the actual or potential recipient of medical care rather than specific programs or program segments.

We note that the bill recommends that the Advisory Council for Medical Assistance have a majority of representatives of consumers and believe that this should be the basic concept for an overall Advisory group. We have, however, one

modification, namely, the addition of the words "representing the major segments of the community" so as to strengthen the assurance of a proper composition of the Advisory Council. Without this clause we are concerned that consumers represented might be selected on a very narrow basis and that in fact the disadvantaged, minority groups, organized labor and other consumer groups particularly concerned with medical care might be excluded from participation. There is substantial experience with the selection of the consumer representatives in the states and communities as well as some of the other advisory councils of Government to indicate that unless this qualification is included the full objectives of such an Advisory Council may not be achieved.

We are convinced that with the major entry of the Federal Government into the area of prepayment for personal health services as well as for the purchase of personal health services, it is of crucial importance that there be available to the Secretary of H.E.W. an overall Advisory Council on general policy in administration of personal health services, and also to provide him with direct feedback on the responses of the consumers of care to the way in which the programs are operating. There is not now an organized way in which the policy makers in H.E.W. can be informed with reasonable promptness on consumer reactions. Furthermore, it is our conviction that the objective of public medical programs is to see to it that there is comprehensive health care available for those persons and groups covered by the legislation, and that there be a single health care program, and that the care be of uniformly high quality.

Remove the deductibles and coinsurance from parts A and B

The Committee has already had ample testimony of the endless complexities of understanding and administering the deductibles and co-insurance. In fact, it is our belief, supported by other knowledgeable persons in the field, that the deductibles serve no useful purpose in saving costs, for the administrative complexities are such that an undue proportion of funds must be spent on processing claims. For example, National Blue Cross reports that 60% of the outpatient claims forms filed resulted in no Medicare benefits—but because of the deductible features these claims had to be filed. Furthermore, the $40 deductible feature on hospital care has, in the opinion of most observers including our own membership, not had favorable effect upon the utilization of hospital care.

On the other hand, particularly with relation to the Part B benefits, the deductibles and co-insurance have a negative effect in that they act as deterrents to older people going for care early when more serious conditions could be prevented. In this sense the legislation as now written is self-defeating and while the initial cost may be higher, in the long run, we are convinced substantial savings would be effected if good medical care principles were applied and deterrents to early diagnosis and treatment in the form of deductibles and co-insurance were promptly eliminated.

We cannot, however, stress too greatly that the present regulations with deductibles, co-insurance, different restrictions for nervous and mental diseases, must in the short and long run be self-defeating. The elderly person is bewildered by Government programs which in essence require him each time he must see a physician or go to the hospital to bring the competence of an income tax expert to the experience. The Congress must help to simplify and make far more understandable these programs than they are at the present time.

Provide for payments for prescription drugs

The members of this Committee are cognizant of the fact that serious consideration was given in 1965 to the inclusion of this benefit under Part B. We urge it at this time. Prescription drugs take about 18¢ out of every consumer dollar for medical care services. When one considers the serious limitations on incomes of the aged, it becomes evident that their health is being harmed by not having such a benefit as part of the program. Studies over the years have shown that very substantial numbers of physician prescriptions remain unfilled largely because of the costs involved. If it is the intent of Congress to approach comprehensiveness of health care for the elderly, as we believe it is, payment for prescription drugs cannot continue to be an exclusion.

Limit payment to physicians to those who are prepared to accept assignment and reimbursement of the usual and customary fees prevailing in their communities

Experience to date indicates that permitting physicians to obtain payment via the so-called direct pay route has caused unnecessary hardship on patients and

considerable escalation in costs. The Committee is doubtless familiar with complaints from all over the country of elderly persons with limited incomes who in advance of receiving medical and surgical procedures are required by physicians to produce cash, which hopefully they will receive back in whole or in part from the Federal Government. Through the use of this device physicians are also inclined to charge "what the market will bear" rather than the reasonable and usual cost in the community. As the Committee knows, somewhere in the neighborhood of half the physician claims are now being paid under the direct pay basis.

The proposal in H.R. 12080 that a third alternative to direct pay or assignment, namely, permitting payment on the basis of unpaid bills sent in by either the patient or the doctor will offer some help to financially pressed older people.

The Association, however, favors limiting payments to physicians to the assignment method since this is the simplest approach as far as the patient is concerned and one to which many of them became accustomed when during their working years they were covered by Blue Cross-Blue Shield or other arrangements.

Reduction of quarters of coverage

We support the provision in the bill for extending the priod of time during which persons who do not have fully insured status may qualify for Medicare and reduction from 6 to 3 quarters of coverage for persons attaining age 65 in 1968.

The CHAIRMAN. Now, our next witness is Miss Jo Eleanor Elliott, of the American Nurses' Association.

STATEMENT OF JO ELEANOR ELLIOTT, PRESIDENT, AMERICAN NURSES' ASSOCIATION

Miss ELLIOTT. Good morning, Mr. Chairman. I am Jo Eleanor Elliott, director of nursing programs, Western Interstate Commission on Higher Education. I am the president of the American Nurses' Association, the professional organization of 180,000 registered nurses in 54 constituent associations, the District of Columbia, Puerto Rico, the Virgin Islands and the Canal Zone.

As one of the professional groups deeply concerned with the health and welfare of the American people and the largest single group of professional people giving health care, we welcome this opportunity to present our views on certain proposals of H.R. 12080, the Social Security Amendments of 1967, as passed by the U.S. House of Representatives.

The American Nurses' Association has supported the provisions of the Social Security Act and extensions and improvements of the system since its adoption. We have been especially concerned with promoting retirement coverage for employees of nonprofit organizations, social security benefits for the disabled, extension of the system to provide health insurance coverage for recipients of OASDI and increased assistance to persons receiving public assistance.

In our statement to the House Committee on Ways and Means we supported the proposal of the administration of a 15-percent increase with a minimum retirement benefit of $70 a month.

H.R. 12080 provides for a general benefit increase of 12½ percent with a $50 a month minimum. We are pleased that some increase is proposed but urge the restoration of the administration proposal. We recognize that this program was designed to provide a base from which individuals could plan for additional retirement income.

However, the present minimum of $44 per month and that proposed by the House in H.R. 12080 is not realistic when we consider the ever-

increasing cost of living. Further, it is likely that many persons who would receive the minimum were unable to set aside sufficient moneys during their working years to supplement the social security benefit. This is true of workers in the health field, especially those who worked in nonprofit organizations. They came under social security coverage at a much later date than industrial workers and those employed in profitmaking organizations. They have received extremely low wages and their employers did not generally provide for a private pension program.

Thirty years after the enactment of a national social security system, nonprofit organizations are still not required to provide coverage for their employees. They may, if they choose, volunteer to cover their employees. Under the present, voluntary coverage provisions, the organizations are covered under social security only if the employing organization files a certificate waiving its exemption from coverage.

The passage of medicare points up the anomaly of the present situation. The responsibility for carrying out key phases of this program rests on the Nation's hospitals and their employees. By and large, nonprofit voluntary hospitals have elected voluntary coverage and a large proportion of hospital employees are covered. However, pockets of noncoverage are significant. One of our constituent State nurses' associations estimates that over 5 percent of the nonprofit hospitals in that State do not provide coverage. Mandatory coverage would safeguard those employees in areas where employers have not elected to cover their employees.

There is no justification for the continuation of the exemption of nonprofit organizations. Their employees are entitled to the same protection and benefits afforded other employees in this country. The advisory council to the social security program has recommended universal coverage. The American Nurses' Association also is convinced that coverage of nonprofit organizations should be compulsory.

At the very least, mandatory coverage should be extended to employees of facilities providing medicare service. This could and should be accomplished by requiring mandatory coverage for all such employees as a condition of payment to providers of service.

H.R. 12080 increases the amount a person may earn without having social security benefits withheld from $1,500 to $1,680 a year. We believe that the present $1,500 ceiling should be increased to $2,700 rather than $1,680 as proposed in H.R. 12080.

Registered nurses are in short supply. It would seem that the nurse of retirement age could contribute substantially even on a part-time basis in meeting the health needs of the community in a variety of ways. To function effectively, it is essential that the nurse's services be available at least 2 days a week. No program can be carried out efficiently on the basis of services offered for less than this period of time.

If the ANA entrance salary goal, and I emphasize this is a goal, of $6,500 annually is used as a base, a nurse's salary for 2 days per week would be $54 or approximately $2,700 annually. Under the present limit of $1,500, or even the proposed $1,680 a nurse working 2 days a week would suffer a deduction in social security benefits.

We are not only concerned with the nurse who has reached retirement age and her incentive to work, but also the nurse who is widowed

before retirement age and is receiving social security benefits. There is little incentive to work when the maximum earnings allowed are $1,500, or even $1,680. Such facts should be considered in the light of Federal and State government expenditures to recruit the inactive registered nurse back into the work force.

The American Nurses' Association is most appreciative of the money which the Government has expended for construction, instruction, and scholarships through opportunity grants to increase the supply of nurses. We believe that increasing the earnings limit would be another way the Government could help to meet the need for more registered nurses.

The ANA supported amendments to the Social Security Act which brought the disabled under certain provisions of the act. In our statement on H.R. 5710 we urged that they also be included under medicare.

We regret the House did not extend the provisions to include disabled persons under 65 years of age in the health insurance program. The disabled have limited income, are likely to require more health services and, in addition, experience difficulty in obtaining adequate insurance protection against the costs of health services. We urge this committee to support the administration proposal.

We do recognize that provision has been made for the Secretary of Health, Education, and Welfare to establish an advisory council to study the problems relative to including the disabled under the health insurance program, including any special problems with regard to the costs which would be involved in such coverage.

This committee is aware that the ANA was the first association in the health field to support the extension of the social security system to provide health insurance coverage. In our testimony over the years when such legislation was before the Congress, we indicated our concern that tax moneys not be used to perpetuate the poor standards of nursing care that existed in some health care facilities. When the Social Security Amendments of 1965 were enacted, the Congress also indicated its interest in the provision of health services of high quality.

When the conditions of participation under title XVIII, medicare, were released by the Department of Health, Education, and Welfare, the ANA was in general agreement that the standards were higher than prevailing ones and should have some impact on raising the quality of care.

We assumed that the conditions of participation required under title XVIII would also apply under title XIX, medicaid. We did not believe that Government would agree that one standard of care was desirable for those persons eligible for medicare, but a lower one was acceptable for recipients of public welfare.

The argument has been made that the Federal agency responsible for the implementation of Title XIX oversteps its authority in establishing standards for this program on the grounds that title XIX is a State-administered program and that Congress intended each State to set its own standards.

The Federal Government, for many years, has been setting certain standards for a wide range of programs that have Federal funding, but are State administered. The ANA believes it has this right and

responsibility, most especially when the health and well-being of people are involved.

At this time we wish to indicate our support of the principles underlying the bill S. 1661, introduced by Senator Moss of Utah for himself and other Members of the Senate, which would amend title XIX of the Social Security Act. When introducing this legislation, Senator Moss stated:

> Having set this vast program in motion, Congress has a responsibility to assure that the program will provide the appropriate types of care, care of high quality, and care rendered in suitable and safe surroundings.

Among the proposals in the bill is one to establish basic standards of quality for nursing home and home health services, in keeping with the provisions already set forth in title XVIII of the Social Security Act. Senator Moss' bill has been referred to this committee and we urge that you give it favorable consideration.

H.R. 12080 provides for the transfer to the Health Insurance Benefits Advisory Council of the functions of the National Medical Review Committee with the added provision to increase the membership of the Advisory Council from 16 to 19 members to provide the council a broader basis of experiences for meeting its broadened responsibilities. At the present time, only one registered nurse serves on the Health Insurance Benefits Advisory Council. Because nursing service forms such a vital part of the total health program we wish the record to show that we believe additional nurses should be appointed to this important council.

We are pleased to note that title III of H.R. 12080 provides for the consolidation of health services for children, bringing existing earmarked programs under a single authorization. H.R. 12080 requires States to make a greater effort in the screening and treatment of disabling conditions and to give more emphasis to services among groups with special problems, especially the needy.

We support the provision of project grants for maternity and infant care, for comprehensive health services for children and for dental care for children.

We support in principle and regard as commendable the provision that States set up work training programs to help welfare recipients become employable and self-supporting. However, we believe that where AFDC mothers are involved, their participation in job training and employment should be on a voluntary basis, premised on counseling and evaluation of what is in the best interest of the child or children.

The provision for establishing day care centers and the work incentive features of earnings exemptions will encourage mothers with an employment potential who can safely leave their children, to voluntarily take training and employment.

While we applaud parts of H.R. 12080 aimed at attacking the problem of hard-core families on welfare, we deplore the restrictive provision, "freezing" the proportion of dependent children at the January 1967 ratio in the respective States. The burden and hardship resulting from such a stipulation will fall ultimately on the children themselves who are not responsible for their straitened circumstances or not in a position to account for themselves. As has been so aptly stated, "it is one thing to provide realistic incentives to encourage

welfare recipients to work. But it is something altogether different to condemn the unborn to meet harsh regulations. This is not social security but insecurity." [1]

We urge the deletion of this provision.

We support the administration's recommendation that States be required to pay the actual amount they themselves determine to be a minimal need payment and that these standards of payment reflect the current cost of living. We believe that the adoption of the requirement that the States pay 100 percent of the monthly allowance is essential and we urge that you include it in this bill.

Mr. Chairman, I thank the committee for this opportunity to appear before it to present the views of the American Nurses' Association on H.R. 12080.

The CHAIRMAN. Thank you.

Let me ask you this: I am told that some people have blamed increases in nurses' salaries for much of the increase in hospital costs.

What is your reaction to that?

Miss ELLIOTT. Undoubtedly the increased cost of nurses' salaries is a factor in the increasing hospital costs. I think it is important, however, that the Committee understand that the lag in nurses' salaries was so large for so many years that it would cause a sudden spurt when nurses start receiving more adequate remuneration for their services.

But this is only one part of increasing hospital costs. I think we have to look at the costs of complex equipment. I think we have to look at the costs of possible duplication of such equipment; the cobalt machines, the million-volt X-rays; as well as the cardiac units and other intensive care units that are being built into hospitals; the additional professional technical people it takes to man and service these machines and units, are all important factors also.

I personally feel, sir, very strongly that nurses should not be blamed for the total cost of increasing hospital costs.

The CHAIRMAN. Well, part of the problem was that prior to this time I suppose that nursing has been hard work, long hours, and oftentimes at very inconvenient hours, so that to get enough people into the profession I suppose it was probably necessary to have a major increase in nurses' salaries.

Now, do you think there are going to be further sharp increases in nursing salaries, or do you think it will stay about the same?

Miss ELLIOTT. I think when nurses' salaries generally reach the levels of those for people of comparable preparation and skills then subsequent increases would be in line with cost-of-living increases in other professional occupational fields.

The CHAIRMAN. Yes.

Well, oftentimes if you do not have enough people in some fields, it is because you are not paying them enough, and I guess that is probably what the situation was with regard to the nursing shortage, I take it.

Miss ELLIOTT. For a long time we defied the law of supply and demand because although nurses were in short supply we did not attract more nurses. We did not push salaries up even though we were scarce. I think that increased salaries will attract more nurses, more people

[1] New York Times, editorial, Aug. 28, 1967.

into the field. I think it is an important recruiting factor. I think the traditional low pay has deterred young people who, in this day and age, as you know, are so sophisticated from choosing nursing as a field. But now I think we are getting competitive in many places. But I think the big spurts have been in the major cities, and we have much to do to get salaries raised throughout the country.

The CHAIRMAN. Thank you very much.

Miss ELLIOTT. Thank you.

(A supplementary statement submitted by the American Nurses Association follows:)

SUPPLEMENTARY STATEMENT SUBMITTED FOR THE RECORD BY THE AMERICAN NURSES' ASSOCIATION

We recognize that in the testimony presented to this Committee a number of comments have been made concerning the increasing cost of hospital care. Much documentary evidence can be produced to show that the costs for such care have been rising at a faster rate than other items in our economy. In this supplementary statement to our original comments to the Committee, we are setting forth the American Nurses' Association's view of where nurses fit in this picture.

During the past year many nurses have experienced significantly large salary increases. A limited study of salary ranges in a selected sample of large non-federal short-term general hospitals conducted by the American Nurses' Association in April 1967 provided some evidence of these salary increases. The range of increases in starting salaries for the staff-level hospital position in a period of no more than a year, ranged from $128–$1,200 in the 103 reporting hospitals with about one-quarter of the hospitals reporting increases of at least $958.[1]

Increasing salaries for hospital personnel have, of necessity, an impact on hospital expenses since, as in all service industries, payroll expenses account for the major part of total operating expenses. However, nurses' salaries do not make up the largest proportion of the hospital's budget. An April 1966 survey showed that the 361,000 professional nurses in hospitals account for about 17 percent of the total hospital personnel complement.[2]

If all of the full-time nurses in hospitals were to receive a $1,000 increase per annum and the part-time nurses received increases roughly equivalent to that, the impact per patient day would amount to about 67¢. Of course, because nurses comprise a greater proportion of those employed in short-term hospitals which provide more intensive nursing care, the impact on those hospitals would be greater. The American Hospital Association in its November 4, 1966 issue of *The Week . . . for Hospitals* pointed out that a $1,500 increase to nurses in nonfederal short-term general hospitals would be a cost per patient day of $1.85. An average increase of $1,500, which relatively small numbers of nurses have exceeded, was what the American Nurses' Association had estimated would be needed to bring about something approaching a minimum salary of around $6,500 in 1966 with appropriate adjustments of salaries of nurses with experience and higher levels of responsibility.

An actual example from a nurse's letter appearing in a Seattle newspaper serves to illustrate what has been occurring. The nurses in Seattle were asking for a $100 a month increase and the average increase in room rates announced by hospitals there was $5 a day. In rough calculations the nurse pointed out that:

". . . On a 36 bed ward each patient will be paying an additional $5.00 per day for an increase in revenue to the hospital of about $5,500. On that same ward there may be ten R.N.'s to cover the three shifts and let's say they're going to get a $4.00 a shift increase (22 days work month). My figures say that isn't quite $1,000 additional salaries to be paid out. How can the powers that be justify this $4,500 disparity?"[3]

---

[1] American Nurses' Association, *Survey of Salary Ranges and Other Employment Conditions for Staff-Level Nurses in Nonfederal Short-Term General Hospitals*, memorandum, June 18, 1967.

[2] American Hospital Association, *Manpower Resources in Hospitals—1966*, Summary Report of a Survey Conducted by the Bureau of Health Manpower, Public Health Service, Department of Health, Education, and Welfare, and the American Hospital Association, 1967.

[3] Letter in *Seattle Post-Intelligencer*, August 5, 1967.

All this just serves to point out that increasing hospital expenses are based on many factors. Rising levels of salaries for all hospital personnel are a factor. However, nurses cannot shoulder the responsibility for increasing hospital costs. Increases in salaries were due to all in the industry. Certainly, Congress itself recognized that changes were overdue when, appropriately, the Fair Labor Standards Act was amended to include hospitals. Such measures serve to increase all salary levels. Payroll expenses have been increasing, as well, because of the addition of more personnel and the additional use of a greater variety of personnel, many of whom are in the professional or technical categories. Total hospital expenses have also been increasing as a result of more complex techniques requiring more complex and expensive equipment and the general rise in the cost of products used by hospitals as well as in the costs of construction.

However, one cannot examine nurses' salaries solely from the point of view of what they cost. The alternative question must be the need for change. That significant changes needed to be made in nursing salaries is attested to by the fact that in July 1966 the average salary of a nurse in a staff level position in hospitals was only $5,226.[4] In comparison classroom teachers in the country averaged $6,821 during the 1966–67 school year,[5] and personnel in beginning professional positions as engineers and chemists averaged even more than that, $7,764 and $7,014, respectively.[6] The need for substantial change in the economic rewards of nurses was recognized back in 1963 when the Surgeon General's Consultant Group on Nursing in its report indicated that:

". . . In today's society, salaries and related benefits not only determine standards of living but also influence the prestige of an occupation. Until the economic status of the nursing profession is improved, nursing will be unable to compete successfully with other fields where pay and benefits are more attractive."[7]

Even with the increases in salaries which have occurred there are still a number of hospitals offering starting salaries to nurses of less than $5,000 a year and a large proportion offering less than $6,000 a year.[8] Thus, it is clear that even greater gains need to be made in nurses' employment conditions before they can meet the level that would satisfy such conclusions as that quoted from the Surgeon General's Consultant Group on Nursing. The April 1966 survey referred to previously showed that in all areas of the country registered nurses were at the top of the list of categories of personnel for which hospitals had "most urgent need." An estimated additional 79,470 professional nurses were needed to provide optimum care to patients, according to the figures the hospitals provided.[9]

Hospital costs have been rising continuously and show every indication of rising even higher. However, the need to increase the financial return to the hospital worker is apparent in any set of data which may be reviewed both from the point of view of attracting qualified workers and from providing to those employees on staff a return which is equivalent to that which other workers in our society receive. In looking at the hospital cost picture it is imperative that overall planning for the health needs of the community be reviewed from the point of view of whether hospitals are being utilized efficiently. Within the hospital itself such factors as the utilization of personnel and equipment and supplies need to be considered.

The CHAIRMAN. Let me see, with regard to the next witness, Mr. George Hecht of the American Parents Committee.

Mr. Hecht, if you can briefly summarize that statement. I suppose I could hear you now; otherwise, we would just bring you back here this afternoon.

---

[4] U.S. Department of Labor, Bureau of Labor Statistics, *Industry Wage Survey, Hospitals, July 1966*, Bulletin No. 1553.

[5] National Education Association, Research Division, *Economic Status of Teachers*, 1966–67, Research Report 1967–R8.

[6] U.S. Department of Labor, Bureau of Labor Statistics, *National Survey of Professional, Administrative, Technical and Clerical Pay, February–March 1966*, Bulletin No. 1535.

[7] U.S. Department of Health, Education, and Welfare, Public Health Service, Report of the Surgeon General's Consultant Group on Nursing, *Toward Quality in Nursing, Needs and Goals*, February 1963.

[8] Op. cit. Reference (1).

STATEMENT OF GEORGE J. HECHT, CHAIRMAN, AMERICAN PARENTS COMMITTEE; ACCOMPANIED BY BARBARA D. McGARRY, EXECUTIVE DIRECTOR

Mr. HECHT. I will be glad to summarize it if my complete statement can be printed in the record.

The CHAIRMAN. We will certainly do that. (See p. 960.)

Mr. HECHT. The American Parents Committee—may I present Mrs. Barbara McGarry, who is the Executive Director of the American Parents Committee.

The CHAIRMAN. We are pleased to have her.

Mr. HECHT. The American Parents Committee heartily endorses the bill's intent to strengthen family life, to reduce the incidence of illegitimate births; encourage work-training for family members over 16 when it is deemed appropriate; increase day care facilities where advisable for young children of working mothers; provide increased protection of any child subject to neglect, abuse, or exploitation; broaden foster care provisions; and provide economic incentive for work experience, through earnings exemption for AFDC recipients.

However, we want to record our strong opposition to the proposed "freeze," under section 208, at the present percentage level of dependent children because of the absence of a parent. We believe this is an unnecessarily harsh and unrealistic fallacy to attempt to legislate the future number of children who shall be in need of help, because of the absence of a parent from the home.

As regards day care centers, day care services, certain legislative provisions which have already stimulated widespread discussion, would benefit from clarification beyond that already given in the bill's accompanying report.

The committee's report also recommends that such cases be periodically reviewed, "to see if the situation had changed to the point where training or work is appropriate for the mother." We appeal to your committee for clarification of the key word "appropriate."

The American Parents Committee has long been on record, before this and previous Congresses, for increased Federal funds for day care facilities. But it has never been our intent—nor that, I am sure, of any legislative proposals—to equate day care facilities with so-called "state nurseries" operated by totalitarian governments.

The situation definitely requires legislative clarification—both as to what authority makes the determination that an AFDC mother is able to work or take training, and as to what circumstances are considered "appropriate" for the AFDC mother to remain at home with her children. I personally feel that if there is no more than one illegitimate child involved, the choice should remain with the mother. In the case of several legitimate children, the younger of which are of pre-school age, the choice might also remain with the mother. In all other cases, local welfare officials, we feel, would be best equipped to evaluate the situation, and make appropriate recommendations.

Regarding family planning services, sharing the committee's concern with the spiraling problem of illegitimate births in our country, we welcome this opportunity to support the bill's recommendation that family-planning services be made available to AFDC clients.

We are distressed to note that more financial support has not been given in the bill to the Special Maternity and Infant Care project grants, as administered by the U.S. Children's Bureau.

It is our feeling that this program, which has already proven its value, is deserving of greatly increased support and expansion. Unfortunately, the bill's adherence to the administration's proposed increase of $5 million will all be absorbed by increased medical care costs in the centers already established, and will not be sufficient to expand the program. We recommend an increase of at least $15 million.

With the appointment of the Chief of the Children's Bureau as HEW's Deputy Assistant Secretary for Family Planning, we anticipate greater impetus and achievement in all related Federal programs.

Regarding Child Health and Welfare, and other proposals for the improvement of child health, we note the elimination of all present earmarked programs beginning July 1, 1968. We also note that the bill transfers the child welfare program from title V to title IV of the Social Security Act. No reason is given for this move. We believe all this needs clarification.

The States would be required to assume all responsibility for project grants beginning July 1972; and as of that date, HEW's project-grant authority will lapse and funds given directly to the States. We question the wisdom of this because the States may not then provide the needed money.

This would, of course, directly affect the Maternal and Child Health Program, and Crippled Children's Services, each one of which functions under separate State grants under the present law. As the House Report states:

> Existing requirements on States such as extending the provision of maternal and child health and cripple children's services to make them available by 1975 to children in all parts of the State and requiring the States to pay the reasonable cost of in-patient hospital care are continued.

As the Committee report states, the consolidation of these formula grant programs will stimulate the States to carry out "more aggressive programs of early identification of children in need of treatment," and we strongly support such consolidation. In view of this proposed consolidation, we are both puzzled and dismayed to learn of HEW Secretary Gardner's executive order of August 15, transferring all crippled children's programs out of Children's Bureau, to the newly formed "Rehabilitation Services Administration."

The APC urges the Committee to use its influence with Secretary Gardner to reconsider this transfer. Our two reasons for this recommendation are: The House bill consolidated the authorizations for crippled children's programs with that of the maternal and child health programs. The Children's Bureau is better equipped to integrate these two related programs.

Secondly, Rehabilitation's administrative experience is largely limited to adults, while 75 percent of crippled children's caseload is composed of very young children. The Children's Bureau consequently is better equipped to administer this program for such children, who need medical care, rather than vocational rehabilitation, at such early age.

For child welfare services, we support the recommended increase from $55 million to $100 million for each fiscal year thereafter. We

regret, however, that the Committee has not seen fit to equate Federa assistance for child welfare services with that now provided for public assistance programs.

Concerning social work manpower, and this is my last point, relate to the bill's proposal to prevent child abuse, neglect, or exploitation, your committee is undoubtedly aware that, while 49 out of 50 States—now pending in Hawaii—have enacted child abuse laws, at the beginning of this decade only one State—California—had such a statut on its books. The American Parents Committee, which supported the child abuse law recently enacted for the District of Columbia, presented testimony before congressional committees showing a critica shortage of trained social workers to implement these State's statutes.

Our research which led us to file an amicus curiae brief in the *Gault* case before the United States Supreme Court, also showed an alarming shortage of such trained specialists in the juvenile court systems of this country. Therefore, we both commend and support the all too modest authorization contained in the bill for social work manpower training of $5 million for fiscal 1969 and each of the three succeeding fiscal years.

Such an authorization means that one dollar is invested in social work manpower training for every $10,000 worth of on-going Federal-State programs.

Thank you very much indeed.

The CHAIRMAN. Thank you, sir.

(The prepared statement of Mr. Hecht follows:)

STATEMENT OF GEORGE J. HECHT, CHAIRMAN, AMERICAN PARENTS COMMITTEE, AND PUBLISHER, PARENTS' MAGAZINE

Mr. Chairman and Members of the Committee, on behalf of the American Parents Committee, Inc., I welcome this opportunity to express our views on the legislation proposed for your consideration. Our special concern is for those parts of the present bill relating to the health and welfare of children.

The American Parents Committee, founded twenty years ago, is a non-profit, non-partisan organization devoted solely to supporting Federal action for child health, welfare, and education. (I might add parenthetically, that Parents' Magazine, with more than 2 million monthly paid circulation, has for over 40 years concentrated its efforts towards increasing parental responsibility towards the total spectrum of needs of children.) On APC's Board of Directors and National Council are over 100 recognized leaders in child study and social work. Each year, at our annual Board meeting in New York City, our legislative goals must be voted on and approved, before support of specific legislative proposals can be authorized. At our November 1966 meeting, the following subjects were unanimously approved for support in forthcoming legislation:

I. Aid to families of dependent children.
II. Day care services.
III. Family planning services.
IV. Child health and welfare increases.
V. Social work manpower.

Regarding these programs I wish to state the following:

I. AID TO FAMILIES OF DEPENDENT CHILDREN

Under Title II, Section 201, we heartily commend the bill's intent to strengthen family life; reduce the incidence of illegitimate births; encourage work-training for family members over 16 when it is deemed appropriate; increase day-care facilities where advisable for young children of working mothers; provide increased protection of any child subject to neglect, abuse, or exploitation; broadened foster-care provisions; and providing economic incentive for work-experience, through earnings exemption for AFDC recipients.

However, we want to record our strong opposition to the proposed "freeze", under Sec. 208, at the present percentage of children dependent because of the absence of a parent. It is, I believe, an unnecessarily harsh and unrealistic fallacy to attempt to legislate the future number of children who shall be in need of help, because of the absence of a parent from the home.

II. DAY CARE SERVICES

Certain legislative provisions, which have already stimulated widespread discussion, would benefit from clarification beyond that already given in the bill's accompanying report (H. Rept. 544).

At one point, the House report states:

> "The States would . . . have to provide day care services needed for the children of mothers who are determined to be able to work or take training," (p. 16)

and yet, much later in the report—

> "The committee recognizes that in some instances—where there are several small children, for example—the best plan for a family may be for the mother to stay at home." (p. 103)

The language of the bill itself emphasizes the latter point of the report, providing that day-care services be assured—

> ". . . only in cases in which it is in the best interest of the child and the mother, and only in cases in which it is determined, under criteria established by the State, that a need for such care exists . . ." (Sect. 422, B-iii, p. 163)

The Committee's report also recommends that such cases be periodically reviewed, "to see if the situation had changed to the point where training or work is appropriate for the mother." We appeal to your Committee for clarification of the key word "appropriate" as quoted in the previous sentence.

The American Parents Committee has long been on record, before this and previous Congresses, for increased Federal funds for day-care facilities. But it has never been our intent—nor that, I am sure, of any legislative proposals—to equate day-care facilities with so-called "state nurseries" operated by totalitarian governments. The situation definitely requires legislative clarification—both as to what authority makes the determination that an AFDC mother is able to work or take training, and as to what circumstances are considered "appropriate" for the AFDC mother to remain at home with her children. I personally feel that if there is no more than one illegitimate child involved, the choice should remain with the mother. In the case of several legitimate children, the younger of which are of pre-school age, the choice might also remain with the mother. In all other cases, local welfare officials, we feel, would be best equipped to evaluate the situation, and make appropriate recommendations.

III. FAMILY PLANNING SERVICES

Sharing the Committee's concern with the spiralling problem of illegitimate births in our country, we welcome this opportunity to support the bill's recommendation that family-planning services be made available to AFDC clients, as stated in the report:

> "Family planning services would have to be offered in all appropriate cases. States would have to develop programs designed to reduce the incidence of illegitimate births, and to establish the paternity of illegitimate children and secure support for them." (p. 16)

And later in the report—

> "Family planning services are to be offered to the [AFDC] recipient and, in accordance with statements on the subject previously issued by the Secretary of Health, Education, and Welfare, *can be accepted or rejected* [emphasis added] in accordance with the dictates of the individual's religion or conscience." (p. 98)

In this regard, however, we are distressed to note that more financial support has not been given in the bill to the Special Maternity and Infant Care project grants, as administered by the U.S. Children's Bureau. As the Committee report confirms:

> "It is these programs that have opened the door to family planning services for thousands of low-income families for the first time." (p. 127)

At the same time, as we have stated in previous testimony, these programs provide comprehensive health-care for low-income, high-risk expectant mothers,

as the soundest possible approach to combatting mental retardation and other congenital defects, the highest incidence of which is to be found in this economic group. In the current total of 55 centers—both urban and rural—where these programs have now been instituted, dramatic reductions in both maternal and infant mortality have also been achieved.

In our assessment of this program's total value, as we have stated:

> "There is perhaps no more effective way to provide for the sustained quality of America's future, than by helping her new born citizens to a healthy start in life, *with the assurance that these new born will be wanted both by their parents and by society.* The tragedy of unwanted and rejected children is a causative factor in juvenile delinquency, as confirmed by the report of the President's Commission on Law Enforcement. Among the Commission's major recommendations for dealing with the problem of juvenile delinquency is providing the availability of family planning assistance."

It is our feeling that this program, which has already proven its value, is deserving of greatly increased support and expansion. Unfortunately, the bill's adherence to the Administration's proposed increase of $5 million will all be absorbed by increased medical care costs in the centers already established, and will not be sufficient to expand the program. We recommend an increase of at least $15 million. With the appointment of the former Chief of the Children's Bureau as HEW's Deputy Assistant Secretary for Family Planning, we anticipate greater impetus and achievement in all related Federal programs.

IV. CHILD HEALTH AND WELFARE

Regarding other proposals for the improvement of child health, we note the elimination of all present earmarked programs beginning July 1, 1968. We also note that the Bill transfers the Child Welfare program from Title V to Title IV of the Social Security Act. No reason is given for these moves. We believe that all this needs clarification. The States would be required to assume all responsibility for project grants beginning July 1972; and as of that date, HEW's project-grant authority will lapse and funds given directly to the States. We question the wisdom of this because the States may not then provide the needed money.

This would, of course, directly affect the Maternal and Child Health program, and Crippled Children's Services, each one of which functions under separate State grants under the present law. As the House Report states,

> "Existing requirements on States such as extending the provision of maternal and child health and crippled children's services to make them available by 1975 to children in all parts of the State and requiring the States to pay the reasonable cost of inpatient hospital care are continued." (p. 126)

As the Committee report states, the consolidation of these formula grant programs will stimulate the States to carry out "more aggressive programs of early identification of children in need of treatment," and we strongly support such consolidation. In view of this proposed consolidation, we are both puzzled and dismayed to learn of HEW Secretary Gardner's executive order of August 15, transferring all crippled children's programs out of the Children's Bureau, to the newly-formed "Rehabilitation Services Administration." The APC urges the Committee to use its influence with Secretary Gardner to reconsider this transfer. Our two reasons for this recommendation are: The House Bill consolidates the authorizations for crippled children's program with that of the maternal and child health programs. The Children's Bureau is better equipped to integrate these two related programs. Secondly, Rehabilitation's administrative experience is largely limited to adults, while 75 percent of crippled children's case-load is composed of young children. The Children's Bureau consequently is better equipped to administer this program for children.

For Child Welfare services, we support the recommended increase from $55 million to $100 million for fiscal 1969, and the recommended $110 million for each fiscal year thereafter. We regret, however, that the Committee has not seen fit to equate Federal assistance for child welfare services with that now provided for public assistance programs.

V. SOCIAL WORK MANPOWER

Concerning the bill's proposal to prevent child abuse, neglect, or exploitation, your Committee is undoubtedly aware that, while 49 of our 50 States (now

pending in Hawaii) have enacted Child Abuse laws, at the beginning of this decade only one state—California—had such a statute on its books. At the time of a special editorial on this subject in Parents' Magazine written by the Chief of the Children's Bureau for November 1964, less than half of the states had enacted such laws. Six months later, the number had more than doubled, rising steadily to virtually complete coverage. However, testimony prepared by the American Parents Committee in support of the proposed Child Abuse law for the District of Columbia showed that in nearly all States, there continues to be a crippling shortage of trained social workers, a situation that inhibits these statutes' effectiveness. More recently, our research leading to APC's *amicus curiae* brief of the *Gault* case before the U.S. Supreme Court has confirmed the alarming shortage of such trained specialists in the juvenile court systems throughout our country. We therefore both commend and support the all-too-modest authorization contained in the bill for social work manpower training of $5 million for fiscal 1969 and each of the three succeeding fiscal years. As the Committee report confirms,

> "The successful operation of public welfare as well as many other programs is dependent upon sufficient number of trained social work personnel . . . The distribution of social workers around the country is uneven and although all parts of the Nation have a shortage, in some parts the shortage is critical." (p. 110-111)

As we have already noted, such an authorization means that one dollar is invested in social work manpower training for every ten thousand dollar's worth of ongoing Federal-state programs.

Finally, in relation to my testimony today, I hope your Committee may find it helpful to examine the following attachment, representing a Resolution passed unanimously at APC's last national Board of Directors meeting in November 1966.

Thank you very much for the privilege of appearing before your Committee today.

RESOLUTION OF THE AMERICAN PARENTS COMMITTEE IN SUPPORT OF THE U.S. CHILDREN'S BUREAU ACTIVITIES

Whereas, The President of the United States has urged that all appropriate measures be adopted to lower our country's infant mortality rate, which in the past year was 24.8 per 1,000 live births and exceeded 100,000 cases, ranking the U.S. twelfth among those countries in the world attempting to reduce their infant mortality rate; and

Whereas, The U.S. Children's Bureau has long been designated by the Congress as uniquely qualified to administer federal programs to combat infant mortality, to promote maternal and child health and child welfare, and youth development; and

Whereas, The incidence of infant mortality and the hazards of pregnancy occur most frequently in low-income families whose children comprise one-third of our nation's child population, concentrated in large cities or depressed rural areas; and

Whereas, To combat these problems, the U.S. Children's Bureau now has 52 comprehensive maternity and infant care projects including those in our ten largest cities, under grants from the 1963 Maternal and Child Health and Mental Retardation Planning Amendments, which amendments will expire on June 30, 1968; now, therefore

Be it resolved: That the Board of Directors, acting in its fall meeting on behalf of the American Parents Committee, Inc. express its support to the appropriate Committees of the 90th Congress, of new amendments to Title V of the Social Security Act which would emphasize the purpose of reducing infant mortality; support intensive-care units in hospitals and follow-up care for infants in the "high-risk" category; and provide an appropriate increase in federal funds in order to extend the above projects to other major cities and rural areas; and respond to increased patient load; and

Be it further resolved: To stimulate a coordinated attack by the States on these problems, taking into account the steadily rising costs of medical care, and the increased costs of administration of the 1965 amendments to the Social Security Act, that the Maternal and Child Health Services provisions of this Act be both extended and appropriately broadened; and

Be it further resolved: That this Act's provisions of Services to Crippled Children be similarly extended and broadened, so that both Services may be made available to all parts of the States by 1975, as required by law; and

Be it further resolved: That a new provision be made in the Social Security Act, for the daily group care of those children so severely retarded that they cannot be accepted in public school programs for retarded children, with expanded emphasis on research relating to maternal and child health and crippled children's programs that, hopefully, will prevent many such instances of retardation in future generations; and

Be it finally resolved: That the American Parents Committee, Inc., through appropriate action by its Board of Directors, record our continued opposition to any proposals to attenuate or transfer these or any other programs administered by the U.S. Children's Bureau; and we hereby reaffirm our appreciation for the dedicated spirit, imaginative and compassionate approach, and skilled administration of the U.S. Children's Bureau on behalf of our nation's children.

For the American Parents Committee, Inc.:

GEORGE J. HECHT, *Chairman.*
MARTHA M. ELIOT, *Vice Chairman.*
BARBARA D. MCGARRY, *Executive Director.*

NOVEMBER 15, 1966.

The CHAIRMAN. Now, the next witness will be Mr. William D. Ginn, president of the Cleveland Welfare Federation.

STATEMENT OF WILLIAM D. GINN, PRESIDENT, THE WELFARE FEDERATION OF CLEVELAND

Mr. GINN. I am William D. Ginn, a practicing lawyer in Cleveland, Ohio, and the president of the Welfare Federation of Cleveland. I appear in support of two amendments proposed to the Social Security Amendments of 1967; namely, amendment No. 294, sponsored by Senator Frank E. Moss and others and amendment No. 298, sponsored by Senator Edward M. Kennedy and others.

The welfare federation is a nonprofit organization which brings together more than 200 organizations for the purpose of community planning in health and welfare in the Cleveland metropolitan area. The federation has had a long history of concern and activity in the field of improving nursing home standards and practices. Approximately 3 years ago, the federation embarked on an intensive study of the expanding nursing home industry with the objective of assuring that our ever-increasing numbers of ill and elderly citizens would have quality care available as needed.

It has been common knowledge for years that the conditions in many nursing homes are deplorable. It had been our belief, until several years ago, that these conditions were traceable to a low level of payments for welfare patients and minimal licensing by State governments. These myths were shattered by our study.

The conditions we found paralleled testimony from the hearings held in various parts of the country by Senator Moss' Subcommittee on Long-Term Care. We were also familiar with the General Accounting Office's report of abusive practices in nursing homes in California. We arrived at the conviction that the Federal Government is not getting full value for the money going into nursing home care; that the problem is national in scope; and that real improvement will come only through Federal legislation directed to enhancing the quality of care actually received by the patient. We believe the amendments proposed by Senators Moss and Kennedy make significant contributions to this result and should receive your support.

THE WELFARE FEDERATION'S NURSING HOME STUDY

The actual facts developed in the federation's Cleveland area study are now well known. The study was the subject of testimony before the House Ways and Means Committee this spring by Mary Adelaide Mendelson, our planning consultant on nursing homes. The pattern of deficiency developed in her testimony comes through all too clear:

Nursing homes operating day after day in open violation of the State licensure program.

Welfare recipients placed in nursing homes at the rate for maximum nursing care, regardless of the patient's actual needs.

Physicians in some instances limiting patient visits to the number permitted by reimbursement policies rather than as required by the patient's condition.

Podiatrists being compensated for routine care which has already been included in the nursing home compensation rate.

Drugs purchased but not necessarily used by the patient for whom they are allegedly prescribed.

Patient's personal expense money not accounted for by the nursing home operator.

Mrs. Mendelson's statement to the House Ways and Means Committee dealt in detail with such deficiencies as these. For convenience we ask that a copy be made a matter of record in this hearing.

The important point for present purposes is what has happened since Mrs. Mendelson's appearance this spring before Ways and Means: Federal and State authorities, prompted by our findings, have conducted their own independent investigations and have confirmed the need for corrective measures.

THE GENERAL ACCOUNTING OFFICE'S OHIO REPORT

First, there was the General Accounting Office report. At the request of Senator Moss the General Accounting Office made an inquiry into alleged improper practices in providing nursing home care, medical services, and prescribed drugs to old-age assistance recipients in the Cleveland area. In April GAO confirmed that conditions, such as our report described, do, in fact, exist, and that the policies and procedures of the State of Ohio enable this to take place.

Then the Department of Health, Education, and Welfare visited Columbus, a flurry of activity occurred and no evident progress has been made.

THE STATE HEALTH DEPARTMENT REPORT

The Ohio State Health Department issued a report praising its own program as rigid enforcement of nursing home regulations, and, in doing so, ignored the GAO finding of 61 homes showing a total of 312 violations relating to patient treatment and care. The health department cited as its evidence of rigid enforcement that seven homes had closed, or were closed, in Cuyahoga County. But we know that one of these closed at one address and opened at another; that another home named has never been heard of by persons involved in the placement of patients and isn't listed in any directories or telephone books; and, in short, none of these homes was closed by reason of enforcement of regulations pertaining to patient care.

THE STATE WELFARE DEPARTMENT REPORT

More recently, the Ohio State Welfare Department announced the findings of a four-man staff committee named to investigate the GAO report. The welfare department is solely responsible for overseeing the actual care provided public assistance patients. The GAO had found one pharmacy billing for drugs to patients deceased and already removed from the welfare rolls. The GAO had found indications of vendors being paid for services which, if performed, may not have been necessary. The GAO had found one physician who was paid for 79 patient visits at several homes over a 30 mile area, all on one Sunday.

The welfare department report says "nonsense—the staff investigated and found no irregularities". Yet in the next breath the welfare department committee acknowledged and recommended:

That doctors be required to sign personally any order for a prescription;

That pharmacists obtain receipts from nursing homes upon delivery of drugs;

That doctors be required to bill for the specific date on which services are provided; and

That the services of podiatrists be provided in nursing homes only on recommendation of a medical doctor.

One is left to conclude that the GAO report has been validated by the State's own investigations, yet the GAO's recommendations of basic procedural protections, such as postauditing of vendor bills, will apparently remain unheeded.

CUYAHOGA GRAND JURY REPORT

Finally, there is the matter of the Cuyahoga County grand jury's investigation. The welfare federation has been seeking correction of nursing home problems, not criminal indictments—the welfare federation is not equipped with either the powers or the authority of an investigating body. Nevertheless, when the grand jury decided to inquire, we turned over our information and the GAO report as well.

The grand jury on July 8 issued its report in the form of a letter from the foreman to the presiding judge. No indictments are returned. The report, less than a page and one-half long, covers only two factual matters, one pertaining to nursing homes presumably closed by the State and the other being an actual case referred to by Mrs. Mendelson and investigated further by the grand jury. Unfortunately, neither factual statement is at all accurate.

First, the statement is made that 81 homes were closed in Cuyahoga County between January 1, 1965, and October 1966 for not conforming to standards set by the State; and the grand jury considered this quite significant. We would agree, if it were true. There are approximately 90 nursing homes in Cuyahoga County. During the period in question not 81 homes were closed in Cuyahoga County, but only eight. And it is doubtful whether any were closed by enforcement of standards relating to patient care—most of the eight simply went out of business due, for example, to retirement of the manager or relocation of the operation.

Second, with respect to the case of the man who has been receiving aid-for-the-aged reimbursements as an M.D., the grand jury report

states that "records in the office of the aid for the aged, who employed this man, do not indicate that he was an M.D." This is simply not the fact. We understand that since the issuance of the grand jury report the GAO has gone back to Ohio, has reviewed the records and has found that during the period from December 1965 to June 1967 the man in question was in fact carried in the records of the aid for the aged as an M.D. We are at a loss to understand how the grand jury could have been misled in its own investigation.

Since neither of the grand jury's factual statements is accurate, we are inclined to doubt the thoroughness of the investigation which it was able to accomplish. Nevertheless the grand jury did recommend that there be "tighter and more frequent inspection" and "more rigid enforcement of present regulations." This is a conclusion with which we wholeheartedly agree; and the grand jury is fully supported by the findings of the GAO.

As for the grand jury's failure to indict, this is, of course, the prerogative of the jury. The fact remains, however, that the GAO report was in the hands of the grand jury and we believe it is significant that the grand jury did not challenge any of the GAO findings.

This experience with the grand jury has served to underscore again the urgent necessity for legislation which will provide basic jurisdiction at the Federal level where much of the needed expansion and improvement in nursing home services will originate under the financial impetus of social security benefits. This important objective can be achieved through the Moss and Kennedy bills.

THE MOSS BILL, AMENDMENT 294

We support the Moss bill, amendment 294, because it provides a number of ingredients which are necessary, as we see it, if the Federal commitment to decent nursing home care is to be meaningful to patients, taxpayers, and the nursing home industry itself.

First, we have no quarrel with the fact that licensing of homes is properly the function of the State. But the Federal Government has the right, and as we view it the duty, to require certain basic standards, such as that nursing care be supervised by a professional registered nurse, that special diets, medically required, be provided under a trained dietitian, and that each patient be permitted the services of his own physician. In short, a nursing home professes to be a health facility and should be so operated and regulated. Amendment 294 provides exactly this.

Second, we also have no quarrel with the fact that nursing homes should be reimbursed for the degrees of care they must provide. But the Federal Government has the right, and as we view it the duty, to insist that the degree of care for which payment is being made actually be provided the patient and that the cost reimbursed be reasonable. These are important concepts. One witness before the Senate Subcommittee on Long-Term Care testified that in 1963, in Massachusetts, nursing homes operating at welfare rates figured on $1,000 profit per year per bed. Amendment 294 provides that the Federal Government pay reasonable costs, and protects this concept with audit rights, limitations on high-interest, long-term capital loans and disclosure of the identity of operators and owners.

Third, many of the most grievous problems in the nursing home industry stem, in our judgment, from the fact that State inspections are concerned almost exclusively with the physical facility—not the patient's care—and the caseworker's job is to check the financial eligibility of the welfare patient, not the level of care needed by the patient. Federal funds theoretically support differing degrees of care, as needed by the patient. Amendment 294 provides the necessary protection in the form of medical review teams who will assure that proper care is provided and that no higher degree of care is being reimbursed to the nursing home operator.

Fourth, if our experience over the last year has taught us anything it is this—that in spite of a reasonably good State licensing program, Federal funds are continuing to subsidize open and actual violation of State standards and policies by particular homes. This has been confirmed to all by the GAO report and those that followed from the State health department and welfare department. Amendment 294 provides the necessary incentive for the prompt correction of violations in the form of withdrawal of Federal matching funds until compliance is complete.

THE KENNEDY BILL, AMENDMENT 298

As will be evident from the foregoing, our conviction is that the Moss bill (294) provides an important addition to the social security package. We are similarly of the view that Senator Edward Kennedy's Amendment 298 deserves your support. The public needs assurance that nursing homes licensed by the State and financed partly through Federal funds are managed by persons of good character and with proper qualifications for their job. It is significant that over half the welfare patients in nursing homes in Cuyahoga County are without any relatives whatsoever; and we believe this is typical of other areas throughout the Nation. Senator Kennedy's amendment would make it mandatory for the State to establish qualifications and to license the operator as well as the home. We view this as a necessary and desirable protection.

CONCLUSION

It is not often that an opportunity arises such as this to make basic changes in a significant area of Federal expenditure. Robert J. Myers, Chief Actuary of the Social Security Administration, in his testimony before this committee last week disclosed that the original estimate for first-year costs under medicare for nursing home services of $25 to $50 million will likely run closer to $250 to $300 million. (And if one includes tax funds going into nursing home care under public assistance programs, the total tax commitment State and Federal, is closer to $1 billion.) In view of these costs no one can doubt the importance of the nursing home business to the Federal taxpayer.

There are excellent nursing homes and fine operators. But the evidence is irrefutable that there are basic problems pervading the industry and there is no indication after 10 years of phenomenal growth that the cure will be automatic. Before further Federal funds are committed, Congress should provide the basic conditions under which the anticipated growth will be healthy and in the public interest.

The Moss and Kennedy amendments provide the needed basic legislation and we urge your support of them.

The CHAIRMAN. It seems to me that what you are advocating here is a higher standard of care in these nursing homes, and that there be better assurance that the care is tailored to the patient's needs.

Do you have any evidence that the conditions and the irregularities that you found in Cleveland exist elsewhere in this country?

Mr. GINN. Well, Senator, the hearings of the Senate Subcommittee on Long-Term Care developed comparable information in other parts of the country.

In addition, the GAO report on California confirmed a comparable situation to that which was developed by the GAO in its checkup on the State of Ohio.

We have a conviction that this is a nationwide problem.

The CHAIRMAN. I suspect that you are right about that, and we are going to take a look at it.

I notice that you say that one of the witnesses before the Senate Subcommittee on Long-Term Care testified that in 1963 Massachusetts nursing homes operating at welfare figures figured on $[illegible]00 profit for a year per bed. That really appears to be a rather extreme profit, does it not, for someone in that business?

Mr. GINN. Senator, you take a 250-bed nursing home—and there are many of those around the country—and that is a tidy sum, $250,000 pure profit per year.

I do not think we are trying to exercise a judgment on what is a reasonable cost, but one of the important ingredients of the Moss bill, and I think it is an ingredient which is of interest to this committee, is that concept; that there should be reasonable costs, and that you should only be paying, as far as the Federal Government is concerned, for care that is actually received in those nursing homes. Our investigation in Cleveland developed enough facts, we feel, that warrant this kind of Federal legislation.

The CHAIRMAN. I have some suggestions from some people that there ought to be a way where people could have the benefit of the money that is available to provide them nursing home care, and if they have additional resources to pay, that they might be able to pay something extra and have better facilities available to them. Do you have any thoughts along that line?

Mr. GINN. If I understand you correctly, Senator, this would be a concept of supplementation?

The CHAIRMAN. Yes; that is right, have the benefit of what the nursing home—in other words, sort of a super nursing home or something better than what you can provide with the funds we have available.

I just wondered if you had given any thought to that, as to what people might be able to provide if they were able to pay, perhaps, twice, what the Government would pay otherwise. If they wanted something better they could provide it for themselves.

Mr. GINN. I really feel, personally, that the Government is committed to a needs test here as it is in much other legislation, and if the need is there for support, that is one thing. If the need is there, then I see no point in the Federal Government allowing a supple-

mentation over and above what is necessary for the basic degree of care that the Government sponsors.

The important thing in this legislation, as we see it, is the objective that the money the Federal Government pours into the nursing home industry go for adequate care and not for inadequate care.

The CHAIRMAN. Right.

Now, you indicate dissatisfaction with the findings of the Cuyahoga County grand jury. Did you have any evidence that the jury did not thoroughly consider Mrs. Mendelson's charges?

Mr. GINN. Well, No. 1, Mr. Chairman, the charges, so-called, of Mrs. Mendelson's were not made in the context of seeking criminal indictments. We are seeking adequate nursing home care.

Now, the grand jury did take the opportunity to investigate, and I would like to attach to my statement the actual report of the grand jury. It is in the form of a letter that passed between the foreman of the grand jury and the presiding judge of the criminal court, and it is less than a page and a half in length.

I think that letter almost speaks for itself, Senator. The type of investigation which is reported there is very cursory compared to the problem involved, and the reason why we feel dissatisfied with the report of the grand jury is that on the two factual matters that the grand jury refers to, in neither one of those factual matters actually is the grand jury correct.

In other words, they said that nursing homes had been closed by the State of Ohio in Cuyahoga County, and they cited 81 homes in a given period, and they said that was for not conforming to standards set by the State. The grand jury, of course, felt that was quite significant to close 81 homes.

Well, the fact is, Senator, that it simply is not true. There are only 80 nursing homes in Cuyahoga County and only eight of them were closed in that period and those eight were not closed by reason of any failure to comply with standards or by enforcement of State standards. They were closed simply because some of them went out of business, the manager retired, the home moved to another location, and it was counted as a closure even though it opened elsewhere, and so forth. So, on that point the Cuyahoga grand jury was simply wrong.

On the second point, which involved the aid for aged reimbursement of a man who purported to be a medical doctor, the grand jury says that they investigated the aid for aged records and they could not find any indication in the aid for aged records that he purported to be a medical doctor.

Yet we understand that since the issuance of that report, the GAO has gone back into Cuyahoga County and to Columbus, they have reviewed the records, and they have found that the records are there, and that during the period December 1965–June 1967, this man is shown as a medical doctor on the records of aid for the aged, although he is admittedly not a medical doctor.

So, when you have the only two factual things that the grand jury mentions being dead wrong, we question the accuracy of the whole report.

Moreover, as you will note from my statement, the grand jury, even as it said in one breath there was nothing wrong, came out and made recommendations for better enforcement, tighter policies on the part

of the State. So, it is somewhat anomalous that they would do that if there was not anything to be found in the investigative process.

The CHAIRMAN. I want to commend you and commend your federation for the good work they have done in this area. I hope that someone can stir up civic organizations in my own State to do more of this type of thing.

We pay taxes and provide money to try to look after people who are sick, people who need care and need help, and it is just outrageous to find that after we pay for it someone victimizes them, makes a big profit and exploits the sick, the poor, for their own selfish advantage at taxpayers' expense. Those kinds of things are just outrageous.

I have been very disappointed that every State, to my knowledge, including the one I have the privilege of representing, is doing a job of providing care for mental patients that just cannot pass muster if any civic group goes and takes at look at it. It just won't do it. Every one I have seen provided by State government is a disgrace to the country. I guess the Federal hospitals provided for veterans' care would be an exception to that. I have been so dismayed just to see, for example, what is being done in mental institutions where in so many cases they are just herding those people together, to separate them from society rather than to provide them with some care and some treatment which they desperately need.

So what you have done here, I think, is a very fine thing, and I urge you to keep it up, and I assure you that we will carefully look at these recommendations.

Is it the Kennedy-Moss bill or the Moss-Kennedy bill? It has two good Senators sponsoring it who are in agreement with you. But that will be thoroughly considered in the committee.

Mr. GINN. Mr. Chairman, as you note in our statement, we are in favor of both of those bills for the reasons we have outlined.

I would like to ask that the chairman make a part of the record here also the statement of Mrs. Mendelson, which goes into the abuses. This was the statement given before the House Ways and Means Committee. I did not include that as part of the detail in this statement for the reason that I wanted to save the Senator's time this morning. But her statement is available and we can make it available to counsel along with the grand jury report which would complete the attachments.

I have just one other item I would like the Senator's permission to mention.

The CHAIRMAN. Yes.

Mr. GINN. There is the impression, possibly, that once you expose abuses by publicity, such as was done as a result of Mrs. Mendelson's statement last April, that something will be done about it, and that concrete results will occur.

We have outlined in our statement the reasons why we feel that those results did not occur in Ohio. I would mention just one specific instance, for example, that came to my attention within the last week, of a woman who put her mother in a nursing home. At the time, according to the woman's own statement to me, her mother was living in a four-room apartment.

She was doing her own laundry, plus the laundry of a former neighbor; she had a good appetite; she weighed approximately 150 pounds. She was able to dress herself, take care of herself, fix her own meals, and so forth.

She was put in a nursing home because she was getting senile, and she was so independent that she would not live with any of her three children. During the first week—and this was only in March of this year—the woman was not permitted to see her mother at all, and when she came after the first week she saw a dramatic change in her mother's appearance and in her attitude. She was meek; she seemed somewhat weak; and within a short time it became apparent that she was having heavy medications. There was a lot of denial back and forth between the nursing home operator and the doctor as to whether the medications were being given or not, and there was no explanation for the purpose.

In a little more than a month this woman lost the effective use of her facilities; her dentures had not been cleaned; her gums became swollen and sore; and she lost the ability to feed herself and to dress herself. Her glasses were taken away, and within a matter of 4 weeks after she had appeared at the door of the nursing home they were strapping her in bed in order to keep her quiet, in order to keep her out of harm's way, as the operator would say.

Finally, in desperation, the woman attempted to remove her mother from the nursing home, and she did so early in June, and this is less than 4 months after the woman had gone to the nursing home. Finally, realizing that her mother was literally dying, she got an ambulance, went to the nursing home, took her mother to the emergency room of a private hospital, and there her mother was admitted unconscious, with a temperature, with pneumonia, with bedsores on her buttocks, a virtual skeleton.

She lasted only 5 days, never came out of her coma, and the death certificate reads, "Death by terminal bronchial pneumonia, dehydration, and malnutrition." The undertaker said she weighed less than 100 pounds at the time they buried the woman.

This happened in less than 4 months. This woman was a patient receiving the aid from the State of Ohio under the public assistance program. The case was referred to the State by the woman herself. She did not come in to us until after the frustrations of the whole thing. Her mother died, but during her mother's lifetime she was at the doors of the State trying to get them to see what was happening to her mother. Her pleas went—well, of course, there were polite letters. There was a letter, for example, from the State nursing home licensing administrator saying, "As you know, unsatisfactory conditions in nursing homes cannot be corrected overnight," and recommending to this woman to see "if your mother can be moved to another nursing home where satisfactory care can be given."

This particular example arose after the State had cleared the nursing home program by the reports that have been brought to the attention of this committee and also the Senate Subcommittee on Long-Term Care, and the House Ways and Means Committee.

So, our feeling, Senator, is that where you have real questions—and we do believe that there are real questions, of adequacy of care throughout the country—we need basic Federal jurisdiction established by law. The Federal Government here is spending a tremendous amount of the taxpayers' money, and we feel that it is incumbent upon the Federal Government to get real value for the money that it is spending.

It is not often that we have this opportunity, really, to come to the Committee on Finance without asking for money. That we are not doing.

As Senator Moss indicated, his bill seeks to be sure, to assure, that the Federal Government gets value for the money that it is spending, and that the money that it is spending goes for adequate nursing care. We feel very strongly that the provisions in the two bills will contribute to that result.

The CHAIRMAN. Well, I appreciate your testimony.

Mr. GINN. We support them.

The CHAIRMAN. I appreciate your bringing this to the attention of the committee. We will certainly look into it.

As you realize, I am sure, the purpose of this whole program is to help people who otherwise might be left in the very kind of condition that you say these people have found themselves in. The purpose was not to let somebody make a killing by victimizing a lot of poor, old, unfortunate people or sick people.

The purpose of the program is to provide these people with care and, frankly, if what you describe here is prevalent in other States, then I think it is time we make a real major effort to clean all that mess up and straighten it out.

So we will certainly take a good look at it.

May I say that is one reason I wanted some additional people on this committee staff, so that they could help me on some of this.

It is sort of depressing to go through some of the nursing homes because a lot of these poor people are bedridden and will never be able to get about again. At the same time, we do want to have good care for them.

Thank you very much.

Mr. GINN. Thank you, Senator.

(The attachments Mr. Ginn referred to follow:)

STATEMENT OF MRS. MARY ADELAIDE MENDELSON, ASSOCIATE EXECUTIVE SECRETARY, THE WELFARE FEDERATION OF CLEVELAND, BEFORE THE HOUSE WAYS AND MEANS COMMITTEE

I am Mary Adelaide Mendelson, Associate Executive Secretary of The Cleveland Welfare Federation. I am speaking neither for nor against HR 5710 in its present form. Rather, I have accepted this opportunity to speak on the issue of whether HR 5710 ought to be revised to deal directly and explicitly with the problems of nursing home care; and it is my conviction—for reasons which will be explained shortly—that a revision must be made in order to protect the financial interest of the Federal government and the human interest in decent care for nursing home patients.

Present with me today is Richard E. Streeter, who is counsel for The Cleveland Welfare Federation. The Federation is a non-profit organization which assists in the planning and coordination of private and public health and welfare efforts in Greater Cleveland. Approximately two and one-half years ago I was employed by the Federation to work in the area of improving nursing home standards and practices. During the course of this assignment, a detailed study was undertaken of nursing home care. The report which has been assembled, of which this is a copy, has been placed in the hands of the Chief Counsel for this Committee. Because the report details factual practices of specific nursing homes, we desire to maintain the confidentiality of its contents. But we would be pleased to discuss it at greater length in executive session should the Committee deem this appropriate or desirable.

NECESSITY FOR ATTENTION BY HOUSE WAYS AND MEANS COMMITTEE TO NURSING HOME REVISIONS IN H.R. 5710

Our work in the nursing home field has led us to the conviction that there is a genuine need for this Committee to be informed about and alerted to the real

facts and issues in the field of nursing home care. The specific Federal financial interest is in Medicare, the health program under Title XIX, Old Age Assistance programs under Title I and Veterans financing programs. Enormous sums are being spent through these programs on patients in skilled nursing homes. There is, we believe, serious doubt whether you, the Federal government, are in fact purchasing the kind and quality of care you think you are purchasing.

You are entitled to ask, for example, whether some of the physicians' services you are purchasing have in fact been furnished—we believe not.

You are entitled to ask whether some of the pharmacies you support financially have actually supplied necessary and proper medications for which they were paid—we believe not.

You are entitled to ask whether Federal vendor payments in the amount of at least $212,000,000 annually are buying either the quality of care you have a right to expect or, in some instances, even the care itself—we believe not.

We are prepared to substantiate our convictions and to offer to the Committee suggestions for amendments to protect Federal interest and the nursing home patients. First, however, it would be well if the Committee were to understand fully the nature of the nursing homes we are discussing and the patients who are being served by them.

DESCRIPTION OF SKILLED NURSING HOMES AND THEIR PATIENT POPULATION

There is a surprising lack of real understanding of the skilled nursing home business. When I speak of skilled nursing homes, I am talking about homes which advertise and provide what is known as "skilled nursing care." Most, and I mean almost 100%, of the patients are over 65 and probably over 70. One half to 60% receive Old Age Assistance benefits. In the Cleveland area, 53% of the public welfare patients have no family. Even where there are relatives, the patient frequently does not see them. These patients are, in other words, alone. This fact is *important* because there is no one interested in protecting or defending most patients. Their stay at the skilled nursing home will average between two and three years, and it terminates with death. They are *not* rehabilitated; they do *not* return to the community; and, as I understand it, medical science today does not know how to rehabilitate them.

Some people refer to these patients as needing "custodial care", meaning just general supervision. It is a fact, however, that large numbers of these patients are on prescription medications; they need help with bathing, dressing and walking, all of which require some skill in handling; and in general they are sick but not so acutely as to be hospitalized.

Contrary to popular belief, many of these people go into a skilled nursing home from their own home—or at least not from a hospital—and are placed there in approximately one half of the cases by the Old Age Assistance case worker. This case worker is required by law to be concerned with the financial needs of the patient more than with the individual's total welfare. And under prevailing law and existing practice the worker will not see the patient for another year at the very best.

The nursing homes, which I am reluctantly describing, will have both private and welfare patients. They will have patients requiring intensive care and patients needing only some supervision. In fact, many of the younger ones or those under 65 are really only alcoholics, but the community has no better plan for them than confinement in a skilled nursing home.

Some of these nursing homes, although not a large number, have been certified as extended care facilities. In other words, the extended care facility and the skilled nursing home may be the same place, and these homes are not merely rest homes or boarding homes, or custodial homes; and the patients constitute a mix—a mix both physically and financially. It is also well to remember that the patient himself is not "static." He can only move downhill physically, demanding more skilled care; and he can only move down financially, even eventually becoming a welfare charge.

UNBELIEVABLY POOR CARE BEING PURCHASED BY FEDERAL FUNDS

This then is the setting. The care furnished is often unbelievably poor. There are many examples but suffice it to relate one story only. A state inspector reported finding that a particular home, having served a light supper at 4:00 p.m., made no provision for breakfast for its 40 patients, approximately 20 of whom were bedfast, and almost all of whom were public assistance recipients. Your

money paid for these unserved meals; and there is evidence that such poor care is all too commonplace.

LOW PUBLIC ASSISTANCE RATES AND MINIMAL STATE REGULATION ARE NOT RESPONSIBLE FOR POOR CARE

It is a common belief, once shared by The Welfare Federation, that deplorable conditions in many nursing homes were due primarily to two factors:

1. Low public assistance rates paid for the care of the many welfare patients;
2. Minimal licensing regulations on the part of state governments.

We now know from our extensive study of nursing home conditions that these premises are in error—that poor care will not necessarily disappear if assistance rates are higher; and the conditions persist in spite of regulations which are hardly minimal—the regulations in Ohio and some other states do not differ measurably from the Medicare Conditions for Participation.

It is necessary to point out, moreover, that some homes provide good care in spite of the many difficulties inherent in performing well. As for the preponderance of homes with the largest number of patients, their operators are not doing a good job. In fact Mr. Chairman and members of the Committee, they are not only doing a poor job but they are to some extent, defrauding the government by not delivering the service for which you are paying.

What then are some of the factual areas where inquiry by this Committee seems warranted?

PHENOMENON OF MULTIPLYING BEDS IN SPITE OF LOW RATES

One subject of interest is the phenomenon of the multiplying of skilled nursing home beds in spite of the large number of welfare patients and attendant low rates. In the Cleveland area, as of January 1966, in a four-year period only 9 homes out of 86 had closed, 13 new homes had opened, and one-half of the 50 homes with whom I have had contact have expanded or plan to expand. I suggest that a proprietary business does not remain in business if it is losing money. Who, one wonders, is financing these homes? The Senate Subcommittee on Long-Term Care found examples of some questionable financing deals involving high interest rates. Indeed, the hearings and other reports which the Senate subcommittee has would provide data that should be most useful to anyone conscious of and concerned about the amount of public money spent for skilled nursing care.

RATES AND COSTS

It should be mentioned that even some homes concentrating almost 100% on welfare patients are expanding in spite of what is considered impossibly low rates. Several nursing home operators—two of whose facilities are now certified extended care facilities—gave me quite revealing stories on their costs—and quite a different story from the usual one. Two claimed their costs, including payments on the mortgage, were below $200 a month per patient; and one—a new facility—claimed costs were below $300 a month. As extended care facilities, they will be getting most likely in the neighborhood of $540 a month from Medicare. Under Title XIX under the Ohio plan, they will be getting $300 a month. Private patients would have paid in these homes a few months ago between $255–$300 a month. It is doubtful if you would find that additional services have been added that would justify an additional $240 a month.

(Incidentally, I am not trying to justify low rates. I am merely suggesting that the Congress should know that low rates have not closed homes. I would hope that the Congress would also agree with me that high rates do not ensure good care.)

PHYSICIANS

Our study also revealed that some physicians who were billing the State for two visits a month for Old Age Assistance patients in the nursing homes were not always seeing these patients two times a month. Bills rendered were for services not provided. In fact, one of the problems that we frequently hear decried is the difficulty of getting medical care for private patients in skilled nursing homes. Such, however, does not seem to be the case with public assistance patients, many of whom were presumably seen more times than the State licensing regulations required or the physical health of the patient necessitated—at least bills to the

State would so indicate. Was the care actually provided? If it was, why are these patients frequently reported by the hospitals or the morgue as being emaciated, covered with bed sores and physically neglected, Yet not once has a physician in my county called the Aid for Aged office to complain about the care provided by the home later criticized by other authorities.

As a further example of possible fraud, I am reminded of payments made under the Medical Assistance program to an MD for alleged medical care furnished a number of patients. This "physician," however, is neither listed in the telephone directories as a physician nor registered with the Academy of Medicine.

DRUGS

Another curious fact, found in some instances, was that drug stores were being paid for "furnishing" more drugs than the patients, or the nurses, or the nurses records indicate were received. To what extent this is prevalent, I am in no position to say. However, it is a fact that one drug store in my community annually does a $170,000 business on Old Age Assistance drugs alone. There is no reason, in my judgment, to assume that these medications were all actually delivered, and if delivered used, and if used needed. Indeed one nursing home administrator has claimed that his particular home, as well as others, normally obtains his household supplies under the guise of drugs for patients, paid for as drugs by Old Age Assistance. Another nursing home operator explained to me, and to the Veterans Hospital social worker, that his drug store had billed a private patient three times in one month, to the amount of around $60, without ever itemizing the bill. The patient disclaimed having received that amount of medicine.

One pharmacist has admitted that several nursing homes offered percentage kick backs if he would service their telephone accounts. It was made clear that if the prescription is not for an unreasonable quantity, there would be no check by the authorities; and there was no way of knowing that the patient allegedly receiving the drugs either sees them or needs them.

There are many other opportunities for supplementing nursing home "income" through drug payments. For example, one of my informers has advised that a drug store in my county popular with nursing homes is owned in substantial part by a nursing home operator managing a large number of beds.

ADDITIONAL FIELDS OF INTEREST

There are still other areas requiring inquiry: lab work that may not be needed, but is paid for by public funds; podiatrists (with a frequency not generally countenanced in well run homes) providing quick and routine toenail care, paid for by Title XIX; payments received for orthopedic shoes when the "patient" is seen wearing only slippers; and so on.

SUGGESTED REVISIONS IN H.R. 5710

There are, of course, good nursing home operators whose service to the community needs support and recognition. In all too many instances, however, the abuses, of which the foregoing are a sample, are of such serious consequences, both financially and for the patients whose lives are involved, that HR 5710 should be revised to deal expressly with nursing home problems.

Because of time limitations, I request, Mr. Chairman, permission to incorporate our suggested revisions as an addendum to this hearing; and should the Committee desire further detail from our study I would be glad to appear at an executive session if this would serve your purpose.

Thank you for this opportunity to appear before the Committee.

ADDENDUM TO STATEMENT BY MRS. MARY ADELAIDE MENDELSON OF THE WELFARE FEDERATION OF CLEVELAND

The conditions which I reported in my testimony have led the Nursing Home Committee of The Cleveland Welfare Federation to suggest some areas in which revisions of the Social Security law should be made. This addendum singles out those areas but does not attempt to develop precise amendments. The report referred to in the testimony provides the factual rationale for proposed revisions.

Title XVIII Part A

REIMBURSEMENT FOR REASONABLE COSTS SHOULD BE FOR CARE IN FACT PROVIDED

The Nursing Home Committee of the Welfare Federation recommends that the law provide a procedure under which reasonable costs for which reimbursement is made reflect services actually rendered. Even at this early date, there are indications that services are not always actually furnished but are nonetheless paid for by reimbursement. Under the law, the casts of services are to be determined and a charge made on the basis of such determination. But the requirements of law can be avoided. For example, the cost of physical therapy can be figured and a charge made, but this does not insure that therapy is actually provided for the patient. No clear provision is made for an inspection of the quality of the care or a determination that care is, in fact, being provided. The law should provide for such inspection and determination.

UTILIZATION REVIEW PLAN

1. Definition of extended care should be refined

There is confusion regarding the kinds of patients who are eligible for extended care coverage. All that is necessary is that the patient be in need of care for the condition for which he was placed in the hospital and that this care be provided in a facility which, among other things, furnishes skilled nursing care. Many patients do need skilled nursing care for the condition for which they are hospitalized, but it is frequently long term care for many more days than the 100 days allowed under Medicare. The utilization review committee of both the hospital and the extended care facility have complied with the law when the patient is sent to and received at the extended care facility. Perhaps this is the purpose of Medicare, but if so, we fear that the patients will have 100 days of extended care and then move to a less expensive skilled nursing home for another year or two.

We think the patient should be saved from the unnecessary and traumatic moves from one facility to another. The patient will be spared when the definition of extended care is further refined so that the utilization review committees can perform their job.

2. Provision for a different kind of a utilization review committee

We further believe that a different kind of utilization review committee should be considered. Presently, in Ohio as elsewhere, a physician must determine the need for nursing home care. The physician may have a financial interest in the extended care facility and, therefore, be unable to render an impartial judgment. Title XVIII provides that there shall be two or more physicians on the utilization review committee. Many extended care facilities may accomplish this by combining their physicians on the committee. Such a committee would not ensure an objective review of admissions, duration of stays, or services furnished.

We have been told that even where a committee of physicians from outside the facility form a part of the utilization review committee, it is very difficult to oppose the house physician. We understand that the committee reviews the records but does not see the patient. We are concerned that the care may not actually be provided. If the patient is not seen, and, for that matter if the institution is not seen, then the utilization review committee is handicapped, to say the least, in making its judgment. We would suggest, therefore, that one of two changes (or both) be made in the make-up of utilization review committees.

First, the law could require that there be a medical team on the state level, composed of a physician, a nurse, and a social worker, which will make a spot check on extended care facilities and the Medicare partients to determine the kind of care given in fact, the conditions of the facility, and the integrity of the utilization review committee's report. Second, the law could require that the hospital utilizations review committee be used as the review committee for the extended care facility with which it has a transfer agreement. If this were done, it is possible that the hospitals would know better the kinds of patients who should go into an extended care facility. They would know what happens to the patients after discharge from the facility. They could follow the actual care of the patient, thus providing a continuity of care not realized under the present law.

INSPECTION SHOULD BE AT LEAST ANNUALLY

We recommend adoption of a provision requiring that the extended care facility be inspected at least annually. The Conditions for Participation allow a state to visit or resurvey institutions where necessary to ascertain continued compliance or to fit into the periodic or cyclical survey of the state programs. Our evidence indicates that homes must be inspected regularly. Information persists in coming to us, even regarding certified homes, that personnel, for example, are added for purposes of the survey and not for the purpose of providing the services needed. A spot check by the medical team suggested for utilization review above would, of course, mean a continuous threat of inspection of both patient care and the facility which in turn would increase the chances that the homes will act in good faith. However, we believe the law should provide an additional check by making inspections mandatory. The Conditions for Participation allow some leeway in compliance. There should be substantial compliance with the standards, if not full compliance, and there can be conditional compliance. In those instances where there is not full compliance, the state is required to resurvey within a prescribed time. Leeway must, of course, be left so that homes making every effort to comply are given the time in which to do so. Based on our evidence, the fact remains, however, that unless there is mandatory inspection and some check on the resurveys by the Federal government there are homes that will continue to be certified, although not, in fact, complying.

OWNERSHIP SHOULD BE DISCLOSED

We question the qualifications of some nursing home owners. We recommend that the law requiring that the extended care facility have an effective governing body should be amended to require further that ownership be fully disclosed. It is of vital importance to know whether a facility is connected through ownership with groups who can have an interest detrimental to the best welfare of the patient.

FINANCING CHARGES SHOULD REFLECT PROPER INTEREST RATES

In light of evidence available of unduly high interest rates charged for mortgage loans, we would like to see that reasonable costs do not permit reimbursement for interest charges above those normal for the area at the time the loan was made.

Title XVIII Part B

(The suggestions of The Cleveland Welfare Federation for amendment of Part B of Title XVIII are not related to the problems discussed in my testimony but are of great significance to nursing home patients.)

BILLING METHODS SHOULD BE CHANGED TO PROVIDE A THIRD CHOICE

Since many physicians bill the patient directly, rather than the carrier on assignment, and since the carrier can only pay if the bill is on assignment or prepaid, patients have been caught in a vice. The doctor who refuses assignment demands his pay. The patient must find the money, which he may only be able to do by withdrawing from his savings or by getting a loan. Either method can and does work a hardship on many patients. Therefore, we recommend a third method of reimbursement, namely, that the patient be permitted to turn his unpaid bill over to the carrier to process. The person over 65 may be easily confused. The simple method of turning over an unpaid bill to be handled for him has the merit of clarity.

PHYSICAL EXAMINATION IN SOME INSTANCES SHOULD BE COVERED

Routine physical examination is not covered by Medicare. But people in nursing homes for long term care present a special situation. Some state licensing regulations, as well as wise health care, require periodic examination by the physician. This should be covered explicitly under Medicare Part B.

Title XIX

COVERAGE—ADDITIONAL CARE SHOULD BE ADDED

Title XIX includes coverage of skilled nursing home care. No definition is provided for skilled nursing care. It is left to the State plan to determine who is

eligible and how he becomes so. There is confusion, however. The confusion arises because there are three different kinds of care into which patients fall, all three of which are provided in the same kind of home: extended care, skilled care and custodial care. Both extended care and skilled care are defined only through describing what the facility shall provide. Custodial care is excluded from coverage in extended care. Some people equate long term care with custodial care. We think that custodial care should be defined. We believe it should be defined to mean personal assistance only. Medication is not a part of the treatment, and the assistance is actually a kind of supervision. These people can take care of themselves, but they might forget to eat, or they might get lost, or they might forget what happened the day before. They need some protection but they do not need the skills involved in bathing, feeding, etc. They may need the protective environment for a long time. Most of the people in skilled nursing homes are also there for a long time. They, however, need more care than personal assistance. We believe that there would be less confusion if the Federal government matched funds for custodial care, although we recognize that it is not medical care. Perhaps in so doing, the other programs of extended care and skilled nursing care would be easier to administer and less likely to be abused.

REASONABLE COSTS FOR NURSING SERVICES SHOULD BE REIMBURSED

Reasonable costs should be paid for skilled nursing care. The necessary studies apparently have not been made to determine what services are needed or what the costs would be. For example, equipment for physical therapy is expensive. The equipment may not be necessary for long term care patients who, nevertheless, need skilled nursing care. Such equipment may, on the other hand, be necessary for extended care patients who presumably can be rehabilitated. The services provided under Title XIX in skilled nursing homes should be only those necessary for the comfort and maintenance of the patient. The reasonable costs should be reimbursed, excluding questionably high interest rates. We cannot expect necessary services or demand reasonable standards unless we agree to pay the fair cost.

FEDERAL STANDARDS SHOULD BE ESTABLISHED

Since most patients need long term skilled nursing care and since 50 or 60% of the patients in the skilled nursing homes receive public assistance, attention must be given to maintaining standards in these nursing homes as well as in extended care facilities. These standards should include provision for a medical team which can check the necessity of the care provided and the fact that care was, in fact, provided. In addition, certain minimal standards relating to nursing staff and medical consultation should be ensured. Some provision for diversional activities might be included, particularly if reimbursement is based on a reasonable cost.

REPRESENTATIVE PAYEE

We recognize that this subject is not a part of Titles XVIII or XIX but we would like to make a comment as a result of our findings. Social Security provides a method whereby a person incapable of handling his own check can be protected through the designation of a representative payee. We understand that a General Accounting Office report has been made which includes evidence of misuse of this procedure. We have found that some nursing home operators have been named representative payees and have abused their responsibility. We do not know what specific corrective measure should be provided, but we feel strongly that some protection should be offered the old and often confused patient who in some instances has been deprived of his Social Security benefits.

JULY 8, 1967.

Hon. PERRY B. JACKSON,
Presiding Judge, Criminal Division,
Court of Common Pleas,
Cleveland, Ohio.

DEAR JUDGE JACKSON: Since there is such wide spread interest in the matter of the charges brought by Mrs. Adelaide Mendelson concerning nursing homes, the Grand Jury has decided to make a separate report.

It is evident from the size of the report that Mrs. Mendelson spent much time and painstaking effort in its preparation and accordingly, the Grand Jury gave it much consideration in study and discussion.

The Foreman of the Grand Jury read the report twice, made personal visits to two nursing homes and had interviews with two persons referred to in her report.

Among those who appeared before the Grand Jury in addition to Mrs. Mendelson was Mr. William Veigel, of Columbus, Administrator of Nursing Homes for Ohio, who explained the rules, regulations and laws affecting the operation of nursing homes in the state. He also discussed new legislation in recent years to improve the homes. It is quite significant that from January 1, 1965 to October, 1966, 81 nursing homes were closed in Cuyahoga County for not conforming to standards set by the state.

We also investigated the accusation that payments have been made for medical services given by persons who are not doctors.

The person Mrs. Mendelson names is a Medical Technician, employed by one of our local hospitals, who was engaged to render some service relating to some laboratory tests, etc. The records in the office of the Aid for the Aged, who employed this man, do not indicate that he was an M.D., neither do the payroll vouchers signed by this man have the letters M.D., after his name. Other detailed investigations were made too numerous to relate in this report.

The Grand Jury concluded that tighter and more frequent inspection is needed and more rigid enforcement of present regulations.

We found no evidence of violation of law which amounts to crime, therefore, the Grand Jury has no alternative but to return a "No Bill".

Respectfully submitted.

HENRY W. HUNTER,
Foreman of Grand Jury.

The CHAIRMAN. The committee will stand in adjournment until Monday, September 11, at 10 a.m.

(Whereupon, at 1:05 p.m., the committee adjourned to reconvene at 10 a.m. on Monday, Sept. 11, 1967.)

SOCIAL SECURITY AMENDMENTS OF 1967

MONDAY, SEPTEMBER 11, 1967

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

The committee met, pursuant to notice, at 10:25 a.m., in room 2221, New Senate Office Building, Senator George A. Smathers presiding.

Present: Senators Smathers, McCarthy, Hartke, Ribicoff, Williams, Carlson, and Curtis.

Senator SMATHERS. All right, the meeting will come to order.

This morning we begin the third week of hearings on H.R. 12080, the Social Security Amendments of 1967. We will conclude these hearings on Friday, September 22. Because of the large number of witnesses who desire to be heard, it is necessary to limit the time available for oral statements. This morning we have asked each of our witnesses to confine his remarks to 10 minutes.

Our first witness today will be Charles I. Bevans, Assistant Legal Adviser for Treaty Affairs, Department of State. Mr. Bevans, I understand your Department feels that certain provisions of present law violate international treaties, by requiring a 5-year residency requirement before nationals of the countries involved may qualify for U.S. social security and medicare benefits. So you tell us in further detail what your objection is and what you think we ought to do about it.

STATEMENT OF CHARLES I. BEVANS, ASSISTANT LEGAL ADVISER FOR TREATY AFFAIRS, OFFICE OF THE LEGAL ADVISER, DEPARTMENT OF STATE

Mr. BEVANS. Thank you, Mr. Chairman.

I have a statement that I would like to read. If it seems too long, I can summarize it.

Senator SMATHERS. It looks like it can get under the limit, so you go ahead.

Mr. BEVANS. I am Charles I. Bevans, Assistant Legal Adviser for Treaty Affairs, Department of State.

Mr. Chairman and members of the committee, I am grateful for this opportunity to appear before you on behalf of the Department of State to discuss the social security legislation.

The State Department's primary concern with this legislation is its bearing upon our treaty obligations. Several of our treaties of friendship, commerce, and navigation provide that aliens shall be accorded the same treatment as nationals with respect to social security

and related matters. For example, our treaty of friendship, commerce, and navigation with the Federal Republic of Germany, signed in 1954, provides in article IV as follows:

Nationals of either Party shall . . . be accorded national treatment with regard to the application of social security laws and regulations within the territories of the other Party . . . in the following cases: (a) sickness, . . . (b) old age, invalidity, or occupational disability . . .

Following enactment of the 1965 and 1966 Amendments to the Social Security Act, the German Embassy in Washington sent the Department of State a note pointing out that under certain of those amendments aliens who have not resided in the United States for 5 years are not eligible to benefits under the hospital insurance benefits program and the supplementary medical benefits insurance program. The Embassy asked for a clarification as to whether or not the 5-year provision regarding aliens in any way affects German citizens living in the United States who, in the Embassy's opinion, are entitled to equal treatment with regard to the application of social security laws under article IV of the 1954 treaty.

I submit for the information of the committee a copy of the note from the German Embassy.

(The document referred to above follows:)

AIDE MEMOIRE

GERMAN EMBASSY,
Washington, D.C.

TO THE DEPARTMENT OF STATE, *Washington, D.C.*

Upon request of a German Consulate in the United States of America the Embassy of the Federal Republic of Germany would like to clarify the following:

The respective provisions of the Hospital Insurance Benefits Program and the Supplementary Medical Insurance Benefits Program (Section 1836 of the Social Security Act) determine that non-Americans living in the United States for less than five years are not eligible for the benefits. The Embassy would be grateful for clarification whether this affects in any way German citizens living in the United States who, in the Embassy's opinion are entitled to equal treatment with regard to the application of Social Security laws under Article 4 of the Treaty of Friendship, Commerce, and Navigation between the United States of America and the Federal Republic of Germany signed at Washington October 29, 1954, and entered into force July 14, 1956.

WASHINGTON, D.C., *October 28, 1966.*

Mr. BEVANS. After studying the 1965 and 1966 Social Security Amendments we have reached the conclusion that three provisions requiring 5 years' residence by aliens should be modified to bring them into conformity with the treaty obligations of the United States. We believe that those modifications should be made by amendments to H.R. 12080.

Section 103 of Public Law 89-97, 42 U.S.C. 426a, which is amended by section 139 of H.R. 12080 and is designated "Transitional Provisions on Eligibility of Presently Uninsured Individuals for Hospital Benefits," includes in subsection (4) a requirement of 5 years' continuous residence in the United States for aliens.

Section 302a of Public Law 89-368, 42 U.S.C. 428, which is designated "Benefits at Age 72 for Certain Uninsured Individuals", contains in subsection (3) the same requirement of 5 years' residence by aliens.

Section 102(a) of Public Law 89-97 added to the Social Security Act section 1836—42 U.S.C. 1395(o)—which relates to individuals eligible for supplemental medical insurance benefits, and contains in subsection (2) the 5-year residence requirement for aliens.

The 5-year residence requirements in these provisions of the Social Security Act give rise to problems in connection with the national treatment commitment in article IV of our 1954 treaty with the Federal Republic of Germany.

These residence requirements also present problems with respect to certain other treaties.

Article IV of the treaty of friendship, commerce, and navigation with the Netherlands, 8 UST 2043; TIAS 3942, and article III of the treaty of amity and economic relations with Vietnam, 12 UST 1703; TIAS 4890, provide that nationals of each country shall be accorded national treatment in the application of laws and regulations establishing compulsory systems of social security in case of sickness. The treaties with these two countries refer to compulsory systems of social security; the program of supplementary medical insurance is a voluntary one. However, the system of American social security as a whole is compulsory, and the hospital benefits for uninsured individuals and the supplemental medical insurance are part of the social security system. The requirement of 5 years' residence by aliens in connection with the benefits mentioned could give rise to problems in the application of the treaties witih the Netherlands and Vietnam.

Our treaties of friendship, commerce and navigation with Greece, 5 UST 1829, TIAS 3057; Israel, 5 UST 550, TIAS 2948; Italy, 63 Stat. 2255, TIAS 1965; Korea, 8 UST 2217, TIAS 3947; Nicaragua, 9 UST 449; TIAS 4024; and Pakistan, 12 UST 110; TIAS 4683, have provisions for national treatment in the application of laws and regulations establishing compulsory systems of social security under which benefits are paid against loss of earnings due to old age. We anticipate problems in the application of these provisions in the face of the requirement of 5 years of residence before benefits are paid to aliens as specified in section 102a of Public Law 89-97.

All of these treaties were fully consistent with the Social Security Act at the time they were signed.

(The treaties referred to follow:)

TREATIES OF FRIENDSHIP, COMMERCE, AND NAVIGATION AND SIMILAR TREATIES BETWEEN THE UNITED STATES AND OTHER COUNTRIES WHICH CONTAIN PROVISIONS RELATING TO SOCIAL SECURITY

DENMARK

Treaty of friendship, commerce and navigation (*Art. IV, para. 2*). Signed at Copenhagen October 1, 1951. Entered into force July 30, 1961. 2 UST 908, TIAS 4797; 421 UNTS 105.

2. In addition to the rights and privileges provided in paragraph 1 of the present Article, nationals of either Party shall, within the territories of the other Party, be accorded national treatment in the application of laws and regulations establishing a system of compulsory insurance in the case of the United States of America and a system of voluntary insurance in the case of the Kingdom of Denmark, under which benefits are paid without an individual test of financial need against loss of wages or earnings due to unemployment.

FEDERAL REPUBLIC OF GERMANY

Treaty of friendship, commerce, and navigation (*Art. IV, para. 2, protocol para. 4*). Signed at Washington October 29, 1954. Entered into force July 14, 1956. 7 UST 1839; TIAS 3593; 273 UNTS 3.

2. Nationals of either Party shall furthermore be accorded national treatment with regard to the application of social security laws and regulations within the territories of the other Party under which benefits are provided without examination of financial need in the following cases: (a) sickness, including temporary disability for work, and maternity; (b) old age, invalidity, or occupational disability; (c) death of the father, spouse, or any other person liable for maintenance; (d) unemployment.

4. The provisions of Article IV, paragraph 2, refer only to laws or regulations which either are national laws or regulations or are based in whole or in part on requirements of national laws or regulations.

GREECE

Treaty of friendship, commerce, and navigation (*Art. XI, para. 2*). Signed at Athens August 3, 1951. Entered into force October 13, 1954. 5 UST 1829; TIAS 3057; 224 UNTS 279.

2. In addition to the rights and privileges provided in paragraph 1 of the present Article, nationals of Greece shall be accorded within the territories of the United States of America, and reciprocally nationals of the United States of America shall be accorded within the territories of Greece, national treatment in the application of laws and regulations establishing systems of compulsory insurance, under which benefits are paid without an individual test of financial need: (a) against loss of wages or earnings due to old age, unemployment, sickness, or disability, or (b) against loss of financial support due to the death of father, husband or other person on whom such support had depended.

IRELAND

Treaty of friendship, commerce, and navigation (*Art. IV, para. 2*). Signed at Dublin January 21, 1950. Entered into force September 14, 1950. 1 UST 785; TIAS 2155; 206 UNTS 269.

2. In addition to the rights and privileges provided in paragraph 1 of the present Article, nationals of either Party shall, within the territories of the other Party, be accorded national treatment in the application of laws and regulations establishing systems of compulsory insurance, under which benefits are paid without an individual test of financial need: (a) against loss of wages or earnings due to old age, unemployment, sickness or disability, or (b) against loss of financial support due to the death of father, husband or other person on whom such support had depended.

ISRAEL

Treaty of friendship, commerce, and navigation (*Art. IV, para. 2*). Signed at Washington August 23, 1951. Entered into force April 3, 1954. 5 UST 550; TIAS 2948; 219 UNTS 237.

2. In addition to the rights and privileges provided in paragraph 1 of the present Article, nationals of either Party shall, within the territories of the other Party, be accorded national treatment in the application of laws and regulations establishing systems of compulsory insurance, under which benefits are paid without an individual test of financial need: (a) against loss of wages or earnings due to old age, unemployment, sickness or disability, or (b) against loss of financial support due to the death of father, husband or other persons on whom such support had depended.

ITALY

Treaty of friendship, commerce, and navigation (*Art. XII, para. 2*). Signed at Rome February 2, 1948. Entered into force July 26, 1949. 63 Stat. 2255; TIAS 1965; 79 UNTS 171.

2. In addition to the rights and privileges provided in paragraph 1 of this Article, the nationals of either High Contracting Party shall, within the territories of the other High Contracting Party, be accorded, upon terms no less favorable than those applicable to nationals of such other High Contracting Party,

the benefits of laws and regulations establishing systems of compulsory insurance, under which benefits are paid without an individual test of financial need: (*a*) against loss of wages or earnings due to old age, unemployment or sickness or other disability, or (*b*) against loss of financial support due to the death of father, husband or other person on whom such support had depended.

Agreement supplementing the treaty of friendship, commerce, and navigation of February 2, 1948 (*Art. VII and Proclamation by President*). Signed at Washington September 26, 1951. Entered into force March 2, 1961. 12 UST 131; TIAS 4685; 404 UNTS 326.

Article VII

1. The two High Contracting Parties, in order to prevent gaps in the social insurance protection of their respective nationals who at different times accumulate substantial periods of coverage under the principal old-age and survivors insurance system of one High Contracting Party and also under the corresponding system of the other High Contracting Party, declare their adherence to a policy of permitting all such periods to be taken into account under either such system in determining the rights of such nationals and of their families. The High Contracting Parties will make the necessary arrangements [1] to carry out this policy in accordance with the following principles:

(a) Such periods of coverage shall be combined only to the extent that they do not overlap or duplicate each other, and only insofar as both systems provide comparable types of benefits.

(b) In cases where an individual's periods of coverage are combined, the amount of benefits, if any, payable to him by either High Contracting Party shall be determined in such a manner as to represent, so far as practicable and equitable, that proportion of the individual's combined coverage which was accumulated under the system of that High Contracting Party.

(c) An individual may elect to have his right to benefits, and the amount thereof, determined without regard to the provisions of the present paragraph.

Such arrangements may provide for the extension of the present paragraph to one or more special old-age and survivors insurance systems of either High Contracting Party, or to permanent or extended disability insurance systems of either High Contracting Party.

2. At such time as the Maintenance of Migrants' Pension Rights Convention of 1935 enters into force with respect to both High Contracting Parties, the provisions of that Convention shall supersede, to the extent that they are inconsistent therewith, paragraph 1 of the present Article and arrangements made thereunder.

EXCERPT FROM PRESIDENT'S PROCLAMATION

Whereas the Senate of the United States of America by their resolution of July 21, 1953, two-thirds of the Senators present concurring therein, did advise and consent to the ratification of the said agreement "subject to the understanding that the arrangements referred to in Article VII, paragraph 1, of the said agreement shall be made by the United States only in conformity with provisions of statute";

Whereas the text of the said understanding was communicated by the Government of the United States of America to the Government of the Italian Republic by a note dated July 24, 1953 and was accepted by the Government of the Italian Republic on a reciprocal basis;

Whereas the said agreement was ratified by the President of the United States of America on September 22, 1960, in pursuance of the aforesaid advice and consent of the Senate and subject to the said understanding, and was ratified on the part of the Italian Republic;

Whereas the respective instruments of ratification as aforesaid, were exchanged at Washington on March 2, 1961, and a protocol of exchange, in the English and Italian languages, was signed at that place and on that date by the respective Plenipotentiaries of the United States of America and the Italian Republic, the said protocol of exchange declaring that "it is understood that the entry into force of the arrangements mentioned in Article VII, paragraph 1, of the said agreement is subordinate in any case to the fulfilling on the part of the United States of America of its provisions of statute and on the part of the Italian Republic of its constitutional requirements";

JAPAN

Treaty of friendship, commerce, and navigation (*Art. III, para. 2*). Signed at Tokyo April 2, 1953. Entered into force October 30, 1953. 4 UST 2063; TIAS 2863; 206 UNTS 143.

2. In addition to the rights and privileges provided in paragraph 1 of the present Article, nationals of either Party shall, within the territories of the other Party, be accorded national treatment in the application of laws and regulations establishing compulsory systems of social security, under which benefits are paid without an individual test of financial need: (a) against loss of wages or earnings due to old age, unemployment, sickness or disability, or (b) against loss of financial support due to the death of father, husband or other person on whom such support had depended.

KOREA

Treaty of friendship, commerce, and navigation (*Art. IV, para. 2*). Signed at Seoul November 28, 1956. Entered into force November 7, 1957. 8 UST 2217; TIAS 3947; 302 UNTS 281.

2. In addition to the rights and privileges provided in paragraph 1 of the present Article, nationals of either Party within the territories of the other Party shall be accorded national treatment in the application of laws and regulations establishing compulsory systems of social security, under which benefits are paid without an individual test of financial need; (a) against loss of wages or earnings due to old age, unemployment, sickness or disability, or (b) against loss of financial support due to the death of father, husband or other person on whom such support had depended.

NETHERLANDS

Treaty of friendship, commerce, and navigation (*Art. IV, para. 2 and Protocol para. 4*). Signed at The Hague March 27, 1956. Entered into force December 5, 1957. 8 UST 2043; TIAS 3942; 285 UNTS 231.

2. In addi ion to the rights and privileges provided in paragraph 1 of the present Article, nationals of either Party shall, within the territories of the other Party, be accorded national treatment in the application of laws and regulations establishing compulsory systems of social security, under which benefits are paid without an individual test of financial need in the following cases: (*a*) sickness, including temporary disability for work, and maternity; (*b*) invalidity, or occupational disability; (*c*) death of father, spouse, or any other person liable for maintenance; (*d*) unemployment.

4. The provisions of Article IV, paragraph 2, refer only to laws or regulations which either are national laws or regulations or are based in whole or in part on requirements of national laws or regulations. Moreover, that paragraph shall not be construed to prevent a Party from relieving aliens temporarily resident within its territories from coverage under its contributory social security.

NICARAGUA

Treaty of friendship, commerce, and navigation (*Art IV, para. 2*). Signed at Managua January 21, 1956. Entered into force May 24, 1958. 9 UST 449; TIAS 4024; 367 UNTS 3.

2. In addition to the rights and privileges provided in paragraph 1 of the present Article, nationals of either Party shall, within the territories of the other Party, be accorded national treatment in the application of laws and regulations establishing compulsory systems of social security, under which benefits are paid without an individual test of financial need: (a) against loss of wages or earnings due to old age, unemployment, sickness or disability, or (b) against loss of financial support due to the death of father, husband or other person on whom such support had depended.

PAKISTAN

Treaty of friendship and commerce (*Art. IV, para. 2*). Signed at Washington November 12, 1959. Entered into force February 12, 1961. 12 UST 110; TIAS 4683; 404 UNTS 259.

2. In addition to the rights and privileges provided in paragraph 1 of the present Article, nationals of either Party within the territories of the other

Party shall be accorded national treatment in the application of laws and regulations establishing compulsory systems of social security, under which benefits are paid without an individual test of financial need; (a) against loss of wages or earnings due to old age, unemployment, sickness or disability, or (b) against loss of financial support due to the death of father, husband or other person on whom such support had depended.

VIET-NAM

Treaty of amity and economic relations (*Art. III, para. 2*). Signed at Saigon April 3, 1961. Entered into force November 30, 1961. 12 UST 1703; TIAS 4890; 424 UNTS 187.

2. In addition to the rights and privileges provided in Paragraph 1 of the present Article, nationals of either Party within the territories of the other Party shall be accorded national treatment in the application of laws and regulations establishing compulsory systems of social security, under which benefits are paid without an individual test of financial need in the following cases: (a) sickness, including temporary disability for work, and maternity; (b) invalidity, or occupational disability; (c) death of father, spouse, or any other person liable for maintenance; (d) unemployment.

Mr. BEVANS. The Department of State recommends that H.R. 12080 be amended to avoid the problems to which I have referred. We would prefer an across-the-board amendment providing that no provision of the Social Security Act shall prevent the fulfillment of any treaty obligation of the United States. We believe, however, that such an amendment might require considerable study before the committee would wish to make a decision regarding it. Accordingly, the Department limits its recommendation in this respect to the removal of the inconsistencies between our treaty obligations and the 5-year residence requirement for aliens.

The Department of State therefore recommends that, in each of the sections where the 5-year residence requirement regarding aliens appears in the Social Security Act, a proviso be included to the effect that the requirement will not be applied contrary to any treaty obligation of the United States.

The Department of State also wishes to recommend amendment of section 160 (b) and (c) of H.R. 12080.

Under section 160(c) the application of Treasury Circular 655 would deprive certain aliens of benefits that they would otherwise have a right to receive. The operation of these provisions would seem to have the effect of penalizing an individual who is entitled to benefits but who, for one reason or another, resides in a Communist country. We understand that one of the basic purposes of the Treasury circular is to protect the individuals concerned. The proposed application of that circular would have the effect, however, of depriving individuals of benefits they had accrued before the amendments embodied in H.R. 12080 became law. And it would affect primarily the old, the widows, and children, a group the United States traditionally seeks to protect.

The provisions in question could also give rise to difficulty in the application of treaty provisions regarding national treatment. When a national of a country with which the United States has a treaty of friendship, commerce, and navigation resides in a Communist country, he is still entitled to the national-treatment rights specified in that treaty. However, section 160(c) would deprive him of these accrued benefits protected by treaty.

The Department of State recommends that the provisions of section 160(c) be modified so that benefits earned before their enactment, as well as benefits that are withheld by the Treasury Department in the future, would be paid to the beneficiary.

Under 160(b) some persons entitled to benefits because they have resided in the United States for 10 years or have 40 quarters of coverage would be deprived of their benefits. We feel that this inequitable treatment of some foreigners will have an unfortunate effect on the foreign relations between the United States and the other countries covered. Moreover, the hardship would fall directly upon persons who have earned the benefits.

I wish to comment also that the Department of State has no objection to S. 110, a bill to amend title XVIII of the Social Security Act and related provisions of law.

I thank the committee for the opportunity to make these recommendations and comments on behalf of the Department of State.

Senator SMATHERS. All right, sir. Thank you, Mr. Bevans.

Senator Williams; do you have any questions?

Senator WILLIAMS. Yes, I have a question.

You refer in your testimony, to the treaties that we may have with Communist countries and the effect on aliens living in these Communist countries. What treaties do we have with Russia or any other Communist country as regards this?

Mr. BEVANS. Senator, we don't have any treaties of friendship, commerce, and navigation with any of the Communist countries.

Senator WILLIAMS. Then what are you concerned about?

Mr. BEVANS. For example, take the case of a German, a national of the Federal Republic of Germany with which we have a treaty of friendship, commerce, and navigation. If he were to reside in a Communist country where Treasury Circular 655 applies, we feel that in such a case the withholding of his social security benefits would be contrary to our treaty with Germany.

Senator WILLIAMS. And you feel that before we make a change in the social security medicare or anything as regards the American citizens we have got to take care of those who go into these Communist countries and retire?

Mr. BEVANS. Well, Senator, we have these problems in connection with our treaties. We perceive that problems may arise.

Senator WILLIAMS. I thought you said you didn't have any treaties with the Communist countries.

Mr. BEVANS. Not with the Communist countries. But we have a treaty with Germany. Under the treaty a German going into one of the Communist countries would still be entitled to his social security benefits. But under the provisions of this bill that we are considering these benefits would be cut off if he was residing in a Communist country where Treasury Circular 655 applied.

Senator WILLIAMS. If a bona fide American citizen desired to retire in Russia, Poland, Germany, or any other country in Europe can he carry with him his medicare benefits under the law? He cannot, isn't that true?

Mr. BEVANS. Well, I don't think he would be deprived of them as much as an alien, a person from another country would, where a treaty right was involved.

Senator WILLIAMS. But that is not my question.

Mr. BEVANS. Yes, sir.

Senator WILLIAMS. I said under the Medicare Act, the existing law, if an American citizen retires in Russia or any other Communist country or for that matter in any European country can he carry with him his medicare benefits, or does he lose them when he leaves the continental United States?

Mr. BEVANS. Well, my understanding of the law is that he doesn't carry them all with him.

Senator WILLIAMS. Certainly he does not carry them with him.

Mr. BEVANS. No, sir.

Senator WILLIAMS. That is correct.

Why are you so concerned about someone who is a citizen of another country who is losing some benefits if he lives abroad?

Mr. BEVANS. Well, I am concerned about the accrued benefits they have obtained under social security, where there have been the necessary deductions made from their wages over a period of years.

Senator WILLIAMS. The same thing would be true with this American citizen; he would have been paying over a period of years and he would have been qualified for medicare if he stays in this country, but the moment he leaves the shores of the continential United States, or our possessions, he loses his benefits. I noticed that you are suggesting that we strike this 5-year provision in its entirety as a requirement, is that correct?

Mr. BEVANS. No, sir, I didn't mean to strike it in its entirety. I meant only to suggest an exception to permit the application of our treaty provisions.

Senator WILLIAMS. You would strike it as it affects any country with which we happen to have a treaty?

Mr. BEVANS. Yes, sir.

I merely recommend a proviso in the provision referred to in order that we can apply our treaty provisions.

Senator WILLIAMS. That would mean that a citizen of any of these countries who was in the United States on a visitor's visa but got a temporary work permit whereby he could qualify in the labor force, would immediately be eligible for benefits in his country? Is that correct?

Mr. BEVANS. Well, I didn't understand that he would become eligible simply because he had been here on a temporary permit.

Senator WILLIAMS. But if he entered the work force, got a permit to enter the labor force——

Mr. BEVANS. Yes, sir.

Senator WILLIAMS (continuing). Where he could qualify under this provision immediately instead of waiting 5 years, is that correct?

Mr. BEVANS. Yes, sir, if he otherwise qualified under the U.S. law.

Senator WILLIAMS. I noticed you say that the Department of State recommends that H.R. 12080 be amended to avoid the problems to which you have just referred, and you would prefer an across-the-board amendment providing that no provisions of the Social Security Act shall prevent the fulfillment of any treaty obligation of the United States: then you continue by saying, "We believe, however,

that such an amendment might require considerable study before the committee would wish to make a decision."

Now, you are not telling me, are you, that the Department of State is recommending this amendment without having made a study as to its effect, the cost implications and so forth? You have made some study yourself, have you not?

Mr. BEVANS. Yes, sir, we have.

Senator WILLIAMS. Would you give us the benefit of your study?

Mr. BEVANS. I don't really see the need for a provision that broad. There may be some provisions in there which we found in the course of time that may be inconsistent with treaty provisions, but the studies we made were of these 5-year provisions and those are the ones where we feel we would have some difficulty.

Senator WILLIAMS. You don't think that it would be necessary to take an across-the-board amendment then, is that correct?

Mr. BEVANS. No, sir; I don't feel that it is really necessary.

Senator WILLIAMS. Well, I notice that you said you would prefer an across-the-board amendment. I now understand that you really don't agree with that particular provision in your statement, is that correct?

Mr. BEVANS. No, sir; I do prefer it, but I felt that in asking for that we would be imposing on the committee too much and we didn't wish to do that.

Senator WILLIAMS. You may be surprised if you give us the benefit of your study; we would like to see it.

Mr. BEVANS. Well, the across-the-board provision is the kind that we normally prefer in the law, that nothing in that law shall prevent the application of any treaty obligation of the United States.

Senator WILLIAMS. Have you made any estimate as to the cost and the amount that is involved in these various payments and so forth, and what effect this change would have on the act?

Mr. BEVANS. No, sir; I haven't. The total amount of money that is withheld from the Communist countries under such provisions, I think, would come to abut $10 million right now. That is as close as I can get to any figures at present.

Senator WILLIAMS. That is withheld from the Communist countries?

Mr. BEVANS. Yes, sir.

Senator WILLIAMS. Perhaps you don't have this information with you, but would you furnish at this point in the record for the committee a list of the payments, the number of participants, and the dollar amount of the payments that are being paid under the social security program in each of the countries?

Mr. BEVANS. Yes, sir.

Senator WILLIAMS. Broken down by countries?

Mr. BEVANS. Yes, sir.

Senator WILLIAMS. For all of them, as it relates to the number of beneficiaries and the amount of payments for the most recent full year which you have it available? Also, is should be broken down as to the number of aliens and the number of U.S. citizens living abroad.

Mr. BEVANS. Yes, sir.

Senator WILLIAMS. I would appreciate that.
Thank you.
Mr. BEVANS. I would be very glad to do that.
Senator SMATHERS. All right, sir, thank you very much, Mr. Bevans.
Mr. BEVANS. Thank you, sir.
(The information referred to above follows:)

DEPARTMENT OF STATE,
Washington, September 18, 1967.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: I am glad to transmit to you the enclosed information regarding dollar payments made abroad under the Social Security Program.

In the hearing before the Committee on Finance on Monday, September 11 regarding H.R. 12080, a Bill to Amend the Social Security Act, Senator Williams requested that Mr. Charles I. Bevans of this Department furnish the Committee information, for the most recent year in which it is available, regarding the total amount of dollar payments, the countries in which it is paid, the number of beneficiaries, the number of aliens, and the number of United States citizens receiving such payments.

The information is included in the following enclosed documents:

1. Tables I and II giving, respectively, the *number* and the *amount* of old-age survivors, disability, and health insurance monthly benefits in current status payable to beneficiaries living abroad, by type of benefit and country or continent, end of December, 1966.

2. Citizenship of Beneficiaries Residing Abroad, with tabulation giving numbers and percentages of beneficiaries classified by citizenship of worker.

3. Medicare and Nonresidents of the United States.

4. Number and Amount of Monthly Benefits Payable to Beneficiaries Living in Communist Countries, by Type of Benefit and Country at end of 1966.

5. Number of Beneficiaries and Total Amount of Benefits That are Currently Withheld From Them Under Treasury Regulations.

There is also enclosed a memorandum entitled "Policing the Social Security Program Abroad" which is submitted pursuant to a request made by Senator Williams, before the meeting was convened, for information regarding measures for avoiding the payment of Social Security benefits to beneficiaries who had died.

I should like to advert especially to item number 3 above entitled "Medicare and Nonresidents of the United States." In this connection I wish to emphasize that the Department's recommendations are not in any manner designed to obtain more favorable treatment for aliens than for citizens of the United States. The Department's recommendations for a proviso with respect to the requirement of five years of residence by aliens are merely for the purpose of fulfilling treaty obligations to accord national treatment to the aliens involved. Its recommendations with respect to the application of Treasury Circular 655 are merely to avoid depriving aliens living in Communist countries of any expectation of receiving Social Security benefits for which deductions had been made.

The corrected transcript of the hearing on September 11 is returned herewith.

If I can be of any further assistance with respect to the proposed legislation I would be glad if you would let me know.

Sincerely yours,

WILLIAM B. MACOMBER, JR.
Assistant Secretary for Congressional Relations.

TABLE I.—OLD-AGE SURVIVORS, DISABILITY, AND HEALTH INSURANCE—NUMBER OF MONTHLY BENEFITS IN CURRENT-PAYMENT STATUS PAYABLE TO BENEFICIARIES LIVING ABROAD, BY TYPE OF BENEFIT AND COUNTRY OR CONTINENT, END OF DECEMBER 1966

Beneficiary's place of residence[1]	Total	Retired workers[2]	Disabled workers[3]	Wives and husbands[4] of—			Children[5] of—			Widowed mothers[6]	Widows and widowers	Parents[7]
				All workers	Retired workers	Disabled workers	All workers	Retired and deceased workers	Disabled workers			
Total	181,171	94,609	3,296	26,436	25,628	808	25,860	23,992	1,868	5,324	24,852	794
Africa	1,064	490	7	189	186	3	238	236	2	34	104	2
Cape Verde Islands	667	293	1	139	138	1	138	136	2	16	79	1
South Africa	149	88	0	27	27	0	17	17	0	4	13	0
Other	248	109	6	23	21	2	83	83	0	14	12	1
Asia	11,841	6,342	121	2,064	2,022	42	1,489	1,398	91	339	1,464	22
Cyprus	358	183	6	73	68	5	56	50	6	4	35	1
Hong Kong	2,387	944	6	663	660	3	229	221	8	72	469	4
India	118	61	1	24	23	1	16	15	1	3	12	1
Israel	1,865	1,227	45	296	287	9	82	65	17	16	197	2
Japan	4,537	2,765	26	637	629	8	409	392	17	138	556	6
Jordan	426	132	12	77	69	8	164	138	26	14	24	3
Lebanon	743	352	7	85	83	2	220	211	9	31	47	1
Macao	233	115	5	58	57	1	22	20	2	2	30	1
Ryukyu Islands	545	280	6	86	83	3	111	106	5	24	35	3
Syrian Arab Republic	122	67	0	16	16	0	27	27	0	2	10	0
Turkey	188	97	0	19	19	0	43	43	0	10	19	0
Other	319	119	7	30	28	2	110	110	0	23	30	0
Canada	25,252	13,479	437	3,393	3,284	109	3,627	3,271	356	738	3,520	58
Central America and West Indies	3,183	2,012	72	295	289	6	412	393	19	81	289	22
Bahamas	206	109	4	28	27	1	32	29	3	6	26	1
Barbados	360	241	9	40	40	0	13	31	0	3	52	2
Bermuda	119	74	1	18	17	1	12	10	2	2	12	0
British Leeward and Windward Islands	425	268	7	56	56	0	40	40	0	4	46	4
Costa Rica	184	100	5	22	20	2	37	32	5	9	8	3
Dominican Republic	176	101	11	16	16	0	30	30	0	2	16	0
Jamaica	885	694	18	61	61	0	41	39	2		60	4
Nicaragua	172	87	5	10	10	0	46	46	0	7	10	1
Panama	131	29	1	7	7	0	63	59	4	13	13	2
Trinidad and Tobago	173	114	2	10	10	0	20	20	0	16	22	2
Other	352	195	9	27	25	2	78	75	3	13	24	3
Europe	109,000	63,281	2,025	16,257	15,869	388	8,019	7,398	621	1,742	17,439	237

Austria	1,583	1,125	33	137	135	2	86	78	8	27	173	2
Belgium	642	392	5	85	85	0	40	36	4	12	107	1
Bulgaria	186	73	0	32	32	0	4	4	0	1	76	0
Denmark	988	700	18	106	104	2	36	32	4	9	119	0
Finland	742	528	13	67	64	3	20	17	3	6	108	0
France	2,334	1,583	55	221	211	10	195	173	22	59	217	4
Germany (U.S. Zone)	10,817	7,412	250	923	887	36	780	715	65	296	1,143	13
Greece	14,956	8,318	220	2,314	2,254	60	1,834	1,749	85	239	1,972	59
Iceland	4,164	2,896	138	332	315	17	332	300	32	71	368	27
Italy	35,835	18,947	671	6,927	6,792	135	1,979	1,785	194	384	6,850	67
Malta	506	279	24	57	51	6	68	57	11	16	61	1
Netherlands	795	452	9	103	102	1	93	91	2	32	105	1
Norway	4,218	2,746	77	620	605	15	179	167	12	41	548	7
Poland	1,858	691	31	307	301	6	30	27	3	2	783	14
Portugal	4,464	2,364	98	905	883	22	416	375	41	51	629	1
Rumania	146	48	0	26	26	0	3	3	0	0	68	1
Spain	5,113	3,127	88	777	762	15	362	334	28	57	693	9
Sweden	4,257	3,164	56	444	438	6	106	96	10	20	464	3
Switzerland	1,766	1,294	27	164	161	3	86	83	3	17	174	4
United Kingdom	8,843	5,223	138	795	759	36	1,114	1,035	79	347	1,210	16
Yugoslavia	4,622	1,811	70	899	887	12	234	219	15	41	1,561	6
Other	165	108	4	16	15	1	22	22	0	4	10	1
Mexico	12,796	3,655	288	1,379	1,272	107	5,677	5,336	341	1,081	561	155
Oceania	922	383	22	67	56	11	292	254	38	74	82	2
Australia	696	300	19	46	39	7	203	187	16	55	71	2
New Zeland	168	68	2	16	13	3	55	46	9	16	11	0
Other	58	15	1	5	4	1	34	21	13	3	0	0
Philippines	15,242	4,113	290	2,595	2,466	129	5,620	5,250	370	1,149	1,187	288
South America	1,551	750	33	180	167	13	341	312	29	70	169	8
Argentina	352	190	7	44	42	2	35	32	3	10	64	2
Brazil	352	164	12	46	40	6	77	62	15	16	35	2
Chile	158	65	2	17	16	1	48	48	0	12	14	0
Columbia	157	71	6	17	14	3	48	39	9	6	7	2
Peru	151	76	2	16	16	0	36	36	0	10	10	1
Venezuela	189	85	2	17	16	1	58	56	2	10	17	0
Other	192	99	2	23	23	0	39	39	0	0	22	1
U.S. possessions	320	104	1	17	17	0	145	144	1	16	37	0
Canal Zone	305	102	1	16	16	0	135	134	1	14	37	
Other	15	2	0	1	1	0	10	10	0	2	0	

[1] Based on monthly benefit check address. Data for places with 100 or more beneficiaries shown separately. All benefit payments were being withheld on Dec. 31, 1966, from beneficiaries living in the following countries in which conditions were such that there was no reasonable assurance that the payee would actually receive the check and be able to negotiate it: Albania, China (including Outer Mongolia and Tibet), Cuba, Czechoslovakia, Soviet Zone of Germany, Hungary, North Korea, and the Union of Soviet Socialist Republics (including Estonia, Latvia, and Lithuania).

[2] Aged 62 and over.

[3] Under age 65.

[4] Includes wife beneficiaries under age 65 with entitled children in their care, and divorced wives.

[5] Includes disabled persons aged 18 and over whose disability began before age 18 and entitled full-time students aged 18 to 21.

[6] Includes surviving divorced mothers with entitled children in their care.

[7] Aged 60 and over for widows and surviving divorced wives, and aged 62 and over for widowers.

TABLE II.—OLD-AGE SURVIVORS, DISABILITY, AND HEALTH INSURANCE—AMOUNT OF MONTHLY BENEFITS IN CURRENT-PAYMENT STATUS PAYABLE TO BENEFICIARIES LIVING ABROAD, BY TYPE OF BENEFIT AND COUNTRY OR CONTINENT, END OF DECEMBER 1966

Beneficiary's place of residence [1]	Total	Retired workers [2]	Disabled workers [3]	Wives and husbands [4] of—			Children [5] of—			Widowed mothers [6]	Widows and widowers [7]	Parents [8]
				All workers	Retired workers	Disabled workers	All workers	Retired and deceased workers	Disabled workers			
Total	$12,466,530	$8,021,899	$339,944	$1,033,956	$1,003,494	$30,462	$1,106,521	$959,041	$57,480	$278,130	$1,720,745	$55,335
Africa	69,484	43,407	808	7,354	7,245	109	9,053	8,951	102	1,820	6,846	176
Cape Verde Islands	42,421	26,618	112	5,357	5,306	51	4,368	3,266	102	729	5,160	77
South Africa	10,883	7,622	0	1,135	1,135	0	956	956	0	274	886	0
Other	16,160	9,167	696	862	804	58	3,729	3,729	0	817	790	99
Asia	784,776	518,461	12,116	75,846	74,191	1,655	60,216	57,128	3,088	20,564	96,019	1,554
Cyprus	21,109	14,255	603	2,302	2,061	241	1,313	1,072	241	206	2,374	56
Hong Kong	138,849	71,248	540	23,206	23,110	96	8,860	8,626	234	4,219	30,458	318
India	8,036	5,136	93	1,002	956	46	687	641	46	198	855	65
Israel	150,692	111,259	4,496	13,881	13,486	395	4,819	4,156	663	1,306	14,765	166
Japan	312,214	221,534	2,580	23,191	22,848	343	20,805	20,121	684	8,760	34,919	425
Jordan	19,474	10,070	1,261	2,201	1,932	269	3,657	2,888	769	660	1,431	194
Lebanon	46,301	30,654	777	2,821	2,754	67	7,302	7,013	289	1,554	3,143	50
Macao	13,927	8,765	480	2,079	2,061	18	521	485	36	131	1,893	58
Ryukyu Islands	31,858	20,716	586	2,823	2,729	94	4,062	3,936	126	1,361	2,088	222
Syrian Arab Republic	7,673	5,604	0	554	554	0	746	746	0	156	613	0
Turkey	13,917	9,163	0	786	786	0	2,037	2,037	0	503	1,428	0
Other	20,726	10,057	700	1,000	914	86	5,407	5,407	0	1,510	2,052	0
Canada	1,716,010	1,083,346	44,050	126,343	123,022	3,321	171,460	161,856	9,604	40,172	245,943	4,696
Central America and West Indies	230,733	164,619	7,183	12,554	12,360	194	19,369	18,538	831	4,722	20,762	1,524
Bahamas	13,869	8,839	411	1,044	1,017	27	1,622	1,491	131	284	1,625	44
Barbados	27,938	20,543	881	1,967	1,967	0	549	549	0	133	3,757	108
Bermuda	9,645	6,831	126	905	892	13	747	645	102	149	885	0
British Leeward and Windward Islands	29,800	22,050	702	2,195	2,195	0	1,214	1,214	0	215	3,071	353
Costa Rica	12,753	8,228	558	970	875	95	1,623	1,388	235	516	666	192
Dominican Republic	11,730	7,472	934	528	528	0	1,466	1,466	0	111	1,219	0
Jamaica	69,218	56,995	1,832	2,776	2,776	0	2,364	2,257	107	467	4,513	271
Nicaragua	10,650	6,090	589	327	327	0	2,099	2,099	0	803	675	67
Panama	7,582	2,392	124	317	317	0	2,927	2,757	170	842	858	132
Trinidad and Tobago	13,149	9,183	164	457	457	0	1,219	1,219	0	199	1,771	156
Other	24,389	15,996	860	1,068	1,009	59	3,539	3,453	86	1,003	1,722	201
Europe	8,153,668	5,505,576	212,668	673,329	656,187	17,142	403,578	378,031	25,547	115,807	1,223,566	19,144

Austria	128,766	98,091	3,478	6,271	6,156	115	5,698	5,273	425	2,114	12,922	192
Belgium	50,381	34,345	518	3,847	3,847	0	2,537	2,380	157	910	8,123	101
Bulgaria	13,449	6,518	0	1,398	1,398	0	151	151	0	55	5,327	0
Denmark	81,612	62,353	1,940	4,957	4,851	106	2,431	2,202	229	739	9,192	0
Finland	58,599	45,002	1,499	2,945	2,818	127	1,163	1,031	132	418	7,572	0
France	183,913	135,888	5,674	10,115	9,641	474	11,505	10,505	1,000	3,881	16,481	369
Germany (U.S. zone)	868,490	642,746	26,152	42,183	40,791	1,392	45,014	42,500	2,514	19,837	91,455	1,103
Greece	1,057,015	720,699	22,216	88,276	85,734	2,542	80,090	76,592	3,498	14,911	126,343	4,480
Ireland	319,740	243,539	14,523	13,059	12,286	773	15,577	14,426	1,151	4,725	26,261	2,056
Italy	2,570,741	1,638,686	69,410	277,723	271,525	6,198	92,642	84,524	8,118	25,769	461,213	5,298
Malta	39,728	25,309	2,792	2,351	2,048	303	3,426	2,898	528	1,174	4,620	56
Netherlands	61,296	38,889	969	4,726	4,678	48	6,115	6,019	96	2,212	8,276	109
Norway	333,180	241,067	9,047	26,906	27,150	756	11,042	10,450	592	3,044	40,524	550
Poland	137,915	61,653	3,279	14,251	13,958	293	1,436	1,284	152	173	55,798	1,325
Portugal	307,869	199,353	10,643	35,048	34,005	1,043	15,915	14,225	1,690	3,079	43,739	92
Rumania	10,708	4,111	0	1,251	1,251	0	179	179	0	0	5,123	44
Spain	398,448	284,779	9,706	33,018	32,241	777	17,543	16,189	1,354	3,675	48,988	739
Sweden	350,292	280,645	6,000	20,579	20,331	248	5,683	5,227	456	1,200	35,948	237
Switzerland	148,194	116,694	2,958	7,819	7,646	173	5,756	5,582	174	1,186	13,419	362
United Kingdom	689,224	452,279	14,143	37,056	35,793	1,263	67,682	64,943	2,739	23,828	92,854	1,382
Yugoslavia	331,078	163,323	7,272	37,790	37,326	464	10,844	10,302	542	2,635	108,624	590
Other	13,030	9,607	449	760	713	47	1,149	1,149	0	242	764	59
Mexico	625,677	282,892	29,283	42,401	39,083	3,318	175,374	166,918	8,456	46,846	37,634	11,247
Oceania	63,790	32,956	2,427	2,836	2,407	429	14,954	13,962	992	4,284	6,193	140
Australia	50,132	26,039	2,111	2,058	1,794	264	11,155	10,659	496	3,209	5,420	140
New Zeland	10,926	5,722	202	610	489	121	2,637	2,335	302	982	773	0
Other	2,732	1,195	114	168	124	44	1,162	968	194	93	0	0
Philippines	692,380	319,393	27,701	84,240	80,508	3,732	137,030	129,319	7,711	38,982	68,790	16,244
South America	110,402	63,445	3,614	8,436	7,874	562	17,634	16,547	1,087	4,145	12,518	610
Argentina	26,720	15,770	802	2,567	2,452	115	2,146	1,980	166	664	4,629	142
Brazil	25,204	14,176	1,304	1,932	1,698	234	3,937	3,450	487	1,075	2,616	164
Chile	11,321	6,095	199	871	810	61	2,443	2,443	0	614	1,099	0
Columbia	9,914	5,564	663	555	434	121	2,074	1,703	371	385	540	133
Peru	12,354	7,380	237	800	800	0	2,350	2,350	0	676	801	110
Venezuela	11,906	6,556	226	706	675	31	2,791	2,728	63	429	1,198	0
Other	12,983	7,904	183	1,005	1,005	0	1,893	1,893	0	302	1,635	61
U.S. possessions	19,630	7,804	94	617	617	0	7,853	7,791	62	788	2,474	0
Canal Zone	19,043	7,614	94	556	556	0	7,563	7,501	62	742	2,474	0
Other	587	190	0	61	61	0	290	290	0	46	0	0

[1] Based on monthly benefit check address. Data for places with 100 or more beneficiaries shown separately. All benefit payments were being withheld on Dec. 31, 1966, from beneficiaries living in the following countries in which conditions were such that there was no reasonable assurance that the payee would actually receive the check and be able to negotiate it: Albania, China (including Outer Mongolia and Tibet), Cuba, Czechoslovakia, Soviet Zone of Germany, Hungary, North Korea, and the Union of Soviet Socialist Republics (including Estonia, Latvia, and Lithuania).

[2] Aged 62 and over.

[3] Under age 65.

[4] Includes wife beneficiaries under age 65 with entitled children in their care, and divorced wives.

[5] Includes disabled persons aged 18 and over whose disability began before age 18 and entitled full-time students aged 18–21.

[6] Includes surviving divorced mothers with entitled children in their care.

[7] Aged 60 and over for widows and surviving divorced wives, and aged 62 and over for widowers.

CITIZENSHIP OF BENEFICIARIES RESIDING ABROAD

The attached table shows the number and percent of benefit payments abroad at the end of December 1960, June 1964, and December 1964, by the citizenship of the beneficiary and by the citizenship of the worker on whose earnings the benefits were based.

This table shows that in 1964, while more than half—52 percent—of the payments abroad were based on the earnings records of United States citizens, more than half of the benefit payments—almost 60 percent—were made to aliens rather than to citizens. Comparison with similar figures for 1960 appears to indicate that the proportion of benefits based on the earnings of citizens has increased slightly and that the proportion payable to citizens has also increased somewhat. There is, however, insufficient information to arrive at a firm conclusion on trends in the number of citizens abroad getting benefits.

At the end of December 1964, 40 percent of the beneficiaries living outside the United States were citizens, 58 percent were aliens, and the citizenship of 2 percent was unknown. Of the citizen beneficiaries residing abroad, 7 percent were born in the United States, 31 percent were naturalized, and the basis of the citizenship of 2 percent was unknown.

BENEFITS PAYABLE TO BENEFICIARIES LIVING ABROAD

BENEFICIARIES CLASSIFIED BY CITIZENSHIP OF WORKER

	Date	Total number	Number based on citizen record	Percent	Number based on alien record	Percent	Number citizenship unknown	Percent
OASI	Dec. 31, 1960	98,791	43,836	44	46,530	47	8,425	9
OASDI	June 30, 1964	150,641	77,992	52	66,834	44	5,815	4
OASDI	Dec. 31, 1964	159,123	83,513	52	69,611	44	5,994	4

BENEFICIARIES CLASSIFIED BY CITIZENSHIP OF BENEFICIARY

	Date	Total number	Number of citizens	Percent	Number of aliens	Percent	Number citizenship unknown	Percent
OASI	Dec. 31, 1960	98,791	33,320	34	65,471	66	.....	.....
OASDI	June 30, 1964	150,641	58,929	39	88,735	59	2,977	2
OASDI	Dec. 31, 1964	159,123	63,435	40	92,513	58	3,175	2

MEDICARE AND NONRESIDENTS OF THE UNITED STATES

Payment under the medicare program can ordinarily be made only for services furnished within the United States (including Puerto Rico, the Virgin Islands, Guam, and American Samoa). However, emergency inpatient hospital services furnished by a hospital outside the United States are covered under certain limited circumstnaces. First, the individual must be physically present within the United States at the time the emergency arise which necessitated the inpatient hospital services. Second, the foreign hospital must be closer to, or substantially more accessible from, the place where the emergency occurred than the nearest hospital in the United States which was adequately equipped to deal with, and was available for the treatment of the individual's illness or injury.

It should also be noted that people who are eligible for cash benefits under the social security or railroad retirement programs on the basis of covered work automatically become eligible at age 65 for medicare protection without regard to considerations of citizenship or residency. However, in order for a person who is not eligible for cash benefits to qualify for health insurance protection, he must,

in addition to meeting the other requirements of the program, be a resident of the United States and either be a citizen or an alien lawfully admitted for permanent residence who has resided in the country continuously for 5 years before filing an application for health insurance benefits.

NMBERNU A DAMOUNT OF MONTHLY BENEFITS PAYABLE TO BENEFICIARIES LIVING IN COMMUNIST COUNTRIES BY TYPE OF BENEFIT AND COUNTRY AT THE END OF 1966

	Bulgaria		Poland		Rumania		Yugoslavia	
	Number	Amount	Number	Amount	Number	Amouet	Number	Amount
Retired workers	73	$6,518	691	$61,653	48	$4,111	1,811	$163,323
Disabled workers	0	0	31	3,279	0	0	70	7,272
Wives and husbands	32	1,398	307	14,251	26	1,251	899	37,790
Children	4	151	30	1,436	3	179	234	10,844
Widowed mothers	1	55	2	173	0	0	41	2,635
Widows and widowers	76	5,327	783	55,798	68	5,123	1,561	108,624
Parents	0	0	14	1,325	1	44	6	590
Total	186	13,449	1,858	137,915	146	10,708	4,622	331,078

NUMBER OF BENEFICIARIES AND TOTAL AMOUNT OF BENEFITS THAT ARE CURRENTLY WITHHELD FROM THEM UNDER TREASURY REGULATIONS

It is not possible to make precise estimates of the total amount of benefits that has been withheld from beneficiaries living in countries where the Treasury bars payments because, once the ban has been imposed in a particular country, the Social Security Administration does not attempt to keep up-to-date records on individual beneficiaries in that country; no continuing investigation is made as to whether a beneficiary has worked or died, as would be the case had the ban not been imposed. Maintaining current records on these beneficiaries through continuing investigation would be administratively difficult, because of the relations between the United States and the particular country, and economically wasteful since it would not serve any immediate purpose.

Until such time as a beneficiary goes to a country where payments can be made or until the Treasury ban is lifted, there is no attempt on the part of the Social Security Administration to determine whether the beneficiary is living or whether he has been continuously entitled to benefits during the entire period during which the ban has been imposed. Instead, when the ban is lifted in that country, the Social Security Administration sends a team of examiners to the country to contact each beneficiary and to determine whether deduction or termination events have occurred since benefits were first witheld and the exact amount of the benefits due. This procedure was followed with Poland, Rumania, Bulgaria, and Yugoslavia and will be applied to other countries which may be removed from the Treasury restrictions.

Very rough estimates would indicate that probably not more than $22.5 million in benefits have been withheld from beneficiaries living in the 12 Communist-controlled countries where the ban has been, and is still, imposed over periods ranging from 1948 to the present. This figure, however, is based on the assumptions that all beneficiaries in a given country were entitled as of the date the restriction was imposed, that they are still living, and that no deduction, suspension or termination events have occurred since that time. These assumptions are completely unrealistic since some beneficiaries became entitled after the ban was imposed, many have died since the ben was imposed, and many have worked at various times during the period. If these and other factors are taken into account, probably about 50 percent of the $22.5 million in benefits would actually be payable if the Treasury ban were lifted in all of the 12 countries.

Attached is a table showing countries where the ban is applicable, when it became applicable, and the approximate number of beneficiaries involved. Also attached is a more detailed statement of the enforcement procedures followed in determining whether beneficiaries living abroad are entitled to benefits.

COUNTRIES WHERE TREASURY BAN APPLIES AND ESTIMATED NUMBER OF BENEFICIARIES FROM WHOM BENEFITS HAVE BEEN WITHHELD

Country	Date restriction imposed	Number of beneficiaries
Albania	Sept. 7, 1948	338
China	Dec. 17, 1950	130
Cuba	May 22, 1963	214
Czechoslovakia	Feb. 19, 1951	900
Estonia	....do.....	7
Hungary	....do.....	257
Latvia	....do.....	4
Lithuania	....do.....	12
North Korea	Dec. 17, 1950	1
North Vietnam	Nov. 14, 1964	0
U.S.S.R.	Feb. 19, 1951	119
East Germany	May 10, 1950	78

POLICING THE SOCIAL SECURITY PROGRAM ABROAD

The Social Security Administration maintains a close surveillance over the foreign aspects of its program. Day-to-day administrative procedures are carried out to insure that benefit checks are going only to those entitled to receive them.

After entitlement has been established, the Social Security Administration requires each beneficiary abroad to complete a questionnaire once a year in which he testifies to his continuing eligibility for benefits. These questionnaires are witnessed by American consular officials or responsible foreign officials and payments are stopped if properly completed questionnaires are not submitted on time. Any questionable situation or indication of irregularity arising from the questionnaires or any other source is investigated without delay, through the U.S. Foreign Service posts, if necessary.

As a method of verifying the results of the regular policing procedures, the Social Security Administration, in cooperation with the Department of State, conducts, on a statistically valid sample basis, systematic validation surveys of its beneficiary rolls in foreign countries. During these surveys, beneficiaries are interviewed by unannounced visits to their homes and their documentation is examined to verify their identity and eligibility for benefit payments. These surveys are an continuing administrative measure over and above the regular policing procedure and any special investigtaions.

Validation surveys have thus far been completed in ten countries which represent over 50 percent of the total beneficiary population outside the United States. Of all beneficiaries contacted thus far in the validation program, there was only one case of an unreported death involving overpayments.

Further, in many countries methods of check delivery have been devised to guard against receipt of the check by one not entitled. (Except for Canada where the checks are mailed direct to beneficiaries, all checks are sent to U.S. Foreign Service posts for distribution.) Some examples of safeguards are: Hong Kong, where beneficiaries are required to call at the American Consulate General each month and prove their identity before checks are released to them; Philippines, where every check in excess of a certain amount is delivered personally to the beneficiary; some areas of Turkey where checks are periodically delivered personally by U.S. Foreign Service personnel. Many beneficiaries outside the United States call regularly at their Foreign Service post to pick up their checks. In many other posts, checks sent by mail are registered and return receipts are required.

Senator SMATHERS. Our next witness is Mr. Norman V. Lourie, first vice president, American Public Welfare Association.

Mr. Lourie, I notice your statement—we will print it in the record in full. It will obviously exceed 10 minutes and so you may summarize it.

STATEMENT OF NORMAN V. LOURIE, FIRST VICE PRESIDENT, AMERICAN PUBLIC WELFARE ASSOCIATION, ACCOMPANIED BY HAROLD HAGEN, DIRECTOR, WASHINGTON OFFICE

Mr. LOURIE. Thank you very much, sir. I will summarize the highlights and some of the points on which we agree and some of the points on which we have some questions about the legislation.

I have with me Mr. Harold Hagen who is the director of the Washington office of the association. I am the first vice president. And in addition to the material which I have presented to the committee I should like to ask that another statement on financing public child welfare services which is pertinent——

Senator SMATHERS. We will make that a part of the record, if there is no objection.

Senator SMATHERS. All right, sir, if you will proceed.

Mr. LOURIE. Mr. Chairman, we are delighted and thank you very much for the opportunity to be here. We feel particularly competent to comment on this legislation because we represent the public welfare departments and the employees of the public welfare departments in the 50 States and in the territories. We have a very direct connection on a daily basis with the people who receive public assistance and other benefits of the Social Security Act and, therefore, we have had long experience with them.

We believe that in an overall sense the public welfare provisions of the bill continue a trend that was begun in 1956 which set in motion the programs to provide rehabilitation and other services to help individuals attain or retain, their capability for self-care and self-support and to maintain and strengthen family life; and, as you will recall, in 1962 when Mr. Ribicoff was the Secretary, we extended these amendments further to give the departments of public welfare in the States additional capability. And we feel that this bill, through the fact that it extends the ability of the States to give additional services in day care and family planning and family counseling, and in the field of work incentives and social work training, gives the States a great deal of additional ability through some more Federal support, and gives us more weaponry than what we have had before to relieve suffering and help to maintain and strengthen family life and to help individuals to attain independence.

We think that it is extremely important to retain in this bill those provisions which give the departments of public welfare the responsibility for work and training.

I know from testimony before you that both Secretary Wirtz and Secretary Gardner have advocated moving this program, work and training program, to the Labor Department. We have no question about the role of the Labor Department in a work program, but we believe that the group of people to whom this particular feature of the bill is directed represent a group for whom we have a particular kind of competence and for whom we can do a great deal in seeing to it that their training and work experience is developed.

This is not merely a question of finding jobs for people. It is a question of getting a great many unmotivated people to become skilled. These are people who need a good deal of education, literacy training, for instance, and we feel we are particularly competent to act as the advocate and broker for these people. We hope that these provisions will be left in this part of the law for administration by public welfare.

We think that the bill is very sound in that it makes permanent authorization for payments of children of the unemployed. We think the bill is faulty in that it does not mandate this on the States.

One of the largest elements in helping to break up families is the element which keeps unemployed fathers off assistance, and we think that States ought to be made to give assistance to this group because if you tie this to another feature of the bill, the work incentive, which we think is highly desirable, this will do as much as anything, we think, to not only get people off assistance, but to maintain the families.

We think that the bill is very positive in that it calls for public welfare departments to develop a plan for each family that comes in for assistance, to see whether or not this family needs one or another kind of service, and we applaud this direction.

The concept of the income incentive is an extremely good one because this moves toward setting up a minimum floor of income. We would, of course, like to see the Federal Government insist on a standard, a floor of assistance for every State based on the cost of living consideration. But since this is not apparently possible in this legislation, since Congress did not see fit to move entirely in this direction, we think that this is a great step. It eliminates, incidentally, a number of inconsistencies. There were a number of incentive programs outside the Social Security Act and this one moves to make all of the incentive programs equal for whatever kind of work the Federal Government might support. We think it important to mention that this incentive of $30 and one-third of the balance is not sufficient. We think the committee ought to give consideration to an incentive payment which is closer to some of the others which have been in force. For instance, for the aged and for the workers in certain of the economic opportunity programs, we have gone so high as a work incentive deduction of $85. We are not saying that amount ought to be used, but more than $30, perhaps $50 and half of the balance would be sound.

We also applaud the emergency assistance, but we maintain 30 days is not enough. We call your attention to the fact that many States still have strict residence provisions which have been tested and are in the process of being tested in the Federal courts in several States. There have been injunctions by Federal courts while a case is being appealed. The question of whether or not States should have residence at all is clearly a current issue and we think that this emergency provision ought to be extended with that in mind.

We approve, of course, the move towards increasing the social security benefits, but we believe the Congress did not go far enough; we think the minimum ought to be $70, and for the people with 25 years of covered employment the minimum ought to be at least $100. The reason we stand so strongly for this from the viewpoint of public assistance is, you must remember, that increasing numbers of old people receive both OASDI benefits and public assistance at the same

time. The number keeps increasing each year. The higher we can go in the OASDI benefits, the more persons are going to be removed from public assistance and, of course, it is the lower income groups which have the greatest needs, and $50 certainly is not enough.

We agree with the provision that support should be obtained from fathers, but we would point out that we hope the administration, when it sets up the regulations for such support, would make it incumbent on the States that they provide a great many services. We think that the unmarried father and the deserting father need to be helped to come back to his family and that punishment by itself is not going to do the job.

We also applaud the combination of AFDC and the Child Welfare Services. We thing this will strengthen the program for children. High quality of services should be maintained.

We think that the additional funds for foster care are going to be very useful, but we would like to point out to the committee that the limitation of Federal dollars for foster care, limitation for children who are adjudicated by courts, is a very serious one indeed. A great many children in this country are placed in foster care because a mother is ill and a father cannot care for the family. We don't think that kind of child, that kind of case needs to be brought before a court. We think neglect, delinquency, abuse should be brought before a court, but we think the Federal Government should also support foster care for children who need foster care for any appropriate reason.

We have some question too about the child welfare financing. We think that the authorization for the additional child welfare services funds is sound, as proposed in this bill. But we would like to point out that we are more in favor of the provisions in S. 1116, Senator Pell's bill, which puts the matching for traditional child welfare services on the same basis as the services provided for the AFDC.

These things we agree with in the bill and I have given some of the modifications we suggest. There are several issues on which we should like to express strong objection.

First is on the freeze, the business of the limitation of Federal participation on a formula base with respect to children of deserting fathers. We think this is a punitive type of measure. We think it is a measure which tends to blame children for the ailments and the sins of adults and of society and we think it produces inequities and that the committee ought to take another look and eliminate it.

The second thing to which we object is what appears to be some tone of compulsion in that part of the bill which talks about work and training. We have no objection to, as a matter of fact, we support heartily, the notion that every able-bodied person in this country ought to work, and indeed in our programs I think we have sufficient evidence to indicate that we have supported work on the part of people. There is a great deal of myth about the business of AFDC and work.

In my own State, Pennsylvania, for instance, where I am the deputy secretary of public welfare of 60,000, the average of 60,000 cases, that we had last year on our rolls, about 18,000 of these cases came on the rolls because people left employment. About 16,000 of these cases left the rolls during the year because people went to employment. We think that women with older children should be urged to work when they are able-bodied and can go into the labor market. We think all able-

bodied men should be urged to work, but we have a very fundamental question about whether in this country with the problems that we are having in the break up of family life, that women with young children should be pushed to work.

In the face of the fact that half of our population will soon be under 25, pushing women of young children to work could be frightening.

You probably are aware of the fact, that about 36 percent of the American work force is already made up of women, and of all women of working age about 47 percent are already working, and when you go to the Negro population about 60 percent of the able-bodied women in the working ages are working.

The question of pushing women with young children to work is a real question with us.

We think young people in need of jobs and I don't think I need to quote to you the problems surrounding the undue amount of unemployment among young people. We think that the need is less compulsion to work than provision of jobs.

In the title XIX provision we think there are issues that the Senate should consider. We have no objection to the fact that the Federal Government wants to set a limit on the entitlement base. We think that the Federal Goverment ought to set standards for the entitlement base for all assistance, and that it ought to be based on some consistent cost of living base. There are still too many people living on very low grants.

We think that the relationship, if a method has to be established, that a relationship between the assistance grants and the medical assistance entitlement is a sound one. We question 133 percent and the relationship, as stated to per capita income of a State. We think that the 150 percent limitation is a sounder one and we thing that some leadtime, perhaps to 1975, ought to be given for conformance.

Eliminating the requirement that States provide five basic services makes possible a program without physicians or hospitals. This is inconsistent for instance with the bill's family planning provisions.

There are a number of other issues with which we have some slight disagreement and make proposals, but those are in our printed material and I hope you will give them consideration.

Senator SMATHERS. Thank you very much, Mr. Lourie.

Senator Williams, any questions?

Senator Curtis?

Senator CURTIS. Yes, one or two.

Mr. Lourie, I would like to ask you as someone who is in the administrative and practicing end of public welfare a few questions.

As you see the bill passed by the House of Representatives, what changes will be brought about in welfare, particularly aid to dependent children and families of dependent children?

Mr. LOURIE. I think that the greatest—in terms of the positive features of the bill, I think that the greatest positive feature of this bill is the fact that it gives to the States an additional ability in the field of providing services that can help to solve problems. As I indicated we started in 1956 and then we went on in 1962. For instance, since 1962 the Federal Government has participated very substantially with us in the salaries or personnel who are giving service. This bill takes it a step further.

Let's be specific. In the field of day care, previously in existing law, the States under the assistance programs could not do anything substantial about providing day care. This bill will allow us to purchase and to establish day-care services. This will make it a lot more possible for women with young children who choose to work to be able to go to work.

Senator CURTIS. Are there any parts of the House of Representatives' bill in relation to child care, particularly under the AFDC program, with which you disagree?

Mr. LOURIE. Yes, sir.

There are two features with which we disagree primarily. One is the freeze which says that the Federal Government will not participate in assistance on AFDC for more than that proportion of children which represents children of absent fathers, the number of children of absent fathers in a State in January 1967 as related to the total population of children. And we think that this is a restrictive provision.

Senator CURTIS. Now, that is a freeze on the total, the total grant to the States.

Mr. LOURIE. It is a freeze on the numbers of children for whom the Federal Government will participate.

Senator CURTIS. But it doesn't freeze it as to the same children?

Mr. LOURIE. Yes, sir.

It says that—well it is not the same children. It is on the total number of children.

Senator CURTIS. It is the total grant?

Mr. LOURIE. Yes, sir, for this group of children.

Senator CURTIS. And that, in effect, is saying to a State unless you do something about the problem which has been on the increase of aid to families where the father is absent we are not going to pay for the increase. Is that what it amounts to?

Mr. LOURIE. In effect, that is what it says. But it doesn't say to the States "if you don't do something." It says to the States "we are giving you the ability to do something" but even if you carry out this program——

Senator CURTIS. That is what it amounts to though? If a State goes on and lets these rolls increase where there is an able-bodied father who is away from home, the Government will not pay for the overall increase, isn't that what it amounts to?

Mr. LOURIE. Yes, sir.

But we are making an assumption that the State can always locate the absent father. There is a great deal of mobility in this country, and an absent father can turn up 10 States away. We agree with the provisions that require us and, in fact, most of us, I believe, have been doing everything we can to locate absent fathers and to get them back to their family and to get support from absent fathers. But we think if we cannot locate an absent father the child should not be made to suffer.

Senator CURTIS. Now, in the House report it says:

This provision should also give the States an incentive to make effective use of the constructive programs which the bill would establish. This provision would not apply to the children of the unemployed fathers or deceased or disabled parents. Therefore, States which have not adopted a program for unemployed fathers would not be disadvantaged by this provision.

Mr. LOURIE. Well, the way in which a State would be disadvantaged is that the application of the Federal formula based on a percentage would affect a great many children on AFDC.

Senator CURTIS. But doesn't the State and locality have some responsibility——

Mr. LOURIE. Yes, sir.

Senator CURTIS (continuing). To prevent this ever increasing of dependency when the father is neither deceased nor disabled?

Mr. LOURIE. No question, sir. We agree with you that within the public assistance program we should do everything that we can, we should promote the family planning programs, for instance, which are made possible in this bill; we should do everything possible to train people. We should use all of the forces of law to find fathers and to get them to support their families. But I should like to emphasize that a great many of the reasons which produce absent fathers and which produce illegitimacy, although you did not mention that, are not caused by the public assistance program. The immorality problems in the United States have to do with a great many issues which we can't solve with this program.

Senator CURTIS. Isn't the basic responsibility for law and order and dency in a community resting upon the States and localities?

Mr. LOURIE. Essentially.

Senator CURTIS. Yes.

And the House has said here:

We are giving you some constructive tools to help at least part of it. You measure up to your responsibility because we are not going to pay for the increase.

Mr. LOURIE. Yes, but, sir, what can happen, for instance in a State, is that the population of children in a State can increase for a great many reasons which have nothing to do with these deserting fathers.

Senator CURTIS. Your objection then is that the ceiling applies to total population and not to the child population?

Mr. LOURIE. Well, the way, as we understand it the way, this formula would be applied, we would take the number of children present in our caseloads because their fathers were deserted in January of 1967, and we would apply it to the total child population that we have in the State at any one time.

Let's take a State where the economy breaks for some reason. Suppose there is a major strike. In my State, when the steel strike came in 1958, we had to appropriate more than $50 million of additional State funds to meet the problem including the difference between the unemployment compensation and families' needs on assistance. If that should happen again and a great many children were to come on public assistance in a State, and this formula would be applied there could be a great many children coming on assistance who would not be getting Federal participation because this formula would apply.

Senator CURTIS. Well, it would probably be reached by other programs.

Mr. LOURIE. Not in the public assistance programs. There is no other program, sir, which provides cash assistance.

Senator CURTIS. Unemployment compensation.

Mr. LOURIE. Unemployment compensation, sir, is a very limited program in terms of families. The average unemployment compensation in my State is about $45. I suspect it is something like that in other States.

Senator CURTIS. Per week?

Mr. LOURIE. Per week.

Nothing is provided for large families. As a matter of fact, although we did not put it in this testimony because it was not particularly pertinent, our association would advocate a major change in the unemployment compensation program. We would like to see the unemployment compensation program become a program that had benefits based on the number of dependents. This would reduce the assistance program.

Senator CURTIS. In other words, you would base it on need?

Mr. LOURIE. Pardon?

Senator CURTIS. Would you base it on need?

Mr. LOURIE. Yes; I would base it on dependents need for support.

Senator CURTIS. Clear across-the-board, base it on need?

Mr. LOURIE. Yes, sir.

This would reduce the AFDC rolls because people who are unemployed who are presently getting both unemployment compensation and public assistance would no longer need to do so.

Senator CURTIS. I think you might find quite a little support for that. There are people who are well able to take care of themselves who sometimes qualify for unemployment compensation.

Mr. LOURIE. The same thing, incidentally, sir, is true of old age persons who are on OASDI and assistance. If OASDI were higher, they could leave assistance.

Senator CURTIS. I am interested in your proposal that you would base it upon need. I understand that there are some companies with a mandatory retirement age, they have a company retirement pension and they also arange that when those people are let off that they immediately file for their unemployment compensation, at least it was going on a short time back. So I think your proposal might—that unemployment compensation be based upon need might find support from a number of quarters.

What is the other thing that you object to about this House of Representatives bill?

Mr. LOURIE. We object to the implication in the work and training section which would lead the States, we believe, to press women with young children to go to work, would lead some States to press women with young children to go to work.

Senator CURTIS. Would that apply to all mothers or would it apply more particularly to those who have demonstrated a certain amount of moral unfitness or laziness?

Mr. LOURIE. That question has been raised many times in discussing AFDC. Our point of view on that is very simple, Senator: We believe that the States, practically every State in the Union, have adequate child welfare laws and adequate laws dealing with morality of parents, and that if there are children who are being abused psychologically or socially, we have machinery to take that family into court. We do not believe——

Senator CURTIS. What could the court do?

Mr. LOURIE. The courts have the ability to remove children from families where they believe children are being abused or neglected either physically, socially, or otherwise.

Senator CURTIS. In how many States is that effectively used?

Mr. LOURIE. We think it is used effectively in a great many States. We think it could be used more effectively. We think that there are still too many children who are abused but we don't think that the assistance program, which is a program of compassionate financial assistance to meet the problems of hunger and shelter and clothing, should be used as a base for dealing with immorality.

Senator CURTIS. Now, explain to me in detail, if necessary, by using a hypothetical case, what you feel the House passed bill does in regard to forcing mothers to seek employment who are receiving AFDC?

Mr. LOURIE. Well, I would have to go back to the language of the bill, but let me put it to you this way: The bill does use the word "appropriate" when it talks about which folks should be made to work. But if you examine the tone of the language of the bill, it appears to give States a kind of urgency which pushes them to get almost everybody who is able bodied off to work. In other words, it does not take the other kind of caution, and in a bill which has the compassionate base which this bill has—after all it is a social security bill, Social Security Act of the United States—to have a provision which, on the one hand, says that you should see to it that all people who are able should go to work, but on the other hand, does not say anything in the same context that we ought to protect family life by seeing to it that women with young children should not have to work. It kind of gives comfort to people who want to use it negatively, that is our feeling.

Senator CURTIS. Here is what the House said in their report. Page 103, the House committee said:

> Your Committee intends that a proper evaluation be made of the situation of all mothers to ascertain the extent to which appropriate child care arrangements should be made available so the mother can go to work. Indeed, under the bill the States would be required to assure appropriate arrangements for the care and protection of children during the absence from the home of any relative performing work or receiving training.

Then notice this:

> The Committee recognizes that in some instances—where there are several small children, for example—the best plan for a family may be for the mother to stay at home. But even these cases would be reviewed regularly to see if the situation had changed to the point where training or work is appropriate for the mother.

Now, you are opposed; to that?

Mr. LOURIE. No, we are not opposed to what the committee says, but we believe that the way that the provision is stated in the law, the proposed law would urge some States to push women of young children into the work force.

Senator CURTIS. Then your proposal is you would like to have that section eliminated or do you have a suggestion to rewrite it?

Mr. LOURIE. I do not have a suggestion to rewrite it at hand, but I should like to provide one to you.

Senator WILLIAMS. What is the particular language in the law to which you——

Mr. LOURIE. I do not have that in front of me, I should like to review that and send it to you.

(Pursuant to the above discussion, the following information was received from Mr. Lourie:)

As I indicated in the written statement which I filed with the Committee, much of our concern arises from the latitude which the bill would give for the interpretation of the terms "appropriate" and "good cause." In this respect the question is not so much a matter of the language of the bill as it is of how it would be carried out in practice. It is therefore our recommendation that the Committee, in its report, call upon the Secretary of Health, Education, and Welfare, to develop specific guides for the application of these provisions that would promote and safeguard the purpose of the AFDC program "to help maintain and strengthen family life and to help such parents or relatives to attain or retain capability for the maximum self-support and personal independence consistent with the maintenance of continuing parental care and protection . . ."

We also recommend that the Committee express the expectation that a welfare agency would provide all possible help and encouragement, over an extended period if necessary, to enable and motivate a mother or other relative to participate in training or to accept employment before terminating assistance.

Senator CURTIS. All right.

As a practical administrator and one who works with other administrators, is there a growing problem of unfit mothers receiving tax money, particularly AFDC?

Mr. LOURIE. We think that there is a growing problem of young mothers who have not had enough education and we think there are a great many moves in the United States, including moves being made in this bill, which would help us to increase the ability of mothers to manage their children.

Senator CURTIS. It is not confined entirely to young mothers, is it? Aren't there some in their thirties and forties?

Mr. LOURIE. Yes, sir; I would say so.

Senator CURTIS. And the number is increasing?

Mr. LOURIE. The number is increasing because, among other things, the population is increasing, and I cite particularly, I mention young mothers particularly, because this is the field in which the unemployment rate is highest among young men. The age of marriage is getting lower in this country, we are getting more marriages of young people for a great many reasons, and there is a great deal of unemployment among young people. We think these things together are a bad combination.

Senator CURTIS. I didn't say a word about unemployment. I asked you about the problem of unfit mothers. Is that problem growing?

Mr. LOURIE. I would say so, yes.

Senator CURTIS. What are you administrators doing about it?

Mr. LOURIE. We are using every resource that we have to try to educate young mothers in homemaking, and we are cooperating with the education departments which are doing a great deal in this field.

Senator CURTIS. Now, if the unfitness——

Mr. LOURIE. We are putting homemakers to work, we are putting home economists to work. We are having group meetings with young mothers. We are going in to try to help them understand better ways of child rearing. We are trying to educate them in how to manage their homes and so on.

Senator CURTIS. This is a problem that has been with us a long time. Sometimes you hear someone, I believe rather thoughtlessly say that

their payments should be cut off. I hold the view that you can't punish the children for the wrong doing of the parent. There are others who say, well, the children should be taken away from the parent. That, too, creates some problems, because the parent never sees the child.

I haven't had a chance to make a personal investigation of this but I am told that there is one country that faced a growing problem of irresponsibility and unfit and morally delinquent parents, who are receiving aid to raise their children. They have instituted a plan where the children are taken away but put in an institution where they are given wholesome food and clean beds to sleep in. At the same time that the court orders the children to that institution, the court sentences the parent to sufficient hours of labor in that institution each week to pay the cost of maintaining the child. The parent gets to see the child, the child gets training, the parent gets training in household duties, in cleanliness, in other work, in cooking, in doing things that would not only equip them for better homemaking, but even possibly supplemental earnings. That isn't done in any State here in this country, is it?

Mr. LOURIE. Sir, in the child welfare programs in this country which are also financed by the provisions of this act, we provide care for thousands of children who are removed from their homes. We also provide in every county of the U.S. child welfare programs, public and voluntary, partially funded by provisions of this act, which help parents to a protective type of service to keep their families together. We believe that the additional authorization for funds in this bill will give us a better way to improve the services in child welfare than we have. But we think that the financing of those services should be the same as for AFDC. There is an inconsistency. The Federal Government appropriates lump-sum allotment of money to child welfare services and then has a percentage formula for AFDC services. This bill now says they should be put together in one unit. We agree with that. HEW is now structured to put these together in one unit in the services, but you have got two sets of financing, one to finance those services which deal with the problems you are mentioning on a more limited basis than we are providing for the services in the aid to families with dependent children. We think there ought to be one base for this and there is a bill in the Senate, Senate 1116, which deals with this problem. All child welfare services should be of high quality and placed in title V.

Senator CURTIS. Now, how many people, including children and adults, are receiving some sort of welfare assistance under the various acts of the social security law in your State of Pennsylvania?

Mr. LOURIE. In my State of Pennsylvania there are presently 382,000 persons on assistance.

Senator CURTIS. Does that include AFDC?

Mr. LOURIE. Yes, sir.

Senator CURTIS. 382,000.

Mr. LOURIE. Persons.

Senator CURTIS. Persons.

Roughly, how many of those are children, approximately?

Mr. LOURIE. I would say about 180,000.

Senator CURTIS. Would you say that all of the 382,000 are poor people?

Mr. LOURIE. Yes, sir; else they would not be on assistance.

Senator CURTIS. How many of them are also receiving something under, from, the poverty program?

Mr. LOURIE. I wouldn't have that kind of figure, sir, but there would be a number, for instance, that would be receiving benefits of other programs. There are some who are concurrently receiving unemployment compensation. There are some who are concurrently receiving OASDI and assistance.

Senator CURTIS. No; I confined it to poverty.

Mr. LOURIE. On the poverty program, I would say there are about maybe 24,500 young people in the Neighborhood Youth Corps, and 5,000 who are fully or partially employed in Economic Opportunity Act programs.

Senator CURTIS. How many?

Mr. LOURIE. About 5,000 I would say, that are employed, and then there have been about 3,000 to 4,000 in work and training programs under title V.

Senator CURTIS. That are receiving, that is the number you say are receiving, something from the poverty program?

Mr. LOURIE. Not receiving cash. Some of them are receiving money through employment. That would be a limited number. There are others who are receiving training, others receiving educational benefits and so on.

Senator CURTIS. Well, does the poverty program in your State have a medical program?

Mr. LOURIE. There are two health centers under development; yes, sir.

Senator CURTIS. Can you tell us to what extent that overlaps with medicaid?

Mr. LOURIE. Well, to the extent that—well, it doesn't overlap with medicaid or with—it doesn't overlap with medicaid. Where a person who uses that service is eligible for medicaid, we would be using medicaid funds to pay. What the OEO health centers will do is to substitute for clinics. I mean they really are a community health service, just as any other clinic is a community health service, and we would purchase from them.

Senator CURTIS. The OEO is not providing any medical service that is not purchased by the welfare department; is that your statement?

Mr. LOURIE. Yes sir. If there are persons who are not eligible for medical assistance payments, I imagine that they would be provided services.

Senator CURTIS. How much are you spending in Pennsylvania on medicaid?

Mr. LOURIE. In the year beginning July 1, about $120 million.

Senator CURTIS. $120 million. How much are you spending for medical assistance to the aged?

Mr. LOURIE. That would be included. When you said medicaid——

Senator CURTIS. That is everything but medicare?

Mr. LOURIE. That is correct, sir.

Senator CURTIS. $120 million.

Do you have any idea how much the OEO is spending on medical care in Pennsylvania?

Mr. LOURIE. I do not know, sir.

Senator CURTIS. That is all, Mr. Chairman.

Senator HARTKE (presiding). Senator Williams?

Senator WILLIAMS. Just one question for clarification. In answer to a question from the Senator from Nebraska concerning the employment, I understood you to say that this bill, would cause the placing into the work force of a large number of small children.

Mr. LOURIE. Of women.

Senator WILLIAMS. Women who——

Mr. LOURIE. Women who had small children.

Senator WILLIAMS. Women who had small children. I thought that was what you meant, because the bill only relates to children as they would exceed the age of 16.

Mr. LOURIE. Correct, sir.

Senator WILLIAMS. Yes, correct.

Senator HARTKE. Thank you, sir.

Mr. LOURIE. Thank you, sir.

(Mr. Lourie's prepared statement with a document referred to previously follows:)

STATEMENT BY NORMAN V. LOURIE, VICE PRESIDENT, AMERICAN PUBLIC WELFARE ASSOCIATION

Mr. Chairman and members of the Committee, my name is Norman V. Lourie. I am the Executive Deputy Secretary of the Pennsylvania Department of Public Welfare. I am appearing before you today in my capacity as First Vice President of the American Public Welfare Associaiton.

The membership of the Association consists primarily of state and local departments of public welfare and the personnel who work in public welfare programs. Our board of directors from time to time adopts positions on issues and objectives related to the field of public welfare, which are reflected in the following statement. My comments are directed principally to the provisions in H.R. 12080 which would affect the substance and organization of public welfare programs.

AID TO FAMILIES WITH DEPENDENT CHILDREN

The predominant feature of the welfare provisions of H.R. 12080 is the design to redirect the AFDC program for the purpose of limiting the continuing increase in the number of recipients and of reducing the federal financial involvement. This would be accomplished through a combination of narrowed and restricted conditions of eligibility, incentives for employment, and expanded programs of job training and supportive services. A major premise of this legislation is that the welfare agencies have failed to make good on the implied promise of the 1962 welfare amendments, that an expanded program of social services would result in a reduction in the assistance rolls.

First of all I want to make clear the position of the American Public Welfare Association that full employment at adequate wages should be the goal for all persons who are employable and whose services are not needed in the home. This Association has long sought the means for enabling individuals and families to attain self-support when it is in their best interests, and we welcome the support for expanded resources in job training, child care, and child welfare and family services, which this bill would provide.

At the same time we must recommend certain modifications in the bill, especially in two respects. One is the freeze on the level of federal participation in assistance for children who are in need because of the absence of the father. The other is that mothers be required to participate in job training and to accept employment when available. We believe that mothers should be given all possible assistance and encouragement to obtain employment when it is in the best interests of the children, but that this objective could be better attained on a voluntary basis.

While it is true that the AFDC rolls have continued to increase since the 1962 service amendments, we believe that these amendments constitute one of the most constructive measures that have been enacted in the field of public welfare. The

additional facilities and services that would be provided under the proposed legislation would be another major step in this development.

At the time the public assistance categories were established 30 years ago there was no concept of social services enunciated, and certainly no authorization in the statute. The primary consideration was to determine eligibility and to pay financial assistance on the basis of the budgeted need. Actually the urgent problems of individuals and families which were encountered in the administration of financial assistance made it imperative that some social services be provided.

But with untrained staff, overwhelmingly large caseloads, and no specific legislative authority, the service component did not attain a high degree of development. From the beginning, however, the American Public Welfare Associations and other organizations having a concern for public welfare have pointed out that a sound and constructive public welfare program must consist of adequate financial assistance and effective social services.

The first legislative movement in this direction came in 1956, when the public assistance titles were amended to declare one of the purposes of the categories to be to furnish rehabilitation and other services to help individuals to attain or retain capability for self-care, and, in AFDC, to help maintain and strengthen family life and to help parents or relatives to attain or retain capability for the maximum self-support and personal independence consistent with continued parental care and protection. This still stands as a statement to which we can fully subscribe, and it did not give the states a better base for building up their service programs. Unfortunately it did not establish the machinery and support needed to move the service programs forward at a significant pace.

In 1961 when Senator Ribicoff appeared before this Committee on his confirmation as Secretary of HEW, he made a promise that he would take a new look at the public welfare programs. As the first step in carrying out this commitment Secretary Ribicoff appointed an advisory committee made up of nationally recognized leaders representing the religious and secular voluntary welfare agenies, professional schools and organizations, the judiciary, and state and local public welfare agenies. This prestigious group advised the Secretary that public welfare should become more than a salvage operation confined to picking up the debris of human lives. It should become a positive force in the community for strengthening and conserving human resources. It should contribute to the attack on such problems as dependency, delinquency, family breakdown, illegitimacy, ill health and disability. The committee pointed out that a second or third generation of a family receiving welfare is a challenge to the nation that financial help alone has not been enough.

Secretary Ribicoff took the recommendations of this committee and fashioned them into legislative proposals which became the basis for the 1962 public welfare amendments. That is without question the most significant legislative measure so far enacted to establish social services as an essential component of the public assistance system. It has resulted in a major upgrading of the professional and technical competence of personnel through formal education and on-the-job training. States have reduced the size of caseloads so that caseworkers now have more time to devote to giving attention to services designed to keep families together, or to arrange for specialized health care, or homemaker, or legal services, or to provide the support and encouragement to participate in job training or to find employment.

While we applaud the advances which this legislation represents, we also realize that solid progress is made a step at a time, and that there is still far to go. One of the remaining questions has to do with the social problems that involve the community as well as the individual family. It is obvious that the public assistance programs have, whether planned or not, and for better or worse, a significant social and economic impact on the larger community. And the social and economic forces of the community, in turn, greatly affect the well-being of the individuals and families receiving assistance. But, with the exception of child welfare, the only federal authorization for public welfare services are those in the public assistance titles. This authority, no matter how broadly it may be interpreted, must in some way be related to recipients of assistance, past, present, or potential. This continues to be an inhibiting factor in developing a comprehensive community-wide service program through public welfare. Prevention and rehabilitation may often require services that involve many persons in the community beyond those who are actually receiving assistance or who may need it in the future. Our Association has advocated that all public welfare services be established under a separate authorization so that there would not be the con-

stant necessity of identifying some kind of connection. While not fully meeting our recommendation, the proposed new sec. 403 (a)(3)(A) iii of the Act, as provided in sec. 201 (c) on page 112 of the bill, would offer better possibilities than ever before for services of this kind.

The Ways and Means Committee expresses disappointment that the services authorized in 1962 have not reversed the trend toward ever-increasing costs in the AFDC program. At the same time it recognizes that the goals of these services are essentially sound, and that worthwhile and important developments have stemmed from this legislation. Therefore the House bill would build upon the foundations of the 1962 amendments by providing for greatly expanded job training programs and supportive facilities and a further strengthening of social services.

I should like to interject the observation that while we urge establishment of social service and job training programs, we attach the highest importance to education as the significant factor in enabling people to become self-supporting. A report published four years ago on a study of the AFDC program conducted by our Association (An American Dependency Challege), stated: "Undoubtedly the basic and all-prevaling factor to emerge from the children's data is the need for far greater encouragement in the area of education. Vigorous emphasis should be placed on keeping the child in school. The striking relationship between adequate education of the homemaker and improved social environment and better occupational, educational, and social adjustment serves to illustrate the importance of education as a basic wedge for breaking the cycle of poverty and deprivation for many AFDC families."

This Association and the public welfare agencies throughout the country share with Congress and the general public a grave concern over the ever-increasing number of families receiving assistance through Aid to Families with Dependent Children. We sincerely welcome additional facilities and resources designed to enable families to become self-supporting when it is in their best interest.

We know that this Committee recognizes the many factors that contribute to this continuing increase, but that the greatest concern is with the growing number of children who are in need because of the continued absence of the father from the home due to illegitimacy or desertion. The bill proposes that the authorization for assistance for children in need because of the unemployment of the father be made permanent. In this we fully concur. In addition to providing for assistance for this group of needy children, it would also have the effect of holding families together during periods of unemployment. For these reasons it is our recommendation that states be required to include this program in their AFDC plans. We also believe that genuine efforts should be made to obtain support payments from the absent fathers of dependent children, that family planning services should be made available, and that the mothers should be given assistance and opportunity to become self-supporting when appropriate. But we strongly object to the proposal to freeze the level of federal financial participation in assistance for children who are in need because of the absence of the father to the present proportion of this group to the child population of a state. The variations in the numbers of these children needing assistance are subject to factors such as the job market, and the general population increase, which outweigh any efforts that the welfare agencies might make in the way of training and incentives for employment, at least in the short run. We are confident that the public welfare agencies will be conscientious in their utilization of the new resources which this bill would provide, but under the best of circumstances we do not see how they would have any appreciable affect by the first of next year. In the meantime, in some states the number of children in this group has already increased substantially beyond the proposed cut-off point. Other states where the AFDC caseload was at a temporary low point at the first of the year would start out at a disadvantage if it should increase in the future. There is no real option open to the states as to whether or not they will provide assistance to these children who are in need. But if federal matching funds are not available the states will be hard-pressed to find the money, and it could turn out that families in like circumstances would receive different levels of assistance depending on the availability of federal matching.

Our second major objection is with reference to the element of compulsion for participation in job training and to accept employment. Every employable father who is receiving assistance should be required to participate in job training if available or to accept an offer of suitable employment. The situation with respect to the mothers, however, is quite different. We know that there are many working mothers who would be eligible to receive AFDC if they were not working.

We know, too, that many mothers now receiving AFDC would go to work if they could find a job, and if arrangements could be made for the care of their children. In fact, there is a constant in-and-out of employment among AFDC mothers who take jobs when they can find them. In households headed by women, more than 12 percent of the AFDC case closings are because of employment or increased earnings. In addition, there is a significant number of mothers receiving AFDC assistance who are working part-time or full-time. Current figures apparently are not available, but in a special study conducted in 1961 HEW found that 4.6 percent of the AFDC mothers had full-time jobs, but with earnings too low to meet the AFDC family budget. Another 8.3 percent of the workers were holding part-time jobs. There were wide variations among the states, with one state reporting that one-fourth of all AFDC mothers were working at full-time jobs. Some of these mothers have to pay for the care of their children at their own expense, which does not leave much net income from their meager earnings.

It is obvious that many more mothers would take employment if they had marketable skills, or if jobs were available, or if arrangements could be made for the care of their children.

The proposed requirement that the welfare agency develop a program for each adult in an AFDC family would serve to identify the potentialities of each individual, as well as the services and facilities that must be brought into play to make the individual's program effective. We are confident that a significant number of persons would voluntarily participate in a training program, and would be enabled to find and keep a job, if the services and facilities were made available to them as proposed in this legislation. We acknowledge that we do not know how large this number would be. Neither do we know in any exact sense how many "hard core" families there are, in which the mother would refuse to take employment even though it were considered appropriate, and if all necessary supporative services were brought into play. We do not know, because the welfare agencies have not so far had these resources and services to offer on a scale large enough to make them available to all who might benefit by them. But we regard provision for compulsory work or training for mothers as impractical and we have serious doubts that it would make any significant difference in the number of families who were enabled to become self-supporting.

It is our recommendation that the welfare agencies be given a chance to try out these new tools, with the recipient participating on a voluntary basis. If the results turn out to be unsatisfactory, the matter can be reviewed and reconsidered.

If the head of a family refuses to accept employment when, according to all reasonable tests, it is considered appropriate, the problem does not go away any quicker by cutting off assistance. If a father's share of assistance is cut out of the budget, he will probably continue to eat at the same table with the rest of the family, with everyone just getting a little less. Or he could desert the family, in which case they could continue receiving assistance. Or the children could be removed, if the court so ordered, at a greater cost than supporting them at home. The only chance for a constructive solution in a situation of this kind is through patient and perhaps time-consuming effort, to encourage and support and enable, and to instill some motivation.

Under the terms of the bill, if an assistance recipient is deemed by the welfare agency to be "appropriate" for training or employment, and refuses to participate in training or to accept a bona fide offer of employment, his assistance would be terminated. Apparently a good deal of latitude for subjective judgment would be permited in making a determination that employment is appropriate for an individual with the potential consequence of termination of assistance. This is in contrast with the other eligibility provisions for public assistance, which set forth the objective conditions in some detail. We are fearful that this provision could be subject to wide variations in interpretation that could be in conflict with the stated purpose of maintaining and strengthening family life. In the event that Congress should decide to enact this provision we recommend that the Secretary of HEW be directed to formulate guidelines for its interpretation and application. Such guidelines should be designed to protect the rights and best interests of families and children. They should spell out what constitutes refusal of employment for good cause and what measures should be taken to safeguard the children in such situations.

The proposal to authorize payment through AFDC funds for the day care of children is a constructive measure. As we point out elsewhere, many mothers now working would be eligible for AFDC if they quit their jobs. Too often the children of these mothers are being cared for during the working day in circumstances that are detrimental to their well-being. We recommend that the facilities that would be supported through this measure be made available in all situations where they are needed to safeguard children of working mothers of low income, and where such care would contribute to the continuing self-support of the family.

Because of the urgent need for day care facilities that prevails throughout the country it is often difficult to maintain standards that assure that children are cared for under safe, healthful and wholesome conditions. If the additional funds for day care should become available as proposed in this bill there would be very great pressures or rapid expansion of day care facilities at the expense of good standards. We would certainly not hold out for the best or nothing at all, and we agree that some experimentation with various arrangements should be encouraged. But there are very real hazards to the basic well-being of children that could develop unless certain safeguards are maintained. We therefore recommend that the Secretary of HEW be instructed to prescribe minimum standards for day care services that would be supported with these funds. This should include a requirement that the agency must make a determination that the children will be adequately cared for before a mother is declared to be appropriate for training or employment.

We are pleased to see the proposal to liberalize and bring more uniformity to the exemptions of earned income. We might wish for some formula that would not require a figuring of percentages each month for families with earnings, and we believe that an even more liberal allowance would provide a more effective incentive. In our view the proposal is basically sound and we recommend its adoption, with a further liberalization, if possible.

We note that the provision in H.R. 5710 to require a state to pay the full amount of assistance as determined by its own budgetary standards, has been deleted in H.R. 12080. It is our position that the very first purpose of public assistance is to provide an adequate level of financial assistance to persons who are in need. In view of the inadequate levels of assistance that prevail in some states, together with the major financial participation of the federal government in all of these programs, the federal government should establish some minimum standards for assistance, perhaps accompanied with a special payment to states which would otherwise be unable to assume this added cost. We have some question as to whether the requirement to pay full budgeted need is the equitable way to accomplish this, in view of the variations in state assistance budgets which are not all directly related to living costs or the fiscal capacities of the states.

CHILD WELFARE AND FAMILY SERVICES

We believe that, generally speaking, the combination of AFDC and Child Welfare Services into a single administrative unit would result in strengthening and improvement of both programs. The type of social services needed for strengthening and maintaining family life and protecting children in the AFDC program are essentially the same as those provided to children in families through child welfare services. The added definition of family services would broaden the range of these services so that a comprehensive and effective program of services for families and children could be maintained.

Our endorsement of this combination, however, is given with the understanding that the professional personnel providing a child welfare and family services do not become involved in determining financial eligibility and figuring assistance budgets. We do not belittle the importance of these functions, but the fact is that they have become so complex and time-consuming and the volume of this kind of work in a public welfare agency is so massive, that the professional child welfare and family services could easily be engulfed and lose their identity and effectiveness unless they are kept free to serve their intended function. The regular casework staff working in the AFDC program could continue to provide the valuable social services together with eligibility determination, as they do now. But the small corps of professional child welfare workers that has been slowly and carefully built up over the years must be kept intact so that its professional competence will be available for those situations where it is needed.

We therefore recommend that specific provisions be made either in the statute or in regulations to insure that this separation of function is maintained within the single organizational unit that administers the AFDC and the child welfare and family services.

We also submit for the Committee's consideration the proposal that the statutory combination of these two services might more appropriately be accomplished by moving title IV, which establishes AFDC, to become a part of title V which establishes the child welfare program. This would serve to emphasize the intent to upgrade the service components of the AFDC program.

We also recommend that consideration be given to the special organizational arrangements that now exist in the States of Illinois and Kentucky, where AFDC and Child Welfare Services are administered by two separate departments. If these states are able to work out satisfactory arrangements for the administration of these services through the cooperation of two departments we believe they should be given an opportunity to do so.

The authorization for the purchase of child welfare and family services and related services such as for family planning, would greatly augment the content and the flexibility of the resources available to the public welfare agency. This is a much-needed and constructive step toward the development of a comprehensive and effective program of public welfare services.

The increased authorization for grants to states in support of the "old-line" (non-AFDC) child welfare services is urgently needed. However, it would still not establish an adequate base for federal financial participation in the costs of this program. The states are now spending on the order of $100 million per year for their child welfare programs, of which federal funds account for roughly 10 percent. The increased federal funds, if appropriated, would substantially increase this ratio for the time being. But with increasing costs and the needed expansion of services, the ratio would soon step downward again.

The proposal that most realistically meets the present requirements of the state child welfare programs is embodied in S. 1116, introduced by Senator Pell This would put the financing of child welfare services more nearly on a par with the services now provided through the public assistance categories. It provides for a flat 75 percent matching for the costs of all salaries and training of child welfare personnel, and variable matching ranging from 50 to 83 percent for all other purposes such as day care, foster care, and administration. This measure has been carefully studied by our Association and by public welfare agencies throughout the country. It is fair to say that it is supported by a more broadly based and urgently felt consensus than any other proposed child welfare legislation in our experience. It represents the culmination of a number of carefully considered recommendations that have been put forward over a period of years. These proposals are similar to the recommendations of the Advisory Council on Child Welfare Services which was established by the 1958 Social Security Amendments. They are also reflected in a statement on "Financing Child Welfare Services," which was endorsed by our Association last year, based upon a two-year study by our Committee on Services for Children and Youth. Mr. Chairman, with your permission, I offer this statement for inclusion in the record.

The proposal in H.R. 12080 for financing that part of child welfare services that would be provided to AFDC families is essentially the same as what we recommend for the child welfare services that are now authorized under title V, part 3. If the H.R. 12080 proposals are adopted as they now stand, however, it would result in a dual system of financing of these two parts of a program which in all other respects would be the same. If the purpose is to combine all of these services administratively, it would be logical to put them all on the same financial footing as well with the AFDC formula applying across the board. This would also result in the strengthening of the services and simplification of administration.

Under such an arrangement, however, the federal financial participation in the costs of foster care should provide for matching for all foster care, along the lines of the plan in Senator Pell's S. 1116. The proposal in H.R. 12080 to expand the coverage of foster care payments through AFDC is not the answer. It still applies only to a limited number of cases who have some kind of identification with AFDC, and only to cases that have been placed in foster care through a court order. There are many situations where placement is properly made without a court order, and where court action is not called for. The real answer to the problem must provide for federal matching for the costs of all foster care which is being paid for by public welfare agencies.

EMERGENCY ASSISTANCE

The proposed program of emergency assistance would make available to welfare agencies a resource that could be utilized quickly and flexibly to meet a wide range of special and urgent situations. In many states assistance of this kind is not available, and in others it is inadequate. It could be especially useful in meeting emergencies in families of migrant laborers. In a number of situations, however, the need for emergency assistance would extend beyond 30 days, and the restrictive residence laws of some states would limit the assistance that could be provided to migrants. We recommend that the authorization for assistance be extended to two or three months, and that participating states be prohibited from refusing assistance because of any residence or settlement requirements.

MEDICAL ASSISTANCE

The Medical Assistance program established under title XIX marks a major step toward the objective of assuring that essential health and medical services will be made available to all needy persons. The states are given considerable latitude in determining how extensive these services shall be and what constitutes financial need. While there are wide variations from state to state in these respects the requirement for substantial state financial participation tends to be a self-limiting factor. However, if Congress finds it necessary to set specific limits on levels of income for the definition of medical need, it is our recommendation that such limits be expressed in relation to the level of public assistance money payments. Any absolute ceilings in terms of dollars or numbers of recipients cannot possibly take into account the program requirements of any state. But there is an inherent and logical relationship between the levels of financial need and medical need. The decision as to what the limits of this relationship shall be must of necessity be somewhat arbitrary, but an income level for medical need of 150 percent of financial assistance payments would appear to be reasonable and practical for the interests of the federal government, the states and the beneficiaries. The limitation of 133⅓ percent of per capita income for a family of four, however, is unduly arbitrary and restrictive and should not be enacted.

We see no useful purpose in permitting the substitution of any seven of the 14 listed health services for the presently prescribed 5 basic services as the minimum requirement for a state medical assistance plan. While we have confidence in the good judgment of the states in planning their medical care programs, the proposed amendment would undermine the rationale for stipulating any minimum program content whatever. Under this proposal a state could conceivably select an approved combination of services without making provision for either physicians' services or inpatient hospital care. Such distorted and unbalanced program combinations surely do not reflect the Congressional intent for this program.

COMMUNITY WORK AND TRAINING PROGRAMS

Sec. 204 of the bill proposes a large-scale expansion of the Community Work and Training Programs under sec. 409 of the Social Security Act. Public welfare agencies would be required to maintain work and training programs in every locality where there is a significant number of persons on AFDC. Federal funds would pay 75 percent of the costs of training, supervision, and materials. The welfare agencies could also utilize the services and facilities of other agencies and organizations, especially the Department of Labor and the state employment offices, for job counseling and testing and placement. The state welfare agency would be authorized to reimburse the employment office for these services for which it could claim 75 percent federal matching. The Ways and Means Committee notes that "This provision will insure that any priorities under which state employment offices put other groups ahead of assistance recipients will not interfere with the objectives of this program." The welfare agencies would also be required to enter into cooperative arrangements for the utilization of the services and facilities available under the Manpower Development and Training Act, and of any other federal and state programs for manpower, training, and work experience, and with federal and state agencies responsible for vocational and adult education. Agreements could also be made for projects to be conducted by federal, state, or local public agencies, or by private employers, organizations, agencies or institutions.

Here at last is the training program the public welfare agencies have been waiting for. It would porvide federal financial participation in large-scale and flexible training programs of a wide variety that could be suited to the special needs of any community or group. It could draw upon the resources of other agencies, federal, state, and local, as well as of private employers and organizations.

This is a most carefully thought out plan. It would be a major resource in enabling families to become self-supporting. We are pleased to recommend its adoption.

We are fully aware that the Secretaries of HEW and Labor as well as other distinguished witnesses have urged the enactment of the work and training proposal as originally set forth in H.R. 5710. The main point of difference is that under H.R. 5710 the responsibility for the training programs would rest with the Department of Labor and the state employment offices, while under H.R. 12080 it would be with HEW and the public welfare agencies.

Supporters of the H.R. 5710 position urge that all manpower training programs should be centralized in the Department of Labor in order to promote coordination and to prevent overlap and duplication. It is also said that the administration of training programs by welfare agencies has been tried and that it does not work.

In response we agree that in general the manpower training programs should be centralized in the Department of Labor. But under the H.R. 12080 proposal the Department of Labor and the employment offices would actually provide much of the service. The key point is that the welfare agencies would have the responsibility to see to it that training services are made available to the assistance recipients. They undoubtedly would actually conduct some of their own training programs, as they could also do under H.R. 5710 in those instances where the Secretary of Labor certifies that it is impractical for him to do so. But to a large extent the welfare agencies would act as a broker in arranging for the utilization of a wide range of public and private training facilities as needed and appropriate, much in the same way as the Department of Labor now arranges with the Office of Education in HEW for vocational education and adult education services. But the welfare agencies would have a continuing responsibility for the overall program of restoring individuals and families to self-support, which does not necessarily either begin or end with the job training. For a substantial number of AFDC recipients, job training is only a part of an overall package of rehabilitative services. The welfare agency must be in a position to coordinate all of these services according to the situation of each individual.

To say that welfare agencies have tried to conduct training programs for assistance recipients and have failed is to disregard the fact that they have never been given a program to administer that has approached the one now proposed, in scale, content, or potentialities. It should also be recognized that the other training programs that are now in operation have not done any better with people starting out with the disadvantages that characterize many assistance recipients.

Over the years public welfare agencies have looked to other agencies that might be better equipped to offer such services as employment training and counseling and placement that would meet the specific needs of people who are unable to compete for jobs because they are unskilled and inexperienced and perhaps illiterate. For the most part, however, the welfare agencies were unsuccessful in their quest to obtain from other sources the specialized kind of services needed to bring these severely disadvantaged people up from the "bottom of the barrel." A number of welfare agencies actually set up training and placement programs with their own resources. Some of these have been in operation for 15 years or more.

The Community Work and Training Program established in 1962 by sec. 409, authorized welfare agencies to assign assistance recipients to work and training projects, but it did not make any provision for the costs of training, supervision, or materials. Thus, these programs were not widely undertaken, although a number have been in operation for several years, with no federal financing for these additional costs.

The Work Experience and Training Program established by title V of the Economic Opportunity Act authorized OEO to transfer funds to HEW for the operation of work and training programs under OEO guidelines. Here, for the first time, federal funds became available for the costs of training, supervision, and materials. Although the public welfare agencies have responded by utilizing the available funds to maintain projects in every state but one, and are acquiring

experience in the operation of the programs, the federal policy is to phase out title V and build up the Community Work and Training Program under sec. 409, which would be administered by the Labor Department and the employment offices.

Assistant HEW Secretary William Gorham has noted, with respect to the title V program, that "it is simply not a straight forward uncomplicated job to alter the effects of a lifetime of deprivation and discrimination, of little success, and frequent failure, of little education, lack of skill, and ill health, and the attitudes which such conditions foster."

Mr. Gorham identifies some of the barriers to earning power that must be overcome by programs such as title V Work Experience and Training. These include the maldistribution of workers in relation to jobs, lack of occupational skills and job experience, lack of basic education requirements for jobs, poor attitudes toward self and work, health and medical problems, lack of child care services, police and bad debt records, and lack of income. He also notes that "evaluations of title V have been hampered by the lack of baseline data with which program performance can be compared. For this reason, aggregate measures of success such as placement rates are practically meaningless for evaluation purposes. Aggregative analyses also overlook the wide variations in the effectiveness of individual projects. Approximately 50 percent of this variation is attributable to differences in prevailing economic conditions, and social and demographic characteristics of participants. These factors operate independently of any particular administering agency."

In a letter dated August 24, 1967, Assistant Director of the Bureau of the Budget, Charles J. Zwick said:

"The successful execution of many of these new programs cannot depend solely on the establishment of clear lines of authority. And, because of our multijurisdictional approach and the growing interrelationships between many programs, it is no longer possible to solve our management and organizational problems simply by transferring functions and grouping related activities under a single agency. In the domestic area that would result in trying to create a Department of Everything."

SOCIAL WORK MANPOWER AND TRAINING

We strongly endorse the proposal in sec. 401 of H.R. 12080 to authorize an appropriation for grants to schools of social work. The need for this additional support for the schools is so great, however, that we recommend that the authorization be substantially increased above the $5 million per year as now provided for in the bill.

Public welfare agencies are faced with a critical shortage of the qualified personnel needed to carry out their assigned responsibilities. At the same time the graduate schools of social work are operating at the limit of their capacity, and there are not enough undergraduate schools offering courses in social work to meet more than a fraction of the needs of the agencies. As matters now stand the demand for qualified workers will unquestionably continue to increase at a greater rate than the capacity of the schools to train them.

The federal government is making a major investment in social service programs, not only through public assistance, but also in such fields as mental health, mental retardation, vocational rehabilitation, health services, child welfare, juvenile delinquency, and corrections. In a very real sense the return on this investment is in jeopardy because of the lack of a sufficient number of personnel qualified to carry out these programs. Therefore this proposed legislation should be regarded as a measure to facilitate the attainment of these program objectives.

SOCIAL SECURITY BENEFITS

While we do not claim expert knowledge on the financing and the benefit structure of the Social Security system it is our general position that whenever possible it is preferable that provision for income maintenance be made through insurance rather than through public assistance. We have only brief comments on the present legislative proposals.

We realize that the extension of medicare benefits to disabled persons under age 65 would be a costly undertaking. At the same time for a great many disabled persons these costs must be covered by some public program. Moreover, we believe these people could be better served by providing for their medical care through the health insurance benefits program. We therefore urge that all possible consideration be given to means whereby this coverage can be provided.

Aged persons drawing retirement benefits at the minimum level are very often those whose need is the greatest. They are the ones most likely to require additional help in the form of Old-Age Assistance. We therefore recommend that the minimum benefit payment be set at $70 as proposed in H.R. 5710, rather than at $50, as in H.R. 12080. For similar reasons we recommend that the minimum benefit for persons who have worked in covered employment for 25 years be set at $100 per month.

* * * * * * *

FINANCING PUBLIC CHILD WELFARE SERVICES

This policy statement was developed and approved by the Committee on Services for Children and Youth, December 1965 and adopted by the Board of Directors, June 13, 1966.

"Provisions should be made for Federal matching of costs of administration and services in state and local child welfare services programs, including the costs of maintenance in foster care of all children requiring such care, on a basis comparable to the matching now available in public assistance."

APWA FEDERAL LEGISLATIVE OBJECTIVES, 1966

Prior to the 1962 Amendments, Federal grants under Title V, Part 3, of the Social Security Act were available for the limited purposes of "establishing, extending and strengthening" services "for the protection and care of homeless, dependent and neglected children, and children in danger of becoming delinquent." Now, under the 1962 Amendments to Title V, Part 3, Federal grants are available to assist the states in the development of comprehensive programs of child welfare services.

Provisions of the 1962 Amendments for Child Welfare Services

Specifically, the 1962 Amendments provide that such grants are to be used for providing ". . . social services which supplement, or substitute for, parental care and supervision for the purpose of (1) preventing or remedying, or assisting in the solution of problems which may result in the neglect, abuse, exploitation or delinquency of children; (2) protecting and caring for homeless, dependent or neglected children; (3) protecting and promoting the welfare of working mothers; and (4) otherwise protecting and promoting the welfare of children, including the strengthening of their own homes where possible or, where needed, the provision of adequate care of children away from their own homes in foster family homes or day care or other child care facilities." (Sec. 528.) The basic legislation in regard to "establishing, extending and strengthening" services still pertains, but the definition of the children to be served has been broadened and made more specific by the new definition of public child welfare services. Moreover, greater responsibilities have been placed on state agencies in "establishing, extending and strengthening" child welfare services.

Conditions of eligibility for Federal Child Welfare Service funds

The 1962 Amendments to Title V, Part 3, impose new and ambitious conditions of eligibility for Federal child welfare funds, as follows:

1. Services are to be provided in all political subdivisions of the state by 1975. In extending these services, priority is to be given to communities with the greatest need for such service, after giving consideration to their relative financial need.

2. Services are to be "for all children in need thereof" requiring an aggressive approach in locating and determining children and families in need of child welfare services.

3. The services to be provided, as indicated by the new definition, must be comprehensive in nature, directed toward strengthening the child's own home where possible, or when this is not possible, providing a variety of substitute living situations to meet the individual needs of children who must live away from their own parents.

4. Services are to be provided to the extent feasible by trained child welfare personnel.

Limitation of Federal funds for child welfare services

A statutory limitation of $60 million for the fiscal year ending June 30, 1970, and for each succeeding fiscal year, is imposed on the amount of Federal child

welfare services funds which may be appropriated by Congress for distribution on a matching formula to the states. Presently the expenditures of state and local funds for child welfare services are estimated to be in excess of $246 million.[1]

To achieve the program goals envisioned by the express terms of the 1962 Amendments, the Federal government must shift the purpose of its grant program from that of stimulating state effort to that of contributing to the total cost of the public program of child welfare services in a manner equal or comparable to the Federal grant for aid and services to needy families with children (AFDC).

Federal share in the AFDC program

Under Section 403, Title IV, of the Social Security Act, the 1962 Amendments increased the Federal share in the cost of providing services in the AFDC program from 50 to 75 percent. States can now receive three Federal dollars for each state dollar spent to provide comprehensive social services, such as: social group work, homemaker services, care by foster families, medical and legal consultation, vocational education. It is proposed that Congress enact similar provisions for Federal grants for child welfare services.

The Advisory Council's recommendation

Convinced that the Federal grant system should be extended, the Advisory Council on Child Welfare Services in its report of December 28, 1959, to the Secretary, U.S. Department of Health, Education, and Welfare, and to the Congress, recommended that:

> *The Federal government pay part of the total cost of public child welfare services of each state and other cooperating jurisdictions through Federal grants-in-aid on a variable matching basis, with provisions for an open-end appropriation, and with continuing encouragement to establishing, extending and strengthening of such service.*
>
> *The statutory provision for an open-end appropriation should be formulated in such a way as to assure that there would be no decrease of a particular state's expenditure of state or local money for child welfare services as determined by the fiscal year 1960 or some other base year.*

The foregoing was the only one of the Advisory Council's 15 recommendations that was not subsequently implemented. However, it is noteworthy that much of the reasoning offered for the recommendation found its way into the substance of the 1962 Amendments. The Council pointed out, for example, that a new Federal-state partnership in financing was necessary in order that the states could develop and expand comprehensive services and so that the Federal government could encourage equalization of services within and between states and provide a basis for overall program standards. As already indicated, the 1962 Amendments affirmed these necessities but ignored the corollary that the Federal government should carry joint responsibility with the states for the necessary financing.

Present services and patterns of financing

An examination of the extent of child welfare services in the states today and the varied patterns of financing them confirms the 1959 report of the Advisory Council:

> There is a wide variation in the extent to which states have organized to provide the specialized services within the definition mandated by the 1962 Amendment. The reasons for these variations include the state's history and traditions in serving its children, its philosophy of state-local responsibility, the part played by voluntary agencies, the economic situation and tax base, and the extent of citizen involvement in public policy issues.[2]

The rate of children receiving child welfare services from state and local public child welfare services ranges from Michigan's 11 per 10,000 child population, to 184 per 10,000 child population in the District of Columbia.[3]

Most states estimate that only from one-fourth to one-half of the children known or estimated to be in need of services are receiving them.[4] Since about

---

[1] Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau, *Fact Sheet—Services for Children, How Title V of Social Security Act Benefits Children*, 1964.

[2] Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau, *Goals, Problems and Progress in Child Welfare*, Child Welfare Report No. 13, 1964, p. 19.

[3] Department of Health, Education, and Welfare, *Welfare in Review*, Statistical Supplement (Washington, D.C.: Government Printing Office, 1964), p. 28.

[4] *Goals, Problems and Progress, op. cit.*, p. 20.

750,000 of the nation's 64 million children under 18 years are currently being served,[5] the total number of children potentially in need of service can be estimated to range from one and one quarter to three million.

Lack of adequate financing has resulted in some states having poor foster care and in others having none at all.

Problems of state legislation for child welfare financing include lack of specific statutory base for financing child welfare services apart from other services; a statutory base for direct services but not for administration; no identification of funds for child welfare in the appropriation act, or no statutory base or appropriation of state funds for locally administered public child welfare agencies.[6] Similar problems characterize local financing for child welfare services.[7]

Enormous discrepancies in the proportion of state and local sharing in the costs of child welfare services and in per capita expenditures clearly demonstrate the differences in the quality and quantity of child welfare services being given by the states.

Percentage distributions range from Alabama's 40.4 percent Federal funds, 59.6 percent state funds and no local funds; to Ohio's 5.9 percent Federal funds, 1.4 percent state funds and 92.7 percent local funds.[8] Per capita expenditures vary from 47 cents in Idaho and Texas to $11.12 in the District of Columbia.[9]

Shift in States' proportion of financing

Emerging from this welter of discrepancies, however, are identifiable trends in providing services and in financing. State plans show acceptance of public welfare's responsibility to extend its range of services and to serve more and more children in need. Except for appropriations, states in all instances now have an adequate legal base for extending services in terms of the 1962 Amendment mandate.

Within a recent ten year period [10] Federal, state and local expenditures for public child welfare services more than doubled:

[In millions of dollars]

Fiscal year	Total	Federal funds	State funds	Local funds
1953	120.3	7.4	46.3	66.6
1963	267.2	26.1	135.8	105.9

In terms of percentage, one can more easily see the decided changes in source of funds over the past ten years.

[In percent]

Fiscal year	Federal funds	State funds	Local funds
1953	6.2	38.4	55.4
1963	9.8	50.7	39.5

There has been almost a reversal in the child welfare financing roles of state and local authorities. While on the average the state now bears the greater proportion of financing, there can be little or no expectation of any great gains from this shift. It is the position of most states that additional funds, particularly in the areas of welfare and education, must come from the Federal government.

Suggested means for obtaining necessary funds

Several alternatives for gaining the Federal funds necessary to achieve the program objectives mandated by the 1962 Amendments have been suggested.

---

[5] *Welfare in Review* (July, 1963), pp. 10–16.
[6] *Goals, Problems and Progress, op. cit.* p. 20.
[7] *Ibid.*, p. 20.
[8] *Welfare in Review*, Statistical Supplement, 1964, *op. cit.*, p. 29.
[9] *Child Welfare Statistics*, (Series No. 75), Children's Bureau, Welfare Administration (Washington, D.C.: Department of Health, Education, and Welfare, 1963).
[10] The 1953 figures were estimated from data made available to the committee by the Children's Bureau and summarized by C. Wilson Anderson, a member of the Committee and Commissioner for the Office of Children and Youth, Pennsylvania Department of Public Welfare. The 1963 figures are from *Child Welfare Statistics* (Series No. 75), No. 9, Table No. 31 (Washington, D.C.: Department of Health, Education, and Welfare, 1963).

One such approach would be to identify services such as homemaker service and foster care as Child Welfare Services and seek additional Federal financing for them. Another would be to secure Federal matching for fully trained child welfare staff, or perhaps for certain categories of fully trained staff; for example, child welfare supervisors. A more comprehensive suggestion calls for Federal matching at 50 percent across the board for services and 75 percent for services provided by professionally qualified staff.[11] Of these suggestions, only the last mentioned holds any hope of meeting the need.

Value in the current method of Federal child welfare service grants

Even though the current method of Federal grants to states for child welfare services will not result in the needed services, these grants have demonstrated a special value over the years. Although small in relation to state and local expenditures, the grants have had great effect on the strengthening and extension of services. Many state and local governments have assumed on-going responsibility for new programs and services as the result of demonstration projects financed by these grants. Major research projects have been developed through modest expenditures from the Federal grants for sound research designs. State agencies, using their Federal grants, have been able to respond quickly and flexibly to changing needs and propitious circumstances that may not have been anticipated during the budgetary process.

The American Public Welfare Association position

It is the position of the American Public Welfare Association that child welfare as a service program should continue to receive the present Federal Grants for Child Welfare Services and should, in addition, receive Federal financial support in conformance with principles already accepted by Congress for other programs such as Aid to Families with Dependent Children. Such Federal support would broaden the base of financing child welfare services in keeping with the need and equalize services both within and between the states. This could be achieved by amending Title V, Part 3, of the Social Security Act, authorizing the Secretary of the U.S. Department of Health, Education, and Welfare to pay states for amounts expended as found necessary by the Secretary for the proper and efficient administration of public child welfare services. Specifically, this would add to present Federal Child Welfare Services Grants a Federal share of 75 percent of state and local expenditures for the services provided as defined in Section 528 of Title V, Part 3, and for their administration and for the training of personnel employed or preparing for employment by the state agency or its participating local agency. In the event the state's approved plan for public child welfare services does not meet all the services prescribed in Section 528, the Federal share would be equal to 50 percent of the sums expended for services, administration and the training of personnel.

No state presently gives or is able to provide adequate child welfare services. The lack of coverage and the lack of basic services to sustain, strengthen, supplement or substitute for parental care, bear shameful witness to the enormous gaps between this Nation's stated goals and values with respect to children, on the one hand, and its level of efforts and achievements on the other. The Federal government cannot do otherwise than respond.

The American Public Welfare Association, therefore, makes the following recommendations:

1. The Federal government, through a matching program, should assist states and localities in financing *all* public child welfare services and other costs associated with such services. The formula should be the same as the current 75-25 percent basis used by the Federal government in matching other public welfare service programs.

2. Open-end appropriations should be authorized for such matching grants, with provision that there be no decrease of state and/or local expenditures for such purposes.

3. The current Federal Child Welfare Services grants to states should continue because they are an essential method for encouraging innovation and experimen-

[11] *Goals, Problems and Progress, op. cit.*, pp. 24–25.

tation, for enabling initiation of services which are new in given states and localities, and for achieving desirable flexibility in the continuous development and provision of adequate welfare services to children.

4. The Federal government should make further study of methods of administration which place more reliance on broad, rather than highly detailed, measures of accountability.

Mr. Chairman and members of the Committee, this concludes my statement. I thank you for the opportunity of appearing before you.

Senator HARTKE. Our next witness is Hon. Garland Bonin, commissioner of the Department of Public Welfare of the State of Louisiana.

Mr. Bonin, I want to welcome you to the committee and express the regrets of the chairman that he is not able to be with you, but he assures me he will certainly follow your statement and will read it most carefully and will act accordingly. In fact there were supposed to be some questions here for you, and I will get to those as soon as you complete your statement. You may proceed any way you see fit. I might call attention to the fact, if you can, all witnesses put your complete statement into the record and summarize such portions of it as you deem are most important which is requested not only by the committee, but also under the requirements of the rules of the Senate. It might be possible for us then to complete the witness list. If we do not do that I am fearful there are going to be people on this list who will not have an opportunity to be heard today. You may proceed, sir.

STATEMENT OF GARLAND L. BONIN, COMMISSIONER, STATE OF LOUISIANA, DEPARTMENT OF PUBLIC WELFARE, ACCOMPANIED BY ALVIS D. ROBERTS, WELFARE SERVICES DIRECTOR, DEPARTMENT OF WELFARE; AND H. K. SWEENEY, GENERAL AND ASSISTANT DIRECTOR, DEPARTMENT OF HOSPITALS, LOUISIANA

Mr. BONIN. Thank you, Mr. Chairman.

Mr. Chairman and members of this distinguished and important committee, my name is Garland L. Bonin. I am the commissioner of public welfare for the State of Louisiana and I appear here this morning in my capacity as commissioner.

Accompanying me this morning are Mr. Alvis D. Roberts, welfare services director of the State department of welfare, and Mr. W. K. (Woodie) Sweeney, the general counsel and assistant director of the Louisiana State Department of Hospitals, the agency which licenses, classifies, and certifies facilities for the title XIX program in the State of Louisiana. Mr. Sweeney has a statement which we would like to incorporate in the record of these hearings. Mr. Sweeney's statement details the past history of nursing homes in our State, the system of classification employed therein, the standards and the progress made by Louisiana in this important segment of health care.

As commissioner of welfare, I am directly involved in the title XIX program of the Social Security Act and indirectly involved with title XVIII of that act insofar as title XVIII promulgations affect title XIX. I suggest:

(1) That supplementation to nursing homes be continued under title XIX and that supplementation be continued as an option to be exercised by the individual States;

(2) That the authority to fix standards for title XIX programs be retained by the individual States; and

(3) That the definition of a "spell of illness" presently proposed by HEW will affect State title XIX programs by increasing the costs thereto both to the individual States and to the Federal Government while working a hardship upon the patient.

The other parts I had intended to touch on in my statement, Mr. Chairman, I will, to conserve time, will not touch upon.

As to the first item, namely, supplementation, the Secretary of HEW in defining requirements for State plans under supplement D, the Handbook of Medical Assistance, purports to prohibit supplementation. Since promulgating these regulations, he has given the States until January 1, 1969, to accomplish this.

At the outset, let me state that if there is to be a policy prohibiting supplementation, then it should be a policy enacted by the Congress and not one left to the discretion of the Secretary. If Congress desires to prohibit supplementation, then supplementation should be phased out over a period of from 3 to 5 years. To phase out supplementation in less time is to impose an abrupt and severe hardship upon the States which now have provisions for supplementation.

My own State of Louisiana is one of those which provide for supplementation in their medical assistance programs. In Louisiana we classify facilities participating in our title XIX plan. Depending upon the facility's classification, supplementation may range from $100 to $115 per month. If provision were not made for supplementation, then given our present program, the combined cost to the State of Louisiana and to the Federal Government would be increased by $9,091,880.

This combined figure of $9,091,880 would be distributed as follows: $2,311,156 by the State of Louisiana and $6,780,724 by the Federal Government. Given the established trend of a continued rise in the costs of medical care, the increased burden upon our taxpayers, both those in the State of Louisiana as well as those throughout the Nation, would also be one of a continuous rise.

The history of supplementation in Louisiana reveals that once the incident of supplementation enabled Louisiana to provide payments to the providers of care commensurate with the services rendered, long-term-care facilities in Louisiana underwent a dramatic change. Nursing homes began to move out of the age of converted dwellings into an era of modern new facilities. The State benefited from this; more important the patent benefited.

The arguments most frequently advanced against supplementation are the following: (1) Supplementation contributes to low State-agency payments; and (2) supplementation results in unequal treatment to those patients unable to supplement the State-agency payment. The experience of Louisiana belies both these arguments.

During the period in which Louisiana has provided for supplementation, the appropriations for medical assistance for the needy made by our legislature have increased by approximately 2,000 percent. As already noted, supplementation has contributed to the advent of better facilities for all patients. It is our experience that the only difference in the treatment of patients able to supplement and those unable to do so is that the former may be placed in private rooms or two-bed wards while the latter may be placed in four-bed wards. In all other respects, the care and treatment are alike.

There is another way of viewing supplementation. Is it the patient who supplements the State's ability to pay or is it the State which supplements the patient's ability to pay? We are inclined to the later viewpoint. In Louisiana, patients unable to provide any part of the cost of their care are not denied that care. On the other hand, the taxpayer is required to provide only that part of a patient's care which the patient is unable to provide.

In conclusion, then, I would urge you to retain the State's option to permit supplementation and I would ask you to make it clear to the Secretary that this option is not to be denied to the States under the guise of administrative regulations issued by the Department of Health, Education, and Welfare.

I urge you to emphasize that the State should do for the individual only so much as the individual is unable to do for himself.

One final thought, the rationale put forth by HEW in support of its effort to prohibit supplementation is as follows:

> If the nursing home is free to seek supplementation, the State may feel less of an obligation to make adequate payments. Conversely, if the nursing homes must accept the State's payment as payment in full, the nursing home is more likely to insist upon adequate payments. In this way, basic State support for the program (and concomitant Federal matching) will be increased.

Thus, one may discern a kind of Machiavellian logic at work here; namely, put the squeeze on—set the State agency, the legislature and the provider-of-service at odds with each other. From the resulting struggle—in which two of the three will probably join together against the third—there should evolve a better situation for the welfare program while the taxpayer shoulders more and more of what is put forth as his moral obligation. All of this at a time when State governments are desperate to make ends meet; when the providers of care are uneasy over the continued rise in the costs of delivering care; when the taxpayer grows weary as the index of the cost of living rises. There is Machiavellian irony here, too, for all this time, the experience of Louisiana is that it is not so much the patient who supplements the State's ability to pay but rather the State which supplements the patient's ability to pay.

Turning now to the second of the three items pertaining to medicare and medicaid which I want to discuss; namely, that the authority to fix standards for title XIX programs be retained by the individual States. I want to emphasize the words "retained by the States."

As a State commissioner of welfare, I belong to the American Public Welfare Association and attend meetings of the State Commissioners of Welfare. While attending these meetings, I have been made aware that there is dispute as to whether the State standard-setting agency for the Secretary of HEW possesses the authority to fix standards of care within the State's title XIX plan.

I want to make it clear that I subscribe to the position that sections 1902(a) (1) through (22)—and particularly (a) (9) and (22)—of title XIX place the authority to establish and maintain standards of care in private and public institutions in the single standard-setting State agency which may but need not administer the individual State's title XIX plan. In Louisiana, this single standard-setting agency is the department of hospitals.

However, I wish to emphasize that I am not a lawyer and, therefore, the possibility exists that I could be wrong in interpreting what the act provides. Having so stated, I want to make it clear that as a commissioner of welfare, I would urge that if the States do not now have the power to so fix standards that the law be rewritten to provide the States with such authority.

The State agency is abreast of the local problem. It knows in detail what its needs are as well as its resources to meet those needs. I am aware that there are those who would yawn and dismiss such words with the term "cliche." Yet, I would remind them that a group of words becomes a cliche because the truth contained within the phrase is so manifestly and immediately clear that it becomes common.

How poignant it is that a truth so clearly at the root of our form of Government which has made these United States the envy of other nations should be dismissed as timeworn and trite.

Nevertheless, the fact remains that what is best for Louisiana may not be so for New Jersey or for Illinois, and so on. I submit that there is no one within HEW—however brilliant he may be—who knows Louisiana's needs and Louisiana's resources better than do the taxpayers and the officials of the State of Louisiana.

We in Louisiana have a title XIX plan which we deem if not the best, then certainly among the best of the plans in the Nation. Our plan provides for checks and balances to insure that the quality of service purchased is in fact what the needs of the State require and at a price which the people of Louisiana can afford.

We, in fact, have standards which are higher than those for extended care facilities in title XVIII and we have standards which are less than those of title XVIII. We have these because not all patients are alike. We classify our facilities and we place our patients in the facility that meets their individual needs.

Louisiana's title XIX plan has flexibility and can adjust to meet our needs as they evolve. To take this responsibility from us and assign it to the Secretary is to run the needless risk of depriving us of that flexibility. The removal of such flexibility is accompanied by the loss of immediate response to any change in our needs.

When national standards are set, the machinery to change them is complex and heavy in its inertia. While Louisiana sought change in inappropriate standards, the patients in Louisiana would be the ones to feel the tragic weight of such inertia.

The Congress, in its wisdom, foresaw this danger when it enacted the Kerr-Mills Act. It is my opinion that it continued this wisdom in its enactment of title XIX. If I am correct in this, then I urge you to retain this wise provision and to make it abundantly clear that the States and not the Secretary have the authority to establish standards of care for their separate title XIX plans. If I am incorrect in this opinion, and if the Congress from inadvertance or for whatever reason failed to carry over this wise provision of the Kerr-Mills Act into title XIX, then I urge you to correct this failure by placing such authority with the States.

Turning now to the third item relating to title XVIII and title XIX; namely, the definition of a "spell of illness." The interpretation presently proposed by HEW in State letter No. 65 will affect State title XIX programs by increasing the costs thereto both to the individual

States and to the Federal Government while working a hardship upon the patient.

In section 1861(a), "spell of illness" is defined as commencing with the first day a patient enters a hospital, uses his hospital and extended care benefits, if this is the case, and ending 60 consecutive days thereafter on which he is neither an inpatient in a hospital or an extended care facility.

Although Congress defined an extended care facility in 1861(j) as being a facility which is primarily engaged in providing skilled nursing care and related services to patients who require medical or nursing care, the Social Security Administration evidently considers this to be the proper definition of an ECF for all purposes except that of determining a "spell of illness."

In State letter No. 65, the Social Security Administration defines an "extended care facility" and "skilled nursing care" so as to prolong a "spell of illness." SSA does so when it defines an ECF as a facility which is in charge of a licensed practical nurse (who need not be a graduate of a State approved school) with aides, orderlies, or attendants on the other two shifts. Such a facility fails in the essential element of an ECF, for such a facility has never been considered in the health care field to be primarily engaged in skilled nursing care and services for patients who require medical or nursing care. This definition of an ECF in State letter No. 65 adds a great deal of confusion to the health care field. However, far more important, the results which follow from this deny our aged people medical benefits which I believe Congress intended them to have.

Although there are many illustrations that could be cited, one example will be sufficient. Let us assume that the State of Louisiana has a welfare patient in a residential care home which has a licensed practical nurse as a charge nurse. Since he has no other home and no resources, this patient will probably be there for the remainder of his life, and, therefore, this residential care home is, in reality, his permanent place of abode. He is eligible for medicare benefits. He is admitted to a hospital with a severe stroke. He exhausts his hospital benefits and is transferred to an ECF. After 60 days, he is discharged from the ECF and returns to his place of residence which is the abovementioned residential care home. This individual can never again receive any medicare benefits, because he will have been judged by the Social Security Administration to have never been outside an ECF or a skilled nursing home for 60 consecutive days. Even though some 2 years later he falls and breaks his leg, he will not be eligible for medicare because this residential care home is defined as an ECF or skilled nursing home in State letter No. 65. It is defined by SSA as an ECF or skilled nursing home because it has a LPN as a charge nurse. The travesty lies in the fact that this residential care home is considered by SSA to be an ECF or a skilled nursing home solely for the purpose of not breaking this "spell of illness." SSA would never certify this residential care home as an ECF or a skilled nursing home for participation in title XVIII or title XIX programs. In those instances, SSA would judge this residential care home to be below the standards required of a facility for it to be certified as an ECF or a skilled nursing home.

On the other hand, if this individual had such resources that after being discharged from the nursing home, he could be taken to his own home, he could receive 200 home health care visits and his new "spell of illness" would start 60 days from the date that he was discharged from the ECF. In other words, an individual is not required to have a 60-day "spell of health." State letter No. 65 makes one's medicare benefits turn on his station in life or on the circumstances under which he is living at the time that he enters the hospital

I am concerned about these individuals because of the harshness and unfairness to them and because this discrimination places a heavier burden on the State welfare program than Congress intended. The States are urged to buy in on part B of medicare and to pay the deductibles for their walfare patients.

Senator CURTIS. Mr. Chairman, may I interrupt for a question right there?

Senator HARTKE. Yes.

Senator CURTIS. Is it fair to say that a spell of illness as defined in the law and as interpreted by HEW has no relation to the beginning and the end of a particular sickness, isn't that right?

Mr. BONIN. I will ask Mr. Roberts to answer that question, Senator.

Mr. ROBERTS. Repeat that again, please.

Senator CURTIS. It is a rather arbitrary calendared operation; is that correct?

Mr. ROBERTS. Yes; it has no relation to what may happen to him under one spell of illness and what happens later.

Senator CURTIS. A person may have one spell of illness that lasts 10 years?

Mr. ROBERTS. Correct.

Senator CURTIS. But if he is mobile enough and his family can provide the interim care he can qualify as having a new spell of sickness?

Mr. ROBERTS. After 60 days.

Senator CURTIS. After 60 days have elapsed?

Mr. ROBERTS. Correct.

Senator CURTIS. And during the interim he is entitled to home calls?

Mr. ROBERTS. Correct.

Senator CURTIS. But a spell of sickness does not mean either in the law or in its operation the time a person takes sick until they are well again?

Mr. ROBERTS. It does not refer to that illness as such. It refers to a number of days.

Mr. BONIN. Sixty days from the time he is discharged.

Senator CURTIS. So your point is if the individual can make the necessary shift to qualify for 60 days can come back on and can repeat that throughout his life?

Mr. BONIN. He would have to leave the nursing home for 60 days.

Mr. ROBERTS. What we say in here the length of time he stays in an entended care facility we can see the reasoning there because he left the hospital and goes to extended care as an extension of this hospitalization that he received for the illness that he originally went into the hospital for. But then when he leaves the extended care facility, no longer eligible for it or in need of it in fact, but is in need of some type

of care, he moves maybe over into another section of that facility which is not qualified, is not certified for extended care, but he is still treated as if he were still in that extended care facility or hospital and he can never get a new spell of illness until he leaves that facility.

Senator CURTIS. That is all. Thank you, Mr. Chairman.

Mr. BONIN. Within the last few days, the Social Security Administration has issued another letter reviewing the matter by adhering to their original State letter No. 65 and to the instructions forwarded to the fiscal intermediaries. I suggest the following: Strike out the period at the end of section 1861(a)(2) and add the words "under title XVIII for the same medical illness." I have discussed this with physicians and others and I am certain that medical illness can be defined or categorized with sufficient detail to formulate a sound regulation without creating hardships as State letter No. 65 does. It makes little sense to define "spell of illness" on the basis of where a patient resides or the type of institution in which he is located. It makes even less sense to define "extended care facilities" or "skilled nursing services" in a manner contrary to long accepted standards. It does make sense to define "spell of illness" in terms of medical illness. Mr. Chairman, this concludes my remarks on supplementation, the first three items, and I do want to thank you and the members of this singularly important committee for having us here this morning, I would request that Mr. Sweeney's remarks be included in the record. And we are now available for questioning and will endeavor to answer any inquiries which you may have.

Thank you.

Senator HARTKE. Mr. Sweeney's remarks will be made a part of the record. (See p. 1035.)

These questions were submitted by Chairman Long and are his questions: Should supplementation not be allowed to continue in Louisiana after January 1, 1969, the date set by the Secretary of Health, Education, and Welfare as final, in your opinion, what would happen to the quality of care to patients now in nursing homes?

Mr. BONIN. Mr. Roberts will answer that.

Mr. ROBERTS. First off, let me say that those disfavoring supplementation assume that the State legislature will appropriate the necessary money to offset the discontinuation of supplementation. From our knowledge of the present economic situation in Louisiana, we have doubt this would happen. In fact, we asked for money in this last session of the legislature when we thought that this supplementation would be discontinued July of this year, and we were turned down on it. So we know that it would not happen. We just can't expect the nursing homes in Louisiana to continue their present care and services on approximately two-thirds of the income which they now receive under our supplementary program.

When you become geared to spending a dollar for a specific item of service and you only budget 65 cents for that same item of service you can only expect to buy a lesser grade of service.

As to what would happen to the patient, I can only speculate. A number of things could happen, all of which I deem undesirable. Most probably since the quality of care would be so adversely affected, the nursing homes themselves would no longer care to participate in our welfare program. More and more of them would turn to the private

patient and medicare patient where the compensation would be considerably more adequate. The incentive to construct modern nursing homes would no longer exist, at least so far as our present title XIX program is concerned and our department would be pressed a great deal to find adequate beds for our present clients as well as those from time to time in the future that will need and demand nursing care.

We have 130,000 old-age assistant recipients in Louisiana and the average age is 75. That means a lot of these people are in the upper 80's and even 90's, so more and more of these people will have to turn to these nursing homes for care and, of course, we will have to pay along with the families. If this supplementation was cut off, I think it would then become increasingly difficult for us to find beds to put these aged and infirm people.

Senator HARTKE. The second question: It appears that the standards of nursing care in Louisiana are quite high as compared to those of some other States. To what specific conditions would you attribute the growth of this apparently improved care in Louisiana?

Mr. BONIN. I will ask Mr. Sweeney to answer that.

Mr. SWEENEY. We attribute that primarily to two factors, one is our classification program wherein new construction is promoted through a system of increased welfare payments and the lower supplementation maximums for those residents in these newly constructed homes offering additional and more skilled nursing services.

In 1961 there were 542 beds in Louisiana classed as "A" beds. In 1967 there are 8,113 beds classified as "A" beds. We think this is a most significant increase in new construction and additional skilled nursing services. Without the supplementation program and without the State being able to provide it, we feel that the promotion or the encouragement and incentives for new nursing homes with more skilled nursing services being offered would be definitely terminated.

Senator HARTKE. Senator Curtis, do you have any questions?

Senator CURTIS. Nothing further.

Senator HARTKE. I have nothing further.

I want to thank you gentlemen for your testimony and thank you for being with us this morning.

(Mr. Bonin's prepared statement and Mr. H. K. Sweeney's statement follow:)

STATEMENT OF GARLAND L. BONIN, COMMISSIONER, STATE OF LOUISIANA DEPARTMENT OF PUBLIC WELFARE

Mr. Chairman and Members of this distinguished and important Committee: My name is Garland L. Bonin. I am the Commissioner of Public Welfare for the State of Louisiana and I appear here this morning in my capacity as Commissioner.

Accompanying me this morning are Mr. Alvis D. Roberts, Welfare Services Director for the State of Louisiana and Mr. H. K. (Woodie) Sweeney, the General Counsel and Assistant Director of the Louisiana State Department of Hospitals, the Agency which licenses, classifies and certifies facilities for the Title XIX program in the State of Louisiana. Mr. Sweeney has a statement which we would like to have made a part of the record of these hearings. Mr. Sweeney's statement details the past history of nursing homes in our State, the system of classification employed therein, the standards and the progress made by Louisiana in this important segment of health-care.

As Commissioner of Welfare, I am directly involved in the Title XIX program of the Social Security Act and indirectly involved with Title XVIII of that Act insofar as Title XVIII promulgations affect Title XIX.

In appearing here today, I want to address some remarks to the following:

(1) That supplementation to nursing homes be continued under Title XIX and that supplementation be continued as an option to be exercised by the individual states;

(2) That the authority to fix standards for Title XIX programs be retained by the individual states; and

(3) That the definition of a "spell of illness" presently proposed by HEW will affect state Title XIX programs by increasing the costs thereto both to the individual states and to the Federal Government while working a hardship upon the patient.

In addition, Mr. Chairman, I want to address myself to the following areas of H.R. 12080:

(1) Title II, Part 1—Public Assistance Amendments, Sections 205, 206 and 208(a) of the Bill;

(2) Title II, Part 2—Medical Assistance Amendments, Sections 228(a) and 230 of the Bill;

(3) Title III—Improvement of Child Health, Section 304 of the Bill; and

(4) Title IV—General Provisions, Section 401 of the Bill.

As to the first item, namely, supplementation, the Secretary of HEW in defining requirements for State Plans under Supplement D, the Handbook of Medical Assistance, purports to prohibit supplementation. Since promulgating these regulations, he has given the States until January 1, 1969 to accomplish this.

At the outset, let me state that if there is to be a policy prohibiting supplementation, then it should be a policy enacted by the Congress and not one left to the discretion of the Secretary. If Congress desires to prohibit supplementation, then supplementation should be phased out over a period of from 3 to 5 years. To phase out supplementation in less time is to impose an abrupt and severe hardship upon the States which now have provisions for supplementation.

My own State of Louisiana is one of those which provide for supplementation in their medical assistance programs. In Louisiana we classify facilities participating in our Title XIX plan. Depending upon the facility's classification, supplementation may range from $100–$115 per month. If provision were not made for supplementation, then given our present program, the combined cost to the State of Louisiana and to the Federal Government would be increased by $9,091,880.00.

This combined figure of $9,091,880.00 would be distributed as follows: $2,311,156.00 to the State of Louisiana and $6,780,724.00 to the Federal Government. Given the established trend of a combined rise in the costs of medical care, the increased burden upon our taxpayers, both those in the State of Louisiana as well as those throughout the nation, would also be one of a continuous rise.

The history of supplementation in Louisiana reveals that once the incident of supplementation enabled Louisiana to provide payments to the providers of care commensurate with the services rendered, long-term care facilities in Louisiana underwent a dramatic change. Nursing homes began to move out of the age of converted dwellings into an era of modern new facilities. The State benefited from this; more important, the patient benefited.

The arguments most frequently advanced against supplementation are the following: (1) Supplementation contributes to low State-Agency payments; and (2) Supplementation results in unequal treatment to those patients unable to supplement the State-Agency payment. The experience of Louisiana belies both these arguments.

During the period in which Louisiana has provided for supplementation, the appropriations for medical assistance for the needy made by our Legislature have increased by approximately 2,000%. As already noted, supplementation has contributed to the advent of better facilities for all patients. It is our experience that the only difference in the treatment of patients able to supplement and those unable to do so is that the former may be placed in private rooms or two-bed wards while the latter may be placed in 4-bed wards. In all other respects, the care and treatment are alike.

There is another way of viewing supplementation. Is it the patient who supplements the State's ability to pay or is it the State which supplements the patient's ability to pay? We are inclined to the latter viewpoint. In Louisiana, patients unable to provide any part of the cost of their care are not denied that care. On the other hand, the taxpayer is required to provide only that part of a patient's care which the patient is unable to provide.

In conclusion, then, I would urge you to retain the State's option to permit supplementation and I would ask you to make it clear to the Secretary that this option is not to be denied to the States under the guise of Administrative regulations issued by the Department of HEW.

I urge you to emphasize that the State should do for the individual only that much that the individual is unable to do for himself.

One final thought, the rationale put forth by HEW in support of its effort to prohibit supplementation is as follows:

> If the nursing home is free to seek supplementation, the State may feel less of an obligation to make adequate payments. Conversely, if the nursing homes must accept the State's payment as payment in full, the nursing home is more likely to insist upon adequate payments. In this way, basic State support for the program (and concomitant Federal matching) will be increased.

Thus, one may discern a kind of Machiavellian logic at work here, namely, put the squeeze on: set the State Agency, the Legisuature and the provider-of-service at odds with each other. From the resulting struggle—in which some two of the three will probably join together against the third—there should evolve a better situation for the welfare program while the taxpayer shoulders more and more of what is put forth as his moral obligation. All of this at a time when State Governments are desperate to make ends meet; when the providers-of-care are uneasy over the continued rise in the costs of delivering care; when the taxpayer grows weary as the index of the cost of living rises. There is Machiavellian irony here, too, for all this time, the experience of Louisiana is that it is not so much the patient who supplements the State's ability to pay but rather the State which supplements the patient's ability to pay.

Turning now to the second of the three items pertaining to Medicare and Medicaid which I want to discuss, namely, that the authority to fix standards for Title XIX programs be retained by the individual states, I want to emphasize the words "retained by the states."

As a State Commissioner of Welfare, I belong to the American Public Welfare Association and attend meetings of the State Commissioners of Welfare. While attending these meetings, I have been made aware that there is dispute as to whether the state standard setting agency or the Secretary of HEW possesses the authority to fix standards of care within the state's Title XIX Plan.

I want to make it clear that I subscribe to the position that Sections 1902(a)(1) through (22)—and particularly (a)(9) and (22)—of Title XIX place the authority to establish and maintain standards of care in private and public institutions in the single standard setting state agency which may but need not administer the individual state's Title XIX Plan. In Louisiana, this single standard setting agency is the Department of Hospitals.

However, I wish to emphasize that I am not a lawyer and, therefore, the possibility exists that I could be wrong in interpreting what the Act provides. Having so stated, I want to make it clear that as a Commissioner of Welfare, I would urge that if the states do not now have the power to so fix standards that the law be re-written to provide the states with such auhority.

The State Agency is abreast of the local problem. It knows in detail what its needs are as well as its resources to meet those needs. I am aware that there are those who would yawn and dismiss such words with the term "cliche". Yet, I would remind them that a group of words becomes a cliche because the truth contained within the phrase is so manifestly and immediately clear that it becomes common.

How poignant it is that a truth so clearly at the root of our form of Government which has made these United States the envy of other nations should be dismissed as time-worn and trite.

Nevertheless, the fact remains that what is best for Louisiana may not be so for New Jersey or for Illinois and so on. I submit that there is no one within HEW—however brilliant he may be—who knows Louisiana's needs and Louisiana's resources better than do the taxpayers and the officials of the State of Louisiana.

We in Louisiana have a Title XIX Plan which we deem if not the best, then certainly among the best of the Plans in the nation. Our Plan provides for checks and balances to protect that the quality of services purchased is in fact what the needs of the State require and at a price which the people of Louisiana can afford.

We, in fact, have standards which are higher than those for extended care facilities in Title XVIII and we have standards which are less than those of Title

XVIII. We have these because not all patients are alike. We classify our facilities and we place our patients in the facility that meets their individual needs.

Louisiana's Title XIX Plan has flexibility and can adjust to meet our needs as they evolve. To take this responsibility from us and assign it to the Secretary is to run the needless risk of depriving us of that flexibility. The removal of such flexibility is accompanied by the loss of immediate response to any change in our needs.

When national standards are set, the machinery to change them is complex and heavy in its inertia. While Louisiana sought change in inappropriate standards, the patients in Louisiana would be the ones to feel the tragic weight of such inertia.

The Congress, in its wisdom, foresaw this danger when it enacted the Kerr-Mills Act. It is my opinion that it continued this wisdom in its enactment of Title XIX. If I am correct in this, then I urge you to retain this wise provision and to make it abundantly clear that the states and not the Secretary have the authority to establish standards of care for their separate Title XIX Plans. If I am incorrect in this opinion, and if the Congress from inadvertance or for whatever reason failed to carry over this wise provision of the Kerr-Mills Act into Title XIX, then I urge you to correct this failure by placing such authority with the states.

Turning now to the third item relating to Title XVIII and Title XIX, namely, that the definition of a "spell of illness" presently proposed by HEW in State Letter No. 65 will affect state Title XIX programs by increasing the costs thereto both to the individual states and to the Federal Government while working a hardship upon the patient.

In Section 1861(a), "spell of illness" is defined as commencing with the first day a patient enters a hospital, uses his hospital and extended care benefits, if this is the case, and ending 60 consecutive days thereafter on which he is neither an in-patient in a hospital or an extended care facility.

Although Congress defined an extended care facility in 1861(j) as being a facility which is primarily engaged in providing skilled nursing care and related services to patients who require medical or nursing care, the Social Security Administration evidently considers this to be the proper definition of an ECF for all purposes except that of determining a "spell of illness."

In State Letter No. 65, the Social Security Administration defines an "extended care facility" and "skilled nursing care" so as to prolong a "spell of illness." SSA does so when it defines an ECF as a facility which is in charge of a licensed practical nurse (who need not be a graduate of a state approved school) with aides, orderlies or attendants on the other two shifts. Such a facility fails in the essential element of an ECF, for such a facility has never been considered in the health care field to be primarily engaged in skilled nursing care and services for patients who require medical or nursing care. This definition of an ECF in State Letter No. 65 adds a great deal of confusion to the health care field. However, far more important, the results which follow from this deny our aged people medical benefits which I believe Congress intended them to have.

Although there are many illustrations that could be cited, one example will be sufficient. Let us assume that the State of Louisiana has a welfare patient in a residential care home which has a licensed practical nurse as a charge nurse. Since he has no other home and no resources, this patient will probably be there for the remainder of his life and, therefore, this residential care home is, in reality, his permanent place of abode. He is eligible for Medicare benefits. He is admitted to a hospital with a severe stroke. He exhausts his hospital benefits and is transferred to an ECF. After 60 days, he is discharged from the ECF and returns to his place of residence which is the above mentioned residential care home. This individual can never again receive any Medicare benefits, because he will have been judged by the Social Security Administration to have never been outside an ECF or a skilled nursing home for 60 consecutive days. Even though some two years later he falls and breaks his leg, he will not be eligible for Medicare because this residential care home is defined as an ECF or skilled nursing home in State Letter No. 65. It is defined by SSA as an ECF or skilled nursing home because it has a LPN as a charge nurse. The travesty lies in the fact that this residential care home is considered by SSA to be an ECF or a skilled nursing home solely for the purpose of not breaking this "spell of illness." SSA would never certify this residential care home as an ECF or a skilled nursing home for participation in Title XVIII or Title XIX programs. In those instances, SSA would judge this residential care home to be below the standards required of a facility for it to be certified as an ECF or a skilled nursing home.

On the other hand, if this individual had such resources that after being discharged from the nursing home, he could be taken to his own home, he could receive 200 home health care visits and his new "spell of illness" would start 60 days from the date that he was discharged from the ECF. In other words, an individual is not required to have a 60 day "spell of health." State Letter No. 65 makes one's Medicare benefits turn on his station in life or on the circumstances under which he is living at the time that he enters the hospital.

I am concerned about these individuals because of the harshness and unfairness to them and because this discrimination places a heavier burden on the State Welfare Program than Congress intended. The states are urged to buy-in on Part B of Medicare and to pay the deductibles for their welfare patients.

Within the last few days, the Social Security Administration has issued another letter, reviewing the matter but adhering to their original State Letter No. 65 and to the instructions forwarded to the fiscal intermediaries. I suggest the following: Strike out the period at the end of Section 1861(a)(2) and add the words "under Title XVIII for the same medical illness." I have discussed this with physicians and others and I am certain that medical illness can be defined or categorized with sufficient detail to formulate a sound regulation without creating hardships as State letter No. 65 does. It makes little sense to define "spell of illness" on the basis of where a patient resides or the type of institution in which he is located. It makes even less sense to define "extended care facilities" or "skilled nursing services" in a manner contrary to long accepted standards. It does make sense to define "spell of illness" in terms of medical illness.

Mr. Chairman, I pass on, now, to my remarks concerning specific points presently contained in H.R. 12080 as reported by the House of Representatives. We are asking for this committee's careful review of certain provisions of H.R. 12080 and for its support for Louisiana's position in reference to them.

Section 205 amends and improves the provision for matching funds for foster care for children who were receiving AFDC. However, we believe the Child Welfare Services Program including its Foster Care Services would be substantially improved if the Congress would provide Federal matching for the entire program, similar to the matching provided in AFDC. There are many children needing foster care who were never eligible for AFDC under the law, or whose families never came to the attention of the Public Welfare Department before the court committed them to our care.

In fiscal 1966–67, this Department paid $5,298,597.25 for 4,731 children in foster care. Only 760 had been AFDC children in the month they went into foster care. The total program of Child Welfare Services (including foster care payments) cost $8,029,183, of which the Federal Government paid only $1,752,559. We ask your support of provisions to provide matching for all foster care expenditures in addition to other Child Welfare Services.

We also ask your support of Section 206 of H.R. 12080. This Department has found emergency assistance to families with needy children often necessary, but received no Federal participation unless the children also qualify for AFDC.

We hope the Senate Finance Committee will review carefully Section 208(a) amending Section 403(d) of the Social Security Act which limits, after 1967, the percentage of children in the State who can receive AFDC on the basis of the absence of a parent to the percentage of children under 21 in the State receiving aid for this reason in January 1967.

We believe it is unsound to penalize a child whose need arises later than 1967—which could happen. This State has had a problem in connection with families whose wage earner leaves the State to find employment and does not return. This is especially true in the agricultural parishes where methods of agriculture have changed so fast.

We ask that the Senate Finance Committee examine carefully all proposals to restrict the AFDC Program as they could easily mean more expenditures in Child Welfare Services, without any advantage to the children, who may well be better cared for in their own homes, if lack of money is the basic problem. We already have a suitable home provision to provide for children who are truly neglected.

We are very much interested in the provisions for training of AFDC parents and children, but we believe there should be more direct financial participation in such training by the Federal Agency. Louisiana is spending a large percentage of income on Welfare and would help on financing such a program. If we could get 90% matching for such costs we could implement this type program more effectively.

We would like to go on record as strongly opposing Section 228(a), which amends Section 1902(a), lines 12–22 on page 157, which provides that the State Medical Assistance Plan effective July 1, 1969, would be required to provide for consultative services by health agencies and other appropriate state agencies to hospitals, nursing homes, home health agencies, clinics, laboratories and other agencies which may be specified by HEW. This consultation would be to assist these institutions with reference to Title XVIII (Medicare), Title XIX (Medicaid) and Title V (Child Health) to qualify for payments, to establish and maintain fiscal records and to provide information needed to determine payments due. This would take the place of the present provisions under Title XVIII, which authorizes HEW to enter into agreements with state agencies to provide comparable services under Medicare.

Under the present law, this activity is 100% financed from Federal funds. Under the amendment, as we interpret it, the states would be required to match on a 25% to 75% to pay for this service. We urge that the Federal Government continue to bear the cost for this activity.

We do not object to (page 159, line 16, section 230) the itemized method for billing the medically needy; however, this Agency would be strongly opposed to this method for billing money grant welfare recipients. We would object to this method on the grounds that many of our recipients are old, infirm, some are senile, others are emotionally disturbed, many are in nursing homes or receiving nursing care in their own homes, illiterate and in many cases completely inadequate. These individuals are badly in need of the services of this Agency and all of the assistance and encouragement our professional staff can give. If they are required to secure an itemized bill from a physician, present it to the Welfare Department, collect this sum and then transmit it to the physician, they would be completely confused and, in many instances, unable to complete this procedure. We are of the opinion that this would be cruel, unfair and unjust to welfare recipients as a whole and, therefore, strongly urge that you do all within your power to retain the present method of Vendor Payments by the Department on behalf of welfare recipients for medical services rendered.

We are strongly opposed to the provision in Section 304 (page 135, lines 6–13) which requires the state agency administering Aid to Families with Dependent Children to pay the Secretary of Labor for expenses involved for "testing and counseling services and other such services."

These services are ordinarily provided without charge to the general public, and we do not understand why the public assistance applicants and recipients are not eligible for the services of the public employment offices on the same basis as others.

Please support Section 401 amending Title VII of the Social Security Act to provide grants for social workers, manpower and training. Lack of technically trained personnel is a constant problem.

Mr. Chairman, this concludes our remarks. We want to thank you and the members of this singularly important committee for having us here this morning. We are available for questioning and will endeavor to answer any inquiries which you or the other distinguished Senators may have. Thank you again.

STATEMENT OF H. K. SWEENEY, GENERAL COUNSEL AND ASSISTANT DIRECTOR, STATE OF LOUISIANA DEPARTMENT OF HOSPITALS

In order to understand the Nursing Home program within the State of Louisiana we must consider some background. I know that all of you are familiar with conditions that our elderly citizens—caught in a changing society—were forced to endure in years gone by. I do not choose to burden you with when and how these conditions came about. So I will pick a chronological point to begin.

Prior to 1952 as a matter of necessity, to protect their clients, the Louisiana Department of Public Welfare had adopted certain minimum standards for the operation of homes caring for the elderly and had certified homes for its recipients. In 1952 the Louisiana State Legislature passed Act 406. This Act authorized the Louisiana State Board of Health to license and regulate homes for the aged, the chronically ill and the phyically infirm or handicapped; to adopt and promulgate minimum standards for their operation; to exercise supervision and inspection of the homes for the ill, the infirm and the aged. Minimum Standards were promulgated based on those previously used by the Department of Public Welfare. As of September 16, 1955, the Board of Health

was still waging a struggle between meeting the demand for nursing home beds and maintaining standards. Their report of that date illustrated the situation as follows:

Homes licensed	66
Almost ready for licensing	24
Problem homes	8
New homes in process	8
Total beds licensed	3,095

At the insistance of the nursing home operators the State law was amended in 1958 transferring the licensing of nursing homes from the State Board of Health to the State Department of Hospitals. At that time there were 100 nursing homes licensed offering 4,185 beds.

One provision of the Act transferring the licensing functions provided for a Nursing Home Licensing Council composed of ex-officio members from the State Board of Health, the State Fire Marshal's Office and the State Department of Public Welfare as well as the Director of the Department of Hospitals. The balance of the Council was and is composed of two members elected from "small" nursing homes, two elected from "large" nursing homes, and one at large member elected by all licensed Nursing Homes. Meetings of the Council are held periodically to discuss trends with possible revision of the Standards. Their function was and is to upgrade standards of operation of Nursing Homes. The last revisions were added in 1963 but with the greater emphasis now being placed on professionalization of staff and more exacting procedures and policies, we are in the process of making other revisions.

After functioning under this system for a few years, the Department of Hospitals and the Department of Public Welfare realized that what they were seeking was not being accomplished very rapidly. Consequently, and with the concurrence of the Licensing Council a classification plan was developed.

May 1, 1961, marked the beginning of the classification of nursing homes in Louisiana. The plan was to form an integral part of an expanding effort to promote improved nursing care for the aged and infirm and in turn, a part of a nationwide effort to promote and maintain the maximum degree of physical and mental independence of nursing home patients. This plan was based primarily on the traditional American system—i.e., value paid for value received.

Recognizing that improved care means higher costs for the owners of the facilities, a graduated schedule of payments was developed, with the Department of Public Welfare paying part of the costs and allowing supplementation by the family or other sources for the balance. The two pressing needs at this time were for the improvement of the physical plants and of nursing care. The payment schedule recognized the home licensed under the Standards developed by the Department of Hospitals as opposed to the previous standards used prior to the promulgation of the more restricted requirements.

The classifications adopted in addition to minimum standards were as follows:

A–I—New construction, registered nurses services 24 hours per day.

A–II—New construction, registered nurse in charge and licensed practical nurses 24 hours per day.

A–III—New construction, licensed practical nurses 24 hours per day.

B–I—Old construction, registered nurses 24 hours per day.

B–II—Old construction, registered nurse in charge and licensed practical nurses 24 hours per day.

B–III—Licensed practical nurses 24 hours per day.

Unclassified—Bare minimum standards met.

With these standards enforced by the Department of Hospitals the Department of Public Welfare agreed to a graduation of payments and a maximum charge for their recipients as follows:

Nursing home classification	DPW payment	Maximum charge
A–I	$165	$265
A–II	150	250
A–III	140	240
B–I	150	250
B–II	135	240
B–III	125	235
Unclassified	110	225

On June 30 of 1961 there were 112 licensed nursing homes in the State providing 6,155 beds. The number of nursing home *beds*, not homes, in each classification was as follows:

A-I	98
A-II	219
A-III	225
B-I	360
B-II	700
B-III	513
Unclassified	4,040

At the present time the schedule of Department of Public Welfare payments and the maximum charge is as follows:

Nursing home classification	DPW payment	Maximum charge
A-I	$225	$325
A-II	205	305
A-III	165	265
B-I	205	305
B-II	185	290
B-III	150	260
Unclassified	135	250

After six years of operation under the classification system, as of June, 1967, there were 199 licensed nursing homes in Louisiana providing 10,899 beds. The number of nursing home *beds*, not homes, in each classification is:

A-I	5,436
A-II	2,163
A-III	64
B-I	482
B-II	1,351
B-III	321
Unclassified	632
As of May 1, 1961:[1]	
Total licensed nursing homes	112
Total beds	6,155
A-I	98
A-II	219
A-III	225
B-I	360
B-II	700
B-III	513
Unclassified	4,040
Total A beds (1961)	542
Total A beds (1967)	8,113
Increase from 1961	+7,571
Total B Beds (1961)	1,573
Total B Beds (1967)	2,154
Increase from 1961	+581
Total unclassified (1961)	4,040
Total unclassified (1967)	632
Decrease from 1961	−3,408

[1] Prior to classification of facilities and graduated payments plus graduated supplementation.

As of June 1967: [a]

Total licensed nursing homes [b]	199
Total beds	10,899
A-I	5,430
A-II	2,613
A-III	64
B-I	482
B-II	1,351
B-III	321
Unclassified	632

[a] After 6 years of classification and graduated payments plus graduated supplementation.
[b] 120 are certified ECF's under Medicare.

You will note the marked increase in the number of beds providing maximum service and care as opposed to the situation which existed six years ago. We feel that this has been a direct result of the classification and incentive system and was brought about through the joint efforts of the Department of Hospitals, the Department of Public Welfare and the Nursing Home operators themselves.

Even before the advent of Medicare with the focus on improved quality care, the Department of Hospitals in consultation with the Nursing Home Association began talks of changing the program so as to recognize other areas of concern as regards patient care. We are presently finalizing a new plan to present to the Department of Public Welfare for its guidance and, hopefully, acceptance. The areas of prime concern other than nursing and physical environment will be clinical records, dietary, and professional consultation. The plan is so devised that it can be altered at any time to put added emphasis on any area covered by the Conditions of Participation for Medicare.

Of the 199 licensed Nursing Homes in Louisiana, 120 of these have been certified as Extended Care Facilities. We feel, we know, that this extremely high percentage is a result of our cooperative program.

If the future goals are well defined and steady progress is *planned* toward those goals, we feel that the future of the nursing home can be built on a firm base. With the problems already encountered in scarce personnel and other areas, it seems impractical to expect immediate fulfillment. Who is better prepared to overcome the obstacles than the local nursing home administrators and state agencies working cooperatively? We offer our past experiences as a basis of what can be done and our hope for the future as a guide for others to equal or better.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., April 10, 1967.

BUREAU OF HEALTH INSURANCE LETTER, STATE AGENCY NO. 65

Subject: Criteria for determining whether a facility is primarily engaged in providing skilled nursing care and related services for purposes of determining when a spell of illness ends.

I. INTRODUCTION

This letter provides revised criteria for determining whether a facility is primarily engaged in providing skilled nursing care and related services within the meaning of section 1861(j)(1) of the Social Security Act for purposes of determining when a spell of illness ends.

The law provides for a limited period of extended care benefits within a spell of illness for those persons who need continuous skilled nursing care after hospitalization. Once a beneficiary has exhausted these benefits, he cannot renew them until he ends his spell of illness, i.e., until he has not been an inpatient of any hospital or of any facility which meets the definition contained in section 1861(e)(1) or 1861(j)(1) respectively, for 60 consecutive days. Since the main purpose of this requirement is to provide a means of limiting the overall costs of the program, it is not intended that a person be able to qualify for benefits again after 60 days of nonpayment by transferring from a participating facility

or participating distinct part of an institution into another institutional setting where, though the facility is not a participating provider under the medicare program, the patient can continue to receive, in effect, the same type of nursing care and related services. For this reason the law makes it clear that a spell of illness continues in an institution which, though it does not meet all the requirements for participation in the program, meets the definition contained in section 1861(j)(1) of a facility which is primarily engaged in providing skilled nursing care and related services. It is, therefore, vitally important to know at the time of beneficiary enters an institution whether that institution meets the definition of a hospital or a facility that would continue his spell of illness.

II. DEFINITION OF AN 1861(J)(1) FACILITY

An institution which will prolong a spell of illness is defined in section 1861(j)(1) as an institution (or a distinct part of an institution) which is primarily engaged in providing to inpatients:

1. skilled nursing care and related services for patients who require medical or nursing care, or
2. rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

(For purposes of the 1861(j)(1) definition, this includes institutions primarily for the care and treatment of mental disease or tuberculosis, even though such institutions are precluded from participating under the program as extended care facilities.)

III. CRITERIA FOR MAKING DETERMINATIONS

A. An institution will be classified as being primarily engaged in providing to inpatients skilled nursing care and related services if the institution meets the following tests:

1. it provides nursing services under the direction or supervision of one or more registered professional nurses or licensed practical or vocational nurses without regard to whether they are waivered or not (this condition will be considered met even if the nurse is also the administrator of the facility or is employed on a part-time basis);
2. there are nursing personnel on duty 24 hours a day (nursing personnel includes registered professional nurses, licensed practical or vocational nurses without regard to whether they are waivered or not, practical nurses, student nurses, nursing aides, and orderlies);
3. the number of full-time equivalent nursing personnel to the number of beds is not less than an average ratio of 1 to 15 per shift. This means that a facility which has three 8-hour shifts would have to have a minimum of the equivalent of three full-time nursing personnel during a 24-hour period for each 15 beds. It is not necessary that the 1 to 15 ratio be maintained for each shift, but the average for all shifts has to be at least 1 to 15. Nursing personnel include all those persons listed in 2 above. In determining the ratio, nurses who are also administrators should be counted as nursing personnel.
4. it provides bed and board to inpatients in connection with the furnishing of nursing care, plus one or more medically related health services such as physicians' services, physical, occupational, or speech therapy, diagnostic and laboratory services, and administration of medication. (Social, diversional, or recreational services provided by the institution would not be considered a medically related health service.)

The following guides should be used in applying the tests to the nonparticipating remainder of an institution (other than a hospital) where a distinct part of the institution has been certified for participation as an extended care facility. If the nursing supervision requirement in the conditions of participation was met by the distinct part extended care facility on the basis of a sharing arrangement with the remainder, test 1 above will be considered met by the nonparticipating remainder. In determining whether tests 2 and 3 are met, the State agency should use the information obtained during the survey of the distinct part extended care facility (State Agency Interim Guidelines 320.6) where there was sharing of nursing personnel. Thus, for example, in determining whether the remainder meets the 1 to 15 nursing personnel ratio, if there are 40 full-time nursing personnel employed in the nonparticipating remainder and 10 of these personnel devote 40 percent of their time to the distinct part extended care fa-

cility, the number of full-time equivalent nursing personnel in the nonparticipating remainder would be 36.

B. An institution will be classified as an institution primarily engaged in providing rehabilitation services if it provides medically oriented services generally recognized as rehabilitative and restorative in intent, such as speech therapy, physical therapy, or other medical rehabilitative services. A rehabilitative center which provides primarily educational, evaluative, or vocational services would not meet the definition.

An institution licensed as a rehabilitation center will be considered as meeting the definition of being primarily engaged in providing rehabilitation services, unless there is evidence that its primary function is to provide educational, evaluative, or vocational services or that it is primarily engaged in furnishing outpatient rehabilitation services.

In those cases where a rehabilitation center has applied as an extended care facility and the institution (or a distinct part of the institution) is being denied, the determination should be confined to whether the entire institution meets the 1861(j)(1) definition. Where a distinct part of a rehabilition center is approved for participation as an extended care facility, the criteria set out above should be used in determining whether the remainder of the institution should be classified as an 1861(j)(1) facility. Where the rehabilitation center has already been classified as a hospital (as reflected in the Directory of Medical Facilities) an 1861(j)(1) determination would, of course, not be required.

IV. DETERMINATION BASED ON LICENSURE INFORMATION, ACCREDITATION APPROVAL OR APPROVAL UNDER STATE WELFARE PROGRAMS

In many cases it will be possible to make a determination on the basis of information that is already available to the State agency. However, where this is not the case, the State agency will need to make a determination as to whether the institution meets these criteria based on the facts in the individual case.

A. Effect of licensure

If a State requires institutions offering nursing care services to be licensed and the State agency finds that the licensing requirements or standards applied to such institutions meet or exceed the criteria described in section III A, an institution so licensed will be deemed to be an 1861(j)(1) facility.

The nonparticipating remainder of an institution which has a certified distinct part extended care facility will also be deemed to be an 1861(j)(1) facility if the institution is licensed as a whole and the licensing requirements meet or exceed the criteria described in section III A. (The only exception is where the institution has a residential section that meets the criteria contained in section V, in which case only the nonresidential section will be deemed to be an 1861(j)(1) facility.)

If the distinct part of a rehibilitation center or a hospital, see sections III B and V A.

B. Effect of accreditation

Any institution accredited by the Joint Commission on Accreditation of Hospitals as an extended care facility as a result of a JCAH survey performed after December 1965 will be deemed to meet the 1861(j)(1) definition.

C. Approval of State welfare programs

A number of States have established standards for participation of skilled nursing facilities under their programs of Medical Assistance for the Aged or other welfare programs. In those cases where the State requirements or standards meet or exceed the criteria described in section III A, any institution that has been approved as meeting the State requirements will be deemed to meet the 1861(j)(1) definition.

V. DISTINCT PART CERTIFICATIONS

A. Hospital-based extended care facility

In those cases where a distinct part of a hospital applies for participation as an extended care facility an 1861(e)(1) determination will not be required for the hospital if it is already listed in the Directory of Medical Facilities. If the distinct part is denied, a separate determination for the distinct part is not needed, since the prior designation of the entire institution as a hospital would also include the distinct part.

B. Nonhospital-based extended care facility

Where a distinct part of an institution (other than a hospital) is certified for participation as an extended care facility, a determination will be made as to whether the remainder of the institution also meets the 1861(j)(1) definition. The determination will indicate whether the entire remainder or only a part of the remainder of the institution meets the 1861(j)(1) definition. Some institutions, such as old-age homes, are organized to provide different levels of care and have separately operated facilities, part of which may be primarily residential or domiciliary in nature. In order to take these situations into account, the State agency should exclude the "residential" or "domiciliary" section of the remainder of the institution from its determination provided all of the following criteria are met:

1. the "residential" or "domiciliary" section is not primarily engaged in providing skilled nursing care and related services as defined in section III A above;

2. the "residential" or "domiciliary" section is a separately organized and operated entity with its own staff, services, and facilities which are not shared with the remainder of the institution;

3. the "residential" or "domiciliary" section is physically separated from the rest of the institution in a different building or buildings (an institution which has several floors, wards, or wings devoted to "residential care" within a nursing facility would not meet this criterion);

4. the facility has been operated along the lines described above for at least 1 year (or for the entire period since it was first opened if it has been in existence for less than a year).

Unless all of the above criteria are met, the 1861(j)(1) determination will apply to the entire remainder of the institution, including any "residential" or "domiciliary" sections. If it is determined that the entire remainder meets the 1861(j)(1) definition, any individual who is in the remainder is considered to be an inpatient of an 1861(j)(1) facility and his spell of illness would continue, without regard to the level of care he is being furnished or whether he is receiving any care at all.

Examples

1. The XYZ Nursing Home is a 100-bed nursing facility consisting of Buildings A and B. Building A, which has 50 beds, was certified and is participating as a distinct part extended care facility. The nursing home did not request participation for Building B. One of the floors in Building B is set aside for its "residents" who are no longer receiving nursing care but need personal care services because of their age. The rest of Building B consists of patients who are receiving nursing care. A determination as to whether the nonparticipating remainder of the nursing home meets the 1861(j)(1) definition would include all floors in Building B.

2. The ABC Retirement Home has a 2-story, 50-bed nursing facility that serves the 300 residents of their retirement community when they become ill. The first floor of the facility, consisting of 25 beds, was certified for participation as a distinct part extended care facility. The home did not request participation for the second floor. The balance of the home consists of a number of apartment houses that form a retirement community. In this case, two separate 1861(j)(1) determinations would be made; one for the retirement community and one for the second floor of the nursing facility.

C. Nonparticipating institution

If an 1861(j)(1) determination must be made with respect to an institution which is not participating in the program, one determination will be made for the entire institution except where it has a "residential" or "domiciliary" section which meets the criteria set out in B above.

VI. PROCEDURES FOR MAKING 1861 (J) (1) DETERMINATIONS

In the very near future State agencies will receive revised procedures to be followed in making 1861(j)(1) determinations on the basis of the criteria contained in this letter. State agencies will also be asked to review all prior 1861(j)(1) determinations in the light of the revised criteria contained in this letter. This will include those facilities now listed in the first edition of the Directory of Medical Facilities as 1861(j)(1) facilities. It is also planned that from time to time a periodic review will be made to verify that 1861(j)(1) decisions are

still accurate. Until then, State agencies should continue to follow criteria and instructions in BHI Letter State Agency No. 49.

ARTHUR E. HESS,
Director, Bureau of Health Insurance.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., August 14, 1967.

BUREAU OF HEALTH INSURANCE, INTERMEDIARY LETTER No. 257

Subject: Custodial care guidelines.

In BHI Intermediary Letter No. 211 we indicated that guidelines to be used by intermediaries in identifying, documenting, and adjudicating cases arising in general hospitals and extended care facilities that appear to involve custodial care were being developed and would be issued shortly. These guidelines have now been established and are contained in the enclosed paper.

THOMAS M. TIERNEY,
Director, Bureau of Health Insurance.

CUSTODIAL CARE CASES

I. INTRODUCTION

As indicated in BHI Intermediary Letter No. 211, custodial care is defined as that type of care which is designed essentially to assist an individual in meeting his activities of daily living—i.e., services which constitute personal care such as help in walking and getting in and out of bed, assistance in bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication which can usually be self-administered—and which does not entail or require the continuing attention of trained medical or paramedical personnel. Before setting forth the guidelines to be followed by intermediaries in making determinations as to whether the care furnished an individual constitutes custodial care, there are two basic facts which must be noted in connection with this definition. First, the definition of custodial care does not contemplate an intermediate level of care between covered care and custodial care. Accordingly, a decision that an individual is not receiving custodial care is also a decision that covered care has been provided. Second, a decision that an individual lacks rehabilitation potential would not automatically result in a finding that the care furnished such an individual constitutes custodial care. Many people who have no potential for rehabilitation require a level of care which is covered under the program. For example, a terminal cancer patient whose life expectancy is not more than a few months who requires palliative treatment, periodic "tapping" to relieve fluid accumulation, and careful skin care and hygiene to minimize discomfort would not be considered as receiving custodial care.

II. SKILLED SERVICES

Generally, the care furnished an individual requires the continuing attention of trained medical or paramedical personnel if (a) the individual's condition is such as to medically warrant the provision of "skilled services" and (b) the need for such services constitutes the primary purpose of the total care furnished the individual. A "skilled service" is defined as one which *must* be furnished by or under the supervision of trained medical or paramedical personnel if the safety of the patient is to be assured and the medically desired result is to be achieved. A service would not be classified as a skilled service merely because it is performed by a trained medical or paramedical person. If a service is such that it can be safely and adequately performed (or self-administered) by the average, rational, nonmedical person, without the direct supervision of trained medical or paramedical personnel, it must be regarded as a nonskilled service without regard to who actually provides the service. For example, following the instructions given him, a person can normally take oral medication prescribed for him by his physician. Consequently, the giving of such medication by a nurse to a patient who is unable to perform the service for himself because he is suffering from senility would not change the nature of the service from a nonskilled to a skilled service.

Similarly, the fact that the conditions of participation for extended care facilities require that all medications be administered by licensed medical or nursing personnel in accordance with the Medical and Nurse Practice Acts of each State does not result in the administration of medications being classified as a skilled service in all instances.

III. PRIMARY PURPOSE OF CARE FURNISHED

Before a determination can be made as to what is the primary purpose of the total care furnished an individual, the intermediary must first determine whether all or any part of the skilled services are *not* reasonable or medically necessary to the treatment of the individual's illness or injury. Should the intermediary determine that some part of the skilled services furnished are not a reasonable or necessary part of the patient's care and treatment, such services should not be included in the intermediary's considerations as to what constitutes the primary purpose of the total care furnished the patient.

In the absence of a need for continuing professional nursing services, the provision of skilled services to inpatients of hospitals and extended care facilities by paramedical personnel (other than nurses) would ordinarily not justify a finding that such paramedical services are the primary purpose for the total care furnished a patient. Therefore, in most instances, a determination as to whether the primary purpose of the total care furnished an individual is to assist him in meeting the activities of daily living or the provision of skilled services will turn on whether the individual's condition is such that it requires that the services of a nurse be available to him at all times.

If an individual's condition is such that it is medically necessary to have the services of a nurse available to him at all times, the need for this service alone would be sufficient to justify a finding that the primary purpose of the total care is the provision of this skilled service. For example, pending stabilization of his condition, the only skilled service a patient suffering from arteriosclerotic heart disease may require is continuing close observation by a trained nurse for signs of decompensation, loss of fluid balance, and the need for adjustment in digitalis dosage. However, since the immediate institution of necessary medical procedures could make the difference between life and death for such an individual where signs of decompensation are noted, such observation by trained personnel is absolutely essential to the individual's well-being. Under these circumstances the primary purpose of the total care provided this individual would be the furnishing of this skilled service and, therefore, the custodial care exclusion would not apply. If, on the other hand, the patient does not require any nursing services, it will usually be found that the primary purpose of the total care furnished the individual is to assist him in meeting his activities of daily living. In those cases where an individual's need for the services of a nurse are only minimal, a determination that the furnishing of skilled services is the primary purpose of the total care furnished the individual would be justified only if it is found that the range and intensity of all the skilled services furnished are such that it would not be feasible, in view of the individual's condition, to have them provided outside the institutional setting. It is anticipated that these situations will probably be limited to those where an individual is hospitalized for the running of extensive diagnostic tests.

If it is determined that the primary purpose of the total care provided an individual is to assist him in meeting the activities of daily living, then the custodial care exclusion would apply and no payment could be made under the program for any of the care furnished him. If, on the other hand, it is found that the skilled services furnished an individual are the primary purpose for the total care furnished, the custodial care exclusion would not apply and payment could be made under the program for those services covered under the program.

It should be recognized that even when a determination of custodial care is reached, it is, of course, possible that only a portion of the stay in the institution has been custodial. Therefore, in such cases a second determination will usually have to be made as to when the care received by the patient became primarily custodial in nature.

IV. STATUS OF PHYSICIAN SERVICES

Any service which a physician performs for a patient would constitute a skilled service. However, even though in an institutional setting the services of a physician may be readily available, the general pattern is for the physician to visit a patient only periodically, delegating to the nurse the responsibility

for keeping, where necessary, close watch over the patient for changes in his condition requiring immediate medical action. Periodic visits by a physician to a patient, therefore, would not justify a finding that the total care furnished an individual is not custodial care. Nor would a finding that the care received by an individual is custodial care in and of itself require the disallowance of a request for reimbursement filed under Part B for the physician's services. Many individuals who require only custodial care may need to have periodic visits from a physician for purposes of having their medical status assessed so a medical decision may be made as to whether any change needs to be made in the type of care they are receiving. Accordingly, as long as the professional services rendered by a physician are reasonable and necessary to the treatment of an illness or injury, such services would be reimbursable under the medical insurance program, even though a finding has been made that the primary purpose of the total care furnished the individual by a hospital or extended care facility is to assist him in meeting his activities of daily living.

V. IDENTIFICATION OF CUSTODIAL CARE CASES

The effectiveness with which the custodial care exclusion is applied will depend to a great extent on the ability of the intermediaries to identify cases that are likely to fall within the custodial care exclusion. In light of the limited amount of information available at the time of the bill review, considerable skill and sound judgment must be exercised if the intermediary is to successfully identify cases involving custodial care and at the same time avoid developing unnecessarily a large number of cases that represent covered care. To this end, in reaching a conclusion as to whether a case may involve custodial care and therefore require additional documentation before it can be adjudicated, the intermediary will need to evaluate each pertinent item of information on the billing form and in the claims file separately and in relation to each other. The intermediary's evaluation should always include a consideration of the following factors.

A. *Length of Stay in the Institution.*—The longer a patient remains in an institution, the greater is the likelihood of a custodial care situation. Therefore, while extended stay in an institution does not in itself indicate a custodial care situation, it does serve to flag a case as one that requires close scrutiny. In the case of bills submitted by extended care facilities, the length of stay in the hospital should also be considered.

B. *Diagnosis.*—In evaluating this entry, reviewers should look to see whether the diagnosis represents a condition which, once it is stabilized, usually requires only custodial care, or one that would normally involve a wide range of skilled services entailing the continuing attention of trained personnel.

C. *History of Inpatient Usage.*—The inability of an individual to remain out of an institution may also be an indication of a custodial care situation. The items on the billing form and in the claims file relating to prior inpatient stays should be analyzed to determine whether the beneficiary (a) has had earlier and, perhaps, repeated admissions to hospitals or extended care facilities, (b) had one or more previous spells of illness during which he exhausted all or most of the number of days available to him, and (c) has a pattern of institutional usage with each spell of illness beginning approximately 60 days after an earlier spell ended and during the interim period the beneficiary was in an institution that is not a hospital or extended care facility within the meaning of either section 1861(e)(1) or (j)(1).

D. *Adverse Utilization Review Decision.*—A decision by a utilization review committee that further stay is not necessary does not, of course, mean that prior to the committee's determination the patient had been receiving custodial care. However, it would raise a presumption that care in the prior period may not have been covered.

E. *Effect of Discharge or Death.*—A patient's discharge from an institution after a relatively short period would tend to indicate that the care furnished him was not custodial. Similarly, the death of a patient shortly after his admission to an institution would tend to indicate that the care furnished the patient was not custodial in nature.

F. *Characteristics of Institution.*—The intermediary will also want to take into account its knowledge of the nature and practices of the institution submitting the bill and the type of patients it serves. If, after evaluating all of the information available at the time of the bill review, there is a reasonable doubt as to whether the care furnished a beneficiary is covered, the institution sub-

mitting the bill should be requested to furnish the documentation necessary to enable the intermediary to resolve the question.

VI. DOCUMENTATION OF POSSIBLE CUSTODIAL CARE CASES

The following list indicates the type of information which is available from institutions and which it is felt would be most helpful in determining the level of care required by the patients.

A. *The Physician's Orders.*—These orders will indicate any special diets, medications, or therapies being received by the patient.

B. *The Patient's Nursing Care Plan.*—The prescribed treatment and long- and short-term goals contained in the plan when considered in conjunction with the regimen prescribed for the patient by the physican should indicate the degree of skilled nursing care and medical supervision being received by the patient.

C. *Progress Notes.*—These notes should provide an indication of the history and present status of the condition, particularly its degree of stability.

D. *The Physician's Recertification Statements.*—The reasons stated for the need for continued inpatient services and the estimate of the period of time the patient will need to remain in the institution viewed in conjunction with the regimen prescribed for the patient by the physician may indicate whether an active plan of treatment is still contemplated by the physician.

E. *The Utilization Review Committee's Decision.*

F. *In the Case of an Extended Care Patient, the Initial Estimate Made in the Extended Care Facility of the Patient's Restorative Potential.*—As was previously indicated, it is not necessary that a patient have rehabilitation or restorative potential to be considered as receiving active medical care. However, the estimate of restorative potential will provide an indication of the level of restoration a patient may be expected to reach and, therefore, the level at which the patient's needs may become custodial in nature.

Reproductions of such documents are, of course, acceptable.

VII. FINAL DECISION RESPONSIBILITY OF INTERMEDIARY'S MEDICAL STAFF

If after the necessary documentation has been received and evaluated it is determined that the care furnished may fall within the custodial care exclusion, the case should be referred to the intermediary's medical staff for its consideration and decision. In borderline cases, the intermediary should consider consulting the attending physician on the case. Where the provider's utilization review committee has not considered the case, the intermediary may elect to refer the case to the utilization review committee or to other appropriate medical committees which have been set up to review such claims. Such consultation will educate physicians to the requirements of the medicare law and result in cooperative determinations. When in the final opinion of the intermediary's medical staff the care furnished an individual is custodial care, the intermediary will apply the custodial care exclusion and refuse payment in the case.

A physician certification or utilization review committee's finding consists of professional judgments about the medical necessity for services. The function of the intermediary is to determine that the services received by the beneficiary are in fact covered by the program. Since under the law custodial care is excluded from coverage without regard to the medical necessity for such services, a determination by a physician or utilization review committee that such care is medically necessary and the intermediary's decision that such care is excluded from coverage under the program do not represent incompatible determinatons.

It is by such coordinated effort that the relationship between intermediaries, providers and physicians can be strengthened. It will serve to achieve understanding among physicians and providers of the nature of the custodial care exclusions.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., August 14, 1967.

BUREAU OF HEALTH INSURANCE, INTERMEDIARY LETTER NO. 258

Subject: Study of medical characteristics of patients in extended care facilities and application of custodial care exclusion to be conducted by fiscal intermediaries.

Experience under the medicare program to date indicates that the cost of the extended care benefit of the program is running considerably higher than expected. Some concern has been expressed that this may in large part be due

to the fact that, despite the specific exclusion contained in the law, payment is being made in a number of cases for custodial care. To assure that payment will not be made under the program for such care, and to enable intermediaries to effectively implement the custodial care exclusion, the guidelines transmitted by BHI Intermediary Letter No. 257 were developed for use by intermediaries in identifying, documenting, and adjudicating cases arising in general hospitals and extended care facilities that appear to involve custodial care.

Since the potential for custodial care is particularly great in extended care facilities, it is felt that one effective way of strongly emphasizing and publicizing at this time the importance of applying the exclusion is for intermediaries to conduct a study of the medical characteristics of patients in extended care facilities. Those intermediaries which are serving extended care facilities are, therefore, requested to undertake a study of a representative sample of medicare beneficiaries currently receiving extended care benefits. We believe that the study should include between 3 to 5 percent of the total number of beneficiaries who at the time of the study are being furnished covered services in those extended care facilities that are serviced by the intermediary. The intermediary should attempt to involve all the extended care facilities it services in the study.

The threefold purpose of conducting this study is to (1) enhance understanding among physicians (and extended care facility administrators) of the nature of the custodial care exclusion and provide concrete evidence that intermediaries will be scrutinizing claims and rigorously applying the exclusion, (2) test the effectiveness and utility in a controlled situation of the custodial care guideline for identifying, developing, and adjudicating potential custodial care claims, and (3) obtain some basic statistical data which may help intermediaries and the Social Security Administration develop a better overall picture of the medical characteristics of patients in extended care facilities. As a device for conveniently compiling the data obtained, intermediaries may want to use some type of checklist. We have, therefore, enclosed a model checklist which the intermediary may use with or without modifications. It is essential, however, that whatever form or checklist is utilized for compiling the data it be designed to facilitate meaningful review of the functional status and medical, nursing, and restorative needs of institutionalized patients.

To prepare the way for this study and to condition extended care facilities for an increase in the intensity of the intermediary's claims review activities as they relate to the custodial care exclusion, the enclosed model letter to extended care facilities has been prepared. Intermediaries should reproduce the letter as quickly as possible, send copies of it to the extended care facilities they service, and make all appropriate arrangements to conduct the study. While it is recognized that the selection of the sample, the arrangements that have to be made with the facilities, and the tabulation of the data obtained will take time it is imperative that the study be conducted as promptly as possible if we are to achieve all the objectives for which it is intended. We are, therefore, establishing October 31 as the date for completion of the study. Upon completion of the study the intermediary should submit to the regional office a brief report evaluating the effectiveness of the custodial care guidelines, the degree of understanding among extended care facility administrators and physicians of the custodial care exclusion, and the data obtained on the medical characteristics of patients. This report should be forwarded no later than November 30.

THOMAS M. TIERNEY,
Director, Bureau of Health Insurance.

MODEL LETTER FOR EXTENDED CARE FACILITIES

Dear ———: As you are aware, section 1862(a)(9) of the Social Security Act prohibits payment being made under the medicare program for custodial care. For medicare purposes custodial care has been defined as that type of care which is designed essentially to assist an individual in meeting his activities of daily living—i.e., services which constitute personal care such as help in walking and getting in and out of bed, assistance in bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication which can usually be self-administered—and which does not entail or require the continuing attention of trained medical or paramedical personnel. To insure that the medicare program is not paying for such care, the Social Security Administration has recently established and issued definitive guidelines to be used by intermediaries in identifying, documenting, and adjudicating cases which appear to involve custodial care. How effective these guidelines will be in achieving their purpose

will, of course, depend in large measure on whether they represent a reasonable approach to the application of the custodial care exclusion.

(For the second and third paragraphs of this letter, the intermediary after having decided how many extended care facilities are to participate in the study should select from the two alternatives set out below the one that is most appropriate.)

1. (To be used if study will involve all extended care facilities being served by the intermediary.)

Recognizing this, the Social Security Administration has asked us to conduct a study of the medical characteristics of patients in the extended care facilities that we are serving. During the study a small sampling of cases will be selected for review. In order to elicit the data needed to conduct this study it will be essential for our visiting team to have access to all appropriate patient records pertaining to the selected cases.

Members of our staff will be in touch with you shortly to discuss the arrangements for conducting the study and to fix a date for the study itself.

2. (To be used if the study will include less than all extended care facilities served by the intermediary.)

Recognizing this, the Social Security Administration has asked us to conduct a study of the medical characteristics of patients in extended care facilities. The institutions to be included in the study will be selected on a random basis. No inference is intended, therefore, that the selection of a facility is in any way related to the manner in which it has applied the custodial care exclusion.

Members of our staff will be in touch shortly with those institutions selected to participate in the study to discuss arrangements for conducting the study and to fix a date for the study itself.

DETERMINING LEVEL OF CARE CHECKLIST

(SUMMARY OF MEDICAL CHARACTERISTICS)

Patient's Name _____
Claim Number _____

1. Significant Admission Diagnoses:

_____
_____
_____

2. Significant Current Diagnoses:

_____
_____
_____

	Check	Comments
3. Mobility: Completely bedridden		
Up in chair only		
Ambulates with help		
Independent ambulation, level		
Independent stairs		
Independent wheelchair		
4. Feeding: Nasogastric tube		
Needs to be fed		
Able to feed self		
5. Elimination: Indwelling Foley or suprapubic		
Ileostomy or colostomy B and/or B		
Totally incontinent B and/or B		
Occasionally incontinent B and/or B		
Continent		

	Check	Comments
6. Personal care: Help in dressing: Minimal		
Major		
Help in bathing: Minimal		
Major		
Help with other personal care		
Independent in personal care		
7. Special treatments or devices: Tracheostomy and/or suction		
Oxygen therapy		
IV fluids		
Regular BP's or TPR's		
Special positioning or skin care		
Soaks or special dressings		
None		
8. Medications and diet: Supervised medications		
Complex or special diet		
No special diet		
9. Special disabilities: Nearly or totally blind		
Minimal cardiopulmonary reserve		
Uncontrolled symptoms.		
Severe debilitation		
Terminal illness		
Decubiti, ulcers, or fistulas		
Amputation: Upper: One ..... Both		
Lower: One ..... Both		
None of above		
10. Mental and behavior problems: Unconscious		
Conscious but unable to communicate needs		
Aberrant behavior		
Confusion: Mild		
Severe		
None		
11. Restorative and other services: Physical therapy		
Occupational therapy		
Speech therapy		
Diagnostic services		
12. Conclusion concerning level of care required: Custodial care only		
Covered care		

Senator HARTKE. The next witness we will hear will be Mr. John F. Nagle, chief of the Washington office of the National Federation of the Blind.

Good morning, Mr. Nagle. It is always a pleasure to have you with us and we will be pleased to hear your statement.

STATEMENT OF JOHN F. NAGLE, CHIEF, WASHINGTON OFFICE, NATIONAL FEDERATION OF THE BLIND

Mr. NAGLE. Thank you, Senator. My name is John F. Nagle, Mr. Chairman and members of the committee, and I am chief of the Washington office of the National Federation of the Blind. My address is 1908 Q Street NW., Washington, D.C. 20009.

I am appearing here, today, Mr. Chairman, to express the views of the National Federation of the Blind with reference to certain proposals contained in H.R. 12080, the social security amending bill of 1967.

Specifically, Mr. Chairman, we object most strenously to section 140 of the pending bill, which would establish an advisory council to study the inclusion of disability insurance beneficiaries in the medicare program.

We ask this committee to reject this proposed study, and to adopt, instead, section 125 of H.R. 5710, which recognizes that disabled persons, just as do elderly persons, have a need for and should receive medical and hospital care as an earned right, rather than continue dependent for such care upon the limited or grudging generosity of relatives or the meager or stigmatizing generosity of public and private charity.

We assure this committee that, to the disabled men and women who receive disability insurance benefits, the social insurance-medicare way is, by far, the preferable way.

The National Federation of the Blind strongly protests against the age-50 eligibility qualification contained in section 104 of H.R. 12080, which would provide social security payments for disabled widows and widowers.

Mr. Chairman, are such persons any less in need of this help when they are 49, or 39, or 29?

We certainly think not.

If this proposal is to be of value in the lives of disabled people, then benefits must be available at the time a supporting spouse dies, whatever the age of the surviving wife or husband.

We urge this committee, therefore, to remove the 50-year-age requirement in section 104 of H.R. 12080.

Mr. Chairman, just as the National Federation of the Blind supported the action of a previous Congress, which recognized the special handicapping problems of persons 72 and over, and made it possible for such persons to qualify for social security payments, even though they failed to work long enough, or even failed to work at all, in covered work—just as we supported this action, Mr. Chairman, the National Federation of the Blind now supports section 102 of H.R. 12080, which raises the level of payments to this category of social security beneficiaries.

We ask this committee to also recognize the special handicapping problems of blind persons, and to liberalize the disability insurance law in order that disability benefits may be available to them to reduce the economic and social disadvantages of blindness in an economy, in a society, geared to sight.

For this purpose, we offer as an amendment to the pending bill S. 1681, a bill introduced by Senator Vance Hartke and cosponsored by 57 Members of the Senate, including eight members of the Committee on Finance.

S. 1681 is identical to bills which were adopted by the Senate in previous Congresses—in 1964, when offered by the then Senator Hubert Humphrey, our measure was approved by a voice vote without a dissenting vote; in 1965, when offered by Senator Hartke, our measure was approved by a rollcall vote of 78 to 11.

It is our earnest hope that with this history of Senate approval of our disability insurance for the blind bill, and with the number of cosponsoring Senators of S. 1681 in this Congress as a conclusive indication of continuing overwhelming support of our measure in the Senate, that this committee will adopt S. 1681 and incorporate it into the provisions of H.R. 12080.

S. 1681 would make it possible for a person who meets the generally accepted definition of blindness and visual loss, and who has worked at least six quarters in covered work, to draw disability insurance payments so long as he remains blind and irrespective of his earnings.

Under existing law, a person must work in social security-covered employment for at least 20 quarters to establish eligibility for disability insurance payments.

We ask you to approve S. 1681, to reduce this requirement to six quarters, in order that benefits under the disability insurance program may be more readily available to more persons when blindness occurs, in order that blind persons, unable to meet the present requirement of employment for 5 years in covered work may be able to qualify under the disability insurance program.

Under existing law and practice, persons who are disabled by blindness and earn anything but the meagerest income are denied disability payments—they are considered insufficiently disabled and, therefore, ineligible for such payments.

Under existing law and regulations, it is not enough that a person is severely disabled, that he is unable to get a job because he is disabled, to qualify for disability insurance payments.

We ask you to change this, to allow persons who are disabled by blindness to qualify for disability benefits upon proof of blindness, and to continue qualified so long as they remain blind, to continue qualified to receive payments even though they are earning, in order that disability payments may be available to them to offset the extra, the "equalizing" expenses incurred in living and competing without sight with sighted men.

Mr. Chairman, the object of S. 1681 is to make of the disability insurance program a true insurance program for blind people, a program that would provide regular income to reduce the economic consequences of blindness, to provide a source of funds that can be used by the blind to buy sight, for whether they are housewives, piano tuners, teachers, or vending stand operators, they must hire sight, they cannot function at all without it.

S. 1681 would condition the right to receive disability payments, and the right to continue to receive them, upon the existence and the continuing existence of a severe visual loss.

Our amending proposal recognizes that the most disastrous of all the consequences of blindness in a person's life is not the physical deprivation of sight, but rather, the severest loss sustained is the economic disaster, the economic handicaps which are a consequence of blindness.

It is these consequences—the abrupt termination of weekly wages, the diminished earning power, the drastically curtailed employment opportunities—these, and not the physical absence of sight, which convert the physical disability of blindness into the economic handicap of blindness.

S. 1681 would provide a partial solution to the financial catastrophe which results from blindness.

It would provide a floor of minimum financial security for those who must learn to live again, to live without sight.

S. 1681 would reduce the competitive disadvantages of sightlessness encountered by employable and employed blind persons.

We ask this committee, therefore, to approve S. 1681, to liberalize the disability insurance law for the benefit of blind persons, as equalizing assistance to them.

Finally, Mr. Chairman, the National Federation of the Blind endorses and urges committee acceptance of section 101 of H.R. 12080, which would raise the level of social security payments to a point where a more adequate standard of living would be possible for retired and disabled beneficiaries and their dependents.

Even though such persons now receive the maximum allowable amount, they still have a great need for the proposed increase of 12½ percent in their payments to be better able to meet always rising living costs.

And persons receiving only the minimum monthly payment of $44 certainly have even a greater need for the increase provided for in this section of the pending bill.

But, Mr. Chairman, if it is the wish of Congress that the proposed increases in social security payments actually be received by the beneficiaries, actually be available to them as additional monthly income, then H.R. 12080 must be amended to make sure that this happens, to make sure that persons receiving public assistance along with their social security checks actually receive the increases as added income, to make sure that they are not absorbed by State and local treasuries.

Since the founding of the National Federation of the Blind in 1940, Mr. Chairman, we have worked in Congress after Congress to secure increases in social security payments.

And Congress after Congress has acted to raise the level of such payments—but, too often, the intended beneficiaries of congressional concern and generosity have not benefited at all from such ameliorative legislation.

To understand the reason for this requires an understanding of the operations of the Federal-State public assistance system:

When a person applies for aid, after consideration of various budgetary items—food, clothing, shelter, fuel, and similar necessities—a dollar amount is determined upon and his total need is established—let us say, at $80 a month.

Then available resources are ascertained—unexempt earnings, regular contributions from relatives, pensions, insurance, and other forms of fixed and regularly received income.

Social security payments, whether received because of retirement or disability, are classified as available resources.

Since public assistance is only intended as supplemental help—help provided in addition to available resources—social security payments are used to reduce the amount of public assistance grants.

Thus, the person who has an established need, according to public welfare standards, of $80 monthly and who receives the minimum social security payment of $44, will be given a $36 monthly public assistance grant.

If this same person's social security payment is raised from the present $44 to $50, as section 101 of H.R. 12080 proposes to do, this rise in social security will have no value at all for this person.

To him it will only mean that, instead of his public assistance grant being $36, it will be $30 a month.

This person, intended by Congress to be benefited by the social security increase, will not be benefited at all.

The State and county where the man lives, which provide his public assistance support, will be the only beneficiary of the congressional generosity.

Mr. Chairman, since H.R. 12080 proposes monthly payment increases for all categories of social security beneficiaries, we have inquired as to the possible number of persons who may fail to benefit at all from such proposed increase.

As of January 1967, more than half of the persons receiving old-age assistance under title I, also received retirement payments under title II of the Social Security Act—1,114,000 out of 2,084,000.

Twenty percent of the needy blind received disability insurance payments from social security—16,700 out of 83,500.

Fifteen percent of the persons receiving aid to the permanently and totally disabled also received social security-based disability insurance payments—90,000 out of 590,000.

So, Mr. Chairman, unless remedial action is taken by this committee, a substantial number of elderly, blind, and disabled persons will not be 1 cent better off from their combined social security-public assistance income, even though a rise in social security benefits is enacted into law by this Congress.

As a solution to this unfortunate probability, the National Federation of the Blind offers S. 1965 as an amendment to H.R. 12080.

S. 1965, introduced by the distinguished and able Senator Hartke, would amend title I, IV, X, XIV, and XVI of the Social Security Act so as to prevent recipients of aid under such titles from having the amount of their aid reduced because of increases in their monthly social security benefits.

S. 1965, enacted into Federal law, would assure that increases in social security payments, provided by Congress to raise the level of such payments, would be received by elderly and disabled persons, would actually be available to them as increased income.

S. 1965 would effectively protect social security payment increases from being absorbed by the intricacies of Federal-State public assistance financing; it would guarantee that the people intended by

Congress to be benefited by such increases would, in fact, be benefited, would, in fact, receive them.

Nor is the concept contained in S. 1965, of exempting certain income from consideration as an available resource when determining a person's need for public assistance, a novel and startling concept, and foreign to the experience of this committee and the Congress.

We would remind you, Mr. Chairman, that in 1965, because of your vigorous efforts and the sympathetic comprehension of this committee, in the social security amendments of that year, Congress did act as we now propose it act again—it provided that the social security benefit increase of that year might be exempt up to $5 monthly from consideration in determining a person's public assistance need.

But, Mr. Chairman, although in 1965, Congress recognized the importance of providing for the $5 monthly exemption, it failed to implement this recognition with effective legislation.

For, in 1965, it was left up to the States whether to exempt the $5 minimum increase in social security payments—and only 16 States have acted affirmatively in this matter—only 16 States have acted to exempt all or a part of the minimum increase of $5 in social security payments adopted by Congress 2 years ago.

In the 34 States which have failed to act on this, the social security payment increase of 1965 has not meant increased income for many elderly and disabled persons residing in those States.

Mr. Chairman, members of the committee, S. 1965 would do, effectively, what Congress did, ineffectively, in 1965.

S. 1965 would make sure that the proposed increase in social security payments now pending before this Congress would actually be received by social security beneficiaries, for the exemption provided for in S. 1965 would be mandatory and binding upon the States and not optional with them.

I thank you, Mr. Chairman, for allowing me to appear.

Senator HARTKE. Thank you, Mr. Nagle, for a remarkable statement and I think probably a lot of people in the room did not realize you were reading not the script as ordinary witnessess here, but that you are a blind person yourself and reading this from braille. I think it is a remarkable demonstration and excellent testimony and certainly it has been my pleasure to work with you and the federation over the years, and I want to compliment you for the high quality of your work and the sincereness of your efforts.

Mr. NAGLE. Thank you, Senator.

Senator HARTKE. Senator Curtis?

Senator CURTIS. I have a question or two, and I assure you that this is not attempting to pry into your affairs, but I just think it is of importance that the Congress know. How long have you been reading braille?

Mr. NAGLE. Let me say first, Senator, I am public property, and any question you want to ask of me, I will be happy to answer it.

Senator CURTIS. I understand that, but I wanted the record clear.

Mr. NAGLE. I lost my sight when I was 13 and I am now 52. I am not sure how many years that is, but it is a lot of years.

Senator CURTIS. Who taught you braille?

Mr. NAGLE. When I lost my sight, I was going to a sighted school. My sight became so impaired that I could no longer function in regular

sighted classes, so I was entered at the Perkins School for the Blind in Watertown, right outside of Boston. As a sighted child, I had a compulsion to read and 2 weeks after I started learning braille, I had achieved some degree of facility in it, and I have continued to read voraciously and perhaps this accounts for my ability.

Senator CURTIS. There are a number of places available to teach braille to adults who cannot return to school, too.

Mr. NAGLE. Yes. Many States maintain a system of home teachers, that is, they are skilled itinerant teachers familiar with the various techniques of assisting a blind person to function normally. These home teachers will travel about the State, will visit newly blinded people, will provide advice and assistance to parents of small children who become blind, and will also provide teaching, too, and perhaps most of all an understanding of the problems of blindness in newly blinded older people, and then teach them various skills—reading of Braille, traveling around a bit with a long cane, perhaps some handiwork such as knitting and they perform a very valuable function.

Senator CURTIS. Are those all supported by tax funds?

Mr. NAGLE. Yes, Senator. By and large, by State tax funds. These involved, the blind person involved is also a client of a vocational rehabilitation agency would the Federal Government share in the expense, the salary of that home teacher. Usually it is a State-supported program.

Senator CURTIS. Do most States have it?

Mr. NAGLE. I believe all States have it to varying degrees. My guess would be that few States totally meet all of the needs of blind people who are homebound, pretty much because the number of blind persons is increasing so rapidly among older people. And, therefore, the demands for help exceed the available people to meet their needs.

Senator CURTIS. Now, what categories of blind and what organizations are directly tied to the National Federation of Blind for which you speak today?

Mr. NAGLE. Ours is a membership organization, Senator, of blind people. We believe, that we, as blind people, possess two obligations: One, that we feel that we know more about blindness than anybody else does and we should make this knowledge generally available; and, second, we feel that we shouldn't sit back and have other people solve our problems. Therefore, we have joined together in the National Federation of the Blind. We have some 37 State organizations, and they are in varying degrees of activity, and our function is to try to solve problems of not just ourselves, but of all blind people.

One of the happy experiences I have, and continue to have in my representation of the federation here in Washington, is when a person contacts me, either by letter or by telephone, the only question I ask is whether he himself is blind and what can I do or whether the person calling is a sighted person with a friend or family member who is blind. It is not my function to say to the person, "Are you a member of the Federation?" before I can provide assistance, nor to condition any help I can give upon their joining the federation. We are concerned about helping blind people.

Senator CURTIS. I understand.

Is your membership, then, individual or organizations, or both?

Mr. NAGLE. Individuals. We operate on three levels. We have local organizations in cities, counties, in areas of a State. They are bound together into a statewide organization, and I believe in your State it is the Nebraska Association of the Blind, and then our State affiliates are members of our National Federation of the Blind.

Senator CURTIS. The babies who are born blind or the infants who become blind at a very early age have some very special problems.

Mr. NAGLE. That is right, Senator.

Senator CURTIS. Because they have no mental image of things that other people have who lose their sight at a later time, isn't that true?

Mr. NAGLE. That is right, Senator.

However, I have argued this many times with many people who have become blind. The importance of this, being able to imagine, being able to visualize when you have had sight or inability to visualize when you have not had sight, I think this, that the person who really is faced with the disaster when he is confronted with blindness is not the child who is born blind. He attends classes, he is educated as a blind child, and grows up into adulthood properly equipped to function as a blind person. Whereas, the man who is in work, already established, his education behind him, perhaps at the age of 30 or 40 or 50, who then loses his sight, this, too often, is an overwhelming disaster that he just is unable to cope with.

Senator CURTIS. Well, at what stage is their education provided, education provided for blind babies?

Mr. NAGLE. This again depends, State-to-State. For example, up in Massachusetts, we have a blind babies' nursery where children, I believe, are accepted at the age of 3 or 4. Then, through the Perkins School System, they go—can go—to kindergarten, and then the regular elementary school, junior high, and high school, and, perhaps, even remain and live there and attend college in Boston.

Now, many States do not have services, except through their home teacher services, to assist parents of children who are born blind or become blind in infancy, and this I can assure you is a tremendous dilemma to these parents.

Senator CURTIS. Is it not true that in most States it is limited to private organizations? I refer to what is done for blind babies before they are old enough to go to school?

Mr. NAGLE. That is right; that is right.

Senator CURTIS. Yes. And is it not also true that that is a very critical period in their mental development?

Mr. NAGLE. It can be. I would say the most critical period, because the parents are completely unequipped to measure up to the problems their little blind baby offers them and may compensate by waiting on the child, waiting on the child to such a degree that the child is very delayed in learning to speak, may be very retarded in ability to move about because the parents are just wanting to protect the child from being injured or falling, or bumping into things. So that, Senator, the expression, "As the twig is bent, so the tree grows," if the child is corrupted by overweaning love, by too much protection when it is a year old or 2 years old, or 3 years old, it will have just tremendous difficulties all its life trying to counteract this.

Senator CURTIS. Yes.

Now, I think the record should show, and I am sure you will agree with me, that there are many—probably not as many as there should be—but there are quite a number of privately financed programs and projects for the blind that are doing a great amount of good, and they are not based upon a level of dependence upon charity; isn't that true?

Mr. NAGLE. That is right, Senator.

Senator CURTIS. And we need those private efforts of various organizations and groups to supplement all these Government programs; is that not right?

Mr. NAGLE. That is right, Senator.

Senator CURTIS. And they deal with many special fields that are peculiar to a particular segment of our blind population; isn't that right?

Mr. NAGLE. That is right, Senator.

Senator CURTIS. One of them is the aid that a few organizations are giving to blind children not yet old enough to go to school or where there is no nursery available.

I want to ask you about one proposal here. At the present time, if a woman becomes a widow, and has some small children, she receives OASDI insurance until the last child reaches a certain age; 18, I believe?

Mr. NAGLE. Eighteen, I believe, Senator.

Senator CURTIS. And then those payments are discontinued and resumed when they can qualify at retirement age?

Mr. NAGLE. That is right, Senator.

Senator CURTIS. What the House has done, they have said, "We are going to initiate a program of paying the benefit if the widow is disabled after 50."

Now, the "after 50" in the House bill does not take away something that is now provided. Your objection to it is that it is not a sufficient start of the new program.

Mr. NAGLE. That is right, Senator. I remember how, originally, with disability insurance benefits, there was the 50-year qualification. Eventually, Congress removed that requirement so that a person who is disabled may qualify, today, at any age.

The same pattern is being followed here. But we are saying that the proposal recognizes that there is a need for the kind of assistance provided for under the disability insurance program, the kind of financial assistance when death occurs, and a supporting spouse leaves a dependent disabled widow or widower without any income.

What we are saying is that this is a disaster whenever the death occurs, whenever the supporting spouse dies, whether the disabled person is 50 years, between 50 and 65, or whether the disabled person is 25, 35, or 40.

Senator CURTIS. That is all, Mr. Chairman.

Senator RIBICOFF (presiding). Thank you very much.

For the benefit of those who are here, the next witness will be Mr. Kershner, to be followed by Mr. Doyle Elliott, who will be followed by Mr. Edelman.

We will then recess until 2:30.

So if there are witnesses under the circumstances, other witnesses listed, if there is something else you might like to do, you may feel

free to go now. But I just want to tell you we will be recessing at 1 o'clock until 2:30.

All right, Mr. Kershner, will you proceed.

STATEMENT OF LEONARD B. KERSHNER, MEMBER, LEGISLATIVE COMMITTEE, INTERNATIONAL ASSOCIATION OF FIRE FIGHTERS; ACCOMPANIED BY ALVIN DAVIS, LEGISLATIVE DIRECTOR, INTERNATIONAL ASSOCIATION OF FIRE FIGHTERS

Mr. KERSHNER. Mr. Chairman, my name is Leonard B. Kershner. I am a member of the legislative committee of the International Association of Fire Fighters, and with me is Mr. Alvin Davis, legislative director of the International Association of Fire Fighters.

I am here, Mr. Chairman, to present to the committee two statements, one very brief, the other of somewhat greater duration, by the president of our International Union, Mr. William D. Buck.

I would first like to direct the committee's attention, Mr. Chairman, to our statement on amendment 295, the Ribicoff amendment, to H.R. 12080.

The International Association of Fire Fighters, Mr. Chairman, strongly supports the social security system and we are sympathetic with and favor any effort to improve it. However, we believe that it would be inappropriate for our union to comment on specific proposals which are designed for this purpose, such as H.R. 12080, because of our commitment to the concept that firefighters should be excluded from social security coverage.

It is for this reason that we will essentially confine our remarks to those provisions of the Ribicoff amendment which are designed to establish under which circumstances and under what conditions firefighters are excluded from coverage under the insurance system.

But before we discuss these provisions, we would wish to briefly review the history and background of social security legislation as it applies to firefighters.

In 1954, when Congress made social security available to State and municipal employees, it specifically excluded firefighters and policemen who were under State or local retirement plans from coverage under the insurance system. This exclusion clause is provided for in section 218(d)(5)(A).

The International Association of Fire Fighters supported them and and continues to support exclusion for the following reasons:

1. The nature of the duties of firefighters is such that it requires retirement at a far earlier age than that provided for under social security. This work demands great physical strength, agility, coordination, stamina, and endurance. Most men begin to lose a good part of these characteristics after they reach 50, thus reducing their effectiveness on the job. Early retirement for such workers is necessary in order to maintain efficiency in the firefighting service.

By the same token, the rigors of firefighting have an increasingly damaging impact on the health of fire department members with each succeeding year after age 45. Medical science has established that advancing age and the work of firefighters frequently are the reasons why such men suffer from heart disease. In order to afford reason-

able protection to the health of the men engaged in this hazardous occupation, firefighters must be permitted to retire at an early age.

2. If social security was made available to firefighters without being accompanied by adequate safeguards to protect the integrity of their State or local retirement systems, such systems would be placed in jeopardy. When we have liberal benefits and early retirement, quite often it is only the exclusion clause which prevents municipal administrators from integrating social security with, or substituting social security for, the local retirement system.

Further, the unqualified availability of social security would serve as a bar against improving those retirement systems which do not measure up to the retirement standards required in firefighting.

Since 1954, when Congress adopted the firefighters' exclusion clause, our international union has been engaged in a continuing fight to preserve it.

Attacks against the exclusion clause have taken two forms:

The first has been attempts to simply repeal section 218(d)(5)(A) of the Social Securtiy Act.

The second involves efforts similar to that contained in H.R. 378 and H.R. 2888, which have the effect of picking us off one State at a time, by removing the States named in such bills from the exclusion clause.

Some of those who support repeal of the exclusion clause argue that the firefighters really have nothing to fear; that the referendum provisions of the Federal statute protect them against being forced under social security against their will.

Unfortunately, this theory ignores the fact that section 218(d)(6)(C) now permits 19 States to divide their retirement system so that a single fire department member can compel every future member of his department to come under social security.

In addition, the Social Security Advisory Council has recommended that this authority to divide the retirement system be extended to the remaining 31 States. The fact of the matter is that H.R. 12080 would make Illinois the 20th State which would have the authority to divide its retirement system, or systems.

If the exclusion clause was eliminated, Mr. Chairman, and the authority to divide the retirement system is extended to all 50 States, social security will be forced on every fire department in this Nation, in spite of the fact that the overwhelming majority of department members are opposed to it.

In the past, we have devoted most of our efforts in this area toward resisting any attempt to repeal the exclusion clause. The International Association of Fire Fighters now believes that the time has come to take a more positive approach to the problem. We are of the opinion that the Ribicoff amendment provides for just such an approach by having the exclusion clause remain in force, except that the insurance system may be made available to firefighters in any State which has a statute requiring that said insurance system shall be a supplement and addition to the State or local retirement system covering such firefighters.

In part, this proposal is in response to those who have argued that a firefighter's local retirement system cannot be weakened or impaired through the imposition of social security. As evidence of this, they

point to the declaration of policy by the Congress which states that such retirement systems shall not be impaired as the result of, or in anticipation of, an agreement which extends social security to State or municipal employees.

Unfortunately, this declaration has no legal effect on States or municipalities. Therefore, in order to make absolutely certain that the intent of this declaration is fulfilled with respect to firefighters, the Ribicoff amendment provides that the only terms under which social security can be made available to such employees is as a supplement and an addition to their own retirement system.

This does not prevent a State or municipality from changing the retirement systems of its firefighters. Instead, it means that they may not integrate social security with, or substitute social security for, the local retirement system. In other words, social security cannot be used as a device through which a municipality might escape from its pension obligations to its firefighters, but it may be made available to such firefighters where the State law protects the integrity of their State or local retirement system.

The Ribicoff amendment also provides that social security cannot be made available to firemen unless it is approved by a majority of the firemen in the retirement system. Voting in such a referendum would be limited to firemen. In the absence of such a provision, other State or municipal employees, who have retirement needs which are different than that of firemen, might be able to participate in the referendum, and to make determinations which are in conflict with the desires and wishes of such firemen.

The Ribicoff amendment further protects the retirement system of firemen to the extent that social security will not be made available where any such system, in effect on the effective date of this proposed amendment, or in effect 3 years prior to a referendum, is diminished or impaired.

Last, the amendment would remove firemen from the section of the Social Security Act, 218(d)(6)(C), which now permits certain States to conduct a referendum on a divided vote basis. Again, under this arrangement, a single fireman could bring social security to an entire fire department, even though the remainder of the department voted to be excluded.

We have had an extensive exchange of correspondence with the Social Security Administration concerning this proposal. It would appear that their opposition to the amendment has narrowed down to their claim that "this proposal would, by limiting the manner in which States or localities could adjust protection afforded by their retirement systems to take into account social security coverage, amount to an unwarranted interference with the States and localities in their relationships with their employees."

We respectfully submit that the reverse is true. If social security was made available to firefighters without adequate safeguards to protect the integrity of their State or local retirement systems, it—social security—would be used as a device by municipal employers to weaken or impair such retirement systems, and would thereby constitute an unwarranted intrusion on the part of the Federal Government into the relationships between firefighters and their employers.

We are convinced that the adoption of the Ribicoff amendment would prevent such an intrusion, and would solve a longstanding problem.

Senator RIBICOFF. Thank you, Mr. Kershner.

Mr. Kershner, how many people are involved in the International Association of Fire Fighters; how many people are covered?

Mr. KERSHNER. We have 129,000 members in the United States and Canada. A little better than 100,000 are in the United States, and 29,000, about, in Canada.

Senator RIBICOFF. Do you cover, or do you represent, all firefighters, or are there more than those members?

Mr. KERSHNER. We represent better than 90 percent of the professional firefighters in the United States.

Senator RIBICOFF. Thank you very much.

Since I have introduced the amendment, I have no questions to ask.

Mr. KERSHNER. Mr. Chairman, we have one brief, half-page, statement to make on another matter that was raised by the President's recommendations on tax relief for the elderly. Unfortunately, the House did not act on it, and we are hoping that the Senate will consider some measure of tax relief and, very briefly, I would like to read to you a statement by our international president on this point.

Senator RIBICOFF. Proceed.

Mr. KERSHNER. The purpose of the retirement income tax credit of 1954 was to equalize the tax treatment of those who have retirement income from sources other than social security or railroad retirement, with those whose source of retirement income is social security or railroad retirement.

Unfortunately, this tax credit no longer fulfills the purpose for which it was established. The maximum amount of retirement income to which the tax credit is applied has not been increased since 1964, when, incidentally, you, Mr. Chairman, introduced an amendment on this point, and it has not kept pace with the maximum benefits payable under social security which are tax free.

On September 12, 1967, which is tomorrow, Mr. Ernest Giddings, representing the National Conference on Public Employee Retirement Systems, and Mr. Rex T. Wrye of the National Education Association, will testify before your honorable committee on the retirement income tax credit. It is our understanding that they will recommend legislation which will cause the maximum amount of retirement income to which the tax credit is applied to be increased so that it conforms to the maximum benefits which will be payable this year under Social Security Amendments of 1967.

The International Association of Fire Fighters, AFL-CIO, takes this opportunity to join with, subscribe to, and support the statements and recommendations which will be made in behalf of the National Conference on Public Employee Retirement Systems and the National Education Association on the matter of the retirement income tax credit.

Senator RIBICOFF. Thank you very much.

Mr. Elliott, please.

STATEMENT OF JOHN DOYLE ELLIOTT, SECRETARY OF THE TOWNSEND FOUNDATION

Mr. ELLIOTT. I am John Doyle Elliott, secretary of the Townsend Foundation, founded by the late Dr. Francis Everett Townsend. I appear as economic consultant and as national lobbyist on behalf of the clubs, committees, councils, and other State congressional district and local entities endorsing and supporting the principles and purposes of the foundation.

We endorse H.R. 12080 and, more enthusiastically, H.R. 5710, for their humane intentions and as far as they go.

We feel they hardly move very far, because the proposed increases in minimum and lower benefits will simply and generally be deducted by the States from public assistance payments on which most minimum and lower beneficiaries are dependent. They will not fulfill the President's hope for "the greatest improvement in the living standards of the elderly since social security was enacted."

Not the poor people, but the local and States' welfare budgets will receive the aid. Tragically, those who should receive the most improvement will actually end up with virtually none.

There is one thing only which can abridge this defeat of good intentions, and it is minimum benefits for all the people under title II high enough to preclude all need for public assistance except in very unusual and extreme cases. This would cost not a penny more except where States and local authorities are not meeting even their own standards of need.

There follow our basic recommendations to make the most of the limited benefit potential of our present system.

First, enact a presumed average wage in covered employment for every American man or woman, whether they have technically engaged in covered employment or not, said presumed wage to be sufficient to qualify each individual man, or woman, for a benefit of $125 a month.

Escalate benefits in step with advances in per capita income, not merely cost-of-living changes.

Per capita income precisely reflects all changes in all factors of cost and of standards.

Then, let us institute a new levy upon the gross receipts of all persons and companies, all business, personal, corporate, or otherwise, at the rate of 1 percent. Business satistics show this broadest of all possible tax-bases now approaching the level of some $3 trillion a year—trillion, not billion.

With these three basic recommendations instituted, eliminate the $50 and $40 and any other deductibles that are proposed in health insurance for the elderly.

Then eliminate the time limits on hospitalization, no 90-day, 120-day, or 180-day, or any other limitations. The longer and permanent cases are the very ones which should be most fully insured because they are the economically most catastrophic. They are the ones which most disasterously devour the resources and impoverish persons and families. They are the ones that counteract health gains by imposing punishing economic damage.

Extend the health insurance coverage and benefits to the disabled and all benefit-categories under social security.

Mr. Chairman, unless the foregoing recommendations are genuinely instituted, we feel sure the present system of social security is not going to contribute to victory in any war on poverty. Rather, it is going to continue foredooming any such effort and crusade to futility.

We feel that history is now forging a new demand for a new concept of justice. Domestic turmoil, violence, rises, history will write, in our opinion, from the very injustices which can only be corrected by the building in this country of a great, national, poverty-barring, retirement and disability pension-system, the benefits of which will be sufficient to protect from poverty persons having no other resources.

Where are going to come the jobs for those now building and maintaining the planes flying in Vietnam, the bombs dropping in Vietnam, and all the rest of it? Where are the jobs for all the Americans who do not die there but come back?

Look at our poverty program. We are constantly "going to" teach legions of inexcusably unschooled youths skills to hold jobs. What jobs, if we continue compelling an ever-larger part of our adult population, our elderly, to live constantly longer years of life impoverished and unable to buy, unable to employ; and to what end employing them if they, too, are to end up retired in poverty?

Our slums are to be replaced with new housing and rebuilt communities. On this morning's radio news, I heard a $200-billion estimate of urban renewal. To what end, unless the people living in them have the money, the income, to buy or rent them?

Unless we get real social security, poverty-barring social security, for the ever-increasing millions inevitably to be dependent on it, new slums are going to develop faster than we can tear out and replace the old ones. They are going to develop for the same reasons the old ones did: too many people unable financially to buy, rent, and live decently.

The same thing is true for real employment. Unless we stop allowing the attainment of old age, disablements, automational displacement of jobs and workers through the devices of science, unless we can prevent such things destroying people's buying power, their license to live, we will continue to create unemployment and unemployability more rapidly than we create work, until justified rage may well bury our glories in civil strife.

History is demanding problem-solving answers, not more evading substitutes.

We must stop spending our wealth and history's gift of time on stingy, prejudiced, unworkable substitutes and put into operation the great, national pension-system capable of barring poverty from the lives of those who have no other resource; an honest and just prosperity, only possible through the principle of the great, national pension embodied in H.R. 5930, attached to my written statement submitted.

Now, as final background, the Census Bureau's annual surveys and current population reports dealing with the distribution of money-income by age and sex groups show that in 1947 those over 65 had only 34½ percent of the money-income dollar as compared to those from 25 up through 64.

In 1965, however, this had dropped down to 30½ percent. We have not gained ground in all these years through the policies and programs we have been following and putting up.

In 1965—and this is the gist of the problem up to date, the real problem—in 1965, men over 65 had a median income of only $2,116, which was $3,247 less than men aged 55 to 64.

Women only had an average income, a median income, of $984, but it was $1,135 less than women aged 55 to 64. This is the gap that has to be filled.

Any efforts to abolish poverty in this wonderful country of ours are going to fail unless that gap is filled, there in those areas; and nothing short of the great, national pension which, in the absence of any other resource adhering to the individual, will bar poverty from the life of that individual; nothing else, or less, we sincerely submit, is ever going to fill that gap and do that job.

Thank you very much.

Senator RIBICOFF. Thank you very much for coming here.

(The prepared statement of Mr. Elliott follows:)

STATEMENT OF JOHN DOYLE ELLIOTT, SECRETARY OF THE TOWNSEND FOUNDATION, ECONOMIC CONSULTANT AND NATIONAL PENSION LOBBYIST

Mr. Chairman, I am John Doyle Elliott, of 5500 Quincy St., Hyattsville, Maryland, Secretary of the Townsend Foundation, founded by the late Dr. Francis Everett Townsend. I appear as economic consultant and as national lobbyist on behalf of the clubs, committees, councils and other State, Congressional District and local entities indorsing and supporting the principles and purposes of the Foundation and my work towards implementing those principles and purposes.

Specific legislation, namely H.R. 5930, embodies and defines the ways and means, authorities, duties and responsibilities properly involved in their implementation.

In 1953 and early 1954—after the House had acted on Social Security Amendments—I presented Senators a list of recommendations, relevant within the framework of the present system of social security and the bill of amendments, designed to realize this system's full potential in terms of providing Social Security benefits for the American people.

The final result was an amendment by the Senate (agreed to by the House) directing the Department to study the feasibility of minimum benefits of $55, $80 and $75 a month—with the purpose of substantially eliminating public assistance, except in unusual, special, or extreme cases.

In 1955, Congress received the Department's report. It admonished that such minimum benefits would entail payroll taxes so high as to endanger continued public acceptance of the system. I have always felt that report contained either insincere, or incompetent areas, Mr. Chairman, because the President, in H.R. 5710 and a parade of others now propose benefits be raised from $44 (unthinkable penury) to $70 and $90 and $100 a month. It certainly is clear leadership has repudiated the Department's 1955 admonition.

Therefore, I now re-introduce those basic recommendations, up-dated to realize the present system's full potential in terms of providing benefits—and in terms of emancipating Americans from the discriminations inherent in public assistance—so that ALL Americans have equal treatment as well as theoretical justice, under law!

Therefore, we indorse H.R. 12080—and, more enthusiastically, H.R. 5710—for their humane intentions—and as far as they go. However, Mr. Chairman, we feel that neither bill moves very far towards realizing President Johnson's commendable hope for "the greatest improvement in the living standards of the elderly since Social Security was enacted." Towards any such aim they are both feeble feints.

They hardly "move"—because the proposed increases in minimum and lower benefits will simply and generally be deducted by the States from public assistance payments, on which most minimum and lower beneficiaries are dependent.

Not the poor people—but local and States' welfare budgets will receive the aid! An ironic frustration (utterly to be foreseen because of repeated experiences in the past)—ironic frustration will mock the humane hopes and good intentions of Congress again.

Tragically, those who should receive the most improvement will actually end up with virtually none at all.

The only thing which can abridge this defeat of good intentions, ever, is minimum benefits, for all the people, under Title II, high enough to preclude all need for public assistance—except in unusual and extreme cases. It would cost not a penny more—except where States are not meeting but neglecting need.

There follow the basic recommendations necessary to make the most of the limited (at best) benefit-potential of the present system. First, enact a "presumed average wage in Covered employment" for every American man or woman (whether they've engaged at all in technically "covered" employment, or not)—said "presumed" wage to be sufficient to qualify each such individual man or woman for a benefit of $125 a month.

Such a minimum benefit, automatically attached, as a matter of right, to each person will end public assistance, except in rare and unusual instances of abnormal need.

Next have escalating benefits in step with advances in per capita income. More cost-of-living advances contemplated limitedly in H.R. 57100 ignore advancing standards of living—ignore all other factors of participation in up-to-date quality of life.

Per Capita Income precisely reflects and measures, in current dollars, changes in all factors of cost and of standards. It's the right reference, the complete reference for the purposes of preventing benefits from lagging behind the various changes induced by our continuing progress.

If any Member really examines the implications of these two recommendations, their invaluable desirability and wisdom will be self-evident, I sincerely believe. To finance them, let us have no more escalation of payroll and self-employment tax-rates and no more raising of ceilings to which these taxes apply. Further, let us set aside the ridiculous notion of tapping general revenue (progressive income and corporation taxes, already involving categories taxed at way over 50 percent), involving sky rocketting rates on some people for benefits to others.

Instead, let us institute a new levy upon the gross receipts (gross income) of all persons and companies, at the rate of one (1) per cent. Business statistics show this broadest of all possible tax-bases approaching the level of $3 trillion (not billion) a year. Theoretically, a 1% rate would create a new money-authorization throughout our entire economy of some $30 billion a year. In any event, short experience would unanswerably establish the revenue-productivity of this broadest of all possible tax-bases and smallest of all possible tax-rates (for any given revenue).

Assuming those three basic recommendations instituted, there are other collateral recommendations we believe to be completely essential to our best prosperity. First, eliminate the $50 and $40 deductibles in the health insurance for the elderly programs. Causing a single American to become subject to the discriminations inherent in public assistance and to its indignities far outweighs the theoretical merits of such deductibles!

Then, eliminate all time limits on hospitalization (no 90-day, 120-day, 180-day, or any other limitations). The longer and permanent cases are the very ones which should be most fully insured—because they are the economically most catastrophic. They are the ones which most disastrously devour the resources and impoverish persons and families—counteracting health gains by punishing economic damage.

Extend the same health insurance benefits to the disabled and all other benefit categories under Social Security. Do these things and President Johnson's hopes and expectations will be significantly realized, not mired in the discriminations and humiliations of public assistance.

Mr. Chairman, unless the foregoing recommendations are genuinely instituted, the present system of social security will not contribute to victory in any war on poverty. Rather, without at least the foregoing, it will continue foredooming any such crusade to futility!

Mr. Chairman, in opposite vein, we sharply disagree with the proposal in H.R. 5710 for Social Security benefits based upon wage, salary and self-employed incomes of $10,000 and $15,000 a year. To propose that the Government (which

means the public, poor as well as rich) match the contributions for buying retirement bonds to give prosperous $10,000 and $15,000 a year people magnificent benefits, under the present system, while most of the people endure benefits dictating punishing penury—such a proposal seems to us simply outrageous!

How often have I heard Members of Congress express fears of "inflation"—how often noted columnists, too, Mr. Chairman—fears of "inflation" when modest benefits have been proposed for the poor. How often have I heard them agasp, in near panic at people "wanting to live off of the Government."

Now, we have the proposition that not the poor, or the people in general, but the prosperous have the Government pay half the buying price of bonds for their retirement. Have the public purse "match" their Social Security taxes.

It's ridiculous and outrageous—especially in the face of the fact such prosperous earners are not the reason we have a social security problem. Rather, we have the problem because of the people whose economic fortunes have been slim, or, however they may have prospered at various stages of life, because of people who've found their later years impoverished from many causes.

What we need, in the name of Social Security benefits, Mr. Chairman is—first and before all other things—benefits which will bar poverty from the lives of Americans who find themselves with no resource other than their Social Security benefits. We need the existence of that protection for every American—if he encounters the hazards and stress of poverty.

What we don't need is a 50 percent public subsidy of special financial support for the affluent!

What we need is a prosperity-insuring, poverty-barring pension supported by all and protecting all—alike, Mr. Chairman.

Frankly, I'm dumfounded to witness this would-be raid on Social Security by people who have every opportunity and means to be and remain free from poverty—while the poor languish.

Let the $10,000, the $15,000 people have their stake in Social Security like everybody else. But, to the extent that they supplement the basic social security system and its benefits, let them pay the whole price for such bonds etc. Let's hear no more about the public purse half-paying for retirement and other Social Security benefits for the well-to-do—while we still have people around here talking about the majority of Americans and the ungifted, unfortunate, handicapped and poor "having Social Security benefits" of $70 to $100 a month as "cornerstones" upon which they (the poor) may "build" funds for their old age!! Let's belay that kind of thing.

That outlandish proposal should die right now, once and for all.

Now, I wish to turn to the Pay-As-You-Go Social Security and Prosperity Insurance Act, embodied in H.R. 5930, introduced by Rep. John J. McFall the day after the introduction of H.R. 5710, Mr. Chairman, embodying the President's proposals.

This is a program for "happiness and freedom successfully pursued"—beyond present envisioning. It reaches, in its potential and purpose and ability, far, far beyond the utmost possible under the present system.

Mr. Chairman, the War on Poverty—which can only mean, sincerely, a crusade to abolish poverty from human life—*absolutely requires this Pay-As-You-Go Social Security and Prosperity Insurance Act.*

Victory in this war demands, can't come, unless the things provided for in this Bill are done—not partially, or even largely—but completely. To the extent they are not done poverty will remain. In this light, colored by the fact our present system, at best, can only finance a relatively feeble displacement (not abolition) of poverty—in this light I beseech the Committee and the Congress to study this Bill. The time available now to describe it is very inadequate; but here's the attempt.

Census Bureau's yearly surveys on Consumer Income distribution (Current Population Reports, Series P-60) show persons 65 and over command *less than a third* the income of younger adults aged 25 all the way up through 64.

That's fact—and p-o-v-e-r-t-y! Furthermore, way back in 1947, just after World War II, the ratio between the two groups was 34.5 cents to the dollar; and in 1965 it had actually slipped to 30.5 cents for the oldster compared to $1.00 for the younger adult.

All the maze of things so far done, publicly and privately, have barely kept the economic position of the elderly from worsening—let alone failing to improve.

While benefiting a fragment here and there, all of it combined reveals absolutely no possibility of any achievement which can be a contribution of significance to the War on Poverty.

There is only one thing which can ever allow and lead to abolition of poverty in the retirement years of life (a constantly lengthening part of a life for more and more people)—and that thing is the national pension for every person alike, as defined and provided in this Bill, sufficient, *in the absence of any other resource*, to bar poverty. As long as it's lacking, a vast poverty will continue—a vast, deep poverty—no matter what else may be done or accomplished.

Nothing else, or less will eliminate the basic problem of our people in their elder years, namely their loss of money-income, *the very license to live*.

Other problems of age and hopeless of solution and the best achievements against them blighted, cancelled, so long as economic inferiority, the indignity of failure, exile from participation in the up-to-date standards of life and living exist even noticeably, down-grading the position of the elderly, corroding their self-respect and their confidence in themselves and our society.

All other prosperities must pale in significance and worth, unless real, up-to-date participation in all phases of life and the benefits of our magic economy crown the final years of life.

H.R. 5930 rests squarely upon the doctrine that our superior prosperity (our high income, tax-base and plenty of capable taxpayers)—this enables us to afford a Viet Nam. An impoverished giant like India can't even think of such an undertaking at all.

It isn't like the World Wars—in which we could convert every resource to the fight, forgetting all other things, quickly crush the foe, then revert to peace. This is a long-term thing, with other such tasks to follow Viet Nam in honor of our promises to mankind to lead them to freedom with justice.

We must perfect our human prosperity to the fullest—because upon it depends everything else. Upon good human health—human prosperity—human education and acquiring of wisdom—upon these things we can't spend too much money, time, labor, or anything else. These things are not "inflationary" or anything else detrimental; rather, they are the very essence of sound, stable, just and enduring human society and freedom—of justice, "happiness successfully pursued."

In short, neglect our *butter* and we'll soon be *gunless!*

Ever-rising prosperity is the might with which we've succeeded. It's the might (if we can amplify it to the future's requirements) to triumph in this new kind of war; and without which we'll fail. With it must rise an ever-clearer symphony of human progress—an unanswerable harmony of social justice, "happiness and freedom successfully pursued."

Today, our leadership is bogged down in the *fallacy* of "butter or guns"—that domestic welfare and progress must give way to finance Viet Nam. No! No! That way lie more and more savage riots in our streets—spreading weakness, material and spiritual, *failure*.

That way—stupidly—we'll fail and never get the chance to face the glorious challenges success in Viet Nam will create. We'll lose the race in space. Our pacesetting of mankind's progress will falter, slip our grip, if we don't perfect to the fullest just, human prosperity, true wealth in the eyes of God and mankind, throughout our own national house.

Mr. Chairman, H.R. 5930 will perfect our prosperity by abolishing unjust poverty, by pension-finance where no other thing can do the job. It is essential to our ability to fulfill our promise to mankind; in the end, even to mankind's survival—for if WE can't achieve freedom with justice, who else can so much as hope?

The fallacy of "butter or guns" will betray us, our country and our children—the principle, "The better our butter, the greater our guns"—that alone can supply the moral and material power for the real victory—the real victory.

Under H.R. 5930, disability is the next hazard of life which must be accorded the same immunity against poverty. First are those forms of disability rising from sickness, injuries of mind and body. In Section 230 (10) and (11), this Bill positively defines disability and impoverishment in terms conclusively immunizing Americans from the honestly preventable miseries and damages of such events.

When the events of various disabilities overtake people, they must be insured against poverty in just the same terms as under old-age retirement, for they are certainly retired.

Now, a new category of human misery, misfortune and poverty is recognized in this Bill. It is the wrongful, unjust occupational retirement, disablement of our people by technological progress eliminating their occupations.

When our technological progress renders somebody's occupation no longer needed, *hence unworthy of hire* (sometimes entire skills, or trades, or industries, like coal mining, for example)—those people are *retired*. Make no mistake about it.

There is no such thing as really comprehending the hurts, miseries and losses this kind of thing has visited—and continues unabated to visit upon Americans. What else is really behind the riots none of us would believed possible a few years ago? The blacks aren't blacker—the whites aren't whiter—the summers were just as hot years ago! No, the difference is the *accumulation* of this technological displacement of labor and its requirement of experience, knowledge these people lack. H.R. 5930 faces up to this evil injustice and provides the only answer, too.

Therefore, in Section 205 (d), with such people insulated from poverty by the same benefits as those of old age and disability, H.R. 5930 provides for their rehabilitation, obligating them to cooperate completely towards their qualification for existing and available occupation—*an end to their wrongful retirement.*

Mr. Chairman, technological progress, our gaining of mastery over ever newer and more effective means and tools for producing wealth—*this never should have injured anybody.* Directly, or indirectly, it should have benefited everybody. Yet, legions of people have been unjustly ruined, wronged beyond description by it.

It is time for an end to this awful and defenseless injustice. And, just because it has been going on for generations, there's no excuse, no good reason for its continuance. In fact, the greediness underlying and causing the wrong, so far and for so long done, that sinfulness must cease in a hurry, by every right and honor. That greedy sinfulness is our greatest danger in this world and this life.

Another vital problem's real and whole solution is provided for through the pension principle of H.R. 5930. It provides that all students aged 18 to 25—so long as they are occupied in full-course, educational, or vocational training and so long as they properly achieve advancement in such pursuits—shall be eligible for the same benefit as disabled and old-age retirees.

Year after year, there is dinned into us the admonition that we are failing to provide the advanced education we should; that we are not producing the educated and trained people we should. Well, let's have an end to that, so far as economic obstacles to the family and the individual are concerned. H.R. 5930 specifically does so. That the pension for these persons will represent a lot of money is certainly true—a lot of money—but, it's far more than offset, profitably in the highest possible sense, once under way, by two factors:

1) It will cost no more, probably less, to educate a person this way than to do it in any other financial manner—if you really do educate him;

2) No investment in the future could possibly be a better one for the individual and/or for society.

This provision will guarantee that nevermore will we have youth who do not achieve the education, training, *for the successful pursuit of happiness and freedom,* God gave them the ability to acquire and the character to desire.

As in eliminating poverty from the later years of life, insuring people from poverty and ruin by disability, enabling them to recover prosperously from technological and automational displacement—only this uniform, national pension, accruing to every person as an unalienable right, only this pension can secure proper education for all.

It's high time to face this truth. The last thirty years have amply demonstrated the futility of the alternatives, all of which are based on the old *age-of-scarcity* concepts of policy and viewpoint. If those old ideas could handle the problems, *we would never have had them, in the first place,* Mr. Chairman.

The amount of the proposed pension: At today's economic levels, standards and costs, prices, were this program in effect now, it would be providing a basic benefit of just about the dollar-value Congress has recently put on the Federal Minimum Wage—$1.60 an hour. On the basis of a regular, 40-hour week, that's about *$260 a month.*

That is Congress' up-to-date judgment as to the minimum compensation, *per individual human being* (not family, or couple), in return for which we can decently employ, or make use for our own ends or profit of the life of another person. The minimum, measured in today's dollars.

The crossing of a birthday line, like 60, or 65 years, becoming disabled or a dependent-burdened mother of children, technologically divorced from employment, economically unable to acquire appropriate education, training, or experience—these happenings is no justifiable sense render an individual (or a group, or class of people) "inflationary" or anything else.

That minimum Congress so recently specified in the Minimum Wage enactment, in terms of present dollars and standards, is exactly as applicable to the man at age 66 as at age 64, so to speak. Human life is the thing of value—and its support and betterment is the essence of all economic value in any sense which may be termed honest.

Now, I sincerely ask each Member to contemplate a simple question. If we had, years ago, instituted the program in H.R. 5930, would we be better off, stronger, or a less wealthy and weaker society than we are? Could our money have done a mightier service in these last years than to have given humanity proof poverty can be mastered, instead of allowing poverty to have generated the upheavals and tensions it has in our own land and in the world?

I believe that anybody who contemplates the differences which would have ruled, had we done these things instead of the feeble alternatives with which we have lived, such persons will readily see we've suffered tremendous and needless losses. Equally, it will become clear that we should tolerate continuation of those losses no longer.

Therefore, let us finance our way out of these problems. By Act of Congress, let us institute a universal contract which will inherently operate whenever business is done, being an inherent part of every future business transaction and contract.

Whenever business is done—transactions and contracts carried out—wages, salaries, profits, commissions, rents, rates, fees, dividends, interest, royalties, all taxes (which simply finance the same things under employment and other contracts between persons and companies with Government)—all forms of costs, through legal contracts, the law of the land authorizes, creates the money and payment.

At the same time, by the same contracts and authority, we simultaneously authorize *all the money-incomes of people* (wages, salaries, profits—all of them), the money-incomes upon which people live and with which they do business.

Those "costs" and those "incomes" to people are identical things, created and monetized by the contract law of the land. Just as an Act of Congress increased the value of gold (gold does not change) nearly $15 an ounce—just as recent passage of a law increases the *money-value* of every working-hour under minimum wage employment-contract by 35 cents—so exactly may we institute a universal contract which will monetize these national pensions proposed in H.R. 5930 without financially burdening any other and existing money or wealth. So may we create new wealth, financially, beyond previous experience. It will prosper all and burden no honest person, or interest.

Simply enact that in terms of the gross dollar-value, determined by trade and commerce, of all contracts, there shall universally be an *additional* monetary factor of two or three percent—an *additional monetary factor* measured in terms of a small percentage of the total sum of all other cost-income factors in all contracts etc. Not taken out of existing cost-income factors, not a lien on them—but, new, additional money for new, additional human life, prosperity, freedom—for an end of poverty which is the greatest evil and injustice in human life, punishing, unjust evil.

Just as validly as the big auto manufacturers and unions could do it for a few auto workers—so may we do it, just as validly for all the American people. The device, the *financial technology*, Mr. Chairman is defined in Section 229 of H.R. 5930—the Gross Receipts, Gross Income tax. There is no *good* reason for people not to have it.

This can be done. I advise every sense of justice dictates its time is at hand. Thank you.

Senator RIBICOFF. Mr. Edelman, please.

STATEMENT OF JOHN W. EDELMAN, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS, ACCOMPANIED BY WILLIAM R. HUTTON, NATIONAL COUNCIL EXECUTIVE DIRECTOR; AND DR. CARL ROBINSON, NATIONAL COUNCIL'S MEDICAL CONSULTANT

Mr. EDELMAN. Mr. Chairman, I would like to submit for the record the text of the three statements which we have prepared: The first one by myself, the second one by Dr. Carl Robinson of Bessemer, Ala., who is medical consultant to the National Council of Senior Citizens; and the third by the executive director of the national council, Mr. William R. Hutton.

Senator RIBICOFF. Without objection, all three statements will go into the record as though read.

Mr. EDELMAN. I would just take, actually, no more than a few minutes to simply say that—I will not even read my summary statement, Mr. Chairman—I think in general our views are fairly well known on the Hill here.

We particularly press for an increase above, in the basic social security benefits above, those proposed, those enacted by the House of Representatives. We stress, particularly, the necessity for a disproportionate raise of the basic minimum.

Mr. Nagle, just here, made a tremendously forceful and full statement on this particular problem of the failure of many States to take action to permit the increase in the social security benefits to be added to public assistance payments. This is a problem which we have stressed, particularly. We make several other points, but these are our basic points.

May I ask, therefore, Mr. Chairman, that perhaps at this point you would call on Dr. Robinson to read his statement, which will be quite brief, but I think since we have taken him all the way from Alabama and away from a busy practice, that it would be more to the point if we heard from him.

Senator RIBICOFF. You may proceed, Doctor.

Dr. ROBINSON. Mr. Chairman, I know I do not need to remind you that not all segments of the health field were in accord with the enactment of the medicare legislation—though I hasten to state that I have always been firmly convinced of the need for this program. I am, of course, a member of the American Medical Association, but I have always been aware of the need for a medicare program for the senior citizens, the disabled and many others who can't afford the high costs of medical care.

Many of the medical people who blindly opposed medicare plainly did not realize what it meant to the elderly sick to have to go to a doctor to ask for his help and tell him they couldn't afford to pay for it. What an affront to human dignity this was. And we can never know how many sick older people resisted the indignity of the system, lived in pain and suffering, and died before their time. These statistics are incalculable.

It is no wonder that the enactment of the medicare legislation has been so enthusiastically welcomed by so many older Americans. And

there is no doubt that it has been welcomed, too, by the middle-aged sons and daughters of the elderly who frequently had to fork out the medical expenses of their parents.

But the truth is that medicare has also been welcomed by most of the providers of health services. Doctors are now being paid for their charity patients—a new source of income. Hospitals and nursing homes are finding new money.

Like other doctors, I see many things wrong with medicare and medicaid but I feel strongly that these programs are a tremendous improvement over what we had before they got underway.

One of the things I consider wrong is the steady rise in fees doctors charge medicare patients. I believe doctors who treat medicare patients are entitled to customary and reasonable fees. I would welcome action by Congress to control excessive or unreasonable fees charged by doctors under medicare and medicaid.

In previous testimony here, Dr. Milford O. Rouse, president of the American Medical Association, contended that medicare and medicaid have been what he termed open-ended programs with costs he said are uncontrollable.

I do not consider medicare and medicaid costs uncontrollable, especially if doctors remain honest, and I would not want to see the medical profession blamed if rising costs force an increase in the present $3 monthly premium for part B optional medical insurance under medicare. That is one reason I urge congressional controls over rising hospital and medical costs.

Most doctors I know work under fee schedules set by doctor-controlled Blue Shield insurance programs and I cannot see why any physician who does this should object to similar fee controls under medicare and medicaid.

I don't want some doctors charging exorbitant fees when treating medicare and medicaid patents and so giving the entire medical profession a black eye.

I believe there can be a happy medium under which the doctor has a fair return for his services to medicare or medicaid patients and the taxpayer is protected against waste, inefficiency, or greed on the part of the suppliers of medical care.

What we are all interested in, or should be, is the best possible health care at the least cost consistent with a fair return to the providers of care.

To achieve that goal, I believe we must simplify medicare by removing the deductibles and including under it all drugs prescribed for medicare patients.

The complicated system of deductibles—$40 for hospital care, $50 down on doctor bills, and the requirement that the medicare patient pay a fifth of the remaining doctor bills, and so on—seems to me to interfere with the aim of providing the best possible health care for medicare patients.

The best medical care is preventive care and it just doesn't make sense to me to discourage frequent visits to the doctor by requiring cash payments as the medicare law does.

From my experience, most old people do not relish the idea of going to a doctor and they like it much less when they have to pay $50 down and a fifth of the remaining bill for the doctor's services.

Four out of five old people have chronic ailments like rheumatoid arthritis, heart and circulatory diseases, diabetes, and cancer, which can be controlled if discovered in time.

For these men and women, frequent visits to the doctor are essential if they are to enjoy their remaining years, and mandatory where a delay in diagnosis can mean the difference between prolonged life and early death.

Keeping people healthy is a lot cheaper than caring for them after they get sick, and this is especially true of medicare patients. I strongly urge Congress to get rid of the medicare deductibles.

I feel sure this would accomplish a great deal in cutting down today's medicare costs.

Just as we should not place obstacles in the form of cash payments and deductible charges in the path of health care for medicare patients, I feel we should not make the elderly bear the heavy cost of medication which the great majority of elderly must have to promote health and prolong life.

I think this heavy financial burden on the elderly should be shifted to the Government so the elderly will be under no pressure to skip taking needed medication because those on low incomes cannot afford to have their prescriptions filled.

I think Congress ought to require that, where Federal funds are used in the purchase of prescription drugs, these be purchased where possible under their low-cost generic or official name rather than under a more costly proprietary brand name.

I recognize that the doctor must be the sole judge of the medication he orders for a patient and I insist on the right of a doctor to write his prescription under a proprietary brand name or a generic name as he sees fit.

From what I have observed in my own practice, medicare has been operating very well for a program that is a little more than a year old. I agree with my colleagues that it often involves a great deal of redtape but I have found that doctor-controlled Blue Shield also involves redtape. But I have never seen a doctor unhappy that his patient has Blue Shield and have never heard one complain about filling out Blue Shield forms.

As time goes on, I hope the useless procedures for collecting medicare can be gotten rid of, and I am glad to see that the House-passed social security bill abolishes the requirement for useless certification of treatment. Under the House-passed bill, the doctor's itemized bill is certification enough, in my opinion.

Senator RIBICOFF. Thank you very much.

Any other comment?

Mr. HUTTON. Just one highlight, Senator Ribicoff. We of the national council express serious concerns about the prospects that the voluntary insurance premiums, which now are standing at $3 a month from both beneficiary and Federal Government, may in the very near future be increased by 50 cents or a dollar per month without any corresponding adequate increase in program benefits.

The National Council of Senior Citizens is convinced that doctor fees to older patients have risen considerably more than they have needed to have done to catch up with fees to other patients. Our older people do not lie to us, Senator; they write and tell us the truth and,

when the U.S. Department of Health, Education, and Welfare finally gets the figures in, we predict they will show extravagant escalations in fees to medicare patients, and we believe that Congress will regret it deeply if it fails to effect reasonable controls on doctor fees now.

Senator RIBICOFF. Thank you very much.

What would you think, Mr. Edelman, should be the overall increase of social security benefits in contradiction to that of the House?

Mr. EDELMAN. Mr. Chairman, obviously, we have a convention stand for a 100-percent increase in average benefits. We are prepared, in view of all of the circumstances that are confronting us, and the practical realities of the day-by-day situation, to suggest that the increase be at least 15 percent, which is far from what it ought to be, but this is what we are urging as of this particular moment, in view of the realities of today.

Mr. HUTTON. We do have a standing convention resolution, Mr. Chairman, for a minimum of $150 per month per person, and $250 for a couple, as being an essential goal for social security, made possible through the addition, of course, of General Treasury funds and funding up to $15,000.

Senator RIBICOFF. In other words, suppose there was an increase of social security benefits over 50 percent and it would require the utilization of general revenues as against social security taxes. Would this have the approval of your organization?

Mr. HUTTON. It does so.

Mr. EDELMAN. It does so. Very definitely, sir.

Mr. HUTTON. We believe it should be done.

Senator RIBICOFF. Thank you very much, gentlemen.

Mr. EDELMAN. Thank you, sir.

(The statements of Mr. Edelman and Mr. Hutton follow:)

STATEMENT OF JOHN W. EDELMAN, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. EDELMAN. As the spokesman for the National Council's 2,000 affiliated clubs, I tell the committee frankly our members are bitterly disappointed with many of the provisions of the House-passed social security bill.

SUPPORT THE ADMINISTRATION'S RECOMMENDATIONS

We of the National Council of Senior Citizens join with Secretary John W. Gardner of the U.S. Department of Health, Education, and Welfare in urging the Senate to support the social security recommendations of President Johnson.

As the President has pointed out, nearly 7,000,000 elderly are poor and, as Secretary Gardner has noted, approximately half the elderly have no substantial income other than their social security benefits.

Because of this, the National Council supports President Johnson's proposal for a minimum social security benefit of $100 a month for recipients with 25 years under social security and $70 for other recipients.

Members of the National Council of Senior Citizens hope the U.S. Senate will show greater concern for the desperate needs of the elderly than did the House of Representatives when it enacted the inadequate

House Ways and Means Committee social security measures (H.R. 12080).

We of the National Council were flabbergasted by the House Ways and Means Committee finding—page 23 of the committee report on H.R. 12080—that it had "no definitive guide for determining what the level of the minimum benefits should be" and that a minimum of $50 a month "appears appropriate to the continuation of a wage-related—social security—system."

Did the 25 members of the Ways and Means Committee reach into the air or, perhaps, use some kind of lottery, to set the $50 a month social security minimum in the House-passed bill?

The House committee members had available the services of Government statisticians who could have readily told them what living costs are, or they might have surmised without expert assistance that $50 a month—$600 a year—is not enough to live on, and that even the average social security benefit proposed under the House-passed bill—$94.50 a month or a little over $1,100 a year—is less than what is needed for minimum comfort and security.

And, right here, I would like to ask how does a Congressman, earning $35,000 a year, decide that other Americans ought to be able to get by on a miserable $600 a year or an inadequate $1,100 a year?

Using the Department of Agriculture's bare bones economy budget, allowing around 22 cents for an individual meal, an aged non-farm retiree needs at least $1,470 a year to get by.

We of the National Council of Senior Citizens consider this a callous denial of bare subsistence—and it fails to grant the elderly a rightful share of the prosperity they helped create and are entitled to participate in as a matter of elemental justice.

INCREASE THE TAX BASE

The House Ways and Means Committee social security report asserts the social security system can finance a 12½ percent benefit increase if $1,000 of additional wages are taxed. The House-passed bill would raise the social security wage coverage from the present $6,600 to $7,600 a year and boost the social security tax by a quarter of 1 percent for an employee and employer.

We of the National Council of Senior Citizens ask why a limit of $6,600 or $7,600 when a great many wage earners' take-home pay is much more than this? Why does the social security tax hit low moderate income wage earners the hardest? Why not ask those most able to pay this tax to bear their fair share of the cost of social security?

When social security began, the social security tax covered 94 percent of wages. As wages rose, reflecting the Nation's increasing affluence, the social security tax became more and more regressive, covering a smaller and smaller portion of prevailing wages until, in 1950, it applied on full wages of only 43 percent of regularly employed men.

Even today, with social security tax applying on wages up to $6,600 a year, only a little over half the men who work for wages get social security credit for all their earnings.

The President's call for broadening the social security wage base to $10,800 a year by 1974 would restore coverage to full earnings of no more than 82 percent of regularly employed men, as Senator Frank E Moss, of Utah, has pointed out.

By contrast, the $7,600 wage base stipulated in the House-passed bill would cover full earnings of approximately 64 percent of regularly employed men.

The National Council of Senior Citizens strongly urges social security taxation of wages up to $10,800 a year by 1974 along with a modest tax increase to provide the 20-percent social security increase recommended by the President.

Why, Mr. Chairman, should low- and middle-income wage earners pay a social security tax on all their earnings while upper-income wage earners, who have the greatest ability to pay, bear a relatively smaller social security tax as is the case under the present law and as would be the case under the House-passed bill?

20 PERCENT ONLY A FIRST STEP

Not that a 20-percent overall social security increase is enough. The National Council supports it only because it is a practical step toward a level of benefits sufficient to lift all the elderly poor above the poverty level. The goal sought by the National Council is a minimum benefit of $150 a month for individuals and $250 a month for couples.

The House-passed social security bill is a cruel disappointment in other important respects, and we of the National Council fervently hope the Senate will do better by the poor and the elderly.

MEDICAID FORMULA

The matching formula for medicaid under the House-passed bill is a drastic reduction below the formula proposed by the President. The House-passed bill limits Federal participation in medicaid to 133⅓ percent of the cash payment level of poor relief—a provision that could eliminate the concept of medically indigent under medicaid in some States.

The President's proposal would allow 150 percent of the highest income standards used by a State in determining eligibility under its program of cash assistance for the poor.

States that would be immediately affected by the House-passed bill include California, Connecticut, Delaware, Illinois, Iowa, Kentucky, Maryland, Michigan, Nebraska, New York, Oklahoma, Pennsylvania, Rhode Island, and Wisconsin.

The law now requires States receiving Federal funds under medicaid to provide, where necessary, hospitalization, out-patient hospital services, doctor services, laboratory and X-ray services and skilled nursing home service. Nine less essential health services are optional. The House-passed social security bill would allow the States to substitute any seven of the 14 health services permitted under medicaid. This would drastically weaken the medicaid program.

We of the National Council of Senior Citizens share the opinion of Congressman Jacob H. Gilbert, of New York, a member of the Ways and Means Committee, on the House-passed social security bill.

In a speech on the House floor, Congressman Gilbert recently declared:

"The 1965 social security amendments that set up medicaid contained a Federal commitment to the States. Under the (House-passed) bill, the Federal Government would be backing out of this commitment.

Ironically, it does this not because the (medicaid) program has been a failure but because it has been a success * * *

"Hardest hit are the States with the most effective programs—the programs that bring assistance to the greatest number of needy persons—the States that show the most concern for their underprivileged citizens. I deeply believe we use the wrong approach when we take funds from States that are meeting their responsibilities to the poor as this bill would * * *."

Mr. Chairman, we of the National Council of Senior Citizens heartily endorse Congressman Gilbert's views.

The National Council of Senior Citizens considers Medicaid—the health program for the needy of all ages—a pioneering program that should be encouraged and extended. We hope the Senate will preserve it.

AID TO FAMILIES WITH DEPENDENT CHILDREN

Most shocking of all the provisions of the House-passed social security bill are its savage restrictions on Federal aid for relief of the poor.

Under this bill, relief to poor families could be shut off entirely or a poor family could have relief payments reduced by arbitrarily cutting off adults from relief and children could be removed by court order and placed with strangers for care.

So great is the concern of National Council members over this threat to children of the poor that I have received many letters from members who, despite their own need for a meaningful social security increase, offer to forgo an increase if this will protect poor children from the plight that awaits them if the House-passed social security bill should—God forbid—become law.

Our members, who have raised families, know the importance of family life to children and can understand the hurt inflicted on them when they are arbitrarily deprived of family life.

Mr. Chairman and other distinguished committee members, the welfare restrictions of the House-passed social security bill deliberately discriminate against cities like New York, Chicago, Detroit, Cleveland, Newark, and other communities with large ghetto areas teeming with the outcasts of our changing agricultural system.

The bill does nothing to prevent the migration of agriculture's human rejects to city ghettos. This migration will continue. Restrictive welfare measures proposed in the House-passed bill are not likely to change this historic movement from the farms to the cities.

I appeal to the committee and the Senate to show compassion for these victims of a changing technology in agriculture. I plead with you to lighten rather than add to the heavy burden the unfortunate poor in city slums must bear.

LET THE LABOR DEPARTMENT TRAIN

The National Council of Senior Citizens applauds the desire expressed in the House-passed bill to train the poor for gainful jobs but we are aghast at the Draconian methods sought to bring this about. We also are puzzled at the lack of specific directions for the training.

If there is to be stepped-up job training for the poor, we urge that it be placed under the manpower training program of the U.S. Labor Department which has experience and know-how in this field. Why set

up a duplicate training project under some other Government agency?

Mr. Chairman, the House-passed social security bill contains other omissions the National Council of Senior Citizens considers glaring.

I find no provision to guarantee social security recipients on relief the amount of the benefit increase proposed in the bill. The National Council of Senior Citizens wants to make sure impoverished social security recipients get the increase.

GUARANTEE INCREASE TO THE ELDERLY

This has been recommended by the Subcommittee on Employment of the Senate Special Committee on Aging and I wish to thank Senator Jennings Randolph of West Virginia, chairman, and the outstanding members of the subcommittee for their concern for the elderly poor.

Only two of the 50 States grant their social security recipients on relief the benefit of the meager 7-percent social security increase in 1965, and without mandatory legislation, there is no reason to think recipients on relief will be better off under the pending legislation.

We of the National Council appeal to the Senate to forbid States using this benefit for purposes wholly unrelated to social security as many States now do. We also ask that pensioned war veterans be guaranteed social security benefit increases without loss or diminution of their pensions.

KEEP PACE WITH RISE OF LIVING STANDARDS

Likewise, the National Council notes the omission of any guarantee in the House-passed bill of automatic social security increases reflecting the rise in living standards or the phenomenal rise in the productivity of U.S. workers.

I remind the committee that the meager benefit increases of 7 percent in 1958 and 7 percent in 1965 fell short of restoring 1954 purchasing power for social security benefits. It is a sad commentary that four-fifths of the 12½ percent social security increase proposed in the House-passed bill will be taken up to give recipients real income on a level with what they had back in 1954.

Meantime, wages have risen at least 50 percent and industry's productivity and profits have been nothing short of fabulous.

We of the National Council welcome the proposal in the House-passed bill to raise from $1,580 to $1,680 a year the amount a recipient may earn without reduction of his benefit and from the present $2,700 to $2,880 the amount above $1,680 a recipient may retain in $1 payments for each $2 in outside earnings.

However, we regret the omission of any provision to help social security recipients who want jobs suitable to their skills. The National Council of Senior Citizens strongly urges establishment of a senior service corps to provide jobs for seniors. We favor a senior service corps bill by Senator Harrison Williams, of New Jersey, chairman of the Senate Special Committee on Aging.

The House-passed bill contains a harshly restrictive definition of disability, forbids for widows without dependent children benefits below age 50, limits the primary benefit for widows at age 50 to half

of the regular benefit with a gradual step-up in benefits determined by the age benefits begin.

The National Council of Senior Citizens urges the Senate to adopt the President's proposal for payment of benefits to disabled widows of insured workers if disability begins within 7 years of the husband's death or within 7 years after social security benefits due widows as mothers end.

In addition, the National Council asks for a reduction from 20 to 10 years the time a divorced woman must have been married to her former husband to be considered eligible for a wife's or widow's social security benefit.

Mr. Chairman and other distinguished committee members, the National Council of Senior Citizens speaks for the elderly. Daily we receive piteous appeals from men and women trapped in poverty and driven to despair. For them, the future holds only misery and neglect unless they get meaningful help.

I am sure the distinguished committee members have received similar pleas from the elderly but, nevertheless, I would like to cite typical letters reaching the National Council. Here are examples:

NEW ORLEANS, LA.—With everything going up all the time, our social security buys less and less. We need a decent increase.

PITTSBURGH, PA.—Please do a good turn for people on social security. We need an increase. Please vote for a 20-percent increase like the President wants to give us.

ALBUQUERQUE, N. MEX.—We have tried hard but we can't get by on the kind of social security we're getting. We have paid into social security 25 years and more and ought to get a better deal than we're getting.

FORT LAUDERDALE, FLA.—People on social security are having a real hard time. My wife and I skimp and go without, but everything costs so much now.

NASHVILLE, TENN.—Will you help get us a social security increase? When my husband was living, we managed, but now I get such cutdown social security that it's very hard going. Please help us.

PROVIDENCE, R.I.—I am on social security and a lot of my friends are too. We're having a rough time because our social security checks are so small. Prices go higher and higher. Prices of some things are double what they were a short time back. We need a decent social security increase.

Mr. Chairman and other distinguished committee members, in considering the desperate need of the elderly poor, I hope you will be guided by Senator Brooke, of Massachusetts, a previous witness.

Senator Brooke cited social welfare benefits provided in the leading European countries to show the inadequacy of the U.S. social welfare system. I add my own observation on this country's lag in care for the aged, as compared with Britain, Germany, and the Scandinavian countries.

I submit, Mr. Chairman and other distinguished committee members, that our country, which greatly excels every other nation in wealth and productivity, can provide decent comfort and security for our aged poor if we will.

On behalf of the National Council of Senior Citizens, I wish to thank the committee for this opportunity to be heard.

STATEMENT BY WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. HUTTON. Mr. Chairman and members of the committee, before I highlight some of the economic problems of older people concerning adequate health care, I want to express the deep regrets of members of the National Council of Senior Citizens that the House bill fails to include the disabled as being eligible for medicare.

INCLUDE THE DISABLED

Frankly, we have received many letters on this from elderly people in all parts of the country. Our aged realized that those who are disabled—like themselves—are living on extremely low incomes. The disabled, like the elderly, have a greater need for health care and because the disabled share with older people the insurance designation that they are a high-risk group, private health insurance costs much more. The letters we have received from our members express consternation that Congress could establish such a beneficial and much-needed program as medicare for 20 million older people and choose to ignore over a million disabled Americans in similar financial plight who have the same obvious needs for the provision of governmental health insurance coverage.

We believe the establishment of a special advisory council to study this problem has all the appearances of a tragic delaying tactic.

CLOSE THE GAPS IN THE PROGRAM

On the subject of the health care provisions under the medicare program, the National Council of Senior Citizens urges the Senate Finance Committee to close the obvious gaps in adequate health care for the aged which have been revealed in the program's operation in more than a year. Our recommendations are based on reports from our more than 2,000 leaders of affiliated older people's clubs in all States concerning the experiences of club members and of other elderly in their communities. We have received thousands of individual letters from senior citizens who have benefited from the introduction of this landmark program. We know that because of medicare hundreds of thousands of elderly people will live out their remaining years in better comfort because of the removal of painful cataracts, or because of the correction of other crippling conditions through hospital operations they couldn't previously afford.

But as deeply grateful as they are to the 89th Congress for the enactment of medicare, our senior citizens are frank to point out gaps and inherent weaknesses in the program. Our older people are looking to the 90th Congress to correct the inequities in the law and its regulations to make it better serve the national good.

STRIKE OUT THE DEDUCTIBLES AND COINSURANCE

We believe Congress should strike out the provisions in the present law calling for deductibles and coinsurance. We are absolutely convinced that there are many proud elderly people in this land who would rather suffer in silence than admit they cannot produce the $40 for the

first day of hospitalization, the initial $50 or subsequent one-fifth of all medical costs, and the $20 for diagnostic benefits. People with plenty of money never seem to have much difficulty getting into a hospital and there is little or no evidence that the deductible or coinsurance features serve as a severe brake on overutilization. Our feeling—as expressed by the many elderly people who have written to us—is that these deductibles merely discriminate against the elderly poor who need the most help.

NO HELP FOR THE CHRONICALLY ILL

We urge the Senate Finance Committee to concern itself immediately with some of the startling exclusions in the medicare law. Among the major complaints of the Nation's elderly, for example, is the charge that while medicare takes good care of the aged suffering from acute illness and requiring hospitalization, there is little help available for millions of older Americans suffering from chronic diseases.

According to the U.S. Department of Health, Education, and Welfare four out of five Americans 65 or over suffer from chronic diseases, heart and circulatory ailments, arthritis, diabetes, and the like, and this costs the U.S. economy a whopping $58 billion a year. Prescription drugs are a part of this cost.

HIGH COST OF DRUGS

Medicare only pays for prescription drugs administered in a hospital or other health institution. But many old people continually need what is often referred to as "maintenance drugs." But the markup in drug prices, particularly in trade name brands, is simply fantastic. And these prices are steadily rising each year. Unfortunately, the data on prescription drug prices represent average charges to all patients irrespective of age, and they tend to understate the nature of the price problem faced by our older citizens.

This is because many of the chronic disorders suffered by elderly people involve prescriptions for new and potent compounds which are covered by patents. Obviously, where a single company—or even two or three—exercise exclusive rights in the marketing of a useful drug, they are going to charge what the traffic will bear. It takes only a glance at the profits of the major drug houses—far higher than those of most companies in other industries—to show that this is exactly what they have done.

But even where essential drugs are free of patent control and price competition actually exists, our older citizens often find these lower priced items inaccessible to them. This is because physicians have been so inundated with the advertising and promotional pressures of the drug companies' "detail men" who visit their offices that the majority simply prescribe the brand names of the big drug companies.

And even if these older patients rather up sufficient courage to ask their doctors to prescribe under generic rather than brand names—because drugs purchased under generic names are infinitely less expensive—they often find that their local pharmacist only stocks the brand name and charges the high brand name price.

SENATE SMALL BUSINESS SUBCOMMITTEE HEARINGS

The National Council of Senior Citizens—and other organizations of elderly in this Nation—have been watching very closely the hearings of the Monopoly Subcommittee of the Select Committee on Small Business of the U.S. Senate which, under the chairmanship of the distinguished and courageous Senator Gaylord Nelson, of Wisconsin, has been concerning itself with the impact of drug industry practices. We believe these hearings have developed considerable evidence that under the present prescribing practices of physicians, the industry has built up a monopoly price structure in drugs sold in local pharmacies, and a heavy burden is placed upon all citizens—especially those living on retirement incomes.

In our own testimony before this committee we declared unequivocably that for far too many older Americans the constant choice must be made between having enough to eat and doing without medicine—or buying essential drugs and cutting costs on an adequate diet. When we look at the high profit returns of the major drug companies and then examine the costly advertising in medical journals and direct promotional material sent to physicians, we are filled with indignation. To tax our impecunious elderly citizens for these purposes is socially wasteful and cruel.

Undoubtedly many of the new prescription drugs do work miracles in prolonging life and promoting health, but unless they are covered under the medicare program they will remain beyond the reach of millions of older people who should have them.

INCLUDE DRUGS UNDER PART B OF MEDICARE

And that is why, Mr. Chairman, we commend to the Senate Finance Committee the bill, S. 17, introduced by Mr. Montoya for himself and many other Senators to amend the Social Security Act to provide expenses for qualified drugs under the program of supplementary medical insurance benefits known as part B of medicare.

Allowances for drugs under this proposal will be based on a schedule to be set by a national formulary committee for a low-cost generic version of the drug of acceptable quality. The proposal in no way interferes with the doctor's right to prescribe a drug by trade name if he wishes, or with the patient's right to have an allowance toward the cost of that drug.

It will be recalled that the Senate in 1966 recognized the need for and merits of this type of legislation, but the proposal was reluctantly dropped in conference with the House. The Montoya bill, which calls for a $25 deductible, is a somewhat more conservative approach than the earlier Douglas amendment, but it makes a good start on meeting the problem.

The National Council of Senior Citizens believes that the U.S. Senate was right in 1966 to seek to include the cost of drugs under medicare part B, and all the evidence we have gathered indicates that this is a gaping hole in the medicare umbrella. We again urge the Senate to support this program and to insist on its inclusion in the final conference bill.

Again we must point out that the task force on prescription drugs set up by the Secretary of HEW appears to us to be no more than another delaying tactic. There's enough evidence that the program is desperately needed this year and we feel that Congress has enough information and authority to act.

Our elderly people recognize that drug benefits could only be added to the part B program by an accompanying increase in part B premiums shared equally between the Federal Government and the beneficiary. The extra burden caused by this raise in premium would, of course, be more than offset by the savings in drug costs which would result to those elderly suffering from chronic conditions and needing drugs. The premium raise would be accompanied by a powerful and much needed increase in benefits.

WILL THEY RAISE PREMIUMS WITHOUT RAISING BENEFITS?

In contrast, the National Council of Senior Citizens wishes to express its serious concern about the prospects that the voluntary insurance premiums—now standing at $3 per month from beneficiary and Federal Government—may in the near future be increased by 50 cents or $1 per month without any corresponding adequate increase in program benefits.

The committee is no doubt aware that, under present law, prior to the new enrollment period beginning October 1 and ending in December, the trustees must decide on a premium which will maintain the voluntary program in actuarial balance. The Department of Health, Education, and Welfare says it has not been able to come up with accurate costs yet on the first year's working of the program. The Department says it cannot get these figures ready in time for these hearings. But we know that overall medical costs rose more than twice as fast as all other cost-of-living items between 1956 and 1966, and this pace has doubled or trebled in recent months.

Doctors' fees are going up all over the country. An 8-percent boost is the average for all doctors' fees last year but the increases in fees to older patients are not measured individually. We know of some which have doubled and even tripled after the introduction of medicare.

The National Council of Senior Citizens is convinced that doctors' fees to older patients have risen considerably more than they needed to have done to catch up with fees to other patients. Our older people do not lie to us. When the Department of HEW finally gets the figures in, we predict they will show extravagant escalations in fees to medicare patients and Congress will regret it deeply if it fails to effect reasonable controls on doctors' fees now.

The medical costs of the voluntary insurance program are reportedly much higher than the estimate made by the Government actuaries. The Department will neither confirm nor deny that serious considerations are being made concerning raising voluntary insurance premiums and it will be a serious matter if these premium increases are granted by the trustees without benefit increases.

MUST THE ELDERLY PAY FOR CONGRESS' FAILURE TO ACT?

Clearly, it is not the fault of the older people of this Nation that Congress has so far refused to consider any amendments which would place even reasonable controls on doctors' fees or hospital charges. If voluntary insurance premiums are raised without increasing benefits the results will be to make our penurious older people pay heavily for Congress' failure to work out a formula of modest controls on escalating doctors' fees.

There are, of course, other gaps in the medicare program which need to be filled. And it should not be beyond the capabilities of this Congress to take care of some of these gaps through additional benefits in the part B medical insurance program.

Medicare will not adequately cover our older people until its provisions include eye glasses and eye care, hearing aids, all surgical and ortheopedic appliances and, in fact, all eye and dental needs as prescribed by physicians. We would like to point out to the Senate Finance Committee that members of the National Council of Senior Citizens have collected more than a million signatures on petitions urging that Congress close these serious medicare gaps. The National Council convention resolution this year also urged inclusion of a planned program of multiphasic screening for preventive care before illness sets in.

BLOOD DEDUCTIBLES

There is an amendment in H.R. 12080 which would create some additional problems in blood replacements for health insurance patients. In the present law the patient is responsible for replacement or payment for the first 3 pints of blood used. After the third pint, health insurance takes over. The amendment steps up the replacement at 2 pints for the first pint used (rather than 1 pint as under present law) and this amendment increases the elderly patient's responsibility for replacement to 4 pints instead of 3. If he could not replace on a 2-for-1 ratio, the patient does not have to pay for more than the first three used. The net effect is to give certain types of blood banks an additional pint, if replacement can be secured.

Since 60 years is the maximum age permitted for blood donors it is difficult and often impossible for the older person to get donors. They usually end up paying for the 3 pints. To push up the replacement is an added burden which seriously upsets many conscientious older people who really try to secure donors.

We understand from the American National Red Cross that 6 million pints of blood are drawn each year in this country. Four and one-half million pints of this are actually transfused. Some of the difference goes into fractions, some into research, but there are still nearly 1 million pints unaccounted for. This is wasted blood, a very precious resource, that is lost because whole blood can only be used for 21 days after it is drawn. The American National Red Cross says the real answer to blood need is cooperation between the varieties of blood banks so that there is a true national inventory, and so that blood sup-

plies can move freely throughout the country. The technology is on hand to do this; only the insularity of certain types of blood banks prevents full use of all blood donated within the 21 days.

ELIGIBILITY FOR MEDICARE

There are two other matters concerning eligibility of older people for medicare on which we urge consideration of the Senate Finance Committee.

Under H.R. 12080 older persons who attain age 65 in 1968 will not be eligible for medicare under the hospital insurance program unless they have had three quarters of social security coverage. You will recall that when the medicare program was introduced all older persons were made eligible whether or not they had prior coverage. They were "blanketed in" through contributions from the General Treasury.

But now, for the first time, we are going to refuse to give older people hospital insurance protection because of the matter of a birth date and lack of social security coverage which is now impossible for them to obtain.

While the amendment has cut the eligibility requirement from six quarters of coverage scheduled under the original law for eligibility in 1968, we urge that the Senate continue to provide for blanketing in of all persons reaching age 65 during the next two years. No one in Government seems to be able to tell us exactly how many older people will reach 65 in 1968 without three quarters of social security coverage. When we visited the Social Security headquarters in Baltimore in July we learned there might be a hundred thousand of such persons not having six quarters of coverage who would be 65 next year. Obviously this figure would be much lower for those without three quarters of coverage. It should not add too great a burden to see that all our 65-year-olds next year become eligible for Medicare.

The National Council of Senior Citizens also wishes to bring to your attention that many of our social security beneficiaries have wives who are younger than themselves. There is extreme hardship when the family is barely existing on the retired worker's reduced income and the man can get medical attention under Medicare and the wife cannot. We urge the replacement of the 65 year age requirement for benefits by a provision qualifying all women at age 62—which is when they qualify for full social security.

EXTENDED-CARE FACILITY BENEFITS

We urge the inclusion in the 1967 Amendments to the Social Security Act of the provisions of Senate Bill S. 1661, sponsored by Senator Moss and others, designed to assure the quality of extended care facility benefits and nursing home services rendered to patients under public assistance programs. In this connection I would like to offer, for inclusion in the record, a study on extended care facility benefits prepared by the National Council of Senior Citizens for submission to the Committee on Ways and Means earlier this year.

APPENDIX A

EXTENDED-CARE FACILITY BENEFITS

A Study Prepared by the National Council of Senior Citizens for Submission to the Committee on Ways and Means as an Appendix "A" to the testimony of William R. Hutton, Executive Director, March 21, 1967.

As early as a year ago some problems could be seen developing related to the quality of the extended care benefit in the Medicare program. Most of these problems and the decisions which have aggravated them flowed from a conception of extended care as a nursing home benefit and the notion that the program was obligated to make nursing home care available to all those who had done their stint in a hospital.

Once this idea was firmly entrenched in the thinking about this phase of the program, mounting pressures were felt to compromise standards in order to qualify some nursing homes everywhere for participation. This process apparently culminated in a kind of panic during the last three weeks before January 1, 1967.

THE NATURE OF THE EXTENDED CARE BENEFIT

Before commenting further on the problems that have developed it may be useful to describe our understanding of the benefit.

The acute hospital is staffed and geared to cope with severe and life-threatening situations. This produces an environment which is unnatural and a bit nerve wracking to those unaccustomed to it. It also is a very expensive environment. Our national experience has been that many patients stay in hospitals beyond the time that they need the full resources of the hospital for their care.

Recognizing this problem, Congress authorized payments to be made for care in an "extended care facility" thereby removing a potential barrier to the care of a patient in a setting suited to his needs and enabling the program to cut down on unnecessary use of scarce and expensive hospital care. It seems perfectly clear from the provisions of the law, however, that the period in extended care is a part of the continuum of a patient's hospitalization.

The difference between this description of the extended care benefit and its simple characterization as a nursing home benefit to which patients are entitled after three days in a hospital are subtle. But they are real and important differences and they have been submerged and obscured in all the talk about being ready to deliever "the nursing home benefit" by January 1, 1967.

THE CONDITIONS OF PARTICIPATION

The signs of compromise were sufficient as much as a year ago to move the Senate Special Committee on Aging to comment in its report of March 15, 1966:[1]

"There is cause for apprehension that the character and quality of the extended care benefit . . . may be eroded."

[1] Developments in Aging—1965. S. Rept. 1078, 89th Congress, Second Session.

The Committee went on to note "with concern the introduction into the draft . . . of the conditions of participation for extended care facilities the highly elastic concept of substantial compliance."

The concept of substantial compliance was retained in the conditions and was joined by what has become known as the "access clause." Nursing homes not meeting substantial compliance may be certified as ECF's if failure to do so would limit the access of beneficiaries to extended care.

A footnote was added to the structural and fire safety standards urging the States to be realistic in applying them. And finally a new category was established; that of "Conditional approval."

Mr. Chairman, we would like to quote once more from the report of the Senate Special Committee on Aging:

"We cannot emphasize too strongly the need to maintain high standards * * *. Substandard and marginal facilities and programs cannot be tolerated—even for a so-called interim period. Experience has shown that, all too often, interims are extended, extended again, and eventually provisional acceptance becomes permanent."

THE CERTIFICATION OF ECF'S

"Conditional approval" evidently was a product of the December panic. Appearances suggest that something like a quota was established for nursing homes to be approved by January 1. Under date of December 16, 1966, the Bureau of Health Insurance addressed a letter to all State agencies instructing them to reevaluate pending denial cases for conditional approval. The States also were instructed to solicit reapplication by nursing homes which had previously been disapproved.

In one State we learned that some homes which had been disapproved by the survey teams had in the end been certified as ECF's. An official of the State hospital association made inquiry of the health department and was informed that this had indeed occurred and that the judgment of the survey teams had been reversed on the instructions of the HEW regional office.

How serious or widespread these situations may be, we do not know, but we suggest, Mr. Chairman, that your committee may wish to inquire of the Department about them.

CHARACTERISTICS OF CERTIFIED ECF'S

Mr. Chairman, the National Council has no way of assessing the quality level of the ECF's that have emerged from this process we have been describing. One other item of information, however, adds to our misgivings.

About the middle of January data became available on the ECF's approved at that time. The total number then was 2,800. Our statement includes at this point a table showing a distribution of these homes by size.

EXTENDED-CARE FACILITIES, BY NUMBER OF BEDS

Number of beds	Number of facilities	Percent
1 to 24	328	11.7
25 to 49	638	23.4
50 to 74	732	26.1
75 to 99	458	16.3
100 to 199	532	19.0
200 to 299	58	2.7
300 to 399	18	.6
400 to 499	6	.2
500 plus	10	.4
Total	2,800	

You will notice from this table that 35 per cent of these homes are less than 50 beds. Almost 12 per cent—328 homes—are 24 beds or less. There seems to be agreement among authorities in health care administration that these are not units of economical size for the demands of modern, skilled care.

It is probable that in many of these cases the structural and safety standards were very flexibly applied. Nowadays one does not build a modern fireproof nursing home of only 24 beds. It isn't economically sound. Nor is it economical to staff this number of beds. The professional nurse supervisor, the dietitian, and the therapists to staff 24 beds can also staff 50 beds; and, obviously, these elements of cost on a patient-day basis will be approximately twice as high in the smaller home.

Thus in approximately one-third of the homes certified we can expect that one of two situations will exist; the homes will not in fact meet the standards required, or the cost of care to the program will be high. And the suspicion abides, Mr. Chairman, that a considerable proportion of these homes would be found to be typical custodial homes operating in converted buildings and licensed under a grandfather clause, and minimally staffed.

DUAL STANDARD OF CARE

Why do we make such a point of the certification of ECF's? Isn't it better to have some nursing home for medicare patients to go to even though it doesn't meet all our standards? We believe not, Mr. Chairman, for these reasons. The ECF is filling a role in the patient's hospitalization. It would be all too easy for our institutional processes to begin to work on the unspoken assumption that young patients complete their hospital stay and go home while old patients go from hospital to nursing home. Where hospitals are crowded and beds are in demand, utilization review committee members will be importuned by their colleagues to move medicare patients out. After all, hasn't the government approved these nursing homes and hasn't the government said medicare patients should be sent to them? The younger patient in an area where true extended care is not available will stay in the hospital where he has access to the physical medicine department, where his special diet is supervised by a qualified dietitian, where he has other special services available; while the medicare patient will be sent to a nursing home that may have none of these services but has been certified.

To the extent that certified ECF's do not actually measure up to the job of substituting for the hospital in the postacute phase of a patient's hospitalization, medicare patients will be exposed to a dual standard and senior citizens may to that extent become second-class citizens in our medical care system.

REPORTS ON DEPOSIT REQUIREMENTS

Mr. Chairman, some reports reaching us on experiences of patients being admitted to ECF's give us concern, and we believe they warrant your committee's attention. These are reports—some of which have been published in local newspapers—declaring that large cash deposits are being demanded by nursing home operators before admitting patients from hospitals for extended care.

The deposits demanded range from $200 to $400. In one extreme case we were told that while the patient was being transferred from the hospital to an ECF by ambulance the ambulance made a stop at the patient's home to pick up the cash deposit required.

Mr. Chairman, we don't believe the program was intended to work this way. Most older people don't have the money for a large cash deposit and this precipitates a financial crisis in the middle of their period of illness. The intent of Congress to relieve our senior citizens of financial crisis in illness is simply thwarted by this practice. We urge that either by amendment to title XVIII or by a formal finding as to the intent of the present law, the Congress eliminate the practice of demanding an advance deposit from medicare beneficiaries.

PROBLEMS WITH TRANSFER AGREEMENTS

We have heard of complaints from operators of some extended care facilities about difficulties in obtaining information from hospitals. Each ECF has a transfer agreement with at least one hospital which includes provisions for transfer of information. But ECF's also are receiving patients discharged from other hospitals with which they do not have agreements. In these cases, the system seems to break down. In some instances the ECF operator has been unable even to get information on the patient's eligibility and has had to apply to the Social Security office for a new determination. One approach to this problem would be to require that patients be transferred only to an ECF with which the hospital has a transfer agreement in effect.

This would temporarily reduce the number of ECF beds available to each hospital until additional agreements could be executed, but in the long run would promote continuity of care and effective relationships between hospitals and ECF's.

Senator RIBICOFF. The committee will stand in recess until 2:30.

AFTERNOON SESSION

Senator MCCARTHY. The committee will be in order. The next witness scheduled is Mr. Martin Morganstern, the national coordinator, National Federation of Social Service Employees, and who will also testify on behalf of Social Service Employees Union. Mr. Morganstern, we appreciate these two groups you represent appearing to present their testimony in one voice.

STATEMENT OF MARTIN MORGANSTERN, NATIONAL COORDINATOR, NATIONAL FEDERATION OF SOCIAL SERVICE EMPLOYEES AND SOCIAL SERVICE EMPLOYEES UNION

Mr. MORGANSTERN. Thank you.

Senator MCCARTHY. Proceed with your statement.

Mr. MORGANSTERN. We appreciate this opportunity to testify before the committee. We believe it is one of the first times that a rank-and-file organization of these workers have so testified. We think we have a unique opportunity to testify on this legislation, because working on the job we are in a position to see which programs function and which don't, which serve to bring people to productivity and which serve literally to increase the production and distribution of paper in the welfare bureaucracies.

I have a somewhat lengthy report, and I don't think that I need read the whole thing. I would like to emphasize certain aspects.

H.R. 12080 calls for a community-built working and training program. We are in favor of a community work and training program. I believe every group that will testify in one form or another is in favor of putting people to work and giving them training. Certainly our experience with the fine organizations, with the administration of the agencies, and with local political figures, indicates they will support these programs.

However, the program as offered in this bill will not aid in developing a meaningful or work training program. On the contrary, it simply won't work, and it will simply waste taxpayers' funds.

The reason that we feel this way is because of the mandatory nature of the program. We have seen other programs which were set up in order to give people training. They are difficult to establish and difficult to make function. We have seen programs established where people were given training to no end. There was no job for them when they finished their training. We have also gone through in this country, a period of work relief where people had to work off their welfare checks and that abysmally failed.

In order to establish a meaningful program, we ought to have meaningful incentives, not coercion. The programs being here established require that the States establish them on a statewide level for all possible recipients, in order to get reimbursed. This means the States are going to be burdened with the people who do not desire to be in the classrooms.

They are going to be burdened with establishing programs which they cannot control. They can't control the intake. They can't control how many people can be accepted. They can't control the programs to see that everyone is placed who gets out of them.

I was a caseworker in the New York City Department of Welfare when the service programs were being implemented. In order to get reimbursement we had several meetings to discuss services. What we discussed was filling out forms and putting the proper numbers in the proper boxes and filling out the case records properly. In short, we discussed recording of services in order that reimbursement may be earned. We did discuss the giving of services.

This program, the States in their desire to get reimbursement, will be establishing the same things, programs that look good on paper, pro-

grams that say everybody is in training, and everybody is working, but in fact merely a facade, in order to get reimbursement for programs.

We are not going to be able to force people to work. We are going to have to motivate them. It would seem that many of the provisions of this law would only provide us with the ability to punish welfare recipients, perhaps mothers of small children and others who do not show good cause, which is not defined in a way to the local welfare bureaucracy.

Again we want the worker in training programs, but they have to be programs which have proper incentives. The incentives offered by the committee are less than already existing incentives under the OEO Act which provides a $85 monthly minimum and 50 percent of the rest of the money can be kept by the client.

That means we have people who are presently receiving work incentives, training programs that will actually get cut, actually get less money as a result of the work incentives in this bill and in any case these incentives are too low. The $30 a month simply is not an incentive to get people to work.

We trace the history of the poor laws. It shows that this approach has failed in the past, but we won't go into that here.

There is one final remark I would like to make on this. On page 105, I believe it is, of the committee report that calls for minimum wage laws in this provision. Down at the bottom of the page they say, however, that:

> The Committee is aware of Federal and State Minimum Wage Laws and with an expanded program as envisioned by this bill, is concerned that these Minimum Wage provisions not handicap the establishment of constructive programs in the states. The original provision in the Community Work and Training is now expanded to give equivalency to the situation under the Wage and Hour Laws and is based on a view that the AFDC participant under the CWT Program, including arrangement for training with private employers is not an employment relationship or otherwise subject, because of this activity, to the wage and hour laws.

Does that mean we are going to create a mandatory work and training act, and tell people they have to participate in it and not pay them Federal minimum wage laws? This is absolutely an intolerable situation, and one which no professional agency could indulge in, and it will really destroy any program that we try and build.

The AFDC youth program now calls for participation only on behalf of people who have shown a substantial relationship to the working force. This might be the proper program for AFDC youth, but the Federal Government is not establishing any programs for the people who are disconnected with the working force. The large majority of the people in our ghettos are disconnected. They have not worked in a year and a half in the last 3 years. They have not been eligible for unemployment insurance.

A 19-year-old Negro who is a high school dropout has not worked the last year and a half. You put in the new changes in AFDC youth, you cut him off the welfare program and you break up the home. You increase illegitimacy and increase desertion, you don't cut down on it.

We know that the committee would give no money for social work manpower. It is a waste of money, and they are better off keeping it if they are going to put in all these provisions, because the social worker will be a policeman. He would be working in a punitive situation, and he will not come to work in public assistance agencies under these provisions.

Even more significant, the manpower problem among nonprofessional caseworkers will be aggravating this problem as a result of a high turnover of staff. We know that turnover results from job dissatisfaction. Putting in these provisions is going to increase job dissatisfaction and increase turnover.

The Federal Government would now, under this bill, have Federal sharing of reasonable expenses in the law enforcement agencies with respect to welfare recipients in their usual administrative expense of the program. They will also set up separate organizational units in every agency for chasing deserting fathers. We are going to create a new bureaucracy to chase down deserting fathers.

The police, if they are going to get Federal funds, they are going to have to follow Federal procedures. They are going to have to fill out forms. They are going to have to account for what they are doing with their time and with the policemen who are assigned to this.

The agencies are going to have to have father-finders, or call them what you will, who go around to track down deserters, check up on the work of the caseworkers who are already doing their work. They are going to have duplication. You are going to have more forms to fill out.

You are going to have a host of people coming around asking the client questions, his neighbors, his children. Eventually you may find a father or two. We ask ourselves how many of the men will be affluent enough to provide any sizable support payments, and how many will themselves be on public assistance or in marginal jobs or unemployed, and will a man earning $60 a week if he has to pay $20 support, or will he run again? If we put him in jail, we have to run the jails, and we can't keep them there forever.

In any case, the jails are not going to prevent a woman who wants a man or a child from achieving her aims. Again this procedure, like the other procedures, simply won't work. We will spend a lot of money in a fruitless chase, on something that we are already doing. We will increase it toward no end.

You don't have to take our word for this. There are facts and figures on this. Let me quote from the deputy commissioner of New York City, the department of welfare in 1964:

> Court and welfare officials are concerned over the rising costs in finding and investigating the resources of the legally-responsible relatives. They find that savings come to States now, not from the relative's contributions . . . but by discouraging eligible applicants from applying altogether. The amount of court order payments realized . . . cannot in and of itself justify the investigative and judicial machinery needed to implement the law. (*The Welfarer*—publication of the New York City Department of Welfare, April, 1964.)

In other words, this law is effective only in that it subverts the intent of the law. It keeps eligible people off the rolls. And it doesn't work at that either.

The illegitimacy and child welfare aspects of the bill supposedly are there because of concern for children. Without going into it because I am sure others will, I would say that the emphasis on vendor payments and protective payments and removing the child from the home again seems to indicate a desire to punish the welfare recipient, threatening him with taking away his children because of illegitimacy rather than getting at the real problems which they face, and we are going to increase here the discretionary judgment of the caseworker or super-

visor and local administrators at a time when we should be moving in the opposite direction to objectify the law, to make everybody who is eligible, eligible without subjecting him to personal decisions and without subjecting him to workers making godlike decisions.

The freeze is totally inexplicable. The other provisions at least attempt to get at a problem. We don't share the thinking that goes into this attempt, but we see it as an attempt to achieve independency. The freeze forgets about the independency and says we are going to cut off at a certain level, dependency or no dependency. The States, as Mr. Mills himself points out in the House in the Congressional Record, will have to give the assistance in any case under the equal protection laws.

Therefore, we are just going to force extra expenses on the State. The State can take the money out of the education or some other aspect of the budget, but we are going to have to provide the funds, unless they use this law as we feel they are going to use it, and that is as a punitive law, to force people who are otherwise absolutely eligible off the rolls.

The committee repeatedly points out that they are dissatisfied with the 1962 amendments. We agree these amendments were oversold. We agree that social workers' intent in using the system pretended they could work miracles with the service amendments, and they can't. We will see this is.

The committee is unfair when they say they have observed these laws for 5 years and they haven't worked. The fact is the key years for services cutting down on the caseloads have not worked in any major jurisdiction, and the law itself gave the community 5 years to implement it, so had they followed the law, they would first be implementing it this July, so they haven't.

We have had three strikes in New York City and we haven't fully implemented it there, and that was a major issue in viewing it. We are not going to offer later recommendations, except to say that the Public Advisory Committee that was set up under act of Congress spent 2 years interviewing people, holding hearings, studying the problems. They had many excellent recommendations, most of which were ignored or twisted around in this 12080.

We would urge that the minimum standards for public assistance payments below which no State may fall, be implemented. That a nationwide comprehensive program of public assistance, based on a single criteria, be implemented; that the States be required to include all types of persons eligible under Federal laws in their State plans for public assistance, and that responsible relatives should be limited to sponsors and parents of minor children.

We also like the fact that the law would increase day care benefits and the emergency assistance benefits, but we point out just one thing in conclusion. None of these recommendations are going to solve the problem we face.

Public assistance can play a small part in solving some of our problems, a real part, but basically we are faced with a situation today where as a result of racism, of ghettoization, of forced migration, and a lack of will to deal with these problems, our communities are in a very difficult situation. We have to provide jobs and decent jobs to everybody. For those who cannot work we have to provide a good decent income by right.

We have to provide good schools. We have to clear the slums. We have to have hospitals and other services available to everybody in a community, and only then are we going to end the problems that we face, and stop illegitimacy and increasing welfare rolls, and this is a problem for the committee, the Congress and the American people today, and this is a problem that they had better address, and H.R. 12080 does not, in any sense of the word, address these problems. Thank you.

Senator McCarthy. Thank you, Mr. Morganstern. Are you generally satisfied that the administration's bill would have been helpful?

Mr. Morganstern. Yes; I am not as familiar with 5710 as I am with 12080, but the reports I have gotten on it, and I have discussed it with Mr. Sonninger of Family Services, it seems to me it would have been generally helpful.

Senator McCarthy. It wouldn't have done as much as you would like to see done, but it at least would be moving within the proper limits and in the right direction.

Mr. Morganstern. That is correct.

Senator McCarthy. Thank you very much. We appreciate your testimony.

(The prepared statement of Mr. Morganstern follows:)

STATEMENT OF MARTIN MORGANSTERN, NATIONAL COORDINATOR, NATIONAL FEDERATION OF SOCIAL SERVICE EMPLOYEES

INTRODUCTION

The following statement is submitted for your consideration by the National Federation of Social Service Employees, an organization representing public assistance, anti-poverty and child welfare workers throughout the United States. With this testimony we add the voice of the worker to the debate over HR 12080—a voice that lays claim to a special and unique expertise in the matters under consideration. Confronted each working day with the problems of applying and implementing the programs and procedures given us by the theoreticians, legislators, and administrators; confronted each working day with the excruciating problems of welfare recipients and applicants, we—the workers—possess a special knowledge—knowledge that must be taken into account in the formulation and administration of a social service policy that will work.

The welfare worker can see what works and what doesn't. He knows which programs and policies satisfy the client's aspirations to end his dependent condition and which satisfy only the administrator's desire to justify his administration. We see clearly which procedures and practices serve to bring recipients to productivity and which serve only to increase the production and distribution of paper by the nation's welfare bureaucracies.

HR 12080, in the words of the *Wall Street Journal*, "attempts to do nothing less than completely revamp the nation's largest public welfare programs, the Federal State Aid to Families with Dependent Children now providing." The Bill was reported out by the House Ways and Means Committee whose chairman (and the Bill's sponsor), Wilbur D. Mills, was quoted by the *New York Times* as saying, "We are rough in this bill—we intended to be—but we did not intend to be inhuman."

With all due respect to the Honorable Chairman, the Bill appears to contain far more roughness than humanity. Indeed, some portions of the Bill must be labeled as inhuman and at the same time, self-defeating. They will, in our opinion, cripple the AFDC program, increase human suffering, add greatly to the problems of an already abused segment of our population, and ultimately work against the best interest of our entire society. They will fail in their intent to decrease need and dependency. Indeed, they will probably increase both the administrative costs of the Public Assistance program and its ineffectiveness, without significantly preventing a growth in the numbers of people coming on welfare. We would like to now deal with those aspects of HR 12080 that we find objectionable, inoperable, or both.

MANDATORY COMMUNITY WORK AND TRAINING PROGRAM

HR 12080 requires that every state establish community work and training programs for AFDC parents and that "Every adult member and child over 16 not attending school for who it was *determined* that work and training is *appropriate* would be required to participate or face the loss of assistance." (Summary of Provisions, p. 11.) HR 12080 (p. 132) provides that if anyone "refuses without good cause to participate in a work and training program" that that person would be ineligible for public assistance. Chairman Mills asks, "Is that not the way we lead people from a condition that I am sure they do not want to be in—of need—into a position of independence and self-support?" (H 10068 Congressional Record 8/17/67.) The answer I am afraid is a most resounding "No."

Certaining we are in favor of work and training for any recipients in any category where the individual is capable of benefiting thereby. We recognize, as does Chairman Mills that the best way to help the welfare recipient is to end his dependency. We agree with Mr. Mills when he says that the people involved themselves do not want to remain in a condition of need. The question is how do we alleviate need and end dependency? It is our feeling that the mandatory program outlined in this law will do much more harm and little, if any, good.

There are several factors that convince us that this is the case. The states are required to establish Community Work and Training programs in order to obtain federal reimbursement! We have found that nothing so motivates state officials as the desire to obtain reimbursement. In order to demonstrate how much motives can operate to the defeat of the intent of the law, let me digress a moment and discuss implementation of the 1962 public welfare amendments. In 1965 I was a case worker in the New York City Department of Welfare. At that time HEW insisted on implementation of the services requirements if full reimbursement was to be continued. In my welfare center I attended three meetings, which involved taking one-half of a work day for all workers, and called in order to discuss "the giving of services." In each of those meetings we discussed the completion of certain forms that HEW required for reimbursement. We were carefully briefed on the proper care and maintenance of these forms and repeatedly admonished concerning their importance. These forms "reported" the time and nomenclature of services being given to our clients. Not one word was ever said concerning the quality or nature of such services, or about why and when they should be offered. Nothing was said about the importance of actually giving services; the only thing of importance, the only thing discussed, was the record keeping which guaranteed reimbursement.

If we insist that the states create Community Work Training programs for all clients or face loss of reimbursement, the results will be worse than they were with the services amendments. There is a great deal of planning, intelligence, time, and efficiency necessary to build such a program. The states that have been working on them for years have encountered less then universal success. (As an example, see the attached report: "Chaos in the Human Resources Administration.") Everyone in the poverty program has seen training programs that don't train and work programs that don't work. Many programs have trained people for jobs that didn't exist, or for which the trainees could be never be hired for reasons other than their own shortcomings. No training program is worth the money invested in it unless it guarantees a man a job at his successful conclusion of the course and unless the trainee really desires such a job. Work prospects as those which many states and counties have instituted where reliefers are used to cut grass, shovel snow, or work for below union scale in dead-end jobs will entice and motivate no one. They will increase the recipient's conviction that the cards are stacked against him and that his only salvation lies in beating the system. Work and training programs that are little more than a return to "work relief" are doomed to waste the taxpayer's money and the welfare worker's time.

There are other drawbacks to this program. The Ways and Means Committee acknowledges that "A key element in any program for work and training for assistance recipients is an incentive for people to take employment" (Report of Ways and Means Committee in HR 12080 p. 106). Yet the Committee relies primarily upon coercive techniques rather than incentives. One of the problems with our current Public Welfare program is that it has inherited the coerciveness of the English poor laws. The examples from which we should learn are many. In 1349 the Statute of Laborers in England demanded that anyone under 60 who was unemployed must take any job available. That didn't work and in 1531 we got new legislation from Henry VIII who said, "Many and sundry good laws,

strict statutes and ordinances have been enacted yet *notwithstanding the number of poor has not in any part diminished but increased in numbers.*" His highness then decreed another "good statute" prescribing whipping, loss of an ear and finally death for unemployed beggars. But that didn't work so 16 years later in 1547 Edward VI tried branding and permanent slavery. This failed. Every 30 or 40 years thereafter English monarchs tried new variations on the punitive theme and poverty continued. The Committee's "new approach" is really old hat.

When the Ways and Means Bill does try incentives it does so half-heartedly and thus ineffectually. The first incentive they recommend is to be provided by the caseworker who will help the client prepare for training by using the social services already authorized under the 1962 legislation (report of the Ways and Means Committee p. 48) to upgrade the client and prepare him or her to benefit from training. Here is the height of irony, for these proposals destroy any hope we may have held for ever properly implementing the services promised in the 1962 amendments. By giving the caseworker and his superiors the absolute power to dictate to a client how she must spend her income, by giving him the right to order her to work, to restrict her activities, and even to take away her children, we have destroyed any chance of creating the environment of trust and understanding that is needed if services are to be accepted by the client.

As for the cash incentives that would reward those who take jobs, they would be excellent if the dollar amounts were not set so low. The Ways and Means Committee correctly points out that the precedent for disregarding some earning of welfare recipients was set in Title VII of the Economic Opportunities Act and Section 109 of the Elementary and Secondary School Act of 1965 and points out that this approach while good, is merely piecemeal and discriminatory. The Committee wisely sets out to correct this by setting one standard that would apply to all income, but it sets the amount of earnings that a client might keep at well below those set in the earlier legislation. The new levels will mean an actual decrease in incentive income for those already covered by existing legislation and in any case is much too low to be a meaningful incentive.

It is our carefully considered opinion, therefore, an opinion that results from long and constant contact with welfare agencies, that given a climate and circumstance where they must, in a relatively short time, establish mandatory community work and training programs the state and local authorities will fail miserably. In making this judgement we take into consideration the fact that these programs must accomodate excessive numbers of persons, many of whom are there involuntarily and resent it, that these programs then have at once a captive audience but a hostile one. We must remember that these programs will not be able to limit or adjust their scope to placements available nor have the benefit of highly-motivated trainees (in fact these trainees may not even be covered by existing laws that protect other workers). These programs will be under a double pressure, first to meet HEW standards as to both inclusiveness without violating "good cause" regulations and second to show immediate effectiveness. The second will exist as public welfare officials will remember the Ways and Means Committee's hasty judgment on the 1962 amendments and be anxious not to lose another program. Further both our experience as workers and poor law history indicate the futility of a punitive "get tough" approach to the poverty problem.

Yet we want to see extensive CWT programs and we believe that the states can create such programs and that they will work. They will work if the states work hard to build programs that provide good jobs and good training so that the recipient will have a better life to look forward to off of welfare. It will work if the cash incentives are set at a more realistic level, perhaps at $85.00 or $100.00 monthly plus one half of the rest. And finally it will work if caseworkers are not overburdened with large caseloads, punitive tasks and extensive paperwork responsibilities and can instead spend their time preparing and motivating clients for work and training projects. Two final points on this topic.

First, if we are panicked into creating CWT projects that are an anathema to welfare recipients they will spend most of their time scheming to avoid work and training. And they will raise a new generation of individuals to whom work and training are evils to be avoided at all costs.

Second, we are alarmed at the possible avoidance of the minimum wage laws under the work and training program. We confess to confusion over the intent of the Committee at this point. In the Bill itself (Section 204 (a)) it is abundantly clear that: "the rates of pay will not be less than the applicable minimum rate (if any) under Federal or State Law for the same type of work and not less than the prevailing rate for similar work in the community . . ." However, in the Report (p. 105) it states:

"The original provision," (as above) . . . "is based on the view that the AFDC participant under the OWT program, including arrangements for training with private employers, *is not in an employment relationship, or otherwise subject, because of this activity, to the wage and hours laws (or the internal revenue, social security, or workmen's compensation laws)*. For this reason, the Committee urges that the Secretary of Labor find it possible to classify the beneficiaries of this program as not being included under the Federal minimum wage law."

If this last paragraph means what it says, it appears that the calumny is complete. It is quite obvious that someone who is not protected by the minimum wage, social security and workmen's compensation laws will not be given the opportunity to participate in the internal revenue system. This is, of course, together with the penalty provisions of the Amendments, a fundamental thrust at depressing the labor force. We urge careful and detailed inquiry into the intent of the Committee and the strictest conformity to the mandates of the original Act.

CHANGING AFDC-U

Loosely subsumed under the work and training provisions is the proposal that continues subsidization of families with dependent children where the father resides in the home but is unemployed. The Bill makes eligibility for assistance contingent on a "substantial connection with the work force." (Report: p. 17) Specifically it requires 6 quarters of work in the past 13 quarters or enough work to have been eligible for, but exhausted, unemployment insurance within the past year. It is unfortunate indeed that the members of the House Ways and Means Committee have ignored the fact that has been documented by so many scholars and that we, as caseworkers, contend with every day—that the poor are simply not participants in our economy. Through discrimination and automation they have for so long been deprived of the opportunity to take part that they have evolved a style of life which enables them to survive in one way or another outside the labor force. Think, if you will, of the *chances* of a 19 year old Negro father to have had a "substantial connection." Change the AFDC-U program as HR 12080 does and you drive this man from his home. If there is one great truth that distinguishes the poverty of today from that of yesterday, it is that *today's* poor are the *dis*connected.

Before leaving this area we would like to point out what appears to us to be an inconsistancy in Chairman Mills' description of the intent of Congress in this legislation. On page H10668 of Congressional Record of 8/17 he says:

"We are not penalising any child. We are not going to take a child off the rolls in any State nor fail to participate with Federal funds in the care of that child, regardless of what his parent does."

While on page H10670 when talking about the proposed new AFDC-U program regulations he says:

"The objective of the provisions in the bill is to tie the program more closely to the work and training program, to which I referred earlier, and to protect *only* the children of unemployed fathers who have had a significant attachment to the work force."

SOCIAL WORK MANPOWER

It is the greatest irony of all that the 1967 Amendments contain a provision for the Federal subsidy of Social Work education for the explicit purpose of ameliorating the manpower shortage in public welfare. The Committee states:

"The successful operation of public welfare as well as many other programs is dependent upon sufficient numbers of trained social work personnel." (Report: p. 110)

In order to accomplish this the Committee is allocating funds for Social Work education. However, via the 1967 Amendments as proposed, the Committee has introduced a series of programs which involve procedures and mandates which force the public welfare worker to violate the basic and deeply held principles and values of social work. Thus, competent and dedicated workers trained in social work will avoid employment in public welfare. The net effect of the proposals then will be to *reduce* the number of trained workers in the public welfare agencies.

In addition we know that the most significant factor in the manpower shortage among non-professional casework staff is the high turnover rate. We know further that the single most important factor in that turnover is that caseworkers are dissatisfied with the content of their job. The 1967 Amendments will only

add to our frustrations and make our job worse. For most the only answer will be to seek other employment.

DESERTION

The law attempts to deal with "a major cause of dependency," parental desertion, in two ways. First, by allowing for "Federal sharing in the reasonable expenses of the *law enforcement agencies* with respect to welfare recipients as a *usual administrative expense of the welfare program.*" (*Social Security Amendments of 1967 Report of the Committee on Ways and Means on H.R. 12080*, p. 102.) Thus, the Ways and Means Committee expects to reduce dependency by bringing deserting fathers to accountibility.

The Bill calls for "cooperative arrangements with appropriate courts and law enforcement officials—including financial arrangements with such courts and officials." (Bill H.R. 12080, p. 110.) The law thus provides that Welfare Departments will reimburse expenses of courts and enforcement "personnel directly involved in—the location of deserting parents" (H.R. 12080, p. 110) and this will be part of the nation's total welfare expenditures. Political demagogues can then boast or complain, depending on circumstances, that we are spending more than ever on the poor. And we will be—on hunting them down. But toward what end?

If the police are to get welfare funds they will doubtless have to account for them by establishing special procedures for separating expenses "with respect to welfare recipients" from normal expenses. Assumedly, a special officer will be assigned to checking on welfare deserters in each neighborhood or town. He will report on his job. He will have a quota of welfare recipients he visited, interviewed, and questioned concerning the whereabouts of a mate or father.

The second aspect of the approach to the desertion problem calls for establishment of a single unit of organization in the "State Agency and each political sub-division, responsible for these functions (establishing paternity, locating and persecuting deserters)." (Ways and Means Committee Report, p. 102–103.) Normally, the Committee expects that there would be special staff "working in this area full time." (Ways and Means Committee Report, p. 103.)

Is it unreasonable to assume then, that in every welfare agency we will have "desertion consultants" or perhaps, "father finders" whose job it will be, to be certain that each caseworker gives his all to chasing the deserters and that the proper form or forms be completed in proper quantities. One for the case record, one for the police, one for the father-finder, one for the central control unit, etc. Probably, the father finders will also be responsible for taking a crack at the tougher cases personally, interviewing the client, her children, neighbors and relatives. If he fails, there's always those "law enforcement personnel," the policemen, who can repeat the same process.

Eventually, some of those who know where the father may be found will probably be broken down and a few fathers found thereby. We must ask ourselves how many of these men will be affluent enough to provide any sizable support payments and how many will themselves be on Public Assistance or in marginal jobs, or among our many unemployed?

And will a man earning $60.00 a week keep working and stay put if he must pay $20.00 or $30.00 weekly for child support, or will he run again? There are always the jails of course, but jails are expensive to run. And can we keep him there forever? Will police or jails keep a father in the home if desperation has driven him to abandon his family? And won't a woman who needs a man (or wants a child) accomplish her ends, no matter how many men we jail? Will these procedures then serve a constructive purpose or will policemen and welfare workers both be spending much, if not most of their time completing forms that justify their existence and their right to Federal funds, but which fail to accomplish substantive goals? Will they really be serving the taxpayer better than if they were fighting organized crime and poverty respectively, rather than in engaging in a basically fruitless search for deserters or in excessive form filing? Will these procedures really cut down on the taxpayers' bill and societies' problems, or will it increase them by adding to the bureaucracy and inefficiency of governmental operations? These are questions that we who work daily on implementing current welfare policies have asked ourselves. Our honest answers in every case argue against this legislation.

We do not, however, ask you to rely solely on our speculation to arrive at a prediction of the consequences and efficacy of this proposal. Under existing laws we have had first hand experience. In the first place, we have been forced

to harrass and humiliate clients, spend countless hours that might have been utilized in the provision of services in the long and most often fruitless search for the putative father, and in the most often fruitless attempts at litigation. We used to have to make "midnight raids"—stripping the last shred of dignity from our clients. (Fortunately, a California court decision recently upheld one of our co-workers who refused when ordered to engage in this degrading practice, and HEW no longer countenances such activities.)

And if an appeal to the sensitivity of the Committee on Ways and Means is not sufficient, perhaps, as tough-minded custodian of the public purse it will be interested in a cost analysis. We have had experience there too. As reported by the Deputy Commissioner of the New York City Department of Welfare in 1964:

"Court and welfare officials are concerned over the rising costs in finding and investigating the resources of the legally-responsible relatives. They find that savings come to the States now, not from the relative's contributions . . . but *by discouraging eligible applicants from applying altogether.* The amount of court order payments realized . . . cannot in and of itself justify the investigative and judicial machinery needed to implement the law." (The Welfarer—publication of the New York City Department of Welfare, April, 1964.)

It would appear then that this is an effective device to reduce welfare rolls *only in so far as it keeps off of welfare those who are eligible!* Therefore, we are spending large sums which we are now going to increase considerably on a procedure which is unjustifiable financially unless it accomplishes an undermining of the intent of law. (Fortunately, the procedure by and large fails to accomplish even this in most jurisdictions.)

The laws of the various states already provide that deserting fathers support their children. New special procedures for chasing down welfare fathers, adding to those already operative, will accomplish nothing constructive. They will cost more money. They will cause more alienation and mistrust between welfare workers and their clients. They will waste valuable time. They may look good to some on the books but they simply won't work!

ILLEGITIMACY AND CHILD WELFARE

It is a basic premise underlying the proposed 1967 Amendments that illegitimate births and paternal desertion are prime and basic causes of dependency. That these are contributing factors on one level of causation is undoubtedly true. However, to us, the more salient fact is that dependency is a prime and basic *cause* of both illegitimacy and desertion. Largely because of this, we have had, in addition to a sense of revulsion, great difficulty in understanding the relevance of most of the provisions of the Bill to these social problems. There *appear* to be several specific proposals and one general requirement that at one and the same time deal with family and child welfare services *and* with illegitimacy and desertion. Other than the provision for family planning services which may, if implemented in sufficient measure have a significant impact on the reduction of legitimate births as well as illegitimacy, it would appear that, in the eyes of the Committee, the relationship of the "child welfare" proposals to the reduction of the AFDC roles lies in the submerged intention to use these services punitively. Thus the Committee establishes the presence of illegitimate children as a criterion of an unsuitable home and encourages their removal from the home by making Federal funds available for foster and institutional care. In other words, the caseworker can now tell the mother or mother-to-be, who is on or applies for assistance, "If you have an illegitimate child, I can take not only your newborn child away from you but also your other children whether they were born in or out of wedlock." If this is viewed within the perspective of the "Freeze" (about which we comment below) this kind of statement becomes not at all far fetched.

Let us examine some other aspects of the Bill in this light. Perhaps related in the eyes of the Committee to the quest for legitimacy and perhaps to a concern for the welfare of children is the emphasis on "protective payments" made to a third party "in behalf of the recipient." Designed principally to prevent the "misuse of assistance money" it adds but another weapon to the mounting arsenal of potentially punitive decisions made *for* the client—not with him. To this point, therefore, we have arrived at the stage where the caseworker is charged with the responsibility of deciding, in conformity with state and local regulations geared to the protection of reimbursement, the

"appropriateness" of work or training for all adults over 16; the "appropriateness" of family planning for the individual; the "suitability" of a particular home for a child and the "proper" management of funds.

In all then we see a situation where the caseworker and his immediate superiors are faced with a great increase in their discretionary powers. At a time when our society is supposedly trying to increase and objectify the rights and privileges of all citizens we subject welfare clients' right to assistance to the uncertainties of personal decision-making and burden workers with God-like decisions.

THE FREEZE

HR 12080 recommends many programmatic changes in public assistance designed to reduce rolls by eliminating need. While we dispute the effectiveness of their approach we can certainly share the Committee's concern for ending dependency. But the proposal that would freeze the rolls in AFDC cases where the parent is absent from the home at existing levels (percentage-wise) for each state is totally bewildering. Representative Mills acknowledges in the Congressional Record (8/17 p. H 10670) the states cannot cut off assistance to those applying on this basis as to do so would be to deny individuals with equal protection. (There are lawyers who maintain that this provision violates equal protection in any case). The result of course would be to force new expenditures on states and larger cities (welfare recipients are largely concentrated in the larger urban areas) when it is quite clear that this is a national problem which demands national solutions. Besides the states simply do not have the resources. Their only alternative will be to divert funds from other essential services. Unless of course they choose to use the previously-described procedures of this Bill as a device for forcing people off of the roles regardless of their need or eligibility.

CONCLUSIONS CONCERNING HR 12080

The Bill is unequal to the enormous task of solving the problems of a rising public welfare caseload. It attempts to impose an unnatural Freeze on AFDC, one that has no relation to reality. Whatever the real intentions of the authors may be, passage of this bill may have some very undesirable results.

The emphasis on child removal, protective payments and vendor payments; the mandatory nature of the CWT provision and the narrowing of the AFDC–U program; the absence of many of the important changes recommended in HR 5710 and finally the Freeze; will not be accepted as attempts to solve the problems of our ghettos by many who inhabit them.

We have outlined a situation developing where many large urban states will be faced with either greatly increased expenditures which they cannot meet or with using the new regulations to force the needy into a position of possible starvation. This will not only destroy the limited efforts that have thus far been made to end the welfare syndrome in coming generations, it will severely limit future efforts to institute effective methods based on knowledge and understanding rather than anger and frustration.

It has been argued that acceptance of HR 12080 indicates a blacklash reaction to this summer's riots by our congressmen. If such Legislation is enacted, those of us who spend much of our time in the ghetto can only predict dire results.

THE 1962 AMENDMENTS

The Ways and Means Committee, having had "the opportunity to assess the effect of the 1962 Amendments on the status of the AFDC program, is gravely disappointed that the services mandated by these Amendments have not had the results which those in the administration who sponsored the Amendments predicted." (Report: p. 96)

It is certainly true that, in their intense desire to humanize public assistance in the United States, the experts attached impossible goals to the provisions of that Legislation. It was overSold, but that does not mean that these provisions are worthless.

A major provision of those Amendments (the 60 caseload) had been essentially implemented in the New York City Department of Social Services only after four years of incessant effort by the New York SSEU. New York City is probably the only major jurisdiction in the country that has come even *this close* to the implementation of this provision as mandated in 1962. Indeed

in observing that they've had five years to observe the effect of the 62 Amendments the Committee ignores the fact that the states were allowed five years to implement the 60 caseload and that all of the services that form the lifeblood of the 1962 Act are predicated on the attainment of the 60 caseload, to say nothing of the 25–35 caseload for "problem families."

Many of the other aspects of the 1962 provisions concerning training, supervision and services were never honestly established. The fact is that the 1962 Amendments have never been tried.

But given the full implementation of the 1962 Amendments—a prodigiously difficult accomplishment—we would still agree with the Committee in that this alone will hardly solve the nation's problems in the public welfare area.

RECOMMENDATIONS

It is our feeling that the use of increased Federal funds for CWT projects (non-mandatory), emergency assistance to needy children and their families, and for increased day care and foster care facilities are excellent ideas and should restore many people to productivity. We add, however, that this will work no miracles and the Congress should understand that most of those now on welfare are unemployable and likely to remain so for some time to come.

In addition we support many of the recommendations of the Advisory Council on Public Welfare, as incorporated in *Having the Power, We have the Duty*. The Council had 12 prestigious members representing every area of American life, Business, Labor, Government, Social Work and the Universities. With a Congressional mandate they held a series of five regional hearings across the nation, hearing public officials from Governor to Probation Officer, Editors, Businessmen; 172 voluntary organizations, 111 state and local public agencies, 20 schools of social work and 39 welfare recipients.

While we do not endorse all of their recommendations we feel they deserve reexamination before the report is scrapped or Mr. Mills' restructuring of their proposals is accepted. We specifically urge implementation of the following recommendations:

1. A Minimum Standard for Public Assistance Payments Below Which no State May Fall.
2. A Nationwide Comprehensive Program of Public Assistance Based Upon a Single Criterion: Need.
3. In Their State Plans for Public Assistance, States Should Be Required to Include All Types of Persons Eligible Under Federal Law.
4. Relatives Should Not Be Required to Support Those Needing Public Assistance Beyond Spouses and Parents of Minor Children.

We believe that implementation of the above recommendations will help alleviate some of the nation's problems. It will not solve them.

We fully understand the concern of the U.S. Congress with the rising welfare rolls. We would point out to those who have not yet noted it, that an analysis of HEW statistics indicates a new phenomenon in this country. Until recently fluctuations in AFDC rolls closely paralleled periods of economic boom or recession. When the economy rose the rolls dropped. Since 1958 however, a constantly rising economy has been accompanied by AFDC rolls that are also rising.

It is clear to us that automation, forced migration, slum-ghettoization, racism and the lack of a national will to deal with these problems have taken their toll and created for a fifth of our population a trap of hopelessness within which desertion and illegitimacy often become prerequisites to survival.

This problem will not be dealt with through changes, good or bad, in the administration of public welfare programs. Racism must be ended. Slums must be levelled and replaced with decent housing that all can afford. Decent jobs must be found for all who can work. Decent income must be provided for all in need. Schools, hospitals and all other essential services must be readily available to everyone, without respect to income or standing in the community.

Do this and we end the welfare problem. Do otherwise and we face continued disruption, disease and degeneration throughout our nation. This is the problem that faces this Committee, the entire Congress, the entire nation, today.

Senator McCarthy. Dr. Joseph Cooper, of Howard University. Dr. Cooper, identify yourself for the committee.

STATEMENT OF JOSEPH D. COOPER, PROFESSOR OF GOVERNMENT, HOWARD UNIVERSITY, AND ADJUNCT PROFESSOR OF GOVERNMENT AND PUBLIC ADMINISTRATION, AMERICAN UNIVERSITY

Dr. COOPER. I am Joseph D. Cooper, professor of government, Howard University, and adjunct professor of government and public administration, the American University. In recent years, I have been concerned with processes of formulating public policy in the field of medicine and health; processes through which legislators obtain balanced scientific and technical counsel; and problems ensuing from the increasing involvement of the Government in the health area, with implications for universities and the private sector.

It may be pertinent, also, to describe briefly a phase of my earlier experience from which I have derived insights applicable to the present legislation. I spent some 24 years in Government employment from 1934 to 1958, most of this time in administrative work and in a diversity of programs and most of this having to do with what might be called the dynamics of innovation. I created entire bodies of policies, regulations, and procedures and saw to their implementation. For 2 years, I directed a Federal regulatory agency. This cumulative experience led to my publication of a number of works dealing with the techniques of regulation, decisionmaking, and organizational structure and process.

Now, the objective of the present legislative proposal has been stated as saving many millions of dollars while assuring and improving drug quality. No one should really quarrel with this as a twin goal. Rather, we should ask:

1. Would the legislation actually bring about the claimed ends of lower cost and higher quality?
2. What would be the effects of the specific proposals on private future research and development of new drugs, the practice of medicine, and the economics of drug distribution and retailing?

As to question one, it is conceivable that a higher level of drug quality could be achieved. This may be an important aim, perhaps more important than the aim of reducing costs. Cost-saving would, however, be a much less likely achievement, for administrative reasons. I will hazard a prediction that proposals in this legislation would raise the net, overall drug bill to the public, when all new costs are included. Furthermore, I believe quality to be more important than costs.

As to the second question, those affected may be expected to overstate the impact, yet certainly there will be profound changes. The physician would have a smaller number of drugs from which to prescribe—which may be both good and bad. The retail druggist would have a new system for computing prescription charges, which might be more convenient from the Government's standpoint, but which could also create a new political and budgetary football, to the ultimate detriment of the corner druggist. And then there's the research factor, which needs little comment here, for you undoubtedly have heard much from the drug industry on this and, to some extent, from the Government. Even if we discount the gloomy warnings of the drug industry, there must be some truth to its claims that research

budgets will be endangered. Certainly, the innovative manufacturer who channels a part of his profits into creative research is entitled to a better price or gross profit break than the generic producer whose sole creativity lies in deciding which drugs to copy when patents expire. And that is all I propose to say on that.

Before analyzing specific provisions of H.R. 12080, I would like to comment briefly on what may be the real problem of providing for availability of drugs under an amendment to the Social Security Act. First, most people will agree that ability to pay should not be a barrier or discouragement to obtaining needed medical service or drugs. The problem is how to deliver service and drugs to those who cannot pay for them without imposing demeaning tests of need on them and without unnecessarily adding to the national debt by accommodating the many who can afford to take care of themselves.

In many other countries, this lesson is being learned. The demand for "free" health service is insatiable. Governments are no longer able to pay the bill—even governments which are not engaged in missile-racing and moonshooting.

In June 1967, a labor member of parliament—a former labor minister who coordinated social policy in pensions, health, and education, Rt. Hon. Douglas Houghton, said:

> . . . may we not get more spent on the Health Service if people can spend more on themselves within the Health Service?

And further:

> While people would be willing to pay for better services for themselves, they may not be willing to pay more in taxes as a kind of insurance premium which may bear no relation to the services actually received.

Throughout Western Europe, governments are studying how to cut back on "free" health services, how to become more selective. And governments in Eastern Europe are becoming conscious of the same need. The social system of the country seems to have little to do with it.

As a general principle, I propose that all health services be available on a coinsurance or copayment basis. More specifically as to drugs, let all minor or nonrecurring drug costs be borne by the citizen. On the basis of financial need—perhaps this might be established impersonally through an income tax code—the citizen might pay a small amount either for expensive drugs or for each refill of long-term-use drugs. Or some variant. The key factors are to assure that those who cannot pay for drugs get them without embarrassment or delay while all who can afford in any way to contribute to cost should do so. Much more can be saved more easily in public and personal expenditures through such gentle-realtistic curtailments than through schemes which put emphasis on administrative paring of prescription service costs.

There are, Mr. Chairman, many things which can be done to improve quality at minimum cost to the Government. Your registration proposal on drug packaging is most interesting. It would establish accountability. Eventually, such a registration procedure could be linked to a licensing system under which drug companies are permitted to manufacture products only within certificated capabilities. The Government will never be able to police all manufacturing batch

by batch. This must be done by drug companies themselves under penalty of losing their product licenses for willful failure or for gross negligence.

I suggest that on the retail cost side you inquire into a practice, in wide use in Europe, of imprinting prescription drug prices on the consumer package. In other words, a list price printed on the factory prepack. I can already hear the howls of objection, yet I merely suggest it for study.

H.R. 12080 seeks to control drug economics through three key devices: A Formularly of the United States, allowable cost ranges for drugs, and a professional fee for retail druggists in lieu of markups. I shall comment on each, but first I would like to note that on almost any topic before us today one can find very little hard data. Surely, one can find proponent and opponent arguments, but solid information is conspicuous by its absence. Hopefully, these hearings will help fill the drug systems information gap.

The Formularly of the United States is proposed to rationalize drug distribution and prescription in part through barring from coverage any drugs which are duplicative of others or found to be of unacceptable quality. I will comment on the duplicative aspect only, as I assume the Food and Drug Administration is the proper agency to insure maintenance of quality.

On surface, the notion of a standard national list of therapeutically useful drugs holds a great deal of appeal. Surely goes the argument, the most informed men of medicine of the land should be able to eliminate "me too" drugs or decide that since one drug does 80 percent of what four other drugs might do, then the other four might be dropped from the list in the interest of simplicity. Once the list has been boiled down, pharmacists would be expected to fill prescriptions with generic equivalents, at the least cost, on the assurance that quality controls would make them therapeutically equivalent.

I will not argue against formularies. Hospitals need them for intelligent and economical procurement, for staff guidance, and for assurance that essential drugs are in supply when needed. A formularly ordinarily should have an escape clause, permitting a doctor to prescribe a drug of his own choice when he believes this to be in the patient's best medical interests. Hospital formularies vary widely, depending on patterns of hospital practice, by departmental specialty, patient characteristics, and prescribing practices.

A nationalized formulary does not, however, afford such lattitude either to hospitals or to physicians or private clinics or group practices. Rather, it introduces a rigidity into medical prescribing for which the practice of medicine is not yet ready. I have discussed this with eminent physicians who have cited many examples of diseases whose treatments are in wide disagreement. It has often been said that medicine is still more art than science. How does one standardize art?

The problem of determining relative efficacy ties in here. This is the decision that one or a few drugs out of a much larger list would accomplish desired therapeutic purposes. Again, this is an appealing notion, for even the drug companies must agree that too many "me-too" drugs are produced, which certainly is not economical. How, though, does one solve this problem? If drug A comes out first with

an effectiveness index of 73, does it forever bar the release of competitive drug B with a modest increment to merely 78? Would B make it if it were to break 80? And would anyone in medicine assert the availability of such effectiveness indexes?

Suppose one drug accommodates 75 or 80 percent of prescriptive requirements. Does this justify depriving 20 or 25 patients out of each 100 of the availability of alternative "minor" drugs, necessary for proper treatment, which they might have if they pay for them personally? Patients are sometimes allergic or unresponsive to some drugs but not to others. A physician told me his patient did not respond to tolbutamide for the treatment of diabetes. He thought he would try propamide, which is a quite different formulation. The formulary didn't list it, so he could either tell the patient to pay for propamide or he could try to make tolbutamide work, which would be ridiculous. In California meprobamate was taken off the welfare formulary, so physicians prescribed an alternative which was chemically and therapeutically different. Is that good medical practice? The California decision was budgetary, rather than medical, but the net effect was the same as would be achieved by the proposed elimination of "duplicative" drugs.

The notion of generic-therapeutic equivalence is now under study by the Department of Health, Education, and Welfare. How long it would take to throw light on this subject in principle alone is a matter for conjecture. Some people maintain there is no such thing as generic-therapeutic equivalence. Others say that for many or most drugs it doesn't matter. Some physicians insist that in their individual practices they encounter no differences, which certainly doesn't constitute scientific proof. A distinguished pharmacologist told me that no responsible physician would want to prescribe digoxin without knowing the brand or manufacturer identity, for generically equivalent digoxins of the same rated potency vary widely in therapeutic effect. Digoxin, incidentally, is used in treating heart failure.

If the insistence by some pharmacologists that therapeutic equivalence can be established only by clinical trials should prove valid—and there is at least some evidence to this effect—the task of rating equivalence would be insuperable. For minor established drugs like aspirin, simple blood-level tests might be adequate, supplemented by other tests of gastric irritancy. For major drugs, especially those which work on vital centers or which are lifesaving or which could be life-threatening under various dosage conditions, controlled clinical trials would be necessary. How does one run trials on 10, 15, or 20 penicillins or on 57 equivalent varieties of something else? Where would one obtain the physicians and laboratory assistants? Has anyone calculated the fantastic costs?

The problems we face with today's drugs might very well be regarded as minor, when the future is comprehended. If we are to heed the National Intitutes of Health, leading academic researchers, and drug industry spokesmen, we are on the verge of a biochemical revolution in which drugs will be engineered to treat not only today's infectious diseases, but the many degenerative and crippling diseases for which cures are not presently available. These new drugs, I am told, will be much more sensitive in application and therefore may require much more exacting manufacturing control.

All in all, the quality control and generic equivalency requirements could very well lead to a great shakeout in the drug industry, leaving it in the hands of relatively few innovators and producers. I am certain this would not be the intent of the committee. I urge, however, that the possibility and any necessary countermeasures be examined carefully.

Earlier I remarked on budgetary control of formularies. In California, the number of drugs on the welfare formulary has jumped up and down over the years, due to a combination of both medical and budgetary judgments. At first, any pharmacopoeial listing was approved. Then any doctor's prescription. Then began cutbacks: alcoholic beverages, food supplements, and vitamins. Next, the list was reduced to 65, including seven for specific diagnoses. Then, once more, the list surged upward to 205, 284, and 512 drug products. The latest act, last month, was to trim the list to emergency and "life-maintaining" drugs and to oral contraceptives—the latter to limit population growth of the poor. Obviously, California no longer has a real drug program. The critical question is whether we should have a device, the formulary, which lends itself to political judgment, but which, in any event substitutes financial criteria for the medical criteria alone which should be governing.

And does it really save money, apart from the added administrative costs? In Pennsylvania, the secretary of public welfare, Dr. Thomas W. Georges, said:

> Our formulary is not "generic." Although there are some few brand name products I think are overpriced, by and large, we found using a quality generic product doesn't produce savings one might expect.

When, however, you nationalize the drug formulary, to the point where exclusion for a manufacturer might mean sudden death or inclusion might mean economic survival, at least, you might bring about the creation of a new national influence structure. And a new area for litigation. And whether or not a formulary could even be brought out then becomes conjectural. Furthermore, what is to be the relationship of the FDA to the Formulary Committee? The first OK's effectiveness; the latter determines relative effectiveness. Does a manufacturer hurdle the FDA at a cost of millions, sometimes, only to have his investment nullified after new representations before the Formulary Committee? And how long does all this take?

Considering all these problems, we can understand why former HEW Secretary Abraham A. Ribicoff shrank from the idea of determining relative efficacy. He said to the late Senator Estes Kefauver's committee:

> We do not seek it. We do not want it. . . . [all] we should have . . . should be an authority that makes the manufacturer prove the effectiveness of the claims he himself makes. . . . We do not want to say that drug A is better than drug B or B is greater than C. . . . We do not think it is necessary.

Among the proponents and opponents of the formulary and generic prescribing, one finds the more eminent scientific members of the medical community growing more and more wary, less and less certain. Only among the economists and other nonmedical types does one find great assurance.

On allowable cost ranges, I shall not comment in depth. It is a complicated subject, made so particularly by our national abhorrence

of Government pricefixing during peacetime. There ought not be a system which bleeds off the creative incentive due to giving an economic advantage to companies who copy only the leading successes. Who then would make the unprofitable "public service" drugs? Would the Government have to procure them under contract and distribute them? And who would have the incentive to budget for their discovery and development?

The case seems not to have been made for Federal intervention in retail drug pricing. Certainly, there are some whose prices are grossly out of line. If their drugs are available through competitive brands or as generics, the play of the marketplace must eventually move prices toward midpoints—in spite of the instances cited of wide variations in price.

We must really look at the overall picture to judge whether Federal intervention is warranted. If we look at the curves of the medical cost components, we see all curves rising sharply, except for drugs. Prescription drugs show up as practically a straight line across the bottom of the chart, with a slight, downward tilt. Are we then justified in nationalizing the economics of the drug industry in order to trim off those whose prices are at the high ends of the ranges, even though these are sometimes unconscionably high?

One practice for which I see no warrant, however, is the charging of one price to hospitals and another to community pharmacists for identical quantities of the same drug under the same labeling.

The professional fee is something else which warrants careful and cautious study. Theoretically, it assures the pharmacist the same average profit. The belief is that he would then be encouraged to stock cheaper generics of equivalent quality. This would also simplify reimbursement and auditing procedures. It would be useful in budgeting.

What the pharmacist should worry about are the second, third, and subsequent years: the bargaining for adjustments upward to accommodate his own rising costs while, at the same time, national and State controllers and budget officers press downward on the professional fee to make up for deficits in less controllable areas of health cost.

Much more needs to be learned about the costs of this legislation, if enacted. How much would the quality controls cost both the Government and industry? These costs must be offset against any savings. What system of reimbursement and auditing would be used under any expanded drug benefits program? These costs must be calculated in order to know the true national costs of a drug benefits program. One might observe that the processing costs for small claims are disproportionately high. That is why private companies usually exclude them. Even the system of excluded cumulative small claims must be a simple one, if excessive costs are to be avoided.

This committee would render a great public service if it were to cause to be brought together the comprehensive data needed to provide bases of decision for the Congress and the electorate. The Department of Health, Education, and Welfare has been making preliminary studies which should aid the committee. The experiences of the Drug Efficacy Review Committee of the National Academy of Sciences-National Research Council should also be obtained, for they

would cast light in some measure on problems to be encountered in determining relative efficacy.

Thank you, Mr. Chairman, for affording me this opportunity to testify.

Senator McCarthy. Thank you very much. We appreciate your testimony.

Dr. Stokes, manager of the Washington, D.C. office, Christian Science Committee on Publication. Dr. Stokes, identify yourself for the record at this point.

STATEMENT OF DR. J. BUROUGHS STOKES, MANAGER OF THE WASHINGTON, D.C., OFFICE, CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION

Dr. Stokes. Mr. Chairman and members of the committee, my name is J. Buroughs Stokes, and I am manager of the Washington, D.C. office, Christian Science Committee on Publication of the First Church of Christ, Scientists, in Boston, Mass. On behalf of the board of directors of this church, I wish to thank you for the opportunity to express the views of the Christian Science Church on H.R. 12080, the Social Security Amendments of 1967.

We would like to draw your attention particularly to title III of the bill, which expands and invigorates the maternal and child health provisions of the Social Security Act. Sweeping projects would be provided under this title to find handicapped and crippled children, identify potential health defects in young children and provide necessary care on an organized and intensive basis.

Let us state at this point, Mr. Chairman, that we do not oppose this, or any other medical program in the act, as applied to the medically oriented majority of the population. The application of this program to Christian Scientists themselves, however, is a matter of concern to us. As you know, Christian Scientists prefer to rely exclusively on spiritual means through prayer for the prevention and cure of disease.

The following quotations from the house report (p. 126–128) give some idea of the intended sweep and intensity of the program:

> States will be required to make more vigorous efforts to screen and treat children with disabling conditions.
>
> Organized and intensified casefinding procedures will be carried out in well-baby clinics, day care centers, nursery schools, Headstart centers * * * by periodic screening of children in schools, through followup visits by nurses to the homes of newborn infants, by checking birth certificates * * *.
>
> In the geographic area served by the project, all the health problems of the children are to be taken care of by the program * * *.

We understand that it is not the policy of the Department of Health, Education, and Welfare to compel individuals to accept any type of service against their own wishes. However, it has been our experience that when projects of this intensity are authorized by Federal law they are sometimes treated at the local level as compulsory.

In Christian Science, healing and the practice of religion are inseparably related, and Government activities which impose compulsion on the care of health are a limitation of the freedom of Christian Scientists to practice their religion. For this reason, we respectfully

request your committee to consider adoption of the following two amendments to H.R. 12080:

At the end of section 514, page 199, line 9, delete the quotation mark and add:

SEC. 515. Nothing in this title shall be construed to require any State to compel any person to undergo any screening, examination, diagnosis, treatment or any other medical, dental or psychiatric measures, care or services provided for in this title, who objects (or, if such a person is a child, whose parent or guardian objects) thereto on religious grounds.

Our second amendment is similar. It applies to the medicaid program.

At the end of section 302(b), page 200, line 8, as a new paragraph, add:

(c) Section 1902 of such Act is amended by adding after subsection (c) the following new subsection:

(d) Nothing in this title shall be construed to require any State to compel any person who has been found eligible for assistance under a State plan submitted under this title to undergo any screening, examination, diagnosis, treatment or other medical, dental or psychiatric measures, care or services provided for in this title, who objects (or, if such person is a child, whose parent or guardian objects) thereto on religious grounds.

These amendments which clarify the right of free people to govern their health care according to their religious convictions are not intended to weaken the maternal and child health program. On the contrary, we believe that citizens who are concerned about the extension of Federal activity into this field will be more inclined to support the effort once this important principle is clearly stated.

Thank you again for this opportunity to present our views.

Senator MCCARTHY. Dr. Stokes, do you have any such exclusion as you recommend in these two amendments, in any other Federal law or in any State laws?

Dr. STOKES. Yes. The Vaccination Assistance Act—P.L. 87-868—which was passed here several years ago by the Congress, when Mr. Ribicoff was the Secretary of HEW, included such a provision. Incidentally, we have gone over this amendment with officials of HEW, and their lawyers are in agreement with the language of the amendment. They do not feel it will hurt if it is agreed to by Members of the Congress.

Senator MCCARTHY. Including even the examination? What would be your position in the case of examination for contagious disease? I can see you might object to treatment, but I don't understand how one could refuse on social grounds to submit to examination which might determine the presence of contagious disease in some person.

Dr. STOKES. That is a very good question, Mr. Chairman. A Christian Scientist does not intend to infect anyone with a contagious disease, and in the event a Christian Scientist is suspect of having a contagious disease, we certainly would submit to isolation or to an examination. We obey the law in every instance, Mr. Chairman.

Senator MCCARTHY. It would be discretionary here as to whether you submit for screening or examination or diagnosis. Then you say, of course, treatment in addition to that.

It seems to me that in trying to establish a point of treatment, it would be a stronger one if you would back up to the point of saying that society or the community couldn't even look at the Christian Scientist to see whether he would have a contagious disease.

Dr. STOKES. Very interesting.

Senator MCCARTHY. Do you accept that your amendment may go too far, which is my point You may be asking for too much.

Dr. STOKES. I don't think it would be going too far. In our experience, sir, with the various States, and also with other pieces of legislation, with the various schools, we have not run into any difficulty in this respect.

Senator MCCARTHY. How do you proceed, in the case of examination in the presence of tuberculosis among the students in the school? Do you submit to that, have your children submit to that examination or not?

Dr. STOKES. I believe that the majority of schools would not compel the children, or today would force children to submit to examinations which have been given in the past—X-rays, patch tests and the like.

Of course, you recognize, as does the medical profession, that this disease comes usually in areas where there are untoward unsanitary conditions and very poor standards of health. I believe that the people who are Christian Scientists would be very quick to watch and detect any difficulty with their children, and to provide them with the very best of health care.

In other words, we do not neglect our children, but we are just as much concerned about their health, watch out for them, and give them the best care that we possibly can. For us that type of health care which is most efficacious is proper, which has proven very beneficial throughout our first 100 years.

Senator MCCARTHY. Thank you very much.

Dr. STOKES. Thank you, Mr. Chairman.

Senator MCCARTHY. Dr. Carstenson.

STATEMENT OF DR. BLUE A. CARSTENSON, ASSISTANT LEGISLATIVE DIRECTOR, NATIONAL FARMERS UNION

Dr. CARSTENSON. Mr. Chairman, if I may, rather than going into a prolonged discussion, I would rather make my presentation with some slides, if this is permissible.

Senator MCCARTHY. All right.

Dr. CARSTENSON. Mr. Chairman, and members of the staff on the committee, I am very happy to be here on behalf of National Farmers Union. I would like to submit the entire statement, including that of President Dechant for the record if I may, and proceed with the slides.

Senator MCCARTHY. All right.

(The statement referred to appears at p. 1112.)

Dr. CARSTENSON. As you know, Farmers Union has been concerned with social security and medicare for a long time, and as you well know, we have appeared before this committee in support of social security for farmers and for people and particularly in support of medicare for a number of years.

We are concerned about the 3 million people in rural America out of the 6 million who are living in poverty, and while many of our farmers are, as this gentleman here, are living well and are enjoying their later years, many of them are active and participating in their community, and many of them such as this park in Arkansas, where people can enjoy their later years, we find too many of them who are

alone and too many of them who are living in deep poverty and destitution.

Some are living, particularly in urban areas, in new senior citizen housing, but here is the kind of housing we find too often in our rural areas, broken down, deteriorated housing. This is a house where one of our green thumbers lives today in Indiana, not really fit for human habitation even when it was new, deteriorated housing.

This is a green thumb worker and his wife hired 2 weeks ago. We found him 2 weeks ago in Wisconsin. The lines of poverty are deep in their faces, and they have to live in this ramshackle mess, despite the cold of winters of Wisconsin, of northern Wisconsin. These are people, this is a house that a couple are living in in Arkansas today. This is a house out in Kansas.

This is the kind of housing I would think that people on social security should have. It would be nice to have. This is what is available now in some of our new senior housing projects. This happens to be a public housing project.

This is the kind of house that we find too often in rural Minnesota and in other parts of rural America, or in Arkansas. This is the kind of bedroom that would be nice to retire to, and here is what we find with very many of our elderly people who cannot keep up with the problem of poverty, poor housing, just unable to even keep up with the things necessary for housekeeping.

This woman, a woman in Arkansas, she is 54 and her husband is 78. They cannot keep up. They have nine children living on welfare. He would love to work, but there just aren't jobs for him, and so they must live in the deepest kind of poverty. Here is the bedroom. They are trying to raise some chickens. In the wintertime they keep the chickens inside because there are no other buildings, and we had to shoo off about 15 of them to get a picture of the bed.

This man is 104, and he is living in Arkansas and he is getting along on his welfare check, primarily because he is also living in public housing in a small rural community. When they have the combination that can get along, but on present welfare payments they are totally inadequate.

This man in northern Wisconsin, who I was with, with Senator Nelson on Friday, was certified to us 8 weeks ago, as starving, by the doctors, and we hired him on Green Thumb. There are many more. We ran into this situation in northern Minnesota, also, Senator.

These men have had it. They have tried to get employment and they have tried to get jobs. This group of men down in Arkansas, old and retired men, are unable to make it on their social security check or their welfare at the present time, and as I say, there are about 3 million, of which about three-quarters of a million of old farmers are eligible and would like to work and not physically able, and probably about a million women living in rural areas. As you know, we run the Green Thumb program, and Project CASA which are trying to demonstrate what is possibe through employment programs.

In our testimony we have shown the level of old-age assistance payments, and they are just totally inadequate. It is not a decent solution for problems of old-age poverty, and it still leaves people in poverty, and we urge, in the strongest possible way, that if nothing else, if you have to abandon every single other benefit, and there are

plenty of nice benefits in this bill, that the stress be placed on the minimum, increasing the minimum payment on social security.

There is nothing else that in the view of Farmers Union, and you know, Senator, I have visited a number of times up in Minnesota. The Minnesota Farmers Union convention felt very strongly on this one point. This is the most crucial matter as far as rural Americans are concerned.

Senator McCarthy. You are speaking of the $70, not $50?

Dr. Carstenson. That is right. We would like to see it go up to $100, because then you could really get a large number of people, and we feel that the present system of public welfare and social security together still leaves them in poverty, and the greatest possible emphasis, I am stressing this increase in the minimum, this is where the need is greatest. This is where the people are in poverty. This is where they are starving. This is where life exists with these miserable conditions.

This would do the most good with the limited dollars, and we do support major emphasis in terms of getting the money in general tax revenues, and increasing the wage rates, not just the amount that the House recommended, but going on up to where it should be, and if we kept up with the increased wage level over the years.

Now, we have hired these old or retired farmers, as Green Thumbers, and they have done a good job. We have done this in part to demonstrate what is possible with low-income people.

Here is a Green Thumb farm out in Oregon, beautiful work which they have done on the highways. These are men who have a green thumb, who have shown they are willing and able to work. We believe there are many in poverty today who would like to work if there were the opportunity. This is the reason we support the new Clark-Javits proposals. We have a lot of experience in this, the Clark-Javits proposal. We also support the work provisions of this bill. But we recommend on the basis of our experience that this be placed in the Department of Labor. There is no question in our minds, in working with the Minnesota State Welfare Department and in the employment department, that this is the place that would best run these employment programs. If it is brought separately you are going to have a fracturing, you are going to have competition, you are going to have a lot of things that will not end up in the best type of program.

Incidentally, the man who is working there, this man is 84, and I was with him on last Thursday. He is doing a whale of a job. Even men on old-age assistance who would love the opportunity to earn their way out of poverty, and this is the whole emphasis that the program should have, not as a club, not as a punishment, but rather an opportunity to earn their way out of poverty, and it should be set up in a way so that when they do earn it, that they will come out above the poverty line, and not just simply remain in poverty.

You can't see this picture too well, but there are seven men here who represent 240 years of farming, and this is northern Wisconsin. These men have done a whale of a job in clearing out a park area. These men, you know, many of the men I think, that we have hired in Minnesota are hard-working people, who would rather, in many cases, starve to death than go on welfare. This skinny guy here, they call him "Snipe" up in Wisconsin, is a real character. He is 82. He really enjoys the fact that he can work now and we urge that this

be especially opened up, work opportunty programs for older people.

Here is a park we built in a county in Arkansas. These are having a major impact on the economics of the community, and I would like to pass up to you a picture of the Saddle Trail in Minnesota, which has had a major impact on the poverty of this county in Minnesota.

Here is a picture in Newton County, Ark. Again, this has had a major impact on eliminating poverty by encouraging the beauty of a rural county in Arkansas. We can tangibly show that it has had a marked impact on the economics of very, very poor counties.

Here is an area in Nekoosa, Wis., I believe that is the right way to pronounce it. We were up there the other day dedicating a park. The park had come up in a beautiful way in terms of the men doing the work, these older retired people. Here is a State hospital in Minnesota, where we have beautified the area. We do undertake training of these men. We believe that all the programs of work opportunitiy should be tied into a training program.

This is a project, the Phelps Mill project up in Otter Tail County, again showing that many of the people who are poor do have skills and can be employed with the Federal Government as the employer of last resort. We think this is the emphasis and direction which this committee should move toward.

Senator McCarthy. The thing that would help you most would be an increase in the minimum benefit.

Dr. Carstenson. Increase in the minimum benefits and the expansion of work opportunities under the Department of Labor.

Senator McCarthy. The other programs in which you participate now—you mean the expansion of them?

Dr. Carstenson. Well, we think that this should be the program which is concerned under this in the House for work opportunities which also should be transferred, and it should be, it is, I think the important part of the work opportunity programs.

Senator McCarthy. I wonder if you could finish your remarks. There is a vote on the floor of the Senate, and I would like to go and vote, so if you will, please finish your remarks.

Dr. Carstenson. I do have one more area I would like to cover. This relates to the drugs. We have had considerable experience on drugs through our direct drug service. We do know that the statements which were made by members of the Senate staff here in relationship to adding generic prescription drugs under the Long bill last year, which I believe you cosponsored and the Montoya bill this year, are actuarily sound.

We know that they will work, and we know that they will be of great benefit to many people. We have just completed a survey of some 300,000 homes, families of old and retired people in Arkansas, and we found that on an average, these are people with an average income of $900 per year per capita.

We have found that they are spending between $25 and $26 a month on drugs. These peaple who are poor, who cannot afford it. We know that the drug prices, drugs under medicare would be of great benefit.

Senator McCarthy. Do you have any other remarks that you want to put in the record? If so, you may.

Dr. Carstenson. I think this will complete my statement. Thank you very much.

(The prepared statement of Dr. Carstenson and Mr. Dechant follows:)

TESTIMONY OF NATIONAL FARMERS UNION, PRESENTED BY TONY T. DECHANT, PRESIDENT, AND BLUE A. CARSTENSON, ASSISTANT LEGISLATIVE DIRECTOR

National Farmers Union appreciates the opportunity to appear before this committee because we feel so strongly about the needs of older and retired low income people living in poverty in rural America today. We also have grave concerns about the nation's public welfare programs which now so inadequately meet the problems of poverty and dependency.

Many of our most active members are 65, 70, and 75 years of age. We have chosen not to forget the widows and those old timers who helped build Farmers Union, American agriculture, and our nation itself. Out of the six million people over the age of 65 living in rural America, nearly a million are still working. Over half of the six million are living in poverty. Over two million are living in deep poverty by any standards. Because of the tragic economic conditions in agriculture, the fact that too many farmers and their widows qualify only for the minimum social security, if at all; and because of a lack of pension plans, between two and three million rural Americans face poverty until the end of their days unless we as a nation act to correct the situation.

When Social Security was passed, its purpose was to supplement private pensions and other retirement savings. The truth is that only 15% of retired people have private pension plans, and only a small percentage have any other major source of income. In rural areas, the proportion receiving private pension plans is estimated at about 2%. Today 88% of the people over age 65 receive Social Security or other government retirement checks. The facts are that Social Security has become the major and quite often the only source of income for most retired people in America. It is in fact no longer a supplement to retirement—it is our retirement plan for this nation.

Our Old Age Assistance program through public welfare is not even coming close to the minimum standards set by state welfare departments.

The following figures show that the old people on welfare are not receiving even what the states call minimum levels. While the number of old people on welfare has decreased, the number of old people who are living in poverty has increased. The elderly are the only group among the poor who are not declining in numbers. Many of those who are receiving Old Age Assistance are still living in deep poverty and hardship. Forty percent of those on Old Age Assistance are still living in unsafe, dilapidated, or substandard housing. Roughly ⅓ of the aged on welfare have no flush toilets, one in six are infirm, yet nearly half of these people who are on Old Age Assistance are also receiving some other governmental "pension plan" (Social Security, Railroad Retirement, Vet., etc.).

In nine states, the average amount paid for old-age assistance are as low as $50 a month, or less

Average payments to recipients, October 1966

Florida	$48.90
Georgia	47.85
Indiana	49.00
Maine	50.10
Mississippi	89.20
Nebraska	46.20
Oregon	47.50
South Carolina	41.30
West Virginia	44.75

Twenty-seven states do not even meet their own minimum standards for welfare payments

Twenty-four states[1] were meeting less than their minimum standards (100% of basic need) according to the latest biennial report (January 1965). Figures for 1967 are not available but would probably reflect changes in some states.

[1] In addition, three states have maximums that do not exceed basic needs by as much as $12 and thus cannot meet most special needs (Colorado, New Hampshire, and Oklahoma.)

State	Total monthly cost standard for basic needs	Percent of full need met by maximum payment to recipient
Alabama	$117.85	63.6 ($75.00)
Alaska	221.00	49.8 (110.00)
Arizona	107.00	79.4 (85.00)
Arkansas	83.00	88.0 (73.00)
Delaware	104.00	96.2 (100.00)
Florida	111.00	63.1 (70.00)
Georgia	81.10	86.3 (70.00)
Indiana	107.00	65.4 (70.00)
Kentucky	84.00	94.8 (79.63)
Louisiana	123.00	66.7 (82.00)
Michigan	108.00	83.3 (90.00)
Minnesota	96.20	73.8 (71.00)
Mississippi	90.32	55.4 (50.00)
Missouri	89.00	78.7 (70.00)
Nebraska	98.50	76.1 (75.00)
New Mexico	107.00	91.1 (97.50)
South Carolina	75.55	92.7 (70.00)
South Dakota	101.90	99.0 (100.90)
Tennessee	78.00	96.2 (75.00)
Utah	100.75	81.4 (82.00)
Vermont	117.00	68.4 (80.00)
West Virginia	62.69	85.0 (53.29)
Wisconsin	99.30	75.5 (75.00)
Wyoming	132.00	75.8 (100.00)

We quote these facts to make these points:

"Old age assistance in America is not a decent solution to the problem of poverty. Welfare payments leave old people still in poverty. Either the older people would rather starve on the minimum social security payments, or welfare departments are being more restrictive in regards to the older poor. There are many people on social security whose payments are so low as to lock them into welfare and poverty."

But these are facts and generalizations. We in Farmers Union have had a great deal of actual contact with the older poor during the past year through our Green Thumb and OASA programs. In addition, the older people living in poverty include many of our friends and neighbors and some of our members.

Through our Green Thumb program, under a grant from the Labor Department, we set up employment programs for older and retired low income farmers in seven states to beautify the highways and build parks. We pay the men, whose average age is 67, whose average income was $900 a year per couple before going to work, a total of $1500 a year for working three days a week. These men averaged 43 years of farming. These men work very hard—too hard—because not only are they accustomed to hard work over the years but because work and the pay mean so much to them. On the basis of our experience and analyzing the available data, we estimate that in the United States there are ¾ of a million able bodied men over age 60 who are living in poverty in rural areas, who would like to go to work to earn their way out of poverty. These are men who can no longer farm and are "too old" for most employers. We estimate there are over a million older low income women who would like to earn their way out of poverty. However, there are not 1¾ million jobs open to people over age 65.

We in Green Thumb have employed men in need. These are men who have come to work for Green Thumb with nearly empty lunch buckets until the first pay day. Men who said that "I was able to buy my first new pair of overalls in four years," or another who said "The job enabled me to buy a pair of shoes, the first in a number of years." One man brought his doctor's exam to the job saying "Able to work but malnourished." Another applied for employment but instead had to be immediately hospitalized for three weeks because of malnutrition. There are waiting lists in many of our nearly 60 Green Thumb Counties for these "hard work" jobs paying only $1500 a year. A good many of these men by income level and age should be on Old Age Assistance, but they are not.

Similarly in project OASA, under a grant from the Administration on Aging, Farmers Union employed older low income persons who have visited over 3000 old and retired low income people in their homes in rural Arkansas. These OASA workers provide both referral services and direct help. Among the 3000 visited they found an average age of 72 and an average annual income of $900. The worst situations were usually the older widows. They found poverty, filth, senility, isolation, illness and loneliness—heart breaking stories of our failure to provide

for our older people. These same type of conditions exists in Indiana, Minnesota, Oregon and almost every other state in varying degrees. We as a nation have casted off too many of our older people leaving them in poverty.

The Social Security Amendments of 1967 (H.R. 12080) will in our judgment leave most of the older poor still in poverty.

Farmers Union, at our National Convention, passed the following resolutions:

We urge that *top priority be placed upon increasing the cash income of the persons receiving the minimum benefits* even it it means forgetting all other desirable benefits. We urge that the minimum benefit for single persons be $100.00, and $150.00 for couples.

We urge that there be *no increase in the Social Security tax rate* but that a *major increase in the wage base* upon which Social Security taxes are paid, be increased to as much as $15,000.00, and *general tax revenues should be used* to increase Social Security benefits. The tax rate is too high, especially on the self-employed and, if anything, it should be kept constant rather than at scheduled increases.

This is not an idle resolution. Already over 400 Farmers Union Members have traveled to Washington and have visited your offices and those of your fellow members over the past nine months urging these two actions by Congress.

One common plea we hear from the old folks around the country—please don't pass a so-called major increase in social security and then allow the Veterans Administration, the railroad retirement board, the state welfare departments or other public retirement systems to deduct the amount of the increase. The last "increase" was a bitter experience to many old people. While a 12½% increase in Social Security sounds good to those who are still employed, it sounds like continued poverty to most older people. Eighty percent of that increase is used up catching up with the increased cost of living.

WELFARE

The House Ways and Means Committee has initialed several new significant and controversial proposals for changes in our welfare system. Farmers Union is opposed to our present system of welfare policies and programs because (1) it does not provide adequate minimum levels of income for the people it is supposed to be helping; (2) it has not had enough emphasis upon retraining rehabilitation and prevention; and (3) it has had such a very ugly image in many areas that those who accepted are branded by many in the community and many who need it are unwilling to be branded.

Our present tax structure and welfare financing places a major burden upon the state and local taxes which are over strained especially in those areas where the greatest poverty and need for welfare exists. These taxes, primarily poverty and sales taxes, fall most heavily upon the old and poor.

The result is that poor rural areas have had insufficient resources to prevent, combat or treat poverty. It is in these rural counties particularly where welfare policies almost by necessity are often the most restrictive and regressive. This situation automatically accelerates the migration of the poor to the big cities and to the slums where at least the welfare checks are more easily available to the poor, are often less degrading, and are more adequate than in the rural areas from which they came.

The article "Can the Big Cities Ever Come Back", in the September 4, 1967 issue of *U.S. News and World Report*, in discussing the 30 million rural people who have streamed to the cities since 1940, said "No longer can they (the big cities) count on a big drop in the tide of the ill-prepared people from the south. Developing in that part of the nation is a virtually inexhaustible reservoir of migration for future years."

The in migration from the farms and rural areas from the plain states and from other rural areas while perhaps more successful than that of the Negro has absorbed most of the jobs, the housing, and the services of our cities so that they have reached the breaking point as shown by the recent riots. Unless the cities can have some relief from this in migration from all the rural areas, they will not be able to cope with the problems of the ghettoes and slums within five or ten or even twenty years.

Farmers Union calls for a public policy which will slow the mass migration to the big cities and in some areas even create out migration to our towns and smaller cities. Our farm policy and food marketing system should be designed to aid the family farmer to remain on the land. Rural community planning is

needed. Greater incentives should be given to industry to locate in rural areas to employ low income people. We are studying with great interest the Pearson-Harris bill which is along these lines. At least as much effort should be made in creating good community services and decent housing for low income families in rural areas as there is in urban areas, if we expect people to remain in rural areas. A major boost in the minimum social security payments will provide a quick economic shot in the arm for rural areas. Most of the retired people in rural areas will of necessity spend all that they receive. The highest concentration of the older poor are in our rural counties. In many rural counties, social security ranks next to farming as a major source of income.

SPECIFIC RECOMMENDATIONS ON WELFARE

We support the concept of training and work experience as an alternative to welfare.

In March of this year our National Convention passed the following resolution:

"We support the revision of the public welfare system replacing much of public welfare with part-time and full-time community service work programs. This is a preferred way to bring low income families out of poverty. Those remaining, who are unable to work; the sick, disabled young, and the very old, should be able to live without hardship and with dignity."

Earlier this year before the House Ways and Means Committee we said "The public welfare amendments in H.R. 5710 would take some steps in the general direction of encouraging employment and giving those remaining on public welfare a minimum standard, but they are not bold enough or creative enough to do the job. No less than a major step will pull us out of the quicksand into which our public welfare system has fallen. Most of the impoverished are not now helped by the public welfare staffs who are overburdened with work, inadequately trained, and inadequately encouraged by the community to do the job needed. Instead, they have too often become engulfed in the red tape of details. The poor are not being helped to live, but only to starve to death.

"This is especially true in rural areas where nobody other than the county welfare director understands the complexities of the law and everyone becomes discouraged with the system. It is no wonder we have found so many poor people in rural America who either were ineligible for welfare, unaware, or disdainful of welfare to the point of being willing to starve, rather than to go on welfare. A dramatic step should be taken here and now to provide public employment as an effective and dignified alternative to welfare for most people, and an adequate existence for those completely unable to work."

The House passed Social Security Amendment (H.R. 12080) contains two controversial amendments. The first calls for worker-training programs, but requires every adult member and child under the age of 16 who is not in school for whom work or training is appropriate to participate or face loss of public assistance. The Committee said that only a few state welfare departments have established work training programs at this time, and only in limited areas despite congressional encouragement.

We urgently request that the Labor Department be authorized to develop these programs in conjunction with other work and training programs which they have that cover most areas of the country. The Administration originally requested that the Department of Labor conduct these programs. We have had experience in employment programs and know that the Labor Department not only will be able to increase the probability of employment but will also save considerable amounts of money. Often welfare recipients could be integrated into regular training programs.

Duplicate parallel programs for low income people sponsored by two different departments would not only be a waste of funds but would breed interdepartmental conflicts.

In our view training programs would give greater dignity to the individual, greater probability of job opportunities, and at less expense to the tax payers. As some of you know, we worked hard earlier this year to help consolidate the work programs under the Economic Opportunity Act in the Department of Labor in order that the federal work-training programs would be coordinated. Having the Welfare Administration run these programs would be poor planning and inefficiency.

We urge that there be an incentive rather than a compulsion so that those on welfare who work or go into training would receive at least the minimum state welfare payment set by the state. People should be able to earn their way out of poverty.

We support the proposed increase in public assistance in demonstration projects.

We strongly urge a 70% matching payment for the states to help meet the cost (not to exceed $1,000) for repairing the home of an assistance recipient if it is substandard. Our experience in project CASA shows that with a few dollars for home repair life can be made much more tolerable for people on welfare.

We support the idea of federal financing of day care services for AFDC mothers. We urge that the Congress direct the welfare departments to employ as many low income welfare recipients as possible in such day care programs as *regular* employees.

We oppose the restrictions on the aid to families with dependent children which would limit forever the proportion of children on AFDC to the current level. Under this provision, if a state had 4% of its minor children on AFDC in January 1, 1967 because their fathers were absent, the state would not get federal matching payments for children in excess of 4% of the population of children under 21 in the state during 1968 or the year after. In our opinion, this is a blind step to force the states to punish illegitimacy. It would not do anything except to punish poor children. It does not consider any potential change in the level of poverty in any state in future years, nor any change in the kind of expansion of services to people who are not being served now and who need help.

This amendment will not take into account any changes in the economic conditions in the state such as the closing of major defense industries, crop failures, recessions, changes in economic industry, and agriculture. Welfare should be responsive to major economic changes which effect families.

Many states are simply not reaching the existing poor families. Today the majority of the poor are not being helped by public welfare. This restriction would ensure that the majority poor would not be served.

We recommend a financial incentive be given to the state for the number of public assistance recipients who are helped out of dependency into self sufficiency.

MEDICARE AND MEDICAID

We are proud that Farmers Union supported the enactment of Medicare. We appreciate the long year of work that some of you and your staff spent in developing this legislation. When it was passed, we all knew that it was not perfect. The Senate added the provision of out of hospital prescription drugs for medicare patients. We support S. 17 and S. 2299 (the Montoya Bills) as an essential step in providing health insurance protection for older people. We have had experience in the problems of the prices of drugs and the impact upon the lives of older people.

The National Farmers Union, in conjunction with the Greenbelt Consumer Co-Op, Cooperative League of the U.S.A., National Council of Senior Citizens, National Association of Veteran and Retired Railroad Employees, Retired Workers-United Steel Workers of America, National Consumers League, plus many other organizations for their members have developed the Direct Drug Service. We are attaching a price list to show the great variations in the prices of drugs between the brand and generic prices. We have encouraged Congressional investigations into these prices. We urge that the proposed program not pay for anything except a reasonable generic price. With a reasonable deduction the costs would not be prohibited. We have analyzed both Committee staff and industry estimates on the cost, and find that the Committee staff estimates are very reasonable and the industries grossly inflated with the intent of discouraging passage.

We support Medicare for the disabled.

We continue to support the concept of a Federal prepaid health care and medical facility insurance program that would enable every one to receive fully adequate medical, dental, hospital and health care services. Such a service would provide for regular and preventative health care services rather than just an attempt to remedy severe illnesses as they occur. While we do not expect Congress to enact this program now, we feel that the experience by the public with Medicare plus the accelerating hospital costs, will bring this to pass. The

three million, plus people who have already received Medicare benefits have not found them as distasteful as the American Medical Association predicted.

We do urge that this Committee as well as the Interstate and Foreign Commerce Committee act now to help tighten up the quality controls on laboratory tests.

We urge that the Preventacare proposal encompassed in the Aiken Bill be adopted as a measure which will, according to the experience in San Jose, actually save money at a future date in terms of doctors and hospital care costs.

We support the increase in the membership of the National Medical Review Committee. We had hoped that the other policy committees could be broadened to include representatives of senior citizens.

We feel that depreciation allowances should be given only where the hospital in the judgement of the Department of Health, Education and Welfare is doing everything possible to curtail hospital costs. (There has to be some sort of lever to help keep hospital costs down and this looks like a good one.) We support experimental efforts to encourage hospitals to cut costs.

We oppose any elimination of the doctor certification. The doctor should be the only one to authorize entry into the hospital. We do feel that this provision might be waived for the first twelve hours in an emergency case, but that no person should go any longer than twelve hours in the hospital without a doctor approving his hospitalization.

We support any action to make determination of age easier for our people when applying for Medicare.

STATEMENT OF JOHN DeCELL, VICE PRESIDENT, MEDICENTERS OF AMERICA, INC.

Mr. DeCELL. Mr. Chairman and members of the committee, Medicenters of America, Inc., was established in April 1965 to provide, through various programs, low-cost, skilled, intermediate health care throughout the Nation. The founders of the company, Messrs. Wallace E. Johnson and Kemmons Wilson, are, respectively, president and chairman of the board of Holiday Inns of American, but the two companies are not otherwise connected. Medicenters is a publicly owned company with approximately 1,500 stockholders in 38 States, Canada, and the District of Columbia. Our company believes—and is proving—that enlightened, efficient private industry can furnish high-quality health care economically. We are convinced that our concept of a proprietary facility operating under the most modern concepts of design and efficiency is essential if the rising cost and other problems of medical care is to be overcome. The same concepts revolutionized the shelter industry—we firmly believe they can do the same in the field of intermediate health care.

In the short 2 years since our organization we believe we have made considerable strides toward this goal. We have opened seven facilities with 660 intermediate-care beds and have under construction an additional six projects with 1,091 beds with 40 facilities, totaling 5,000 beds in some stage of development in 25 States.

We are particularly proud of our accomplishments in assisting two of the largest university hospital centers in the country to upgrade their facilities. I would like to draw your attention to an article which appeared in the Boston Morning Globe on October 20, 1966, photocopy of which is attached to this statement. This announced signing of the contract for a $1.75 million, 232-bed medicenter to be physically linked with Boston University Medical Center. Through the use of an enclosed walkway patients will be transferred from the intensive-care bed of the hospital to our medicenter. While hospital personnel will continue to serve the patients in the medicenter, the cost to the

patient for this service will be reduced to approximately one-third of the cost of hospital care.

Similar arrangements have been reached with Vanderbilt University Medical Center in Nashville, Tenn. Ground was broken for a 178-bed medicenter there. This medicentor facility will likewise become an additional arm of the hospital, allowing continued service by skilled hospital personnel with drastic reduction in cost to the patient. We are currently completing negotiations with the University of Alabama Medical School for a medicenter in Birmingham. This interoperation with a hospital center is, we feel, a unique approach to the problems of crowded hospitals and escalating costs. These three projects, and other similar projects still in the planning stage, well illustrate what can be done with the kind of enlightened, efficient organization we are developing.

Our objective is to establish, through various programs, a nationwide operation providing uniform quality care under rigidly enforced standards. Each medicenter must conform to quality controls established by the national organization to regulate every phase of construction and operation of the facility from the selection of the site to preparation of daily menus. The economics of a uniform, large-scale operation allow substantial cost reductions which are passed on to our patients in lower costs for our services.

The medicenter program is designed to work in cooperation with existing hospitals and other intensive health care units to provide progressive skilled care for recuperative inpatients of all ages above 15 years. The medicenter fills the void between the intensive-care hospital and the home. Patients who no longer need the intensive care of hospitals but require more attention than is generally available in a nursing home or at home are treated at a medicenter. Where a medicenter facility has been established the patient is moved from the high-cost hospital room to the much lower cost medicenter room as soon as possible to continue recuperation until he has recovered to the point where his doctor determines that he may return home.

Medicenters of America, Inc., is particularly concerned with the statement of Robert M. Ball, Commissioner of Social Security, before the Senate Finance Committee on H.R. 12080. He proposes an amendment to the Social Security Act, as amended, to provide that hospitals be required to fund depreciation payments made to them under medicare and that substantial capital expenditures be in conformity with any recommendations of the federally supported health planning activities of the State. While this is specifically limited to hospitals, the possibility that such a recommendation could be expanded to include extended care facilities prompts this expression of concern.

Hospitals are either publicly financed or financed by nonprofit organizations without mortgage financing. Financing considerations of proprietary and of nonproprietary institutions are completely different. The proposal for funding depreciation is completely inapplicable to proprietary institutions, practically all of which necessarily depend on long-term-mortgage financing. In fact, such a proposal, if applied to proprietary institutions, would completely eliminate them as an effective force to provide intermediate health care.

In ironic contrast, a report on rising medical costs prepared by the Department of Health, Education, and Welfare and presented to the

President on March 1, 1967, stated, "Much of the care given in hospitals could be given less expensively outside." The report also recommended the broadening of private and public health insurance to include "stays in extended-care facilities."

Medicenters of America, Inc., respectfully submits that such a requirement would drastically inhibit—if not entirely destroy—the ability of our organization as well as others to meet the rapidly expanding need for extended-care facilities throughout the country. If extended-care facilities such as medicenters (average cost of $7,500 per bed) are not built, then more acute hospitals (average cost of $26,000 per bed) must be built. Accordingly, we urge the committee that if Commissioner Ball's proposed amendment is enacted it be limited to publicly financed institutions.

The question of funding depreciation was initially presented before the Senate Finance Committee at hearings conducted in May 1966 to discuss proposed hospital insurance reimbursement guidelines with officials of the Department of Health, Education, and Welfare. The transcript of these hearings clearly expresses the concern of officials of the Department of Health, Education, and Welfare and of members of the Senate Finance Committee that legislation be enacted to prevent waste and duplication. Particular attention was paid to the problem faced with publicly financed institutions receiving depreciation on assets which were paid for with Federal funds under Hill-Burton construction grants and other Federal programs. Reference was had to situations where the need for such institutions in certain areas had diminished resulting in wasteful operation of an obsolete facility. To the extent depreciation provides funds for perpetuation of the facility such depreciation payments under medicare are wasted. The solution recommended by HEW and the staff of the Senate Finance Committee was legislation requiring funding depreciation coupled with State planning operations. When viewed in light of the evil to be remedied—and when limited to nonproprietary facilities—this proposal may have its merits.

The objection of medicenter is not to the proposed amendment as such but rather to the all encompassing nature of its coverage to include the proprietary portion of the Nation's health care industry.

We do not believe that the ever-increasing need for intermediate health care facilities can be satisfied without the active participation of private enterprise in their construction and operation. To command such participation investors of private capital must be able to foresee a reasonable but, of course, not an excessive, return on their investment. Unlike the publicly financed institution the capital cost of erecting and equipping a proprietary intermediate facility naturally requires very substantial mortgage financing, the interest on which must be paid each month and regular repayments of principal made.

It can almost categorically be stated that the income flow from a high-quality, moderate-cost, extended-care facility cannot offer a reasonable investment return if in addition the proprietary provider must duplicate principal and interest payments by setting aside an immobile reserve for depreciation.

Commissioner Ball's proposal is quite obviously intended to provide available reserves at the time the present facility becomes obsolete, and to assure, through State planning, that the reserves are not unwisely

expended when the obsolete facility must be refurbished or rebuilt. We submit that this same protection is built into the proprietary system.

Prior to initial construction of any medicenter facility the parent company conducts a feasibility study to determine the need for the facility. Where such a need is found to exist a franchise commitment is issued and the operator undertakes to obtain financing for construction. The lender independently determines the question of need and the consequential probability of successful operation. Most importantly, upon completion of construction and commencement of operation, the payment of amortization effectively provides the funding for the proprietary facility which Commissioner Ball's proposal seeks to require. Such payment reduces the mortgage financing and, in effect, provides a source of new financing for future repair or replacement at such time as obsolescence occurs. Since such a facility has a useful life far in excess of the 20-year mortgage which is generally obtained for its construction, the mortgage will be paid off, or at least substantially reduced, long before the need for a large reserve fund arises. When the mortgage is paid, the property, free of liens and representing a long-established, successful operation, can easily be refinanced, if necessary, to raise funds for remodeling or reconstruction. If, by this time the need for the facility no longer exists, neither the proprietor nor the lender will invest in an operation proved to be unsuccessful.

If funding of depreciation is required of the proprietary health care operation, it is our considered opinion that few, if any, private investors will be able to obtain mortgage financing and, of these, none will receive a reasonable investment return. The effect will be to stagnate investor response to the Medicare program. Unless private industry is encouraged to enlist its tremendous resources in the provision of good health care facilities, we are convinced medical costs must continue to rise and the health care needs of our population will not be met, without placing an additional heavy load on the taxpayers of this country.

Medicenters of America, Inc., therefore respectfuliy submits that the proposed amendment to the Social Security Act requiring funding of depreciation for proprietary as well as publicly financed hospitals is not in the best interests of the health care industry and the Medicare program. Accordingly, we urge the committee to limit the proposed amendment to publicly financed health care institutions.

[From the Morning Globe (Boston, Mass.) October 20, 1966]

BU TEAMS WITH INDUSTRY IN NOVEL HOSPITAL UNIT

(By Alexander Uerbach, financial reporter)

A novel link-up between a non-profit hospital and private industry came into being Wednesday with the signing of a contract for a $1.75 million "intermediate care" center at the Boston University Medical Center.

The new facility will be built and operated by Medicenters of America, Inc., a Memphis-based firm which runs a number of similar units around the country at a healthy profit while saving the patient a good deal of money.

Room rates at the Medicenter will be about $15 to $20 per day; in the hospital next door they are between $45 and $57.

The reason for the drastic difference in cost is the less intensive care provided in the Medicenter. Patients will stay in the Medicenter during the recovery

period after the need for intensive hospital care has passed but before they can return home.

The 282-bed unit, scheduled to be completed next Summer, will free a number of hospital beds now occupied by those on the mend but not yet fully recovered.

The structure, to be built at the corner of Harrison Ave. and East Newton St., will be connected by an enclosed bridge with University Hospital.

Because of its affiliation with the hopsital, personnel from there will also serve patients at the Medicenter. Beds also will be open to patients from other institutions.

Much of the economy of the facility is traceable to less expensive technical equipment, less nursing care and easier housekeeping.

According to Wallace E. Johnson, board chairman of Medicenters, some cost-cutting is due to volume purchasing.

Johnson, who is also president of the board of Holiday Inns of America, noted that both organizations use the same techniques of mass purchasing and uniform construction.

"Look at it this way," Johnson said after the contract signing. "We are the biggest purchasers of teaspoons in the nation. That gives you some price leverage when you're buying teaspoons, doesn't it?"

The Medicenter is the second area of the B.U. Medical Center's operation to be contracted out to an outside firm. In August the center turned over its food servies to Stouffer.

The Medicenter, being a profit-making facility, will be subject to taxes—a fact which drew applause from Mayor Collins.

"At a time when the city is desperately in need of new sources of income, the agreement signed today by Boston University and Medicenters is a step toward a solution of a most serious problem," he said in a telegram to B.U. Medical Center.

"Congratulations . . . for your concern, not only for the health of the citizens of Boston, but also for the financial future of this great city," the mayor concluded.

Senator McCarthy. The committee stands adjourned until 10 a.m. tomorrow.

(Whereupon, at 3:30 p.m. the committee adjourned to reconvene on Tuesday, September 12, 1967 at 10 a.m.)

SOCIAL SECURITY AMENDMENTS OF 1967

TUESDAY, SEPTEMBER 12, 1967

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

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

Present: Senators Long, Gore, Talmadge, Hartke, Ribicoff, Williams, Carlson, Bennett, and Curtis.

Senator TALMADGE. The hearing will come to order.

This morning our first witness was to have been Gov. John A. Volpe, of the Commonwealth of Massachusetts; however, I understand he has been delayed and cannot get here until later in the day.

That being the case, we will hear first from the Honorable John V. Lindsay, mayor of the city of New York. Mayor Lindsay, we are pleased to have you with us. We know of the school teacher crisis going on in your city, and it is giving you some concern, and we appreciate very much your being here today. We know that you attach great importance to this legislation or you wouldn't be here, so you may proceed as you see fit.

Senator CARLSON. Mr. Chairman, may I add my words of welcome. We are very happy to have the distinguished mayor and former Member of Congress in our presence this morning.

STATEMENT OF HON. JOHN V. LINDSAY, MAYOR, CITY OF NEW YORK, ACCOMPANIED BY MITCHELL GINSBERG, COMMISSIONER OF SOCIAL SERVICES

Mayor LINDSAY. Thank you, Mr. Chairman and Senator Carlson.

May I first introduce the commissioner of social services and the designated administrator of the human resources administration in the city of New York, Mr. Mitchell Ginsberg, who is at the table with me this morning.

Senator TALMADGE. We are delighted to have you here, sir.

Mayor LINDSAY. Mr. Chairman and members of the committee, everybody talks about welfare, to paraphrase Mark Twain's observation about the weather, but everybody wants to do something about it.

Certainly few of the people involved with welfare would give unreserved endorsement to the system under which we now operate.

The recipients—among them the jobless, the handicapped, the poverty-stricken—don't like it, because almost no one truly wants to live on handouts. The administrators are appalled by the paperwork and

disillusioned by the lack of constructive results. And the taxpayers are more and more resentful of the millions of dollars that are being spent on public assistance with no diminishment of the welfare rolls.

The legislation before you, H.R. 12080, reflects that national mood; it evolves from an understandable and energetic desire to redesign a social welfare program that in many ways has been a philosophic and financial flop.

We in New York City support the primary objective of this bill, insofar as that objective is to reduce dependency upon the government; to enable public welfare recipients to lead constructive, independent lives, free of government maintenance and supervision.

The goal is admirable. It is, however, one that has eluded us for decades, and experience alone should compel upon us a precise, realistic examination of the strategy by which the goal now is to be attained.

Our review of the amendments has convinced us that many of them will not work. Some will make our jobs more difficult. Others will make them more expensive.

In summary, this legislation contains elements that in our judgment may have the ultimate effect of converting a deeply troubling situation into a thundering crisis.

Before proceeding with our analysis of the bill, I should like to present a brief review of New York City's involvement in social welfare. Because of its enormous size and diversity, New York magnifies every domestic problem common to the country's metropolitan centers. Accordingly, New York's experience may afford the committee some fresh insights into the many difficulties and few successes to be found in this Nation's effort to provide for the poor.

A fundamental, perhaps shocking fact is that New York City contains as many hard-core poor people as there are residents of the District of Columbia. If we count all those who live in the sections of our city that have been declared poverty areas, the total almost would match the entire population of the Washington metropolitan area.

More than 670,000 individuals are receiving welfare aid in New York City, and that number is going up at an average rate of 12,000 a month. We have budgeted $913 million for welfare costs during this fiscal year, but it may not be enough to finance the increasing number of recipients. Our welfare budget, I might point out, has gone up more than 200 percent since World War II—the highest rate of increase of any city budget category.

I'm sure you're familiar with the usual explanations for the spiraling number of people on the welfare rolls. One is that more and more people are discovering they are eligible for assistance. Another holds that our increasingly sophisticated, automated economy has thrown hundreds of thousands of unskilled employees out of work and has reduced the demand for others entering the labor market. The explanations are sound, but they cannot account for the boom that welfarism has experienced in New York and other American cities.

The forces generating the rise in the welfare rolls of our cities are of national scope. The cities have been victimized by two complementary movements: The first is the exodus of middle-class white families and the industries that employ the unskilled and semiskilled from the large cities. The second is that automation in rural areas,

often exacerbated by regressive social welfare policies, is driving low-income families to the urban areas.

Between January 1960 and April of 1967, approximately 220,000 persons received welfare support in New York City as nonresidents because they had not yet lived there for the 1-year minimum period. The vast majority of these 220,000 came from other States. Lacking the skills or education to maintain themselves out of poverty, most were unable to find employment that would pay them a living wage. By 1970 it is estimated that 20 percent of the city's welfare rolls will be people who originally received their assistance as nonresidents, and came from other States.

Jonathan Lindley, of the Economic Development Administration, has predicted that this trend will continue for at least 10 years. A Fordham University survey of the Borough of the Bronx concluded:

The technological revolution in American agriculture, which has driven these people off the land, is a national problem and the primary responsibility for coping with it is the Federal Government.

In New York City we are developing a whole new set of tools with which to aid those receiving public assistance in their efforts to achieve self-support. Many of these programs we have financed independently while waiting for the Federal Government to assume its share of this national responsibility.

Through the municipal and voluntary hospitals, the health department, and the Planned Parenthood Association, over 100,000 women are now receiving birth control services each year. We have won authorization from the State to allow our social caseworkers to inform welfare mothers of the benefits of family planning. At the same time a program of neighborhood clinics operated by several city departments in conjunction with community groups is being established in a dozen neighborhoods. By the end of this year we expect to be operating at an annual level of $1.5 million and to be reaching 50,000 now not taking advantage of family planning services. At the end of the second year of the program, these neighborhood clinics alone are expected to give guidance to 100,000 women. I strongly endorse the provisions in this bill to strengthen States efforts to provide family planning.

The city now provides working mothers with 98 day care centers where 7,000 children receive daytime supervision at a cost of $8 million. We have budgeted $3.5 million this year for an experimental family day care-Headstart program which will provide full day supervision for an additional 3,200 children in 800 homes. The program will give direct employment to 800 women, and release another 1,600 to enter job training programs and to seek employment.

We have placed $10.7 million in this year's budget to fund the manpower and career development agency.

The CHAIRMAN. Mayor Lindsay, may I stop you for a question about the statement which you just made. You have involved there let's say 2,400 women, 800 looking after these day care centers, as I understand it, 1,600——

Mayor LINDSAY. Released.

The CHAIRMAN. Who are released to go to work. Now, that is a total of 2,400. Now, how many of those women working in that situation would not be available to work if you did not have the program? What is your guess on that?

Mayor LINDSAY. I don't think any of them would be available.

The CHAIRMAN. In other words, let us assume that you have perhaps 24 women, let's assume for the sake of argument that they are all mothers.

Mayor LINDSAY. Yes. That is a safe assumption too.

The CHAIRMAN. If that is the case, then where in one instance you would have all 2,400 mothers tied to the home, you would be in position then for 600 to go to work, and offer the other 1,600 the opportunity to accept training and work.

Mayor LINDSAY. That is right.

The CHAIRMAN. So that, hopefully, 1,600 would be added to the labor force, and one-third—you have 2,400 to add to the labor force, but 800 of them would be working to look after the children while the other 1,600 would be a net gain for the labor force.

Mayor LINDSAY. Also for the tax rolls; they would be taxpayers.

The CHAIRMAN. Yes.

Mayor LINDSAY. It would mean increased revenue to the city and to the Federal Government as well. Ideally, a system would be established of living room day care centers in a block, where the mothers who take care of the children in a neighborhood grouping would be paid by the other welfare mothers who are released to work. It would be a cooperative effort, financed totally by the private sector, supplemented in individual cases by partial maintenance, which we have been experimenting with in New York in a demonstration program. We have found that it works.

The CHAIRMAN. We have the good fortune, both in my office and at my home, to have people working for us who have children that must be cared for, and they find ways to do it, but they don't have any formal program to help with it, and there are perhaps a lot of other people, as you are indicating here, who could use this to be a part of the labor force and do something much more productive than to simply stay at home with one or two small children. That is what you are advocating.

Mayor LINDSAY. Yes.

The CHAIRMAN. If there is no one to take care of the child they have to stay there.

Mayor LINDSAY. That is right. Not long ago we ran an experiment in New York City. The city paid the Port of New York Authority funds to establish a training program for clerical and typing work for welfare mothers at the port authority headquarters. One hundred and eight welfare mothers were brought into the program. The city arranged for day care help for all of their children. One hundred percent of them had children, and almost 100 percent of them had no male breadwinner in the family.

After the training program of 15 weeks, in which the attendance was almost 100 percent, all but a handful completed the program and were placed with blue-chip corporations in clerical and typing jobs where they are still working. Their record of attendance has been excellent. In other words, the system has worked, providing you make arrangements to take care of the children.

Senator TALMADGE. How much did it cost per trainee to do that?

Mayor LINDSAY. Well, that was an experiment, and it was expensive. I can't give you the exact cost of it. It is higher than it would be once you get rolling in the proper living room day care program.

Senator TALMADGE. How long was the training period?

Mayor LINDSAY. Fifteen weeks. We are laying our plans in New York City through the Human Resources Administration, of which Commissioner Ginsberg would be the new administrator, to go into the business of living room day care in the block in a very big way. That can be cheaper and faster and even more effective than the normal system of rather elaborate day care centers that are removed in some cases from the immediate vicinity of the block.

The CHAIRMAN. One thing that somewhat disturbs me is this idea that all these mothers who are drawing welfare money to stay at home have to be provided with a top paid job, that they have to be trained so they can be the top secretary in your office. You know somebody has to do just the ordinary everyday work.

Now, if they don't do it, we have to do it. Either I do the housework or Mrs. Long does the housework, or we get somebody to come in and help us, but someone has to do it, and it does seem to me that if we can qualify these people to accept any employment doing something constructive, that that is better than simply having them sitting at home drawing welfare money with one or two children who may theoretically——

Mayor LINDSAY. Correct.

The CHAIRMAN. That is an inefficient use of labor.

Mayor LINDSAY. Well, we found that these women want to work. One of the problems has been for a wife or mother with three or four children to get to work and get back from work and to arrange for her children to be taken care of. In many cases, the work that is provided doesn't pay them enough to live, or for their children to be taken care of. These women do not demand top jobs. All they wish to have is a living wage.

It is true that the past welfare system has been ridiculously rigid, in that it has been all or nothing, and it is true also that in many areas of the country, a welfare mother is in a better position if she hasn't worked than if she did work. I say better position. It is still substandard, but employers have to understand that in the case of people who have never been exposed to the world of employment, and a welfare mother particularly, which is most of the cost problem that we have in the Nation and in New York, you cannot regard this as a 9-to-5 proposition, because the problem is far beyond 9 to 5.

We have placed in New York City $10.7 million in our current budget which funds the manpower and career development agency within the human resources administration. All job training programs funded through this agency give the highest priority to providing employment for those now receiving public assistance.

We have established in New York City a series of 18 neighborhood manpower centers, and integrated into the work of these centers the formerly independent division of employment and rehabilitation of the welfare department, thus making far more efficient use of the limited employment resources available and greatly expanding the ranges of jobs open to public assistance recipients.

We have, in cooperation with the city's voluntary social agencies, created a child-care system that shelters about 22,000 homeless children.

We are doing everything possible to find the absent fathers of illegitimate children and require them to contribute to the youngsters' support.

We have begun an experiment with an economic incentive to allow welfare recipients to keep the first $85 a month they earn, plus 30 percent of any additional income. This form of economic incentive may be the most effective way to reduce welfare expenditure and encourage independence.

The CHAIRMAN. You know, Mr. Mayor, it really does cause a lot of business people and taxpayers to become extremely resentful of our public welfare programs when they try to hire people and those people won't go to work because they say they will lose their welfare benefits. I am talking about people who are able to work, and who are qualified to at least be a part of the labor force, but who say that they can't go to work because that would jeopardize their welfare payments. It is pretty difficult for the businessman who has a "Help Wanted" sign out in front of his business to be told that there is no help available to him because they are all drawing more in welfare benefits than they would get going to work for an honest day's pay, at a time when he is trying to make that business succeed. He has to pay taxes for welfare, but at the same time he can't get anybody to work because they are drawing it.

Mayor LINDSAY. Well, in 99 percent of those cases the reason is that the job that is open to that particular person pays him a wage that—after work-related expenses—does not provide a better life.

The CHAIRMAN. That is why we ought to amend this program to work out some middle ground rather than this all-or-nothing approach.

Mayor LINDSAY. Correct.

The CHAIRMAN. A change so that a person could draw part of his welfare payment and still proceed to have earnings from work as well as doing something which would lead to greater earnings for him as he learned how to do the job.

Mayor LINDSAY. Absolutely. It would save the taxpayers a great deal of money. We have found in the demonstration program that we have been running in New York, which permits the welfare recipient to keep the first $85 plus 30 percent of any additional income, is working. It leads to a reduction in cost.

Senator TALMADGE. Mr. Mayor, on that point, assume you have a mother with three children. What are the total benefits she would receive in the city of New York under those conditions, under aid to dependent children?

Mayor LINDSAY. Mr. Ginsberg tells me it would be about $2,850, not counting medical allowances.

Senator TALMADGE. In other words, about $225 a month, so she couldn't take a job earning less than that without forfeiting her welfare benefits. In other words, if she took a job as a maid in the city of New York at $60 a week, she would be better off not working than she would be working.

Mayor LINDSAY. Because of the children. She has to make provision for the children.

The CHAIRMAN. Now with regard to that very mother——

Mayor LINDSAY. And don't forget commutation costs.

Senator TALMADGE. I beg your pardon?

Mayor LINDSAY. Don't forget commutation costs—travel costs.

The CHAIRMAN. Now with regard to that very mother, it is quite possible that she might do domestic work for 4 hours a day and make this amount of earnings. If you had some arrangement where she could keep some substantial portion of those earnings then she might find it to her advantage over and above the cost of getting back and forth.

Mayor LINDSAY. She will work.

The CHAIRMAN. Yes.

Mayor LINDSAY. She will work. She will want to work, definitely. We are providing supplemental assistance to families in which the breadwinner is fully employed but does not earn enough to support his family. With no Federal assistance, the city and the State together are supplementing the income of 13,000 heads of families, who in turn support 65,000 individuals. We make up the difference between what the breadwinner earns and what the minimum welfare allowance would be for such a family if the adult were unemployed. It costs us $90 million a year.

But if these programs are to work—any of them—they cannot be forced upon the clients. We can provide day care facilities, but we cannot force a mother to turn her children over to them. We can develop employment opportunities, but we cannot force a person to take the job and expect a satisfactory employee; in all likelihood an unwilling worker will be fired. We can offer family planning advice, but we cannot, and should not, force a woman to accept it.

The CHAIRMAN. Mr. Mayor, that is one thing that does concern me a little bit about the work part of it. With regard to unemployment insurance, we talk about something a person has earned. He earned it by working for it, and he has a right to expect it—somewhat different from welfare.

I just hope we never get to the point where everybody has a right—able-bodied people have a right—to expect welfare payments although they decline to work. It seems to me that the right to go hungry, if you don't want to work, should be preserved in this country.

Mayor LINDSAY. I think, Mr. Chairman, the best answer to that is some of the facts and figures which I am about to give you.

The CHAIRMAN. But why wouldn't the same logic apply——

Mayor LINDSAY. The fact is that if New York City is any test of the country, that there are not numbers of people who have job opportunities and refuse to take them because they don't want to work, and therefore are on the welfare rolls.

The CHAIRMAN. But is there anything voluntary about concerning a man or a woman drawing unemployment insurance benefits? If decent employment is offered to them and they decline to take it, they just don't get unemployment insurance.

Mayor LINDSAY. Under the present law in New York, no one is entitled to welfare who is in the position to work. They are not entitled to it. If you are able to work, you must work. Otherwise, you are not entitled to be on the welfare rolls.

That is the present law. Let me give you some facts and figures here. This may help resolve this point.

The belief, you are quite right, is very common, and it is unfortunate, I mean it is a false belief, but it still exists, that the welfare rolls in

New York City and in other cities are burgeoned with the lazy and the shiftless—in other words, that able-bodied men and women who should be working are on relief. The facts don't substantiate the stereotype that so many people have.

In a spot review of the 600,000 persons who were receiving public assistance in New York City at the end of last year, we found:

Seventy-nine percent were children and adults caring for children. The approximate breakdown was 98,500 mothers and 300,000 children.

Fifteen percent were aged, sick or disabled and wholly unable to support themselves.

Two percent consisted of families with an employed male with an earned income so low that he could not support his family at a subsistence level.

Four percent were potentially employable persons unable to obtain a job because of inadequate skills or training.

Of this last 4 percent, or 24,000 men who are technically considered employable, only 2,600 have enough occupational ability to move into employment without considerable training and rehabilitation. I think those figures are compelling.

About 43 percent of the 24,000 technically employable men are considered ready for training or remedial education and are either involved in or are awaiting assignment to such programs in New York. The remaining 44 percent of that small percent who are technically employable are so disabled as to require massive counseling, rehabilitation, health services, close guidance and long-term followthrough.

I might note that this basic and enormously difficult task—finding jobs for those who cannot now qualify for jobs—is the principal aim of the National Urban Coalition I and other mayors are organizing. It has become frustratingly clear to me as a mayor that the public sector cannot marshal the resources—in money and in brains—to move against the problem. But the private sector, which has given a nation the world's highest living standard and yet has not been brought into the fight against poverty, can get results far exceeding governmental abilities.

If the commercial and industrial giants of this country will undertake a total effort to provide training and employment for the poor, I think we can make our present efforts look almost rudimentary. The institution of that commitment is underway, and we in the cities have high hopes that it can succeed where we have so consistently failed.

The concern for the Nation's public assistance program that is expressed in H.R. 12080 is a concern we all share. The Congress, the taxpayers, the social work profession, and the poor themselves have witnessed the weaknesses of the program over the past 30 years.

The public assistance program was designed to provide basic financial support for the destitute, as well as services to encourage self-support where possible. On both counts, it has clearly not succeeded:

Support payments in most States are too low to sustain even a minimal, decent standard of living.

The method by which these payments are delivered encourages feelings of worthlessness that lock recipients into dependency.

And the complex administrative structure prevents an investment in the time and skill required to offer constructive help.

It has been demonstrated amply over the years, we think, that more investigations of eligibility are not the answer, that forced work is not the answer, that removing children from their homes is not the answer, that denying Federal assistance to intact families is not the answer, that arbitrary caseload ceilings are not the answer, that increasing the stigma of welfare is not the answer, that welding services and income maintenance is not the answer.

The Nation has 30 years of experience with these devices and the results are plain. They have not succeeded in controlling the caseload and they have not helped people. I submit that it is equally evident that some of the provisions of H.R. 12080—adhering as they do to the familiar route of control and threat—will fail. Aside from the morality of penalizing children with the proposed ceiling on the aid-to-dependent-children caseload, removing children from parents who decline to work, and forcing mothers into work and training that may not be appropriate—there are also questions of practicality and effect.

At a time when we are agreed that the problems of the urban communities pose the greatest challenge to our domestic policies, we are in danger, through this bill, of striking at the very group most involved. The fine programs now under discussion in the areas of employment opportunities, better housing, improved police protection, revitalized education, and more accessible health programs could in large measure be vitiated by a return to more restrictive, coercive methods of public assistance:

The House-approved freeze on the number of AFDC recipients at the January 1967 proportion of the State's entire child population is harsh and self-defeating.

The fastest growing category of public assistance has been the aid to families with dependent children, AFDC, and I endorse the intent, expressed by the House committee report, to "reduce the AFDC rolls by restoring more families to employment and self-reliance."

However, the means to this end is not to put an absolute limit on the number of children that a State may have on AFDC recipients.

For New York this would create three equally unacceptable alternatives:

The city and State together could pay for the overage without Federal aid, which would add $50 million a year to the costs of the governmental units least able to pay. That money would have to be taken from other municipal services, and I need not remind this committee that one of the chief agonies of the cities of the Nation today is the agony of their operating expense budgets to provide ordinary services to the people of this center-core, hard-core city areas that are enjoyed by the entire region as well as by those who travel through and visit these cities.

The second choice left to us is that the children who exceeded the limit would receive no assistance, thus compelling their families to somehow stretch the funds they presently receive, which is impossible, which once again puts the burden directly on us at a time when we ought to be going in the opposite direction.

The third choice would be to somehow force off the welfare rolls a sufficient number of families to remain within the quota. Once again we have to make provision because we cannot allow people to starve.

Ninety thousand New York City children would be affected by this legislation in 1967–68.

The report of the House Ways and Means Committee has estimated that the House-passed bill will reduce the AFDC rolls by about 300,000 persons from its present total of nearly 5 million. Since we have found that forced work, coercive paternity searches and other restrictive measures do not, in fact, lead to independence from public aid, the attainment of this reduction is highly unlikely. Even if we were to believe in it as a matter of rightness or morality or principle, and apply all of the forces at our command to its implementation, it still would be impossible and would not work.

But even if the bill's restrictive provisions were to be effective in reducing the number of recipients of AFDC, these are likely to be the results:

1. The removal of children from parents who decline to participate in community work and training would merely shift the financial responsibility for their care to another part of the program, at a higher cost. Foster care, whether it be an institution or a foster family, is far more expensive than AFDC.

2. The removal of Federal participation from post-freeze AFDC cases would open up a series of undesirable alternatives: The financial burden for the care of destitute children would be shifted to the States and localities that can least afford it. States with well-developed programs and commitments to their poor residents would be penalized for continuing to help; poorer States would be forced to reduce their payments and develop even more punitive and restrictive relations with applicants than they have now.

Finally, persons who were unable to conform with the requirements for AFDC—since they cannot be left to starve in 20th century America—will have to be absorbed into other programs. I repeat: It will cost New York City and New York State a combined total of at least $50 million a year to do so.

3. The children who remain covered by the AFDC program would be penalized, as well as those who are unqualified merely by virtue of their numbers. The effect of disqualifying children who exceed the required numbers would be to reduce an entire family's grant. For example, a mother with three children may today receive $200 a month, or $50 a per person. When a fourth child is born and exceeds the number to be covered, the effect would be to reduce each grant to $40, thereby penalizing the other children.

4. The multiplication of areas of discretion in the delivery of public assistance and the added sanctions on individuals will most certainly aggravate tension in ghetto communities where residents are just beginning to organize in their own behalf. The experience of most urban antipoverty programs has been that a high percentage of time and effort is spent in defending the poor against unreasonable, arbitrary public welfare policies.

The committee report, however, makes it plain that such progressive contributions as Federal support for day care, training and employment programs, foster care, family planning and family counseling are included in the bill only as specific devices for reducing the AFDC rolls. They are not intended to encourage cities and States to grapple with the massive social problems that face our urban communities.

With respect to the provisions for mandated community work and job training, I doubt that the House bill can achieve its objective by requiring participation in job training and employment to qualify for public assistance.

Senator GORE. Mr. Chairman, may I ask a question? Mr. Mayor, I agree with much that you have said. I wish to explore with you, however, your view of the possibility of providing work for these 24,000 employable men in New York City to whom you earlier referred who are now receiving welfare payments.

Mayor LINDSAY. Potentially employable.

Senator GORE. You mean by that, I take it, they are ablebodied.

Mayor LINDSAY. Yes, able bodied with severe problems, however, whether it be a partial illness through narcotics or whether it be some handicap by total absence of education as to have very limited ability to read or write. The commissioner reminds me that 50 percent of this particular group is functionally illiterate.

Senator GORE. Illiteracy is not an impairment for labor.

Mayor LINDSAY. That is right.

Senator GORE. It may be an impairment for employment in the private sector of our economy at the minimum wage. But this country, by act of Congress, with approval of the President, adopted a policy of full employment. This full employment policy does not distinguish between literates and illiterates. You have said that many things are not the answer, but you haven't provided us with an answer yet. You have eliminated a number of things and I am inclined to agree with you on these. But I would like to find a positive answer.

Now with the adoption of a policy of full employment, which we have never implemented, I would like to know your views on a positive program of providing work for a man who is ablebodied, maybe not too well prepared mentally, but unfortunately they are with us—at a decent wage, if not in private industry, through supplement, subsidy or otherwise in a public works program to build more parks in New York City, more sidewalks, plant a few more trees, reseed some of the worn grass areas. What would be your views in that regard?

Mayor LINDSAY. You are right. Let me give you a couple of specific examples. The other day we opened up, without a dime of Federal or State money—a portion of the Brooklyn Navy Yard which had been one area of unemployment, thanks to the Federal Government withdrawing that facility for job opportunities in New York, without compensation, and then requiring us to pay for the acquisition of the land. We made the portion available for job opportunities. We opened it up to 570 ghetto people for on-the-job training. They are paid as they are trained for trailer-truck, fork truck, and taxicab driving, through a manpower training program run by our manpower commission within the human resources administration. Now, this type of thing we are springing up throughout the entire city.

In the police department, for example, we are opening up a training program for ghetto dropouts in which we train youngsters in basic reading and writing skills, pay them to assist them through high school, and then pay them to go through the police academy to train them for jobs on our police force. We do the same in a multitude of other areas of city agencies.

This past summer we have had 41,000 young men and women between the ages of 16 and 21 employed, principally public service type programs in the parks, playgrounds, hospitals, government agencies of various kinds, and some in the private sector, paid by public funds.

In this 41,000 number is the Neighborhood Youth Corps category. With the end of the summer I should like to add, 30,000 of those come off the rolls, and no provision is made for them, which is the reason why I have been pleading with the Congress and the Federal Government to continue the Neighborhood Youth Corps program on a year-round basis. We will absorb many of these teenagers into public service type work in our city. But there is only so much that we can do with our limited resources.

We find that as we continue in the area of job training and job placements, it is expensive, and we need more. The Scheuer program is good, and we are making maximum use of it in New York City. There are Federal funds that enable us to train people, and assign them to productive jobs.

But it is not cheap to hire people for sweep-up campaigns or to put them through training programs in order to make them literate, and to expose them to institutions, public or private, that will give them further training and put them on the ladder toward career potential jobs.

We are organizing a local urban coalition in New York, in order to interest the private sector in the importance of training programs for the bedrock poor. It will be expensive, but we are trying to persuade them it is to their advantage to do so.

So between the public commitment and the, I hope, increasing private commitment, we think we are on the track. The Congress could help by moving in the direction of the Clark bill on manpower training. The bill could help instantly by not putting New York in the position of having to drop off the payroll 30,000 young men at the end of the summer. We will have to find positions for them someplace because our guess is that in New York a minimum of 6,500 will never see the inside of a schoolhouse.

They have dropped out of society, and they have no connection with it except for these jobs that we are able to provide, and that is true in every city in the Nation where they need help on the problem of having the necessary funds to provide jobs and to train young men for public jobs. The private sector ought to be induced and persuaded by various means to do the same.

Senator GORE. I expect to support the Clark bill, because it does move in the direction of a positive answer to the problem of employment. I take it by your remarks that you are favorably inclined toward it.

Mayor LINDSAY. Absolutely. We find, Senator, if I may interrupt again, that things like the rental program, automobile and truckdriving, are so useful. Our city is doing it again without assistance from other governmental groups in the area of nurses and technical assistants, where we are taking ghetto people, 99 percent black or Puerto Rican, and paying them at our taxpayers' expense to be trained for hospital aid and technical aid jobs in our massive hospital system.

We have 21 city hospitals in New York, and to staff them is a terribly burdensome thing, and we are reaching into the ghetto communities to train women and men, in order to put them at least on the bottom rung of the ladder so that there is the hope that even some of them may eventually become registered nurses.

Most of these programs we are underwriting ourselves. Between that expense and the costs of collective bargaining and the costs of public employees, I don't know where we are going to find the funds to do it and stay afloat.

Senator GORE. I would like to direct your attention for a moment to perhaps a tangent of this overall problem. A great many people with whom I talk and who express considerable impatience at what they call the welfare state think of pick and shovel jobs as means of employment. I think I may have erred in that direction some years ago in expressing an estimate of the number of people who would be employed in constructing the Interstate Highway System.

I wonder what you would think the difference in cost would be in constructing the Interstate Highway System if we maximized the pick and shovel instead of the mass machinery system by which they are now constructed?

Mayor LINDSAY. Senator, you are talking to the wrong man, because if you take all that money you have been putting into highways and put it in mass transit in cities, we would be in better shape.

Senator GORE. That is an entirely different tangent. The point I am trying to make is that with the increased mechanization of construction, whether of streets and highways, sidewalks or buildings, there are, percentagewise, relatively fewer and fewer jobs for the unlearned——

Mayor LINDSAY. Right.

Senator GORE. The unlearned man.

Mayor LINDSAY. That is true.

Senator GORE. Not many contractors want to turn over a $50,000 piece of machinery to an illiterate to operate. It requires some intellectual acumen to work in the construction industry now, though there must be some jobs yet available to these 24,000 of whom you speak.

Mayor LINDSAY. There are, and there are many jobs which many people would regard as pure pick-and-shovel-type jobs, manual labor jobs, but which are very, very good jobs. Most of them are within the union structure, as you well know, and it depends really.

If a job has attached to it an adequate hourly rate, it takes on a new status, even though it may not have the appearance of having a great career potential attached to it. A good electrician may be an electrician all his life, and not be advanced necessarily into the supervisory or management rolls, but he is satisfied. He is getting a good wage. Likewise, a person who is a street maintenance man filling up potholes in the city of New York is in the same category. We have a massive highway department in New York, with a great many people engaged in street maintenance. Although through the municipal union structure they push us to the wall every 2 years when the bargaining comes up, the fact of the matter is that they are good potentially, and they maintain their families reasonably comfortably.

Senator GORE. We have discussed one partial answer. I said earlier you have eliminated a large number. What further positive suggestion, if not in the nature of an answer or in the nature of a positive approach to the problem, can you give?

Mayor LINDSAY. I mentioned one specific, the Neighborhood Youth Corps on an ongoing year-around basis. I picked that out because it has proven its worth. It really is noncontroversial. It is not like community action programs which are very controversial in the Congress and elsewhere, so it is doable, it is specific, it could be done tomorrow by the Congress.

(2) Manpower training money, such as the Scheuer program, expanded in the Nation generally, and we are expanding it locally in New York and funding it. Both of these are job programs, and go to the question of jobs.

(3) Legislation designed to provide the carrot that the private sector needs to get moving in the ghetto areas of the big cities and all the cities. I shouldn't use the words "big cities" because the city problem is a common one regardless of its size these days. Such legislation that would be an inducement and an enticement and an encouragement to business to do two things:

(1) Hire and train persons that up to now they would not be willing to hire and train for productive employment.

(2) Construct in ghetto neighborhoods for their own uses.

(3) Take into partnership in that construction or investment indigent people by means of various devices including banking devices that will make it relatively easy for indigent people to borrow sufficiently to begin their equity ownership in whatever portion of the business might be located in their area.

(4) Don't enact amendments of the type that the other body shoved into this bill, which is the subject of this conversation today.

Senator GORE. That is not positive. You have eliminated that already. I am inclined to agree with you.

Mayor LINDSAY. Further on the positive, fully fund model cities. Step up your urban renewal commitments. Urban renewal almost has a bad name these days because it is thought of as being a bulldozer technique, but that is changing very rapidly in cities and is changing in our city. It gives us a tool to work with that is very important.

And finally, step up housing commitments in general, because if I could point to one area of specific need in our city, and I believe this is probably true in other areas too, other than jobs, I would put my finger on the question of housing.

Senator GORE. Thank you, Mr. Mayor. Thank you, Mr. Chairman.

Mr. RIBICOFF. If Senator Gore has covered this question, please don't feel that you need answer it, Mayor Lindsay. In talking about job training, if New York had the money today, how many jobs would you be able to fill with people who aren't basically trained, in your parks, your libraries, your schools, your colleges, your streets? Was this covered at all?

Mayor LINDSAY. No. The number of persons that with proper training could be introduced into the job area and held to it was not specifically mentioned. The answer to that in part depends on how sufficient your training programs are geared up to train them.

In many cases training is the key, and education and teaching is the key. Possibly before you came in I did mention some of our police program for school dropouts, which is highly individualistic. Here we are talking about 300 or 400 youngsters who have to be taught and educated before they are in a position even to qualify for police examination.

We could tomorrow find work for youngsters between the ages of 16 and 21, males, which is the Neighborhood Youth Corps age, probably for up to 400,000 young men in this category. We went up to 41,000 on Neighborhood Youth Corps this summer, and our manpower people were telling me during the course of the summer that they believe that they could fill slots upwards of a quarter of a million if we had them.

Senator RIBICOFF. A quarter of a million people in the "service" category?

Mayor LINDSAY. If you went beyond this into women and men over the age of 21, you have got another quarter of a million at least, so you are talking in the areas of a half million to a million jobs alone. The urban coalition called for a million jobs immediately.

Senator RIBICOFF. A half million to 1 million would reduce the unemployment in this category to what percentage, in New York alone?

Mayor LINDSAY. Let's talk in the area of welfare. Our total welfare number is almost 700,000 individuals. The male and female percentage of that in numbers who are over the age of 16 would be what?

Mr. GINSBERG. Better than 150,000.

Mayor LINDSAY. Call it 200,000. Then add to that the 200,000 or 300,000 who are not on the welfare rolls but who could be, and you have got a welfare situation of persons who might otherwise be in the job market of close to half a million. Add to that another category of persons who are just outside the welfare area but in definite need of public assistance of some kind such as medicaid and you have another category.

Senator RIBICOFF. Mr. Ginsberg can answer this if you do not have it at your fingertips. I would like the numbers for whom you could supply jobs in the "service' category, private or public service. I am talking about private hospitals; I am talking about private colleges and universities as well as public. Have you any idea what your welfare costs are to maintain the same people who could have jobs and be paid a week's pay, how much this is costing you and your welfare budget?

Mr. GINSBERG. Well, if we could find places for 50,000 people, let us say, in the kind of jobs you are talking about, that would be roughly about a fifth of our welfare costs and that fifth would be close to $200 million.

Senator RIBICOFF. In other words, you could substitute $200 million of welfare payments for people who are just receiving payments alone for doing nothing and give them a job for the same $200 million?

Mr. GINSBERG. Yes, I think if we had that money, we could find those jobs in the public sector, counting the two categories that you have mentioned. I would not hold it to an exact figure but given a period of time you could put 50,000 people in for the amount you are talking about.

Senator RIBICOFF. I personally believe you are one of the outstanding welfare administrators in this Nation, and now you are about to assume more important responsibilities. From your observations, what happens to an individual and his family who has a job, receiving his own week's pay and doing what he wants with his money as against the same person receiving a welfare payment whose budget and his expenditures are supervised? What impact does that have on the individual and his family?

Mr. GINSBERG. It is two different worlds, Senator, not only for him at that moment but in the future, too, because when you have them on welfare you build up a situation where the evidence indicates pretty clearly the children ultimately end up that way also. You build up a feeling of dependency which is not their fault, but which you have built into the system and so literally you not only change his life in that but you are changing the life of families to come.

Senator RIBICOFF. Is not the problem that we are facing in America today, one of the basic problems contributing to the violence of the cities, is that affluent America does not understand this world?

Mr. GINSBERG. Exactly.

Senator RIBICOFF. In other words, this is a world all of its own that no matter how educated, no matter how sophisticated or knowledgeable we are, is completely beyond the ken of American society.

Mr. GINSBERG. I say it is a different world, Senator.

Senator RIBICOFF. Now, basically what you are trying to do, what we are talking about now in this conversation, is how to take that world and make it like the rest of America.

Mr. GINSBERG. That is right.

Senator RIBICOFF. And the key to that is jobs.

Go back to another phase of the House bill, in which they are limiting the number of children with respect to whom Federal payments may be made, and I read, "Notwithstanding any provision of this act the number of dependent children who have been deprived of support," et cetera, "shall not exceed the number which bears a ratio to the total population of such State under the age of 21," et cetera, et cetera. You know the clause I am talking about.

Mr. GINSBERG. Yes.

Senator RIBICOFF. What is the inmigration to a city like New York from the Southern States today of women without husbands and with children?

Mayor LINDSAY. The inmigration has always been very substantial from Southern States to New York City and also from Puerto Rico to New York City. That inmigration has decreased in recent years, for two reasons. One, a higher rate of industrialization in the South, and the attraction in the North of smaller cities, other cities, and also suburban areas around New York and around other cities.

The rate of persons who are on welfare or become welfare recipients currently coming in from the South would be what?

Mr. GINSBERG. Four percent; about 30,000 a year.

Senator RIBICOFF. 30,000 a year. Do you have a residency requirement in New York.

Mayor LINDSAY. No, we do not.

Senator RIBICOFF. For receiving welfare payments?

Mayor LINDSAY. No.

Senator RIBICOFF. Suppose the Senate adopts the House provision. Do you see then an influx into States with higher welfare payments of that segment of the population that is closed out of receiving benefits under the House bill?

Mayor LINDSAY. Yes; we do.

Senator RIBICOFF. So, in other words, what this would mean, that if you closed out welfare payments because of a rise in percentage of illegitimate children in certain sections of the country, in relation to the population, that immediately these families will flock to the northern cities.

Mayor LINDSAY. Yes.

Senator RIBICOFF. Compounding the difficulty.

Mayor LINDSAY. Yes.

Senator RIBICOFF. There is no residency requirement, and apparently the Supreme Court——

Mayor LINDSAY. It would not make any difference if we did.

Senator RIBICOFF. If you did or not, you assume the burden of paying.

Mayor LINDSAY. We still have to assume the burden of taking care of poor families, and in fact even that percentage of those—let us hit this on the head right away: A year's residency under any circumstances is not going to change anything. The total percentage of welfare people in New York City who have been in New York City less than a year is less than 2 percent, and of that figure, the same average applies between men and women as applies for those that are there more than 1 year. In other words, 80 percent would be women without a male breadwinner, and even if you have the residency requirement, we would have to provide for the subsistence of those persons.

Curiously enough, the other night I took Mr. David Ginsberg, Executive Director of the President's Advisory Commission on Civil Disorders, on a tour of the city. We were in Brownsville during the evening at one point, which is adjacent to Bedford-Stuyvesant, and by comparison makes Bedford-Stuyvesant look like Fifth Avenue and 72d Street. That is how bad Brownsville is in its deterioration and poverty.

We went into one tenement, the conditions of which were indescribable, and interviewed a very bright young Negro woman, with three or four children, no male breadwinner around. She had come from a deep Southern State to New York. I said to her, "Why did you come to New York?" She said, "To get a better life." I said, "Do you think you have found it?" looking around at the conditions under which she was living. She said, "Yes." Her answer somewhat surprised me.

I said, "Would you like to work?" She said, "I certainly do and I was working last winter, but the summer is here and school is out, and I had some friend who helped me with the younger children."

I asked, "If you can find a friend or arrangements can be made, are you going to look for a job?"

"Yes, I much prefer it."

Now, that story probably is common to a great many city areas. And I am sure that any national program that creates by one method or another or allows within States uneven conditions to exist is going to encourage people to move from one part of the country to another because they think they are going to achieve a better life.

Senator RIBICOFF. How many youngsters can you accommodate in the various day care centers, both private and public, in New York City?

Mayor LINDSAY. We are now accommodating a total of, what is the figure?

Mr. GINSBERG. We now have between 7,000 and 7,200. We could—there are easily 100,000 kids who need that care and their mothers would then be able to go to work if we had the money.

Senator RIBICOFF. In other words, you find a definite tie-in between the number of children that can be accommodated in day care centers and the potential of a mother being trained and/or finding a job?

Mayor LINDSAY. Yes.

Senator RIBICOFF. In other words, if you could accommodate 100,000 children in day care centers, how many families could be taken off the welfare rolls?

Mr. GINSBERG. 100,000 children, Senator, would be 25,000 more families.

If I may say so, an employment training program without day care does not have a chance in the world of working.

Senator RIBICOFF. In other words, the question comes if we are going to pass some laws, they might as well have some coordination and meaning. To say that you are going to require a woman to be trained and women to have jobs, if you have no places for the children, then we are making ourselves ridiculous.

Mr. GINSBERG. That is right.

Senator RIBICOFF. And we should save the money.

Mr. GINSBERG. That is right.

Senator RIBICOFF. And not put a requirement into law for job training, if you have no place to place the children.

Mayor LINDSAY. That is correct.

Senator RIBICOFF. And yet if you tied up day care centers, and had accommodations for the children, then suddenly and finally you could start giving some meaning to the training and start moving people off of relief.

Now, in your opinion, the bill before us, how effective is it in trying to move people off the welfare rolls?

Mayor LINDSAY. There are some positive provisions in it that are very needed and very necessary, particularly those that permit partial maintenance. But the ones that I mentioned earlier, that have mandatory provisions and also forced ceilings on the number of children that can qualify for aid, would be negative, would not help us, would not solve the problem, would compound our problems in New York City in fact, because they would add to the burdens that we already have.

Senator RIBICOFF. Would you or Commissioner Ginsberg send us as committee memorandums as to what changes you believe there should be in the welfare laws in the bill before us, to help move people off of welfare, and to be constructive in the job training field? I would appreciate receiving from you such memorandums before we start marking up the bill.

Mayor LINDSAY. In addition to the comments that are made in the main testimony here?

Senator RIBICOFF. That is correct, if you would, because, as I say, from the long experience in following the work of Commissioner Ginsberg, I feel he is one of the most constructive forces in this field in the country.

One more question or one more series of questions, Mr. Mayor, Commissioner Allen, education commissioner for the State of New York, again who I believe is one of the outstanding education commissioners in the Nation, a few months ago made the statement that education as a whole in the urban centers of our country were an out-and-out failure. Now, of course, as a mayor who is bedeviled with an education strike by the teachers, and the schools are now closed generally, what is New York doing about changing its curriculum to make education meaningful for the people in the ghettos of New York?

Mayor LINDSAY. I think a word of defense of the Board of Education of New York City and the superintendent of schools is in order here, because they have been under tremendous pressure in all of these areas over and beyond the current problem that exists in New York, with the teacher strike.

There is much to criticize in our tremendous school system in New York, which has 1,100,000 pupils in it, and almost a thousand school houses in the city, with a cost to the city alone of over $1 billion. There is much to criticize, because of its bureaucracy, its overly complicated administration, its rigidity, its curriculum, and 100 other areas where there are problems.

However, the board has been experimenting and changing and is moving in a number of areas on all of these fronts, whether it is decentralization and reducing the bureaucracy or whether it is in curriculum. They have a long way to go and they admit it.

What we are doing in the city to assist that is the following: (1) The Ford Foundation has been enormously helpful in creating arrangements under which we by next month can produce a report on all of these subjects. That is a committee that is headed by McGeorge Bundy. Its membership consists of a newcomer to New York, Dr. Frank Keppel, well known to you, Senator. Bonita Washington, who is the wife of the new Commissioner of the District of Columbia, Antonio Mantoma, a Puerto Rican editor in New York, Alfred Giardino himself, and also the current administrator of the Human Resources Administration of New York City, Michelle Sverdorf.

We have created in our Human Resources Administration in the city an office of educational liaison which is designed to do exactly what mayor's offices are not supposed to do under our current system which is to play a meaningful role in the education process in the neighborhoods of our city. We agree with the complant that is made in neighborhoods that neither the management of the schools nor the curriculums that is laid out in the schools has sufficient relation to the specific needs and wants of the neighborhood for the education of their children and advancement, and it is for that reason that we think that our Human Resources Administration, which includes the anti-poverty structure, must have within it an education component.

There are those who initially charged that this was interference on the part of the political arm of government and of the process of education. I think that that criticism has disappeared now as people

have realized that there is something wrong, and that changes are in order.

The report that the McGeorge Bundy panel issues next month will undoubtedly touch deeply on the question of curriculums, and that will be something that will be most welcomed by our board of education and superintendent of schools.

Whether or not there is total agreement with all its parts remains to be seen, but in any even we think that there is a willingness in New York on the part of our educators to recognize the problem, to define its dimensions, and to move toward solutions.

Senator RIBICOFF. Thank you very much.

The CHAIRMAN. I am going to ask that committee members withhold their questions until Mayor Lindsay has completed his presentation in chief. The reason I say that is because in addition to the mayor of the largest city we also have the Governor of Massachusetts, the Comptroller General of the United States, the Commissioner of the Food and Drug Administration as well as eight other prominent witnesses scheduled for today's session. As we so often are compelled to do, we have to try to abbreviate our hearings and even ask witnesses to provide us with additional information after they have completed their statements.

I do not want to cut any member short, but I do hope we can proceed as expeditiously as possible.

Mayor Lindsay, I am sure having served in the House of Representatives for a number of years, you understand what our problem is.

Mayor LINDSAY. I certainly do, Mr. Chairman.

The CHAIRMAN. We are very proud to have you here, and I believe all members agree that your statement is most interesting and certainly deserves the full consideration of the Senate.

Mayor LINDSAY. I think in the interests of conserving your time, Mr. Chairman, that on the prepared statement I am going to skip the balance of it, two or three pages of the prepared statement, on this problem of the social security law, the welfare amendments that are contained in it, because some of it we have covered in questions and answers already. In sum what it amounts to is that a forcing of conclusions that we are trying to reach through programs is not the answer. It would be equivalent to paving over the whole area of the problem that we have, saying you have solved it, when all you are doing is building a potential for an explosion through the pavement sometime thereafter. The answer to it has to be in the programs that solve them.

The second part of that too is just what we have been discussing, which is the need for day care centers, and then again the need for jobs and job training systems.

Now the other problem that we have is the medicaid problem and our view in New York is that the restrictive provisions in the bill as they relate to the States' title 19 programs would have a negative effect similar to that of some of the public assistance provisions.

The House Ways and Means Committee report does not make any attempt to disguise its intention, which is to penalize New York State specifically for the comprehensiveness of its program. The Medicaid Act required all States to reach a certain point in developing its medical assistance programs by 1970, and now we find that New York

is to be penalized for having advanced that far as fast as we have, and the question has to be raised I think, what will happen to the program as other States implement this requirement, which we think is the most revolutionary and significant piece of social legislation that has been enacted in 30 years.

Will the medically indigent population of every State be encouraged, recruited, and enrolled and then offered quality medical services and then be told eventually that they must give up the protection they just began to receive, and that is precisely what this will do in New York City.

Passage of this legislation would force New York City to remove approximately 33,000 families from the medicaid eligibility list, a total of 121,000 individuals would be adversely affected including 44,000 children, and if New York was to provide compensatory health services, it would cost in excess of $30 million a year, and in fact if this provision should be enacted, this is what the additional cost now will be in New York City because of it.

The progressive nature of these amendments would mean that in 1969 and 1970 New York City would be faced with the loss of $70 million in Federal aid, forcing 150,000 families off medicaid, thereby affecting the total of 600,000 people of whom 200,000 would be children. In other words, as the problem escalates and we are required and have to provide for the medical attention of these families, and indeed we have been doing it in past years, and this is one reason why the city was close to bankruptcy, we would be forced back into the same condition, but it would escalate.

Medical expenses can be the determining factor in a family's climb out of poverty. In central Harlem a full 25 percent of the unemployed cannot work because of health reasons. Reduction of the support for medical attention achieves only the most short run of savings.

The original legislation declared the intent of Congress to protect a large proportion of the population from potential destitution by guaranteeing high quality medical care, and I recall that having been a Member of the Congress at the time it was passed. Both the definition of the issues and the intent of Congress are as valid today as they were when the bill was passed. We believe that the States should be given the opportunity to experiment with different formulas for eligibility, and we urge the Congress not to impose arbitrary ceilings.

You may be interested in some facts and figures about New York City's experience in medicaid. I do not give you this by way of the suggestion that we have all the answers because we do not, or that we have solved our medicaid problem in its administration because we have not. We have a terrible problem on our hands and we have made some bad mistakes and we will probably make some others. The major benefits have been with marginal income families, in the trembling areas that you have to worry about, who for the first time can receive health care of their own choosing. The reimbursement of institutions for the costs of services has brought much-needed revenues to chronically underfinanced hospitals, and those revenues will result in much-needed improvements. It has brought medical care facilities into the ghetto areas where few or none existed before. At the beginning of this month more than 1,650,000 individuals had obtained medicaid coverage, and that figure will climb to almost 2 million by the end of

this year. Thousands of doctors, dentists, optometrists, and pharmacists have participated. More than 50 percent of all eligible service providers have enrolled; 40,000 recipients receive dental care each month; 60,000 are examined for eyeglasses each month; and 11,000 patients are treated in hospitals each day. As I said, it is true that the program has not been perfected.

The cost of medicaid during the next fiscal year, for example, will exceed $430 million, but 85 percent of that sum represents institutional care which we hope to reduce through neighborhood health centers. Preventive medicine can, as you well know, help people to stay out of the hospitals.

We do not believe, however, that lowering of eligibility standards is the answer. Fulfilling the health needs of the poor is a critical issue in the troubled areas of the city, and the cutback of ongoing efforts, particularly these days, will not help. And if New York's experience is representative, and possibly it is, we have not seen a rush to enroll by what the House Ways and Means Committee calls the middle class. Only about 4 percent of the 1.5 million persons presently enrolled in New York City are in families earning in excess of $4,500 a year. What we have seen is that low-income families are receiving dental treatment that they never received before, heads of families are receiving treatment for debilitating ailments that had threatened to take them out of the labor market, mothers are getting regular care for conditions that would otherwise have prevented them from caring for their children.

We cannot tell these people who have begun to enjoy the kind of health care that should be available in an affluent society that this care is no longer available.

As with other provisions of 12080, this will force us to frustrate the legitimate expectations of our citizens, and the inevitable consequences will have to be faced in the cities.

So, in conclusion, I would urge the Senate to adopt the positive features of H.R. 12080, to restore some of the excellent provisions of the administration bill, and to strike out the punitive, coercive measures that will move us even further down the road that is now clearly labeled as a deadend.

To remove the coercive provisions would encourage States to develop alternatives to welfare for their poor residents. It would also avoid contaminating the positive features with the atmosphere of threats and punishments.

I would also urge the Senate to strengthen the public assistance provisions by restoring H.R. 5710's requirement that States meet their own minimum standards by adding measures to simplify the terms of eligibility for public assistance and by separating the two functions of social service and income maintenance. This will enable social workers to spend all their efforts to strengthen family life, assist family members to retain capability for maximum self-support and personal independence, to use the words of the House Ways and Means Committee report itself.

The retrogressive provisions of 12080 on the contrary would lock social workers even further into the investigator's role, a role that has proven both futile and wasteful both of public funds and professional skill as Commissioner Ginsberg can tell you at great length.

My purpose here today has been to indicate that aside from the philosophy of 12080 with respect to public welfare, which is contrary to our growing understanding of the roots of poverty and its remedies, the bill's punitive and compulsory provisions simply will not work.

While these provisions will be costly and burdensome for the States and local communities, they will not achieve the goals of providing a minimum standard of living for all Americans and the opportunity for self-support for those who are able.

I recognize in closing that there are major problems with both the human and financial costs of the welfare program in the Nation today. Commissioner Ginsberg has long urged the necessity of basic fundamental changes. We feel strongly that it is time for Congress and the public to begin discussing new ideas, new answers rather than turn back again and again to the methods that have failed us in the past. We have been wasting both money and lives in this program for 30 years. I recommend that we now begin to develop the new approaches that can meet the needs of the 1960's and the 1970's. Under the leadership of this committee I believe the Senate can make that beginning.

I apologize for the length of this testimony, Mr. Chairman, but it is a lengthy subject.

The CHAIRMAN. Thank you very much, Mr. Mayor. You have made a very fine statement here. You have given us a great deal of deep thought and suggestions of ways that this bill could be improved. I do think it is fair to say that this committee in recent years has not been disinclined to consider new ideas. I think when we passed the medicare bill, the last big social security bill, we had 504 Senate amendments on that bill, and of that number, about 120 of them were important substantive amendments, many of which have worked I think well and some of which you have made reference to here in your testimony, and I believe that in large measure we are striving toward the same purpose, and our differences, if they exist, tend to be in terms of details of precisely how we achieve a purpose, not the main purpose that we are hoping to accomplish here.

I had a number of questions I thought I could ask, Mr. Mayor, but I will perhaps direct them to you later on. I do have a bill drafted, may I say, that would employ one of your ideas which you have suggested here, that we ought to have something in the way of a tax credit for companies that spend money in terms of teaching people good citizenship and training them to qualify for jobs that they are not presently qualified for, and in due course I would urge the committee to consider it, and I do believe that we really in the main hope to help you achieve just what you are talking about here, even though we may find some difference which I think oftentimes amounts to a distinction without a difference on precisely how we are going to go about it, so I want to thank you for your very fine statement.

Mayor LINDSAY. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Carlson.

Senator CARLSON. Mr. Mayor, I just wish to state that I appreciate very much your appearance here this morning and I am sure, as every other member of this committee, we are concerned about new approaches and I hope we will have sufficient time to go into many phases of it. Your testimony has been very helpful. Thank you very much.

Mayor LINDSAY. Thank you, Senator Carlson.

The CHAIRMAN. Senator Bennett.

Senator BENNETT. Mr. Mayor, I have been very much impressed by your frankness and the depth of your information and experience. I think this should take us out of the realm of theory in some of these problems and give us a sound ground on which to build our legislation. I am very happy you have been here.

Mayor LINDSAY. Thank you, Senator Bennett.

The CHAIRMAN. Senator Gore? Senator Ribicoff?

Thank you very much, Mr. Mayor.

(The prepared statement of Mayor Lindsay follows:)

PREPARED STATEMENT OF MAYOR JOHN V. LINDSAY OF THE CITY OF NEW YORK

Mr. Chairman, members of the committee, everybody talks about welfare, to paraphrase Mark Twain's observation about the weather, but everybody wants to do something about it.

Certainly few of the people involved with welfare would give unreserved endorsement to the present system.

The recipients—among them the jobless, the handicapped, the poverty stricken—don't like it, because almost no one truly wants to live on handouts. The administrators are appalled by the paperwork and disillusioned by the lack of constructive results. And the taxpayers are more and more resentful of the millions of dollars that are being spent on public assistance with no diminishment of the welfare rolls.

The legislation before you, H.R. 12080, reflects that national mood; it evolves from an understandable and energetic desire to redesign a social welfare program that in many ways has been a philosophic and financial flop.

We in New York City support the primary objective of this bill, insofar as that objective is to reduce dependency upon the government; to enable public welfare recipients to lead constructive, independent lives, free of government maintenance and supervision.

The goal is admirable. It is, however, one that has eluded us for decades, and experience alone should compel upon us a precise, realistic examination of the strategy by which the goal now is to be attained.

Our review of the amendments has convinced us that many of them will not work. Some, will make our jobs more difficult. Others will make them more expensive.

In summary, this legislation contains elements that in our judgment may have the ultimate effect of converting a deeply troubling situation into a thundering crisis.

Before proceeding with our analysis of the bill, I should like to present a brief review of New York City's involvement in social welfare. Because of its enormous size and diversity, New York magnifies every domestic problem common to the country's metropolitan centers. Accordingly, New York's experience may afford the committee some fresh insights into the many difficulties and few successes to be found in this nation's effort to provide for the poor:

A fundamental, perhaps shocking fact is that New York City contains as many hard-core poor people as there are residents of the District of Columbia. If we count all those who live in the sections of our city that have been declared poverty areas, the total almost would match the entire population of the Washington metropolitan area.

More than 670,000 individuals are receiving welfare aid in New York City, and that number is going up at the rate of 12,000 a month. We have budgeted $913 million for welfare costs during this fiscal year, but it may not be enough to finance the increasing number of recipients. Our welfare budget, I might point out, has gone up more than 200 percent since World War II—the highest rate of increase of any budget category.

I'm sure you're familiar with the usual explanations for the spiraling number of people on the welfare rolls. One is that more and more people are discovering they are eligible for assistance. Another holds that our increasingly sophisticated, automated economy has thrown hundreds of thousands of unskilled employees out of work and has reduced the demand for others entering the labor market. The explanations are sound, but they cannot account for the boom that welfarism has experienced in New York and other American cities.

New York, particularly, has always been an open city. As the nation's leading port, it has served as the point of entry for millions of new Americans. Most eventually settled across the country, but many remained in New York.

The city, and I think it deserves some admiration for this, has offered every newcomer the opportunity to make the best of himself. It has held out all the rewards that this country can offer, and the competition for them has not only given the city a unique dynamism, but has attracted the ambitious, the talented, the young, the fearless; the promoters as well as the poets, the confidence men and the reformers.

At the same time, New York has built a tradition of compassion. It always has directed the wealth of its commerce and industry toward the less fortunate. More than any city it has tried to help the illiterate, the diseased, the persecuted, to help themselves. This policy, too, has attracted those in search of a better way of life. But many of these newcomers have arrived with almost no preparation for entrance into the rigorous environment of the city.

The forces generating the rise in the welfare rolls of our cities are of national scope. The cities have been victimized by two complementary movements: The first is the exodus of middle-class white families and the industries that employ the un-skilled and semi-skilled from the large cities. The second is that automation in rural areas—often exacerbated by regressive social welfare policies—is driving low-income families to the urban areas.

Between January 1960 and April of 1967 approximately 220,000 persons received welfare support in New York City as non-residents because they had not yet lived there for the one year minimum period. The vast majority of these 220,000 came from other states. Lacking the skills or education to maintain themselves out of poverty, most were unable to find employment that would pay them a living wage. By 1970 it is estimated that 20 percent of the city's welfare rolls will be people who originally received their assistance as non-residents, and came from other states.

Jonathan Lindley of the Economic Development Administration has predicted that this trend will continue for at least 10 years, and a Fordham University survey of the Borough of the Bronx concluded:

"The technological revolution in American agriculture, which has driven these people off the land, is a national problem and the primary responsibility for coping with it is the Federal Government."

In New York City we are developing a whole new set of tools with which to aid those receiving public assistance in their efforts to achieve self-support. Many of these programs we have financed independently while waiting for the Federal Government to assume its share of this national responsibility.

Through the municipal and voluntary hospitals, the Health Department, and the Planned Parenthood Association, over 100,000 women are now receiving birth control services each year. We have won authorization from the state to allow our social case workers to inform welfare mothers of the benefits of family planning. At the same time, a program of neighborhood clinics operated by several city departments in conjunction with community groups is being established in a dozen neighborhoods. By the end of this year we expect to be operating at an annual level of $1.5 million and to be reaching 50,000 now not taking advantage of family planning services. At the end of the second year of the program, these neighborhood clinics alone are expected to give guidance to 100,000 women.

The city now provides working mothers with 98 day care centers where 7,000 children receive day-time supervision at a cost of $8 million. We have budgeted $3.5 million this year for an experimental family day care-Headstart program which will provide full day supervision for an additional 3,200 children in 800 homes. The program will give direct employment to 800 women, and release another 1,600 to enter job training programs and to seek employment.

We have placed $10.7 million in this year's budget to fund the Manpower and Career Development Agency. All job training programs funded through this agency give the highest priority to providing employment for those now receiving public assistance. We have established a series of 18 neighborhood manpower centers, and integrated into the work of these centers the formerly independent Division of Employment and Rehabilitation of the Welfare Department, thus making far more efficient use of the limited employment resources available and greatly expanding the ranges of jobs open to public assistance recipients.

We have, in cooperation with the city's voluntary social agencies, created a child-care system that shelters about 22,000 homeless children.

We are doing everything possible to find the absent fathers of illegitimate children and require them to contribute to the youngsters' support.

We have begun an experiment with an economic incentive to allow welfare recipients to keep the first $85 a month they earn, plus 30 percent of any additional income. This form of economic incentive may be the most effective way to reduce welfare expenditure and encourage independence.

We are providing supplemental assistance to families in which the breadwinner is fully employed but does not earn enough to support his family. With no Federal assistance, the city and the state together are supplementing the income of 13,000 heads-of-families, who in turn support 05,000 individuals. We make up the difference between what the breadwinner earns and what the minimum welfare allowance would be for such a family if the adult were unemployed. It costs us $90 million a year.

But if these programs are to work—any of them—they cannot be forced upon the clients. We can provide day care facilities—but we cannot force a mother to turn her children over to them. We can develop employment opportunities—but we cannot force a person to take the job and expect a satisfactory employee; in all likelihood an unwilling worker will be fired. We can offer family planning advice—but we cannot—and should not—force a woman to accept it.

Although the belief is common that the welfare rolls are burgeoned with the lazy, the shiftless, able-bodied men and women who should be working rather than loafing along on relief checks, the facts do not substantiate the stereotype:

In a spot review of the 600,000 persons who were receiving public assistance in New York City at the end of last year, we found:

Seventy-nine percent were children and adults caring for children. The approximate breakdown was 98,500 mothers and 300,000 children.

Fifteen percent were aged, sick or disabled and wholly unable to support themselves.

Two percent consisted of families with an employed male with an earned income so low that he could not support his family at a subsistence level.

Four percent were potentially employable persons unable to obtain a job because of inadequate skills or training.

Of this last four percent, or 24,000 men who are technically considered employable, only 2,600 have enough occupational ability to move into employment without considerable training and rehabilitation.

About 43 percent of the 24,000 technically employable men are considered ready for training or remedial education and are either involved in or are awaiting assignment to such programs. The remaining 44 percent of that small percent who are technically employable are so disabled as to require massive counseling, rehabilitation, health services, close guidance and long-term follow-through.

I might note that this basic and enormously difficult task—finding jobs for those who cannot now qualify for jobs—is the principal aim of the National Urban Coalition I and other mayors are organising. It has become frustratingly clear to me as mayor that the public sector cannot marshal the resources—in money and in brains—to move against the problem. But the private sector, which has given a nation the world's highest living standard and yet has not been brought into the fight against poverty, can get results far exceeding governmental abilities.

If the commercial and industrial giants of this country will undertake a total effort to provide training and employment for the poor, I think we can make our present efforts look almost puny. The institution of that commitment is underway, and we in the cities have high hopes that it can succeed where we have so consistently failed.

The concern for the nation's public assistance program that is expressed in H.R. 12080 is a concern we all share. The Congress, the taxpayers, the social work profession and the poor themselves have witnessed the weaknesses of the program over the past 30 years.

The public assistance program was designed to provide basic financial support for the destitute, as well as services to encourage self-support where possible. On both counts, it has clearly not succeeded:

Support payments in most states are too low to sustain even a minimal, decent standard of living.

The method by which these payments are delivered encourages feelings of worthlessness that lock recipients into dependency.

And the complex administrative structure prevents an investment in the time and skill required to offer constructive help.

It has been demonstrated amply over the years, we think, that more investigations of eligibility are not the answer, that forced work is not the answer, that removing children from their homes is not the answer, that denying Federal assistance to intact families is not the answer, that arbitrary caseload ceilings are not the answer, that increasing the stigma of welfare is not the answer, that welding services and income maintenance is not the answer.

The nation has 30 years of experience with these devices and the results are plain. They have not succeeded in controlling the caseload and they have not helped people. I submit that it is equally evident that some of the provisions in H.R. 12080—adhering as they do to the familiar route of control and threat—will fail. Aside from the morality of penalizing children with the proposed ceiling on the aid to dependent children caseload, removing children from parents who decline to work and forcing mothers into work and training that may not be appropriate—there are also questions of practicality and effect.

Our judgment is that the principal amendments in H.R. 12080 will not reduce the number of Americans in need of public assistance. On the contrary, we believe the enactment of provisions for an AFDC ceiling, mandatory work and training and restrictions in the AFDC–UP program will increase the number of hearings and court challenges . . .

Aggravate tension in ghetto areas with a high proportion of welfare recipients . . .

Further cripple the administration of public assistance by multiplying recipients . . .

Penalize the children who are already penalized by their families' reduced circumstances . . .

And place intolerable financial burdens on states and localities that try to maintain their programs.

At a time when we are agreed that the problems of the urban communities pose the greatest challenge to our domestic policies, we are in danger, through this bill, of striking at the very group most involved. The admirable programs now under discussion in the areas of employment opportunities, better housing, improved police protection, revitalized education, and more accessible health programs could in large measure be vitiated by a return to more restrictive, coercive methods of public assistance:

The House-approved freeze on the number of AFDC recipients at the January, 1967, proportion of the state's entire child population is harsh and self-defeating.

The fastest growing category of public assistance has been the aid to families with dependent children, AFDC, and I endorse the intent, expressed by the House committee report, to "reduce the AFDC rolls by restoring more families to employment and self-reliance."

However, the means to this end is not to put an absolute limit on the number of children that a state may have on AFDC recipients.

For New York this would create three equally unacceptable alternatives:

The city and state together could pay for the overage without Federal aid, which would add $50 million a year to the costs, of the governmental units least able to pay. That money would have to be taken from other municipal services.

Or, the children who exceeded the limit would receive no assistance, thus compelling their families to somehow stretch the funds they presently receive.

Or, we would have to somehow force off the welfare rolls a sufficient number of families to remain within the quota.

Ninety-thousand New York City children would be affected by this legislation in 1967–1968.

The report of the House Ways and Means Committee has estimated that the House-passed bill will reduce the AFDC rolls by about 300,000 persons from its present total of nearly 5 million. Since we have found that forced work, coercive paternity searches and other restrictive measures do not, in fact, lead to independence from public aid, the attainment of this reduction is highly unlikely.

But even if the bill's restrictive provisions were to be effective in reducing the number of recipients of AFDC, these are likely to be the results:

1. The removal of children from parents who decline to participate in community work and training would merely shift the financial responsibility for their care to another part of the program, at a higher cost. Foster care, whether it be in an institution or a foster family, is far more expensive than AFDC.

2. The removal of Federal participation from post-freeze AFDC cases would open up a series of undesirable alternatives: The financial burden for the care of destitute children would be shifted to the states and localities that can least afford it. States with well-developed programs and commitments to their poor residents would be penalized for continuing to help; poorer states would be forced to reduce their payments and develop even more punitive and restrictive relations with applicants than they have now.

Finally, persons who were unable to conform with the requirements for AFDC—since they cannot be left to starve in 20th century America—will have to be absorbed into other programs. I repeat: It will cost New York City and New York State a combined total of at least $50 million a year to do so.

3. The children who remain covered by the AFDC program would be penalized, as well as those who are unqualified merely by virtue of their numbers. The effect of disqualifying children who exceed the required numbers would be to reduce an entire family's grant. For example, a mother with three children may today receive $200 a month, or $50 per person. When a fourth child is born and exceeds the number to be covered, the effect would be to reduce each grant to $40, thereby penalizing the other children.

4. The multiplication of areas of discretion in the delivery of public assistance and the added sanctions on individuals will most certainly aggravate tension in ghetto communities where residents are just beginning to organize in their own behalf. The experience of most urban anti-poverty programs has been that a high percentage of time and effort is spent in defending the poor against unreasonable, arbitrary public welfare policies.

The committee report, however, makes it plain that such progressive contributions as Federal support for day care, training and employment programs, foster care, family planning and family counselling are included in the bill only as specific devices for reducing the AFDC rolls. They are not intended to encourage cities and states to grapple with the massive social problems that face our urban communities.

With respect to the provisions for mandated community work and job-training, I doubt that the House bill can achieve its objective by requiring participation in job training and employment to qualify for public assistance.

We all want people to work instead of relying on welfare, but should we try to accomplish that by forcing women to leave their homes? I see little hope that compulsory employment will be effective.

The results of such a program probably will be that large amounts of time and money will be devoted to training a woman for a job she does not want and will not keep; to reduce the family's allowance and thereby penalize the youngsters for their mother's refusal to comply with the regulations; and to lengthen the waiting lists we now have of children who desperately need foster care.

The problem now is not the lack of the will to work, but the absence of both adequate skills and jobs. Conventional wisdom on the motivation of residents of poverty areas was challenged by a recent United States Department of Labor study in New York City, which found that three out of four persons in Central and East Harlem, and four out of five in Bedford-Stuyvesant wanted jobs. More than half said they would be willing to go back to school, if necessary, to get a good job.

Of the men interviewed in the three communities, almost 25 per cent said they would even be willing to move to another area to get work.

The Urban Coalition called last month for the creation of one million jobs. It urged the development of programs "to end once and for all the shame of poverty amid general affluence" and recommended as one measure an emergency work program to provide jobs and training opportunities.

However, the compulsory nature of the work and training provisions in H.R. 12080 make them impractical, coercive, possibly unconstitutional and most likely ineffective.

Our experience has been that persons who take training or employment merely because it is required as a condition for assistance are so un-motivated that they never really become self-supporting. They leave the job after a few days and are unable to stick with training. It is vital, I believe, to handle the employment potential of each client on an individual basis, in terms of each family's needs and capacities.

There is no doubt that educating low-income families to the value of employment and training programs is essential. But to mandate rather than to

make available these resources as a condition for continued financial assistance opens such wide areas of discretion that it constitutes an open invitation to abuse.

It violates the basic premise on which Congress based the Economic Opportunity Act: That if the opportunity to choose a better way of life exists, and if the government fulfills its obligations to provide opportunity and the chance for self-determination, then Americans will embrace those opportunities.

Instead of focusing on a coercive means to push people into job training and employment, we should lend our efforts to broadening the job market and providing the necessary training facilities.

Similarly, requiring that an unemployed father—to be eligible for AFDC-UP—must have a recent connection with the labor force and be receiving no unemployment insurance will not turn men from the welfare rolls to employment. On the contrary, those with the most recent work experience are the most likely to be employable if given adequate training.

Our support should be directed toward keeping such families intact while work is found for them, rather than stripping these families of public assistance or forcing the man to leave the home so that his family could qualify for AFDC support.

Equally destructive of family stability is the increased incentives for the states to provide foster care for illegitimate children receiving AFDC support. Family care, if provided only by a single parent, is far less damaging to the child than institutional care. It is the parent that is at fault for the child's birth out-of-wedlock. Removing the child to an institution punishes the child.

Vital to any massive employment program for recipients of public assistance is the provision for an adequate employment incentive. A mother with three small children, for example, might receive about $3,000 a year on AFDC. If she took a job for 40 hours a week, 52 weeks a year, at $1.50 an hour, she could make $3,120 a year before taxes.

But after paying job-related expenses, such as baby-sitting fees to a neighbor, carfare, the extra clothing required for a steady job—she might be far below the welfare standard and even below an amount required to sustain life in a city.

As I said earlier, New York City is allowing welfare recipients to keep the first $85 a month they earn, plus 30 per cent of the rest. We hope the policy will avoid the handicaps I have just described.

The $30 a month incentive in the House bill, however, probably is insufficient to provide a real incentive. The Administration's proposal for an exemption of $50 a month plus one-half of the remainder may also prove inadequate for such purposes. An incentive is ineffective unless it provides a substantial income supplement. I recommend that New York City's policy—based on O.E.O guidelines—be endorsed nationally. We think it will prove its value.

One of the most disturbing aspects of this legislation is the planned establishment of a job training mechanism within the Department of Health, Education and Welfare.

We in New York City have been working very hard to bring together under a single agency the various job training programs. Much of the scattering at the local level is the result of the proliferation of Federal programs and agencies operating in this field. It would be disheartening just as we begin to make progress at the local level to see even further dispersal of Federal efforts. Such programs rightly belong under the supervision of the Department of Labor, and the Administration proposal to have public assistance funds for such purposes funneled through the Department of Labor is the most sensible arrangement.

I now direct my testimony to the proposed amendments to the Medicaid program:

My view is that the restrictive provisions in H.R. 12080 as they relate to the state's Title 19 programs would have a negative effect similar to that of some of the public assistance provisions—the frustration and denial of rising expectations.

The House Ways and Means Committee report makes no attempt to disguise its intention to penalize New York State specifically for the liberality and comprehensiveness of its program.

The Medicaid Act required all states to reach a certain point in developing its medical assistance programs by 1970. Now New York is to be penalized for having advanced so far so fast.

The question must be raised, then, about what will happen to the program as other states implement this, the most significant piece of social legislation in 30 years? Will the medically indigent population of every state—encouraged, recruited, enrolled and then offered quality medical services—be told eventually that they must give up the protection they just began to receive?

Passage of this legislation would force New York City to remove some 33,000 families from the Medicaid eligibility lists. A total of 121,000 individuals would be adversely affected, including 44,000 children. If New York was to provide compensatory health services, it would cost in excess of $30 million a year.

Here again, the local governments least able to pay would be sent the bill.

The progressive nature of these amendments would mean that in 1969–1970 New York City would be faced with a loss of $70 million in Federal aid, forcing 150,000 families off Medicaid, thereby affecting a total of 600,000 people, of whom 200,000 would be children.

Medical expenses can be the determining factor in a family's climb out of poverty. In Central Harlem a full 25 per cent of the unemployed cannot work because of health reasons. Reduction of the support for medical attention achieves only the most short-run of savings, at a usurious long-range cost.

The original legislation declared the intent of Congress to protect a large proportion of the population from potential destitution by guaranteeing high-quality medical care.

Both the definition of the issues and the intent of Congress are as valid today as they were when the bill was passed in 1965. We believe that the states should be given the opportunity to experiment with different formulas for eligibility and urge the Congress not to impose arbitrary ceilings.

You may be interested in some facts and figures about New York City's experience under Medicaid:

The major benefits have been that marginal income families, for the first time, can receive health care of their own choosing. The reimbursement of institutions for the costs of services has brought much-needed revenues to chronically-underfinanced hospitals—and those revenues will result in much-needed improvements. It has brought medical care facilities into ghetto areas where few or none existed before.

At the beginning of this month, more than 1,650,000 individuals had obtained Medicaid coverage. That figure will climb to almost 2 million by the end of this year.

Thousands of doctors, dentists, optometrists, and pharmacists are participating. More than 50 per cent of all eligible service providers have enrolled.

Forty thousand recipients received dental care each month.

Sixty thousand are examined for eyeglasses each month.

And 11 thousand patients are treated in hospitals each day.

It's true that the program has not been perfected. The cost of Medicaid during the next fiscal year, for example, will exceed $430 million. But 85 per cent of that sum represents institutional care, which we hope to reduce through neighborhood health centers which through preventive medicine can help people to stay out of hospitals.

We do not believe, however, that lowering of eligibility standards is the answer. Fulfilling the health needs of the poor is a critical issue in the troubled areas of the city, and a cutback of ongoing efforts will not help.

If New York's experience is representative, and I think it is, we have not seen a rush to enroll by what the House Ways and Means Committee called "the middle class." Only about 4 per cent of the 1.5 million persons presently enrolled in New York City are in families earning in excess of $4,500 a year.

What we have seen is that low-income families are receiving dental treatment that they never received before.

Heads of families are receiving treatment for debilitating ailments that had threatened to take them out of the labor market.

Mothers are getting regular care for conditions that would otherwise have prevented them from caring for their children.

We cannot tell these people, who have begun to enjoy the kind of health care that should be available in an affluent society, that this care is no longer available.

As with other provisions of H.R. 12080, this will force us to frustrate the legitimate expectations of our citizens. The inevitable consequences will have to be faced in the cities.

In conclusion, I urge the Senate to adopt the positive features of H.R. 12080, to restore some of the excellent provisions of the Administration bill and to strike out the punitive, coercive measures that will move us even further down the road that is now clearly labelled as a dead end.

To remove the coercive provisions would encourage states to develop alternatives to welfare for their poor residents. It also would avoid contaminating the positive features with the atmosphere of threats and punishment.

I would also urge the Senate to strengthen the public assistance provisions by restoring H.R. 5710's requirement that states meet their own minimum standards. By adding measures to simplify the determination of eligibility for public assistance and by separating the two functions of social service and income maintenance.

This will enable social workers to spend all their efforts to "strengthen family life, assist family members to attain or retain capability for maximum self-support and personal independence," to use the words of the House Ways and Means Committee report itself. The retrogressive provisions of H.R. 12080, on the contrary, would lock social workers even further into the investigator's role —a role that has proven both futile and wasteful both of public funds and professional skill.

My purpose here today has been to indicate that aside from the philosophy of H.R. 12080 with respect to public welfare—which is contrary to our growing understanding of the roots of poverty and its remedies—the bill's punitive and compulsory provisions simply will not work.

While these provisions will be costly and burdensome for the states and local communities, they will *not* achieve the goals of providing a minimum standard of living for all Americans and the opportunity for self-support for those who are able.

I recognize that there are major problems with both the human and financial costs of the welfare program in the nation today. Mitchell Ginsburg, the city's new Administrator of Human Resources, has long urged the necessity of basic, fundamental changes. We feel strongly that it is time for Congress and the public to begin discussing new ideas, new answers, rather than turn back, again and again, to the methods that have failed us in the past.

We have been wasting both money and lives in this program for 30 years. Now let's begin to develop the new approaches that can meet the needs of the '60's and '70's. With the leadership of this committee, I believe the Senate can make that beginning.

Thank you.

The CHAIRMAN. Our next witness will be the Honorable John A. Volpe, the Governor of Massachusetts.

Is the Governor present?

Governor Volpe, we are pleased to welcome you before this committee. I believe this is our first occasion to have you testify before the committee. I am happy to welcome you here.

STATEMENT OF HON. JOHN A. VOLPE, GOVERNOR, STATE OF MASSACHUSETTS

Governor VOLPE. Thank you very much, Mr. Chairman.

The CHAIRMAN. As a matter of protocol, may I say, Governor, we had planned to schedule you as our first witness. I believe Mayor Lindsay got here first so we put him on first.

Governor VOLPE. We certainly concur with that decision. I had a bill in our State legislature on the automobile insurance that I thought would be completed last evening but our legislature decided to put it over until today and I must hustle back quickly in order to take part in the maneuvering that will go on this afternoon to pass or not to pass the bill on the automobile insurance.

May I add, I was pleased to see there is a House committee which apparently is going to report on September 30 on this very subject which is, I think, of great importance to our people.

Chairman Long and members of the committee, I am very pleased and grateful to have this opportunity to testify before your distinguished committee on one of the most important bills to come before the Congress in this session.

At the outset, let me say I realize the enormous complications that confronted the House Ways and Means Committee in drafting H.R. 12080. I had hoped that the committee might this year consider linking social security benefits to the cost-of-living index.

But the committee has performed a difficult task, and my comments today also reflect my appreciation of the committee's efforts.

In order to keep my testimony brief, I shall touch only on those sections of the bill which I feel can and should be changed to improve this legislation.

So long as this country's rural areas fail to provide adequate employment or the hope of an existence above that of abject poverty, the white and nonwhite from these areas will continue to migrate to the urban centers. This migration will continue for at least another 10 years, not solely because the cities provide higher welfare payments, but because a friendly community of earlier migrants already exists there.

Unfortunately, industrial employment in the core cities has been moving to outlying areas, compounding the problems of the recent arrivals and those who follow after them. The proposed ceiling limiting the proportion of children of broken homes who may receive aid for dependent children to the total population under 21, as of January 1, 1967, does not recognize this sociological fact.

I am sure that every Governor would support those programs in H.R. 12080, which are intended to encourage AFDC recipients to find employment and to keep that employment through the wage incentives.

It is in the States' interest to cut back the poverty rolls, but I do not feel that this arbitrary ceiling would relieve the States of their obligation. By making no provision for local, State, or National economic emergencies, this provision would obviously require local and State welfare officials to determine which families would remain on the rolls and which would be eliminated.

What would be the effect in our cities of a sudden rise in unemployment while AFDC is tied to the January 1 ratio?

The Federal Government, in effect, would be penalizing those States with the greatest need, and, in many areas, would tend to encourage discriminatory practices to the detriment of needy families with children, if the family is determined to be "unworthy" by State or local public welfare officials.

Such a situation also would unduly discriminate against those local areas which have a disproportionate share of families in the program.

The broadest possible tax base for maintaining the program is desirable, so as not to give undue financial burdens to those communities with such a disproportionate share of AFDC recipients.

The original concept of AFDC was to keep families together. Section 201, by requiring that mothers enter the labor force, unless they can show good cause for not doing so, would negate this concept.

While mothers of school-age children should be encouraged to find employment, this should not be required of mothers of pre-school-age children.

The recommended expansion of day care services is an excellent provision. Many of the AFDC mothers could be trained to provide these services.

This appears to be the best plan for mothers who are seeking work, or who require day care for their children.

Safeguards should be provided so that no pressure is put upon mothers to leave their children in order to go to work. The wage incentive provisions of H.R. 12080 are excellent and should be most helpful in encouraging AFDC recipients to enter the labor force and increase their job skills, removing them from AFDC rolls at an early date.

I would urge that section 202 be amended so that wages of children under 21 who are going to school part time should be treated in computing the family's eligibility for AFDC, the same as the wages of children attending school on a full-time basis.

Surely, the children of the poor should be given every incentive to gain a total education.

The proposed increase in the Federal contribution for training for social welfare will help the States' most pressing problem in this area. In the past 5 years recipients of child welfare have more than doubled, but because we have been unable to find trained personnel to increase staff resources, the quality of the service has been necessarily diluted.

While these training programs should continue to be a function of the Department of Health, Education, and Welfare, I hope your committee will give careful consideration to the work-training programs for AFDC recipients.

I urge the committee to very carefully consider the recommendations made by both Secretaries Gardner and Wirtz that the provisions of the administration's bill H.R. 5710 relating to work-training programs for welfare recipients be incorporated in this bill.

Section 235, which will move the existing child welfare programs from part 3 of title V, will be a progressive step, if the program will assure the establishment and maintenance of standards and the extension and improvement of services, such as have been developed by the Children's Bureau.

My comments concerning title XIX will be brief. The establishment of a 133⅓-percent ceiling for AFDC eligibility—as has just so eloquently been indicated by Mayor Lindsay—when applied to medicaid will eventually require those States with forward-thinking programs to make additional moral judgments.

The States, already overburdened financially, must assume those costs which exceed the proposed ceiling, or they must retrench on a program vitally needed by the poor and underprivileged.

Certainly, it is not the intent of anyone to abandon or punish the poor.

Section 223, by eliminating comparability, may be a step backward toward separate and unequal care by downgrading the level of health and medical care for AFDC children, their caretakers, the disabled, and the blind, even though much-needed additional funds are recommended in the bill.

These children are the neediest in the country and should have not less but more in standards of quality, amount, duration, and scope of programs of assistance.

While medicare for the aged is a long overdue program, we must not forget that the health of our young people is a long-term investment in our country's future.

Certainly, those eligible for medicaid should receive the same quality of care as the aged receive under medicare.

Mr. Chairman, I urge that your committee review those sections of this bill which single out AFDC families to apply mandates not applicable to any other group in our society, and I urge that you provide in this legislation safeguards to assure the dignity that should be accorded to all our citizens, especially the poor.

It is my sincere belief that every man and woman who has the capacity to work should be given the opportunity for gainful employment. This may well require stepping up our manpower training programs and the establishment of additional skill centers.

Not only will we be able to reduce the welfare rolls in this way, but we will be restoring to those who need it most a basic requirement for human dignity. These people represent a vast reservoir of untapped human resources and talent, which if properly utilized can add much to the future greatness of our Nation. Those who have the ability to work must be afforded the opportunity. Those who now seek jobs must be given work.

I certainly want to thank the committee for this opportunity and privilege of appearing before you, and to tell you I am sure that this committee, all of the members of which who are here today I have known in prior years and in prior testimony before public works committees particularly—I am sure that they have the capacity and the judgment to improve the bill as passed by the House.

Senator GORE. Thank you, Governor, for a very enlightening statement which shows an understanding of the problem and compassion for the people concerned. I take it from your remarks that you believe every person willing to work and able to work should be afforded an opportunity, that you might look with favor upon the bill reported out by the Senate Labor Committee providing a vigorous attempt to provide employment in the cities, known as the Clark bill.

Governor VOLPE. I am not intimately familiar with the details of the Clark bill, but certainly I am in favor of doing everything we can to eliminate the root causes of the disturbances in our core cities, and this is one way in which we can do it.

Senator GORE. How do you explain the failure of the country and the Nation's Government to implement the full employment policy which was adopted so overwhelmingly a few years ago?

Governor VOLPE. Well, I suppose the answer to that question would probably give us the answer to perhaps all of the problems we have in the country today. I do not believe I could give an answer to that in the limited amount of time available here.

I can only say that I believe in our attempt to upgrade the standards of our citizens in the Nation we have possibly thought too frequently of upgrading those who in many cases might have been able to do for themselves what government has done for them.

I believe we have not got right down to that 17-year-old boy who left school for one reason or another, did not see an opportunity ahead for himself, and found—it appeared to him at least that the world

was "agin" him. It seems to me that one way or another we just have not reached that boy's mind.

As Governor in my first term I was appalled to see the large number of those who were applying for pardons of offenses that had been committee in years gone by, some when they were 17, 18, 20 years old, and some even younger, the cases of those applying for pardon, about eight out of 10 came either from boys, in some cases girls, but primarily boys who were dropouts or, secondly, came from broken families. This is where I think our biggest job is, is to prevent the broken families, through the family courts, through family counseling, through the opportunities that could be created by skill centers directly in the area where the unemployment exists to the largest degree.

I cite Boston for one example. We have a skill center now in East Boston. East Boston is an island across the harbor. Those that live in Roxbury where the greatest unemployment is, some five times the average unemployment rate in the State, would have to take I think three different forms of transportation to get to the skill center in East Boston. I have recommended to Secretary Wirtz that a skill center be established right in Roxbury where the heart of the problem is. It is my belief that such a project would engender the feeling on the part of those who are in that real pocket of unemployment and ghetto living, would without question respond, if that opportunity existed right in their neighborhood, and if we provided other forms of an unemployment center right in that area instead of their feeling that they have to go 5 miles away or 3 miles away to some other center.

Senator GORE. I have benefited by your testimony and that of Mayor Lindsay today. For whatever it may be worth, perhaps very little, I have long felt that in our system of society we must depend upon and build upon and instill, inspire, and create the maximum amount of self-reliance, self-respect, self-esteem, ours being an individualized society.

In that respect, I have been anxious to move as vigorously as possible toward the goal which you suggest, of making available decent employment, jobs at a decent wage, for those willing and able to work. I have been a little slow in approving the philosophy of something for nothing.

I know that charity is necessary. It is laudable, and I approve of that. But to provide welfare for a person who is willing and able to work is degrading our system of society rather than upgrading it. We should provide, as you say, the opportunity for a man to earn his own way, for a woman to earn her own way. Do you agree with this?

Governor VOLPE. I certainly do, Senator, and America was not made great because people loafed. America was made great because people were willing to work, and I can say from my own personal observation, having been born in this great country some over 50 years ago, that my parents were very poor, but there were opportunities for work. My father was able to start as a laborer. He graduated to the trade of plastering. He taught his son what it was to work for a day's pay and the difference between right and wrong and why it was that a dollar or a dime was so important to earn and to save.

It might be well to have more of that pioneering spirit, that was available in those days, today. But, on the other hand, I think we have to place ourselves in the position of that young boy in a very crowded,

broken-down tenement area, who sees no opportunity and has not really felt the hand of the poverty programs or felt the hand of some of the other wonderful programs that have been developed by this and other administrations and the Congress of the United States, so that he does not know that anybody cares about him.

Our big job is to make sure that somebody does care about him; even if he has to be taken by the hand and given the lesson of private initiative and private opportunity, and given the opportunity to get a good education and a job.

Senator GORE. And you think that he would be given more confidence; that he would have more confidence in the concern of his country, of society, for him, if he were given an opportunity to earn his way, than if given welfare contributions, however adequate or inadequate they might be?

Governor VOLPE. There is no question in my mind that not just the average human being but I would think practically all human beings, would feel a lot better going home at night and going to bed with the feeling that they had contributed something to society that day and every day rather than feeling they just had taken something out of society and given nothing to it.

Senator GORE. Senator Carlson?

Senator CARLSON. Governor, I just wish to state it is encouraging to members of this committee and to Members of Congress, to have individuals such as you in an executive capacity also concerned with our problems of our States and Nation, and to come before this committee and give us the benefit of your knowledge and the concern that you have had in your own State.

Having served as Governor of a State myself, I know some of the States' problems; and I know your concern about working together with the Federal Government and some of the problems involved. All I want to say is that I appreciate very much your appearance here this morning.

Governor VOLPE. Thank you, Senator Carlson.

Senator GORE. Governor, I would like to exchange views with you further, and also to hear other witnesses, but we have a vote scheduled in 1 minute from now on the floor of the Senate, so thank you very much.

The committee stands in recess until 2 p.m. today.

(Whereupon, at 12 o'clock noon the committee recessed, to reconvene at 2 p.m., the same day.)

AFTERNOON SESSION

Senator HARTKE. The committee will come to order. The first witness we will hear this afternoon will be Mr. Ernest Giddings, the legislative representative, National Retired Teachers Association, and other associations. You may wonder why we changed the order. The chairman indicated that he is going to be here in about half an hour. I am substituting for him, and he wanted to hear these other witnesses personally. You may proceed, sir.

STATEMENT OF ERNEST GIDDINGS, LEGISLATIVE REPRESENTATIVE, NATIONAL RETIRED TEACHERS ASSOCIATION, AMERICAN ASSOCIATION OF RETIRED PERSONS, NATIONAL COUNCIL ON TEACHER RETIREMENT OF THE NATIONAL EDUCATIONAL ASSOCIATION, NATIONAL CONFERENCE OF PUBLIC EMPLOYEE RETIREMENT SYSTEMS, AND NATIONAL ASSOCIATION OF RETIRED CIVIL EMPLOYEES, ACCOMPANIED BY JAMES RUBIN, LEGISLATIVE ASSISTANT; REX T. WRYE, EXECUTIVE SECRETARY OF THE PENNSYLVANIA PUBLIC SCHOOL EMPLOYEES RETIREMENT SYSTEM AND PRESIDENT-ELECT OF THE NATIONAL COUNCIL ON TEACHER RETIREMENT OF THE NATIONAL EDUCATIONAL ASSOCIATION; AND LUTHER L. MILLER, VICE PRESIDENT, NATIONAL ASSOCIATION OF RETIRED CIVIL EMPLOYEES

Mr. GIDDINGS. Mr. Chairman and distinguished members of the Senate Finance Committee, my name is Ernest Giddings. I am legislative representative of the National Retired Teachers Association and the American Association of Retired Persons. I am accompanied by Mr. James Rubin. The other two gentlemen will be introduced when we reach the part of the testimony with which they are concerned.

The combined membership of the two associations totals over 1,200,000 persons age 55 or older. We are nonprofit and nonpartisan; dedicated to promoting age as an achievement; and to encouraging purposeful living throughout one's later years.

Our representatives have had the privilege to testify before your committee on several occasions—encouraging your efforts to strengthen the Social Security Act to meet the economic, health, and social needs of all our citizens.

When the act became law in 1935 it was generally accepted that social security was intended to prevent poverty rather than to relieve that condition after it occurred. The purpose of the cash benefit program is to replace, in part, earnings lost when a covered worker retires, dies, or becomes disabled. Benefit levels are intended to provide a floor of income only, not to constitute the sole or major source of income after retirement or disability.

Yet today nearly 85 percent of individuals receiving social security benefits exist on their monthly payments. Some 5 million persons over age 65 have yearly incomes under $1,850 a year. Two million others live on less than $3,000. For one reason or another it seems that many older persons have been unable to prepare adequately for their retirement years.

We who have watched the system grow are aware that social security was never intended to provide an adequate retirement pension. Yet, we also know that many persons now feel that it should do so. They view social security as the means by which this Nation will ultimately provide a guaranteed annual income for its older citizens.

Whether this approach has merit is of little importance at this time, for even a casual glance at our national problems tells us that all the needs of the elderly will not be met at once. There are too many pressures on the economy, both domestic and foreign, to allow you to do everything you might like to do in 1967.

Thus, as you, we find ourselves in a difficult position. We know that many Americans, old and young, lack even the meanest comforts of life, and we feel obligated to speak in their behalf. We must urge a reasonable expansion of the programs that mean so much to them. We do ask for fair and equitable treatment for the millions of older Americans. We ask for upgrading of their benefits in line with their needs and with the ability of our economy to meet these needs.

As you consider this legislation you will also be deciding what obligation this Nation owes to its elderly citizens. It is an awesome task, for you have been asked to determine the limits of the public conscience.

Perhaps it is time to consider how far we have come in the last 30 years and to see just where we are going with social security. You may find that a level of benefits needed to provide an adequate retirement income cannot be earned under the present system of contributions. Many persons, for example, fear that adoption of some of the new proposals will ultimately mean the end of the time-honored "insurance principle." If this occurs, traditional lines separating social security and public assistance must be blurred.

Today we have a situation where those who worked under social security for much of their lifetimes can no longer exist on their "earned" benefits. They are forced to ask for higher monthly payments, increases which to them are little more than a form of public assistance. In fact, to some retired workers it may seem that the only difference between an across-the-board benefit increase and "welfare" is that social security places the financial burden on future, rather than present, generations.

We have confidence that this committee will approach the needs of older Americans from a broad point of view, in the best interests of young and old alike. It is not our place to say whether social security taxes are too high, or that general revenues should be used to finance future benefit increases—that is the job of Congress. I am sure that members of this committee and the Congress are aware that there is a point where payroll taxes can become confiscatory. With this in mind, Mr. Chairman, we would like to comment on several matters placed before you.

BENEFIT PROVISIONS

We are pleased that the House of Representatives took positive action to bring the social security payment structure more in line with the cost of living. We do urge, however, that your committee recommend increasing the present $44 minimum to at least $70 a month and the general level of all cash benefits by not less than 17 percent.

We are happy to see that the administration, as well as many Members of both Houses of Congress, is also urging a $70 minimum. When we realize that this is the sole support of many Americans who served this Nation so long and so well, we feel it is not asking too much, especially when we consider that most problems facing the elderly are

economic in nature. We feel that the increases we propose would do much to establish an income level for retired people more consistent with today's economy.

EARNINGS LIMITATIONS

We are not happy with the treatment of the earnings limit written into the House bill. Of the 17 million persons over 65 eligible for benefits, these limits affect 2.6 million who lose some of their earned benefits. We believe that the increase from $1,500 to $1,680 is merely a token one, falling far short of overcoming the objection that the limit is a "penalty" provision. Most older persons do not understand or appreciate this restriction on their earnings; they feel it creates a barrier to job placement, discriminating against those who need additional income the most and are willing to work for it. Some of these persons, of course, are those who financially may not be able to retire; and they are aware that social security supplemented by permissible earnings of $1,500 in 1 year under present law, or of $1,680 under the House bill, would be insufficient to allow them to live modestly with self-respect and independence which we all cherish.

We assume that a reasonable earnings limit is justified as long as the present method of financing benefits is used. However, because we are also dedicated to promoting useful activity on the part of older persons, we strongly urge increasing the earnings limit to $200 a month. We realize that to go higher might create major fiscal problems; we are not sure. But to keep it below $200 a month will serve to reduce initiative. It will diminish the opportunities for older people to carry on meaningful activities. It will sentence many to an unproductive existence during their sixties and seventies at a time when their skills are badly needed by their employers and communities.

And let us not forget that the additional earnings can be subject to income taxation, so that these people can help pay, in an equitable way, the expenses that this Nation is incurring—just as they have always done in the past. These are not people sitting idly by asking the rest of the Nation to pay them merely because they exist; these are people who have a lot that they can contribute to this country and want to be given the economic freedom to do so without having to look forward to the frustration of inactive retirement years.

Senator HARTKE. Mr. Giddings, I would like to compliment you upon both of these statements. I just wonder, do you believe really that increasing the amount of the minimum to $70 a month as the administration recommends is sufficient?

Wouldn't it be better to go at least to $1,200 a year per person? That still leaves some below the poverty level, as I understand it, the poverty level being about $1,500 under normal conditions for a person over 65. Don't you think a person is entitled at least to exist in poverty if he is going to have social security? Will you be in favor of a $100 minimum?

Mr. GIDDINGS. I have no position to state, as a personal position. I am stating the position of an association where the policy determination is made by a legislative council of about 20 responsible members.

Senator HARTKE. Didn't you take up my recommendation of a $100 minimum, or did you ignore me?

Mr. GIDDINGS. No, no, I didn't ignore you. I would be glad to——
Senator HARTKE. It has been there. It has been introduced.
Mr. GIDDINGS. Yes, I know.
Senator HARTKE. And it is ready for you. If we could get some support from some of these organizations that come forward and listen to the administration, the administration did not do very well in the House. Maybe the Finance Committee could do better in the Senate by itself.
Mr. GIDDINGS. I think it would be a good thing if they would do better, so that in a conference committee, they would come out with a better amendment. However, I do want to point out that the legislative council of our associations recommended a $70 minimum at least a year in advance of the administration.
Senator HARTKE. I am not interested in a conference committee. I am not talking about that. I would like to find out whether your organization would be at least in favor of a man having $1,200 a year income on social security.
I think that a man, as I understand it, $1,500 is at the poverty level for a single person over the age of 65, and this would still be below the poverty level. Don't you think a man ought to be entitled to at least $100-a-month minimum? You take it up with your association, will you?
Mr. GIDDINGS. I will be glad to do that. I assure you that our policy-making body, a 20-member legislative council, will be openminded but responsible and realistic. In trying to be representative of our membership, they seek to consider both older taxpayers and social security beneficiaries.
Senator HARTKE. Let me tell you if you don't make it, I will withdraw it and write to your people, your retired people, and tell them you folks aren't in favor of it. I want you to come out on this earnings limitation also.
Are you really concerned about this question? You talk about how you are going to pay for this. The problem here is that no one seems to be worried about the fact that we don't worry about paying for it for unearned income. The man who goes out and works with his hands or is gainfully employed and earns his income, and then the Government comes along and takes part of it away, do you think that is fair?
Mr. GIDDINGS. In that connection, it is interesting to note that the substitute teacher who is 65 years of age or older and is eligible we will say for the $44 minimum social security might go out and substitute this fall for 3 months, and by her earnings in that 3-month period make her ineligible for even the minimum social security benefits.
Senator HARTKE. That is right, and the retired teachers came to me and said they wanted to teach, the net result is that on substitute teaching they could teach for nothing, is that right?
Mr. GIDDINGS. That is right.
Senator HARTKE. Here you have a shortage of teachers. You are asking them to be substitutes, and if they go out and teach, they have to go out and teach on a substitute basis, they will have to teach for nothing.
Mr. GIDDINGS. Unfortunately, that is true.

Senator HARTKE. That is sort of a foolish way to approach this situation, but if you are a rich person who has some stock and are cashing a dividend check, you can keep it, right?

Mr. GIDDINGS. That is right.

Senator HARTKE. And you have some property and collect your rent, you can keep it, and if you have a big bank account and are drawing lots of interest, you can keep it. But if you want to go out here and teach on a substitute basis, you have to give the money back to the Government.

Mr. GIDDINGS. The principle was written into the social security law in the beginning, which the Congress has not been able to correct in this time.

Senator HARTKE. Maybe if we had more forcible push from some of the Senators, maybe we could get that done.

Mr. GIDDINGS. I hope that you can.

Senator HARTKE. Contact each one of them individually and tell them you want to support the unlimited earnings amendment. I will introduce it for you.

Mr. GIDDINGS. Of course on a limited earnings——

Senator HARTKE. You are not in favor of unlimited earnings, is that it?

Mr. GIDDINGS. We are trying to be realistic about it. In seeking to keep our eye on the possible, we have always sought improvements by reasonable steps.

Senator HARTKE. I am very realistic about it. I want to be very realistic. I want to treat a teacher here who wants to teach, I want to treat him just like I do that person who happens to have inherited a lot of money. Don't you think that is fair? Or do you think the rich people have a special right above your retired teachers?

Mr. GIDDINGS. Well, I think that is a problem that Congress hasn't dealt with realistically.

Senator HARTKE. Don't say Congress hasn't dealt with it. We are dealing with it. It is going to be brought up in the Finance Committee, and they are going to get a chance to vote on it.

Now I may be the only person who votes for it, but I will say this, I suspect that it won't get many votes. You may proceed.

EXCESS BLOOD BANK REQUIREMENT

Mr. GIDDINGS. We would also like to point out that it is unfortunate that an elderly person who has required the use of blood during his hospital stay would have to replace his 3-pint deductible with 4 pints of blood under the House amendment. That is, the first pint he uses must be replaced with 2 pints either by himself or a person acting on his behalf. It is our understanding that this additional pint is used by the hospital for its own profit.

We are very much in favor of encouraging donations of blood. Although most elderly persons are not able to donate blood themselves, many of our members are volunteer workers with the Red Cross and several of our chapters are working with their local Girl Scouts in helping recruit blood donors. However, it does not seem that giving hospitals a profit on blood donations will encourage such donations. We ask you to consider whether the 3-pint deductible should not be on a 1-for-1 basis.

MEDICARE-HEALTH INSURANCE BENEFITS

We were disappointed to learn that H.R. 12080 fails to assure medicare coverage to all persons attaining age 65 after December 31 of this year regardless of their quarters of coverage under social security. Specifically, the person who reaches 65 in 1968 will not be eligible for medicare unless he has acquired at least three quarters of social security coverage. While the bill does improve present restrictions somewhat, it does not alter the basic cause of our concern. Among the individuals who become 65 in 1968, a significant number will surely find themselves not eligible for benefits under the medicare program unless this 90th Congress acts to protect them.

At the present time we have no way of determining how many Americans will never be eligible for medicare until the Congress takes some action. We do know, however, that this list includes many of the 2.5 million employees of State and local governments who remain outside the social security system.

Although most employees in the United States are now covered by social security, this is not necessarily the case with regard to public employees. The Social Security Act places a tax on both employers and employees. Since Congress has never tried to force the issue of taxing a State or local government, coverage for their employees has been on a voluntary rather than on a compulsory basis.

Consequently, public employees in 13 States, several cities, and Puerto Rico have chosen not to come under the social security program. Most are covered by their own retirement systems, which generally provide a level of benefits superior to social security. Most of them, however, do not have programs similar to the hospital insurance features of medicare.

Regardless of the method finally adopted by Congress to assure medicare coverage to all Americans at age 65, we believe the step must be taken by the Congress. Of course, there is a bill before the committee, introduced by Senator Ribicoff, which we assume will be given consideration.

FULL MEDICAL AND DRUG DEDUCTIONS

Next, Mr. Chairman, we hope the committee will once again take action to restore the right of full medical and drug deductions to persons age 65 and over on their Federal tax returns. As long as medicare is burdened with exclusions and deductibles, the 4.2 million taxpayers over age 65 need this protection. Let the record show that we strongly support amendments now pending in the Senate to restore such deductions to the older taxpayer.

INCREASE IN BENEFITS FOR CERTAIN UNINSURED INDIVIDUALS

Two years ago, in 1965, Congress established a "transitional insured status" for persons age 72 and over who were excluded from social security benefits because their working lives were completed or substantially completed before coverage was extended to their former occupations.

Last year, in 1966, a Senate amendment granted a special minimum benefit to certain individuals lacking quarters of social security coverage. Although the House obtained a cutback in conference, we believe

the final agreement marked a significant beginning and would urge that Congress take the next logical step. We deplore the fact that the blanketing-in amendment finally passed last year denied the meager $35-a-month special benefit to the 72-year-old teacher or other retiree who is drawing as much as $35 a month in any form of public pension. Such an injustice is contrary to the original intent of the Prouty amendment and should be corrected by the Congress without delay.

We recommend that the remaining 750,000 Americans age 70 and over be blanketed in the social security program at the minimum benefit of $50 recommended in the President's message on the elderly and now written into H.R. 12080. Reasonable eligibility requirements may be established to prevent granting additional "pensions" to persons otherwise qualified for retirement benefits under other programs or not in need of subsistence income.

The number who would benefit from this recommendation is not large and will eventually be eliminated by time, yet many of these individuals are the retired teachers who, after a lifetime in the classroom, in some States, are receiving monthly payments of $50 or $60 and have not been included by recent improvements in teacher salary and pension programs. Widows of World War I veterans would also fall in this low-pension group. These are proud individuals who have not applied for public aid but who met every accepted definition of poverty except that of the spirit.

When the Railroad Retirement Act was passed in 1935, all retired railway workers were included in its provisions for immediate basic benefits. This precedent might well be used to correct the oversight of these individuals in previous amendments to the social security program and recognize our debt to them for past service and to provide a true measure of security in their last years.

REDUCTION OF RETIREMENT BENEFITS DUE TO SOCIAL SECURITY INCREASES

Although we are certainly pleased to see that there will probably be a raise in social security benefits this year, Mr. Chairman, we note with alarm a report by the Subcommittee on Employment and Retirement Incomes to the Senate Committee on Aging which points out that raises in social security too often do not secure the recipient an overall raise, since his other retirement benefits are decreased accordingly. In fact, sometimes a raise in social security will give the beneficiary an overall drop in benefits.

We feel that this is very unfortunate, since it destroys congressional intent. Therefore, we urge you to take action as soon as possible which would alleviate this problem.

RETIREMENT INCOME TAX CREDIT

Mr. Chairman, at your request the organizations urging updating the retirement income tax credit have joined together in one statement and designated me to present their request to your committee. The organizations include:

National Council on Teacher Retirement, National Education Association. The NCTR membership includes most of the State teacher retirement systems and many city and county teacher retirement systems. They are represented by Mr. Rex T. Wrye, on my right.

National Conference on Public Employee Retirement Systems, consisting of more than 100 retirement systems of which the Fraternal Order of Police and the International Association of Firefighters are well known to you.

National Association of Retired Civil Employees.

National Retired Teachers Association.

American Association of Retired Persons. They are represented by Mr. Miller at my left.

Speaking for all of the above-named organizations, I respectfully urge your committee to adopt a conforming amendment to section 37(d) of the Internal Revenue Code of 1954, the section pertaining to the retirement income tax credit.

As the committee is aware, enactment of this section in 1954 removed an earlier tax inequity and created a partial parity in tax treatment between tax exempt retirement income—social security and railroad retirement—and nonexempt retirement income.

In framing section 37 in 1954, and in the subsequent amendments, Congress limited the benefit to an amount equal to the exemption for maximum primary social security benefits, but in the form of a tax credit.

In keeping with the historic development of the retired income tax credit and to follow the precedents of previous adjustments, we ask your committee to approve an amendment to base the retirement income tax credit on $2,268 instead of on $1,524 for the single person and on $3,402 instead of on $2,286 for a man and wife. Such an amendment will update the retirement income tax credit from the social security maximums of 1962 to the maximums recently written into the House-passed bill, H.R. 12080.

Assuming, however, that the social security maximums which will presumably be written into the bill finally passed by the Congress this year may differ somewhat from those figures passed by the House of Representatives, it would be our hope that your technical staff would supply the necessary revisions to provide a true conforming amendment.

Mr. Jack Kennedy, president of the National Conference on Public Employee Retirement Systems, has asked me to express his regrets that he could not personally be present to speak in support of the position I have presented. Mr. Rex Wrye, speaking for the National Council on Teacher Retirement, will present for the record a statement setting forth the support of his organization.

Mr. Chairman, we wish to express the appreciation of our several associations to you and your committee for the splendid spirit of cooperation and understanding we have always received in all of our relationships with this committee and the individual members of the committee. Mr. Wrye and Mr. Miller would like to present their statements.

Senator HARTKE. Did you want to submit your statement, or did you want to read it entirely?

Mr. MILLER. Mr. Chairman, my name is Luther L. Miller and, in the absence of Clarence M. Tarr, our president, I appear for the National Association of Retired Civil Employees. I will not take the time to read the entire statement.

Senator HARTKE. The entire statement will appear in the record.

Mr. MILLER. Our association has more than 133,000 members, principally retired civil employees of the United States, but including also their dependents and survivors and widows of employees who died in the service. We have more than 1,000 chapters throughout the United States. We speak for more than 500,000 retired Federal employees and more than 250,000 dependents and survivors of former Federal employees. We are also concerned with the welfare of millions of other elderly retired citizens living on pensions under State or local governmental plans, or under private plans, or with retirement income in the form of dividends and interest, who share only meagerly or not at all in social security benefits. We thank Mr. Giddings for his statement in our behalf, but wish to add a few words in our own behalf.

I will let the statement speak for itself. We in the statement pinpoint two things which Mr. Giddings has brought up. That is the matter of the retirement income credit and the restoration of the privilege of deducting medical expenses for income tax purposes for taxpayers over 65.

Also I call your attention to another statement which he has made with regard to the reduction of retirement benefits due to social security increases. That also applies to cost of living increases for civil service retirees, and it is quite likely that the present trend, if it continues, will bring about cost of living increases for civil service retirees the first part of 1968, and this could cause hardship for some of our membership.

I would like to see the committee not only change the present rules in order to help those who would receive social security increases, but also to help those who might secure civil service increases under the cost of living.

(The entire statement of Mr. Miller follows:)

PREPARED STATEMENT OF LUTHER L. MILLER, VICE PRESIDENT, NATIONAL ASSOCIATION OF RETIRED CIVIL EMPLOYEES

Mr. Chairman, my name is Luther L. Miller and, in the absence of Clarence M. Tarr, our President, I appear for the National Association of Retired Civil Employees. Our Association has more than 133,000 members, principally retired civil employees of the United States, but including also their dependents and survivors and widows of employees who died in the service. We have more than 1,000 Chapters throughout the United States. We speak for more than 500,000 retired Federal employees and more than 250,000 dependents and survivors of former Federal employees. We are also concerned with the welfare of millions of other elderly retired citizens living on pensions under State or local governmental plans, or under private plans, or with retirement income in the form of dividends and interest, who share only meagerly or not at all in social security benefits. We thank Mr. Giddings for his statement in our behalf but wish to add a few words in our own behalf.

PUBLIC SERVICE

Many are prone to overlook the importance of persons in the public service in the building of the Nation's greatness. Our industry could not have grown to its present magnitude without the protection of our National Government, which could not function without its staff of civil employees. There could be no prosperity without the protection assured by State and local governments. Our vast systems of schools and universities could not exist without devoted teachers.

Our medical knowledge could not have been developed without great research institutions staffed largely by public employees. These public employees have their owner retirement systems, and most of them do not participate in benefits under the social security system. Unlike the social security and railroad retirement systems, where benefits are not subject to either Federal or State

income taxes, those retired under governmental staff retirement systems find that their retirement incomes must be reported as taxable income on Federal income tax returns and on State income tax returns in many States.

PRIVATE RETIREMENT INCOME

There are also a substantial number of our elderly citizens who receive retirement income under the form of interest or dividends which is subject to tax, whereas benefits under social security and railroad retirement systems are free from taxation.

DISCRIMINATION IN INCOME TAX LAWS

We have contended for many years that it is manifestly unfair to exempt some forms of retirement income from Federal income taxes while refusing to exempt other forms of retirement income. We cannot see any basis for this discrimination in favor of employees retired from private industry and against retired Federal workers, retired State and municipal employees, and retired school teachers. In 1954, this discrimination was partially alleviated by a retirement income credit of $1,200, which was the amount of the maximum tax-free individual benefit under social security, although less than the corresponding amount under railroad retirement. Later, when the maximum annual individual benefit under social security was increased to $1,524, the retirement income credit was promptly increased to $1,524. Furthermore, in 1964, the retirement income credit was extended to married couples over 65 years of age to compare with the combined tax-free social security income of a similar couple. This gave a couple over 65 years of age a retirement income credit of $2,286.

RETIREMENT INCOME CREDIT

Social security benefits were increased substantially in 1965, but there was no corresponding increase in the retirement income credit. Still greater increases are pending as the result of the House approval of H. R. 12080, now pending before this Committee. Furthermore, the income base was increased in 1965, and a further increase in this base is pending in H. R. 12080. As a result of these increases, the retirement income credit should be correspondingly increased to $1,860 for an individual and $2,790 for a couple in 1967, with a further increase in 1968 to match increases resulting from H. R. 12080.

MEDICAL DEDUCTIONS

We have another serious tax problem. Through the year 1966, taxpayers over 65 years of age were permitted to claim as exemptions on their Federal income tax returns practically all of their medical and dental expenses, which was very important for persons who have to pay out large sums of money for medical care. This was drastically changed by an incidental provision of the law authorizing medicare, and now we find severe limits to the amount of medical expenses we can claim as deductions. It is true that medicare helps with many of our medical problems, but we have many members who do not share its benefits. You will recall that most Federal employees who retired since July 1, 1960 were specifically excluded from medicare benefits but were not excluded from the change in income tax deductions. Also, there are a great many others who have medical expenses which were not helped by medicare, as for example, the persons who have tremendous outlays for prescription drugs and medicines. These are the people most hurt by the new restrictions on medical deductions.

SUMMARY

Our members are loyal Americans who have demonstrated their devotion by long careers of public service prior to retirement. They are still loyal Americans willing to bear whatever just tax burden they must assume for the benefit of their country. In all justice, we should not have to pay more than our fair share. And so we respectfully urge elimination of the present discrimination against us in Federal income tax laws, and the restoration to us of the medical deductions so necessary to persons in our stage of life.

Therefore, we ask that H.R. 12080 be amended by your Committee to provide an increase in the retirement income credit to equal tax-free social security

income, and to restore the unlimited medical deductions for persons over 65 years of age.

Mr. Chairman, I thank you for this opportunity to appear and present our views in this matter, and I will endeavor to answer any questions you or other members of the Committee may have.

Mr. WRYE. Mr. Chairman, I am Rex T. Wrye, executive secretary of the Pennsylvania public school employees retirement system and president-elect of the National Council on Teacher Retirement of the National Education Association.

I want to consume only enough time to endorse the testimony of the National Retired Teachers Association as just presented by Mr. Ernest Giddings insofar as it applies to amending section 37 of the Internal Revenue Code of 1954 to equalize for all taxpayers the amount which may be taken into account in computing the retirement income credit thereunder. To further expedite matters, I respectfully request that the formal statement I am about to file be made a part of the record of this hearing.

Thank you, Mr. Chairman, for affording us this chance to appear before this committee.

Senator HARTKE. The entire statement will appear in the record.

(The prepared statement of Mr. Wrye follows:)

PREPARED STATEMENT OF REX T. WRYE, NATIONAL COUNCIL ON TEACHER RETIREMENT, NATIONAL EDUCATION ASSOCIATION

Mr. Chairman, my name is Rex T. Wrye, executive secretary of the Pennsylvania Public School Employees' Retirement System, and President-Elect of the National Council on Teacher Retirement of the National Education Association. The Council's membership is composed of teacher retirement systems, state and local education associations, and is the NEA unit which represents these organizations and teachers in the field of retirement. The NEA has over 1,00,000 members.

My testimony is limited to the retirement income tax credit set forth in Section 37 of the *Internal Revenue Code of 1954*. As you know, H.R. 5710, the Social Security bill which was considered by the House Ways and Means Committee and reported out and passed as H.R. 12080, contained a provision on the taxation of the elderly in Title V. The provisions of Title V were not included in H.R. 12080, nor were any other provisions on the taxation of the elderly. For this reason, we find it necessary to urge this Committee to consider a conforming amendment to Section 37 of the *Internal Revenue Code*.

As the members of this Committee know, the purpose of the retirement income tax credit is to provide tax equity for those who do not receive tax-free Social Security benefits, but do receive taxable retirement income from other sources. In order to provide this equity, the base on which the tax credit is taken must conform to the maximum payable under Social Security. Section 37 has not been amended since 1962, although Congress has increased the maximum benefits payable under Social Security. Therefore the present tax credit base remains at $1,524 for a single person, and $2,286 for a married couple. This Committee is now considering an increase in Social Security which would make the inequity greater. For this reason, we recommend that the base be increased from $1,524 to $1,835 for single persons and from $2,286 to $2,753 for married persons.

I have attached to my testimony a draft bill which we believe would accomplish the tax equity we seek. The figures in the bill are those I have just given you and are based on what we believe the maximum under Social Security will likely be when you have finished your deliberations. Of course, we will not know what the final figures should be until the Congress has enacted the 1967 Social Security Amendments.

The National Education Association, representing the teaching profession, along with the other public employee groups represented here today, have had an active interest in the retirement income tax credit since it was first enacted in 1954. Since that time we have urged, and the Congress has adopted, increases in the tax credit base as Social Security maximum benefits have increased. This

is what we are doing today. We request that the Congress again establish tax equity between those who receive retirement benefits which are taxable and those who receive Social Security benefits which are not.

Thank you for your consideration. We appreciate this opportunity to express our views to this distinguished Committee. You can be assured of our willingness to cooperate with you at all times.

A BILL To amend section 37 of the Internal Revenue Code of 1954 to equalise for all taxpayers the amount which may be taken into account in computing the retirement income credit thereunder

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 37 (d) of the Internal Revenue Code of 1954 (relating to limitation on retirement income) is amended by striking out "$1,524" where it first appears and inserting in lieu thereof "$1,835."

SEC. 2. That section 37 (i) is amended by striking out "$2,286" where it first appears and inserting in lieu thereof "$2,753."

SEC. 3. The amendments made by the first two sections of this Act shall apply only with respect to taxable years beginning after December 31, 1966.

Senator HARTKE. I want to thank you gentlemen for your testimony. The next witness will be Mr. Mark Berke of the Mount Zion Medical Center, on behalf of the American Hospital Association.

STATEMENT OF MARK BERKE, DIRECTOR, MOUNT ZION HOSPITAL AND MEDICAL CENTER, SAN FRANCISCO, ON BEHALF OF AMERICAN HOSPITAL ASSOCIATION, ACCOMPANIED BY WILLIAM J. MUELLER, PARTNER IN THE ACCOUNTING FIRM OF ARTHUR ANDERSEN & CO.; JOHN R. STAGL, DIRECTOR, PASSAVANT MEMORIAL HOSPITAL, CHICAGO; KENNETH WILLIAMSON, DIRECTOR, WASHINGTON SERVICE BUREAU, AMERICAN HOSPITAL ASSOCIATION; AND DR. E. J. CROSBY, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. BERKE. I am Mark Berke, director of Mount Zion Hospital and Medical Center, San Francisco. I appear here today in behalf of the American Hospital Association, as a member of the board of trustees of the association. Joining me at the table is Dr. Edwin J. Crosby, executive, vice president of the association.

With me is William J. Mueller, a partner in the firm of Arthur Andersen & Co., known nationally and internationally as public accounting authorities. Accompanying Mr. Mueller is John R. Stagl, director, Passavant Memorial Hospital, Chicago, who will join us in discussing any matters presented. With us also is Kenneth Williamson, associate director of the American Hospital Association and director of its Washington Service Bureau. Senator, I have a fairly lengthy document here which, with your approval, I will not read entirely but I would like it to appear in the record.

Senator HARTKE. It will appear in its entirety in the record, and you may cover such portions of it as you think are necessary to cover orally.

Mr. BERKE. Thank you, sir. In my statement I will discuss the general area of hospital costs and operations from the viewpoint of an administrator engaged in the day-to-day operation of a large hospital. Also, I will present specific comments and the recommendations of the association on certain aspects of H.R. 12080. Mr. Mueller will follow me and discuss various technical financial aspects of the medicare law and particularly the basic questions involved in the consideration

of the long-range capital financing needs of hospitals. In the following two pages I review the significant roles of hospitals in the implementation of the medicare law.

The hospitals of this country have been, beyond any doubt, a major factor in the successful implementation of the medicare law. I know of no other program undertaken by the Federal Government involving so many millions of our citizens that has been so smoothly implemented in so short a period of time.

We must bear in mind that not only was this a complicated program in terms of benefits, but also it was one that presented difficult problems in administration and implementation. The great majority of hospitals were faced with a completely new approach to reimbursement by the Federal Government. Widespread concerns, and even fears, about a Federal program of this magnitude had to be overcome. Public uncertainty and confusion about the details of the program required a major and speedy communications effort by hospitals, so that the public generally and patients specifically might have a clearer understanding of the intent and provisions of the law.

Broad speculation and prognostications that there would be waiting lines of the elderly outside every hospital, and that every acute hospital bed in the country would be filled with older patients—hypotheses with which, incidentally, the hospital field never agreed—failed to materialize. The medicare law with its broad social significance has been made to work, and the sick elderly of the Nation have been well served, together with the sick of all ages.

From my own experience with the institution I serve, I can assure you emphatically that these desired results simply could not and would not have been achieved without the full support of the hospitals of the Nation, and without complete cooperation among the hospitals, their medical staffs, the intermediaries and the Government. Of course, this has not come about without some real problems, and it was to be expected that a program of this magnitude would require various adjustments which have become evident through our joint experience. These are the matters to which we wish to address ourselves today.

Senator HARTKE. We will have to recess because that is the final vote on the elections bill which is in the Senate. At least we did get in 40 minutes of testimony.

(Short recess.)

The CHAIRMAN. I will call the hearing back in order. Will you proceed.

COSTS OF HOSPITAL CARE

Mr. BERKE. The Federal Government has indicated that it is greatly concerned with the costs of hospital care and the future of such costs as they will bear upon the overall financing of the medicare program. We fully understand this concern, and we share it. However, we are troubled by the depicted image of hospitals and the explanation being given wide expression that the increasing costs of hospital care result from the inefficiency of hospitals and their lack of incentives for good management. We believe this is a gross misstatement of the facts.

It seems fair to assume that any discussion of hospital efficiency and effectiveness will be, and must be, based upon a comparison with other industries or endeavors; and I must say now that we have absolutely

no fear of hospitals being compared with any other industry or business enterprise in the country, either from the standpoint of general management or on the basis of the efficiency of their operation. A factual comparison would, I am certain, reveal that hospitals will "look good" when compared with such fields as education, business, industry and most assuredly the whole administrative area of government.

Most of these organizations operate 5 days a week and, generally, only one 8-hour shift a day, as compared with the continuous, year-long, round-the-clock operations of hospitals and other medical care institutions. There is an obvious and enormous capital investment in plant and in equipment that lies unused for long periods of time in many of these nonhospital endeavors.

One can note this particularly in the whole field of education, where facilities often lie idle for long and frequent periods of holidays and summer recesses. The nonprofit, voluntary hospital, of which there are 3,478, is operated by a board of trustees, and I would estimate that there are more than 30,000 such trustees across the country. Trustees are drawn from all walks of life, but largely from business and industry, and they bring their acumen and expertise to bear on the question of hospital operations. I have not heard that they are critical of the hospital operation in itself as being an inefficient one. Furthermore, there have been numerous examples of industrial engineers and others widely experienced in various phases of management in the general field of business and industry who, upon becoming involved with hospitals, have found that the hospital is a difficult, intricate and sensitive operation to administer—much more so than most businesses.

The most important criterion of the hospital is now, and always has been, and I hope always will be, the quality of its product. We are completely willing and anxious to compare the quality of the product of hospital care with the quality of the product of any other commodity which the American public purchases. In fact, I would say flatly that if the quality of hospital care is not sustained at a higher level than many other services or commodities purchased in our country, I would feel very sorry for the public.

In talking about the hospital field we must constantly remember that we are not speaking about a monolithic structure in which all elements think and speak as one. Hospitals do not all turn at once when father says "turn," nor, when they do turn, do they turn at the same time, or at the same rate of speed, or even in the same direction. This may be seen as a weakness; but, in a pluralistic society, it is also a major strength.

The median size of hospitals nationwide is 67 beds, and, in fact, 60 percent of our hospitals are less than 100 beds in size. Thus, we are looking at some very large organizations; and we are looking at a great number of very small organizations. In spite of this diversity of size, there is, I believe, no industry in our country that is administered by more highly trained or skilled administrators. There are 17 university master degree programs in hospital administration in the United States, and they have graduated a total of over 5,000 students, most of whom are working in hospitals in administrative positions. These schools are now graduating 350 students per annum,

who are largely employed by hospitals. The students are all required to have at least a bachelor's degree and are required generally to take at least 1 additional academic year although some programs are now increasing this to 2 years with an additional year spent in residency under an approved preceptor.

Another area in which the hospitals are deeply involved is the training of medical personnel through internships, residencies, schools of nursing, and other programs for health personnel. Thus, 806 of our hospitals have programs involving 10,366 interns, 1,442 programs involving 31,762 residents, 752 registered-nurse programs involving 139,070 student nurses, and 311 practical-nurse programs involving 36,729 student practical nurses. This work is essential to the future of health care and, of course, represents a very significant element of the cost of operating these hospitals.

All in all, I do not wish to imply that there is no room for improvement in the management of hospitals—there is, indeed, a great deal of room, as there is in any business, industry, or any other form of human endeavor. I know of no other enterprise in the country in which there is shown a greater sense of conscience and responsibility. The hospital field is completely aware of its accountability to society, so that self-criticism and self-analysis are constantly at work. Furthermore, no other field that I am aware of has been as ready and willing as have hospitals to accept evaluation by outside groups, not only of professional standards but also of business and administrative practices; and I would like to outline briefly for you some examples of programs that are in effect throughout the hospital field to measure and to provide tools and information for improved administration:

1. Commission for Administrative Services in Hospitals

This program is an example of one that develops the use of industrial management techniques in hospitals, particularly in the area of nursing services. The program started in 123 hospitals in California. Similar programs are now being developed on a large scale in Virginia, New York, Michigan, Georgia, Florida, and Illinois. Although a number of hospitals already had industrial engineers on their staffs, these programs have stimulated the employment of industrial engineers on the staffs of a growing number of hospitals across the country. The program is also being employed with great effect in the laundry and food service departments of several hundred hospitals.

2. Hospital Administrative Services

The 2,500 hospitals now participating in this computerized program—representing well over one-half of the acute-care beds in the Nation—are provided with comparative productivity and financial data. The obvious value of hospitals gearing up to participate in the program in this reporting system has brought about considerable improvement in the internal operation of hospitals and furnishes them comparative statistics on which they can evaluate their own operations.

3. Cost Allocation Program

Approximately 1,000 hospitals participate in this rapidly growing, centralized computer program, designed to provide the individual hospital with detailed allocation of costs. The program has recently been accepted as meeting the medicare reporting requirements of the Social

Security Administration. Based on this acceptance, it is believed that many hospitals will be able to more efficiently carry out the burdensome cost allocations required by the medicare program.

4. Management Review Program

This is a program, financed originally through a Ford Foundation grant, which, by establishing criteria for effective hospital management, stimulates good management and helps administrators to improve management procedures through qualitative evaluation by independent surveyors. More than 3,000 hospitals have been surveyed to date, and have received benefits from the program.

5. Association Educational Services

The American Hospital Association and allied hospital associations have for years provided other services to maintain and improve quality and effective management in hospitals. More than 250 manuals, monographs, and pamphlets are in current publication by the American Hospital Association and provided to the members. These cover the broad range of hospital activities including such areas as financial management, personnel administration, engineering and maintenance, laundry, planning, and infection control. These are supplemented by monthly publication of periodicals and newsletters.

In addition, the association conducts an ongoing program of institutes and workshops in which the newer techniques and practices of all hospital activities are carried to the field; in 1966, 58 formal institutes were held. These educational activities of the association are coordinated with the educational activities of other health field associations at regional, State, and local levels and by other professional groups within the health field to reach the broad population of hospital supervisory and other personnel. Thus the skills of the field are kept well honed by constant interchange of up-to-date ideas, practices and techniques.

6. Quality Controls

A. Joint Commission on Accreditation of Hospitals

The commission program, jointly sponsored by the medical profession and hospitals, establishes standards by which the quality of care rendered in hospitals may be measured through the procedure of personal inspection by a physician. This is a major voluntary effort to assure the public of high-quality care and, in fact, forms the basis for medicare acceptance of participating hospitals.

Approximately 70 percent of 3,013 acute short-term general hospitals have met the standards of approval of the Joint Commission on Accreditation of Hospitals.

B. Commission on Professional and Hospital Activities

1. *Professional activities study.*—This voluntary program is cosponsored by the American Hospital Association, American College of Physicians, American College of Surgeons and the Southwestern Michigan Hospital Association, and is participated in by 1,004 hospitals. It provides detailed information on the utilization of hospitals, by specific illness categories, and is an important tool by which the professional staffs of participating hospitals may evaluate their quality control and overall performance. This thoroughly computer-

ized program constitutes a most significant effort in self-analysis by hospitals and their medical staffs of their medical and hospital practices.

2. *Medical audit program.*—Subscribing hospitals are furnished computerized materials to facilitate their own evaluation of the quality of medical care they are providing to their patients. I would like to point out here we are not talking of just a few hospitals involved in these programs, but thousands of hospitals in the United States.

How effective have the above programs been, and what impact have they had on the hospital field? I would like to discuss some examples, especially in larger departments of the hospitals, because it is in these areas that the results show most quickly in significant terms.

1. Dietary Services

There is widespread and free exchange of information among hospitals on new developments concerning food service programs. The Hospital Administrative Services centralized computer programs provide comparative cost data, and these are watched very carefully. In the case of Mount Zion Hospital and Medical Center, for example, our raw food cost for 6 months was $236,178; and our total food cost for the same period was $551,148. Because we serve 50,000 meals monthly, an increase in cost of only 1 cent per meal is the equivalent of $500 per month, or $6,000 per year; and, therefore, merits immediate review and inquiry.

Hospitals necessarily maintain and use the best of equipment and facilities, and the level of sanitation is held and must be held at a superior level.

It must be remembered that at least one-third, and in larger hospitals a substantially higher percentage of patients, are on special dietary services which involve special skills, services, and costs. To a large extent, this obviates the use of production line approaches for these patients. There is widespread research into the most effective and most efficient means of transporting food to patients within the hospitals; and there has been much experimentation in the interests of economy resulting, for example, in the generally accepted use of prepackaged food. There is promise in the possibility of reconstituted food and other methods which are currently being explored.

2. Nursing

The major change in inpatient care over the years in hospitals has been the reduction in the length of stay for the individual patient. Modern nursing care has been a substantial reason for this.

Recently, Mr. Henry S. Rowen, president of the Rand Corp., in addressing a large hospital audience, stated that studies indicated that there had been an 80-percent increase in productivity on the part of physicians. For myself, I can affirm that this increase is in very large measure due to the organization of services which hospitals have provided, and which have encouraged and enabled the individual physician to use his time most effectively for the care of his patients. Increasing the productivity of physicians has, however, contributed substantially to increased hospital costs. The process has certainly required a great deal more nursing service to patients.

The significant factor for the public is, however, the conservation of the time of the physician, because this has contributed importantly

to the overall effectiveness of the health care system of the country, and has measurably offset the national shortage of physicians.

To utilize the professional nurse only in those areas which require her particular skill and education, there is developing a widespread use of various types of nursing aides and highly skilled technicians to perform increasing numbers of special tasks within the hospital.

3. Electronic Data Processing and Computer Techniques

I believe the hospitals of the Nation have demonstrated their sense of responsibility by the conservative attitude with which they have approached electronic data processing. This is, we find, an extraordinarily expensive procedure. There are now more than 250 hospitals, either individually or joined in groups, engaged in the use of computers. Hospitals have been genuine innovators in the use of this equipment.

In addition to the customary use of computers for business offices, recordkeeping, information retrieval and similar applications, hospitals are developing sophisticated approaches in some unusual and imaginative programs for medical care. For example, some systems that are presently in use, or are being planned, are:

(*a*) A joint effort of four hospitals (Charlotte Memorial, Presbyterian, and Mercy in Charlotte, N.C., and Greenville in Greenville, S.C.) to speed data communication and retrieval from clinical laboratory, pathology, and radiology enabling faster diagnosis and treatment specification. The aim is to reduce the average patient's length of stay by one day.

(*b*) Mount Sinai Hospital, New York, carries on computer analysis and reporting of electrocardiogram results.

(*c*) The University of Missouri Medical Center conducts computer evaluation of laboratory tests for accuracy and content, and reports are made to the floor by computer. This system also accumulates test data, which are instantly available for diagnostic or research purposes.

(*d*) At the Mayo Clinic, a monitoring system displays changes in the patient's blood pressure, temperature, breathing rate, and heart rate on a television screen during neurosurgery.

(*e*) The Mayo Clinic also has an ECG system which records 50 ECG's per hour for subsequent computer analysis at the rate of 250 per day.

(*f*) Kaiser Foundation hospitals perform 19-step multiphasic screening physical examinations for 4,000 patients each month. A computer compares the measurements taken with stored standards, and prints out abnormalities.

(*g*) A computer at Memorial Hospital for Cancer and Allied Diseases in New York determines radiation dosage for patients. Mount Zion Hospital and Medical Center in San Francisco is linked to this system by means of a teletype machine.

Hospitals are experimenting with the development of data processing in the whole matter of logistics for the utilization of resources.

The use to which hospitals are proposing to put data processing obviously requires all the skills and experience which the authorities in this field can bring to task. In many universities and in industry, advanced research is going on, while at the same time, hospitals are trying to make sure that the use of the equipment and related proce-

dures is warranted, and will contribute to effective and economical operations.

Of course, we share with all other users of such equipment the marked shortage of skilled personnel needed, and I must remind you again of the large number of hospitals that are small in size. The cost of development of these techniques in a single institution is prohibitive and we are, therefore, striving for the development of cooperative endeavors.

At present, however, many efforts at cooperative endeavors in this and many other areas of hospital operation are largely frustrated because of the adverse actions of the Internal Revenue Service.

The CHAIRMAN. Why did you say the Internal Revenue Service frustrates this proposal?

Mr. BERKE. I come to that a little later.

The CHAIRMAN. Go right ahead.

ELEMENTS OF INCREASED COSTS OF CARE

Mr. BERKE. The increasing costs of hospital operations are due to labor increases, to increased costs for materials and supplies, and to the effects of the regular inflationary spiral.

These wage patterns are reflected in national cost analyses and predictions. Hospitals are particularly vulnerable to the impact of changes in salaries and wages, because salary costs account for 60 to 70 percent of hospital expense. This compares to an industry rate of some 20 to 30 percent. Thus, in the increasingly costly labor market, a raise of 5 cents per hour to employees across the board represents an increase of $1 per patient-day in the hospital field, compared with the cost to industry of 40 cents per day for the same 5-cent hourly increase.

Ever since the end of World War II, hospital wages have been edging up, spurred by the inflationary trend and by the competitive need to bring admittedly low wage levels closer to the prevailing levels in the community. In San Francisco, where hospitals have been unionized for many years, the annual increase averaged between 3 and 5 percent, and this applied to all personnel, including nurses. In 1966, however, hospitals were subjected to the first major break in this pattern of wage escalation; and during the year 1965–66, salaries for nurses in many parts of the country rose 15 to 20 percent.

Data on nursing service salaries from a random selection of 1,889 hospitals across the country show the following further increases for the 7-month period from September 1966, to April 1967: 1,122 hospitals, 10 to 15 percent; 767 hospitals, 5 to 10 percent.

Between September 30, 1965, and September 30, 1966, the total expense per patient-day increased 9.8 percent. On the basis of "Hospital Indicators" information plus results from supplemental cost studies on nurse salary increases, the following cost increases are anticipated between September 30, 1966, and September 30, 1967:

	Yearend, Sept. 30, 1966	Yearend, Sept. 30, 1967
Average annual salary—all personnel	$4,382.00	$5,140.00
Salary expense per patient-day	29.88	35.90
Other expense per patient-day	18.95	21.03
Total expense per patient-day	48.83	57.93

Following figures represent actual experience in the last 6 months of fiscal year 1967:

	1st 6 months of 1966	1st 6 months of 1967	Percent increase
Average annual salary	$4,311	$4,857	12.6
Salaries and wages per patient-day	29.25	33.91	15.9
Other expense per patient-day	18.94	20.93	10.5
Total expense per patient-day	48.19	54.84	13.8

In California, and on the west coast generally, nurses' salaries went up between July 1966 and April 1967 approximately 36 percent; and salaries for 18 other hospital employee classifications increased from 10 percent. In the case of Mount Zion Hospital and Medical Center, this means our payroll will increase $1,180,000 over a 12-month period, and additional increases will be requested in union negotiations during 1967. In the case of San Francisco's St. Luke's Hospital, the increased cost is $329,454; and for California Hospital in Los Angeles it is $600,000.

METHOD OF PAYMENT

We recommend that the provision of 1861(v)(1) be amended to delete the requirement that reimbursement be limited to the costs incurred for the individuals covered under the medicare program.

Mr. Mueller will, in his testimony, discuss the impracticability and fallacies involved in attempting to segregate patients by age or similar groupings on the basis of costs. I would like to stress at this time the medico-social reasons against such an approach, bearing in mind that the hospital is a social instrument as well as a medical institution, since it is a method created by society to meet certain of society's problems.

We have developed an excellent voluntary hospital system in the United States. There are numerous reasons for the high quality and high standards of our voluntary hospitals; and one of these reasons is the flexibility we have shown in the development of new programs, such as the dramatic open-heart surgery advances of recent years. While costs have always concerned hospitals, they have not deterred us from growth and development, for we have been able, when necessary, to spread the cost of new developments among large numbers of patients, rather than charge a few patients who benefit from them, the extremely high costs their illnesses dictate.

An example of this is the intensive care unit, a service adopted quickly by many hospitals since its effectiveness was first demonstrated a few years ago. At Mount Zion Hospital and Medical Center, we estimate our costs per patient day in the intensive care unit to be $115, whereas our charge is $64.50. California Hospital, with a cost of $100, has a charge of $65. The intensive care unit is a life-saving service, and we learned early that, if we attempted to recover the full cost from each patient, there would be resistance by the patient to the use of the facility and that this would result in unnecessary deaths or in unduly long, complicated and costly hospitalizations.

The coronary care unit is a similar development. At California Hospital, this costs $120 per patient-day, whereas the charge is $65, for the same reason. When Dr. Michael DeBakey's artificial heart operation becomes a routine procedure, it will obviously be extremely costly. Shall we then deny this procedure to all but the very wealthy, as we will have to do if the cost of the procedure is borne only by the patient receiving the service? It seems obvious to me that if this direction continues, hospitals will be loath to introduce new programs—no matter how lifesaving they may be—in view of the inability of the individual receiving the service to pay for it, and with no opportunity to apply the insurance principle of spreading the risk, and the cost, over many patients.

It may be argued that such advanced procedures as heart surgery and organ transplant affect only the few. There are other, more common, examples bearing vital sociological implications. The present system of reimbursement places an additional financial burden on the millions of young parents just getting their start as independent citizens of our great Nation. I refer, of course, to maternity and pediatric care. Accurate figures are hard to come by because, as I indicated earlier, most hospitals spread such costs among a large number of patients. However, since the early 1930's, county hospitals in California have been required by law to maintain an accurate charge structure related to their costs. I have information that the Sacramento County Hospital is contemplating new charges in the maternity department that will total $441.84 for a 4-day stay for mother and baby. A comparable figure at Mount Zion would be $357. The difference is attributable to the fact that we do not charge at our full costs for all services for our maternity patients.

This difference, of course, must be made up by other patients. The difference could be even greater. At Sacramento County, for example, they charge a flat $60 for the use of the delivery room. Many other hospitals charge by the hour for the delivery room. An example of what an hourly charge could do can be seen in the experience of a Washington area hospital. In that hospital, the charge for use of the delivery room is $43 an hour. However, on the basis of actual accounting, the cost of the delivery room is $125 per hour.

We think it behooves us to consider what we are doing to our total system of medical care, and not simply the cost of the medicare program. Before we force changes on a system that has been proved by its results, we should be sure that the changes will produce a better system than we had before.

There are, in reality, two kinds of costs incurred by every patient. The first of these involves the costs attributable to the individual's care and the services he receives. The second kind of cost is related to the necessity of the hospital being available to the community 24 hours per day, and involves all of those services and personnel essential to fulfill the "readiness to serve" mission of the hospital. If these costs had not historically been assumed by all paying patients in hospitals, the institution would have been unable to continue operation; and, under these circumstances, the services would certainly not have been available when they are needed by the community. Also, as I have pointed out, the inability to spread costs would have mili-

tated against the development of numerous lifesaving services within the hospital.

Therefore, we believe strongly that the Federal Government has an obligation to meet its full responsibilities as a partner in the health endeavor and to assume its full shart of all these costs in exactly the same way as you and I and every other patient have to bear our share of these essential costs. When it is realized that in the future perhaps 50 percent of the patients in most hospitals will be under medicare and medicaid, it becomes increasingly evident that neither the private patient nor the community will be willing, or perhaps even able, to assume the high-cost elements which are necessary for hospital service but which are not paid for by medicare and medicaid.

FURTHER COMMENTS ON 12080

We are pleased that the House has proposed a number of improvements in the medicare law which should facilitate its overall administration. I wish, however, to comment specifically on some matters which we believe should receive further consideration by this committee.

The CHAIRMAN. Before you get to that, I want to ask you about the statement you made that the second kind of cost is related to the necessity of the hospital being available to the community 24 hours a day, "and involves all of those services and personnel essential to fulfill the 'readiness to serve' mission of the hospital."

Now I am told that if a hospital stays open 7 days a week on a full-service basis, that actually results in a saving of money, because otherwise you tend to have patients in a hospital over the weekend who could be discharged over the weekend.

Mr. BERKE. Yes. if you develop your occupancy so that the occupancy is equally spread over the 7 days, this is true. For example, it is quite typical in hospitals throughout the country that over the weekend the hospital tends to have a reduced occupancy. Patients go home Friday, they want to spend the weekends with their families.

Now, if you can arrange the matter so that the services are available in the hospital on a 7-day-a-week basis, while it costs you more to put in the services, you have an increased number of patient days and the hospital patient days should tend to be reduced.

This is true if it can be done that way, but in many cases we find a number of difficulties in having patients come in over weekends. Mothers need to stay with their families over weekends. The whole question of arrangements with physicians comes into this. You still need all the standby services in the hospital regardless of whether you have the occupancy or not. You have personnel in the operating room, for example, operating room nurses who are there regardless of whether the facility is used. We would all like to use the facility more, but whether or not we are able to is another story. The standby costs still exist.

The CHAIRMAN. So, if you can operate your hospital on the basis of a 7-day schedule, scheduling people throughout the full week and you can get your doctors to provide services on a 7-day-a-week basis—that doesn't mean each doctor works 7 days, but if he is not working somebody else is—then you get more efficient use of your hospital, and you should be able to reduce the cost per patient day, I take it.

Mr. BERKE. I think that is true. It isn't quite as simple, of course. There are many complications, but if ideally we have the hospital utilized at a high level of occupancy throughout the year, then you would still have shortage of personnel to consider in this too because you have to hire additional personnel to have the operation go on on a full 7-day-a-week basis.

You still have all your other standby costs, and it is not simply—Senator, you are referring, of course, to weekends, and this is true, and holidays also, but you still operate 24 hours a day. You are on a standby basis 24 hours a day. We have nurses in the operating room evenings and nights for emergency cases, for patients presently in the hospital for whom, for example, surgery is not anticipated. You still have to have those standby services.

The CHAIRMAN. You are saying that certain services have to be avoidable 24 hours a day, 7 days a week. Other services tend to be concentrated during the first 5 days of the week.

Mr. BERKE. That is right.

SECTION 127—PODIATRY SERVICES

This section amends the definition of a physician—relative to part B benefits—so as to include a doctor of podiatry and the functions he is authorized to perform under the laws of the state in which he practices. We believe it is necessary to make clear that this will not in any way assure podiatrists the right to practice in hospitals.

Hospitals must be able to continue to protect the patients and community by carefully selecting those professionals who are permitted to use the hospital facilities. Therefore, the recommendations of the Joint Commission on Accreditation of Hospitals will guide hospitals in this regard. Hospitals will grant the privilege of using their facilities on the basis of the individual's qualifications. Patients will be admitted by, and under the ultimate responsibility of, a doctor of medicine who is a member of the hospital staff.

SECTION 129

This provides for hospital outpatient services, both diagnostic and therapeutic, to be covered under the supplemental medical insurance program, part B, rather than under the hospital program, part A, as they are at present. Also, it is provided that these services would be subject to the $50 a year deductible and the 20 percent coinsurance features, both of which are a part of part B. The present $20 deductible and 20-day limit provided under part A would be removed.

In some respects, this is an improvement and will assist in easing certain of the existing administrative problems; however, we are disappointed that the House did not accept the recommendation which we made for the handling of outpatient services.

We recommended and we still recommend that all outpatient services be provided in part A of the law and that the deductible requirement be removed, as well as the 20-day period, and in lieu thereof a straight coinsurance factor be provided which could be applied to each individual service.

In respect to the provisions of H.R. 12070 and in this same connection, we believe the $50 deductible is very likely to be a deterrent to

the provision of outpatient services. It is our belief that many of the patients applying for outpatient services in hospitals will be receiving physicians' services anyway, and thus will be having to make arrangements for the payment of the $50 deductible in connection with these physicians' services.

We believe that the $50 deductible proposed is an unnecessary burden and one that will be expensive to administer since in any event, if the patient cannot pay, the amount would be reimbursable as cost under the medicare or medicaid programs. Also, we should point out that some hospitals will undoubtedly require an advance payment of 100 percent of the charges up to $50 at the time the individual applies for outpatient care.

It is recommended that the $50 deductible be removed from any outpatient services provided in hospitals under part B. The remaining 20 percent coinsurance can be applied easily and in a very understandable manner to everyone concerned. This should also be a sufficient deterrent to any tendency for overuse.

SECTION 181

This section provides for payment of inpatient services of radiologists and pathologists on the basis of full reasonable charges from the part B fund. The $50 deductible and 20 percent coinsurance otherwise applicable to part B will be eliminated.

This constitutes a considerable improvement in the administrative handling of these services. We believe, however, that it fails to solve the basic problem and that, instead, it perpetuates the requirement that there be two billings to two trust funds. Although the House report indicates that single billing and the use of a single intermediary is permitted, the bill does not specifically so provide.

We recommend the bill be amended to authorize single billing and the use of a single intermediary.

SECTION 402—REIMBURSEMENT EXPERIMENTS

The Department of Health, Education, and Welfare would be given authority to enter into agreements with hospitals to develop and engage in experiments under various methods of reimbursement, and to demonstrate possible methods of increasing the efficiency and economy of health services through the creation of additional incentives to these ends without adversely affecting the quality of services.

Hospitals have a long history of interest in the development of the most effective and economic systems of rendering high quality hospital care. We are anxious to lend every possible assistance to the Department in the development of experiments that may lead to improvement in these areas. It should be pointed out that the goals underlying the experiments should be clearly understood if the experiments are to be successful, and Mr. Mueller will discuss this subject more fully.

The philosophy of the experiments should be: How to adequately reimburse hospitals for providing high-quality patient care in an effective and efficient manner. However, our full support of such experiments in no way changes our conclusions as to the inadequacies of reimbursement now provided and the need to now adopt the recommendations which we have made. It may well be a matter of several

years before the results of the experiments become known. Any delay of this nature in correcting the deficiencies in reimbursement will be seriously damaging.

TITLE 19

As I have previously mentioned, we were greatly distressed that the Federal Government decided to adopt the reimbursement provisions and procedures being followed under title 18 with all of its inadequacies and deficiencies. We met with representatives of the administration, and strongly protested the adoption of title 18 reimbursement for title 19. We have not made any recommendations with respect to reimbursement under title 19 in our statement, as we believe our primary emphasis should be directed to title 18; and if, therefore, the recommendations we have made under title 18 are accepted, the difficulties being encountered under title 19 will be corrected.

In our testimony before the House Ways and Means Committee, we pointed out that the present language of title 19 requires that hospitals be reimbursed for the reasonable costs of their services. However, no similar assurance is provided in the law in respect to nursing homes and other types of health care facilities.

We recommend, therefore, that the language be amended so as to provide that extended care facilities, nursing homes, and other long-term-care facilities be reimbursed on the basis of their reasonable costs.

Our recommendation was not accepted by the House. However, we repeat it here and hope that this committee will see fit to include such an amendment in this legislation.

AMENDMENT TO INTERNAL REVENUE CODE

Earlier in my testimony I referred to numerous areas in which hospitals are striving to join together in cooperative endeavors in the interest of economy and improved operation. Examples of these activities are joint laundry facilities, joint data processing programs, joint purchasing, et cetera. We had proposed to the Internal Revenue Service that these joint enterprises, made up of hospitals having a section 501(c)(3) exemption, be granted the same exemption that each participating hospital has. We have been unable to secure from the Internal Revenue Service approval of the exemption and consequently numerous proposed cooperative ventures are at a standstill.

Senator Carlson and Senator Metcalf of this committee have jointly introduced S. 2315 to correct this situation.

We recommend that the committee give prompt and favorable consideration to S. 2315. This could be accomplished by incorporating its provisions in H.R. 12080.

In conclusion, gentlemen, the Congress of the United States has guaranteed health care to a large segment of the country's population and has asked the hospitals of the Nation to join in a partnership with the Government to provide the care. We want to do this. If we are to do it well, and if we are to continue as a dynamic, growing source of medical care in this country, then we ask you to help us to meet these administrative problems; to assure us an adequate amount of working capital to do the job that must be done; and to think through with us the total impact of Government programs on the health system of the

United States, recognizing that our requirements for the rendering of a high quality of patient care go beyond the discipline of pure and raw accounting.

I appreciate the opportunity of presenting the views of the American Hospital Association to the committee and hope they will be helpful in its deliberations. Mr. Mueller will present further testimony.

Mr. MUELLER. Mr. Chairman, I am William J. Mueller, a partner in the firm of Arthur Andersen & Co. I have national responsibility within our firm for the administration of our hospital practice. I appear here today on behalf of the American Hospital Association. With me is John M. Stagl, director, Passavant Memorial Hospital, Chicago, Ill., who will join me in discussing the matters I present.

The purpose of my testimony is somewhat different from Mr. Berke's; whereas he is primarily concerned with the specific content of H.R. 12080, I am more concerned with what that bill does not contain. The primary omissions in the House bill coincide with areas in which I have had the greatest opportunity to observe the involvement of hospitals in the program—the areas of financial reimbursement and the requirements concerning recordkeeping and other administrative aspects of the payment system.

Before discussing these problem areas in detail, I would like to discuss the general background of the American experience in the capital financing of hospitals, for it was onto this setting that the medicare reimbursement system was superimposed, and it is in terms of these financial patterns that its adequacy must be judged. There are two essential dimensions to the problem of the capital financing of hospitals: (1) the hospitals' needs for capital, and (2) the sources of funds available to meet these needs.

THE CAPITAL FINANCING NEEDS OF HOSPITALS

Capital is used by hospitals to acquire adequate facilities in which to carry on their stated purposes. These facilities are most apparent in the land, buildings, and equipment which the hospital uses in providing its public service. Less apparent, but equally important, are the working funds it needs to finance current receivables and inventories. While buildings and equipment represent the largest single component of capital investment and will often amount to as much as $30,000 per bed on new construction, continuing needs for working capital are also significant and can, and often do, run as high as $4,000 to $5,000 per bed.

The needs for capital funds in hospitals have been staggering. The increase in such needs since World War II has been almost unbelievable—although perhaps not so unbelievable when it is recognized that the population has increased from 150 million in 1950 to 195 million in 1965, or an increase of 30 percent over this 15-year period. To meet this population increase, as well as the rising demand for hospital services, the number of non-Federal, short-term general hospital beds went from 505,000 in 1950 to 741,000 in 1965, an increase of 47 percent.

This tremendous expansion in hospital facilities has been expensive. During this same period—1950–65—almost $17 billion have been spent on hospital facilities. Interestingly enough, only 6 percent of this sum was spent on Federal construction; 12 percent, or slightly over $2

billion, represents the Hill-Burton share of non-Federal expenditures for hospital facilities.

During this same period of time, the cost to construct new facilities has skyrocketed; based on a continuing study made by the U.S. Public Health Service on new general hospitals financed in part under the Hill-Burton program, the cost to construct and equip a hospital bed has increased from approximately $12,000 in 1948, to $30,000 in 1965. Thus, the cost increased some 2½ times over this same period and has averaged an annual increase of 5½ percent compounded annually.

This astounding increase in cost per bed is the result of many complex factors. To some extent, it is the product of inflation, and, to a very large extent, the product of the requirements of medical technology for larger and more complex facilities. For example, the American Appraisal Co. construction cost index has increased approximately 3½ percent per year, compounded annually, over this same period. Other construction indexes show substantially equivalent results. It would certainly appear reasonable to assume from this that the difference between the 3½ percent cost increase of general construction and the 5½ percent cost increase applicable to hospital construction has been due for the most part to the increased requirements of advanced medical technology. In this regard, it should be noted that professional health care costs as distinct from the hoteling services in hospitals (costs for housekeeping, occupancy, dietary, laundry, administration and other nonprofessional services) have risen from approximately 40 percent of total patient care costs in 1946 to almost 65 percent of the patient care cost today.

The annual increase in knowledge in the medical sciences seems to be in geometric rather than arithmetic proportion to any measure of its prior fund of knowledge and resources. This tremendous growth, while in some part reflecting itself in marvelous new miracle drugs and surgical techniques, also seems more and more to be reflecting itself in increasing needs for "massive doses" of hospital facilities, that is, hospital capital.

Stated another way, many of the new breakthroughs seem to be "brick-and-mortar oriented," as is evidenced by the increasing reliance on computers as patient-monitoring devices, new types of diagnostic equipment, a proliferation—I might say a wonderful proliferation—of new specialty areas and therapy areas throughout the hospital field. All of these things are desirable and in line with our overall health service objectives, and we are spending millions of dollars per year on research so that they can be developed. On the other hand, once they are developed and become a part of the hospital scene, they cause significant increases in the needs for hospital capital to finance them.

In summary, there is nothing on the horizon to suggest any diminution in this historical pattern of rapidly increasing capital needs for hospitals. Although the aggregate rate of population growth has diminished slightly, the rate of adult population growth is actually increasing and this group represents the principal users of hospitals. Even compensating for growth, the demand for hospital services by the population has also increased due to increased levels of per capita income, health prepayment and insurance plans and the government's commitment as to the availability of medical care to the elderly and the medically indigent. There is no sign of a reduction in America's

ingenuity to design new and better forms of medical treatment. All of these factors can be translated into a forecast of significantly greater capital needs for hospitals in the next 20 years.

SOURCES OF FUNDS FOR MEETING THE CAPITAL NEEDS OF HOSPITALS

I would now like to turn to the equally important problem of how hospitals have been able to develop means whereby funds can be obtained to meet these capital needs.

There are really only three basic sources of capital funds—public donations, governmental grants, and day-to-day hospital operations. Each of these three sources has in the past been supplemented by either long- or short-term borrowings. It is important to note, however, that borrowings are not a source of capital, they are only a substitute for capital which must be repaid. In other words, you do not get "richer" by borrowing money; I believe that most persons acknowledge this fact in their personal lives, but tend to lose sight of it when considering the corporate destinies of either their business or their hospital.

I do not believe that any broad national averages with respect to the relative impact of each of these three sources of capital funds is particularly important or significant to the individual hospital. In this respect, each hospital is novel and each has its own particular problems and ways of solving them. The extent to which public donations are an important factor in meeting the capital requirements of hospitals varies significantly from institution to institution. Some institutions have in the past relied almost 100 percent on public donations; others have found that this is a very insignificant source for their capital funds. Governmental grants have been more important in some areas than others. As indicated previously, Hill-Burton funds have amounted to approximately 12 percent of the amount spent on capital facilities for short-term general hospital beds during the 15-year period, 1950–65. This does not mean that each hospital can count on 12 percent of its capital costs being met from this source. Some will be able to attract considerably more of this type of money; others will be unable to attract any of it.

If there is one common denominator in the field of capital financing, it is in the importance to almost all institutions of the ability to maintain and, in many cases, increase capital through results of day-to-day hospital operations.

Most hospitals which are well run from a financial point of view have historically been able to accomplish several financial objectives from their operations. First, they have been able to recover from patients all of their out-of-pocket costs—I mean such items as salaries and wages, supplies, utility bills, etc. These costs have been covered by the patients who pay their bills, not by the patients who do not pay their bills. Consequently, in most cases, patients who were able to pay their bills have all had to "chip-in" and pay a part of the bills of the people who, either because they were medically indigent or because they were "deadbeats," did not meet their obligations to the hospital. This has in the past been considered fair and proper because a part of the cost of keeping the front doors open, is the cost of caring for the nonpaying patient.

In addition to covering all out-of-pocket costs incurred by the hospital, paying patients have, by and large, paid in amounts equivalent to the accruing depreciation on the hospital's plant and equipment. They also, by and large, paid in additional amounts to cover the amount by which the customary accounting methods of providing for depreciation on the basis of historical cost, are inadequate to maintain the current purchasing power of the dollar. And also, as a rule, they paid in such additional amounts as were necessary to permit the hospital to maintain itself in a modern and up-to-date condition, that is, to meet the needs of an advancing medical technology.

The degree to which capital expenditures of hospitals were financed from depreciation and "net income" was shown in a recent study by the California Hospital Association, which showed that for the 10 years ended in 1966, 50 percent of the expenditures of voluntary nonprofit hospitals for capital improvements came from depreciation and net income, and that only 31 percent came from grants, contributions, and other sources. The balance, or 19 percent, came from long-term financing, which presumably would have to be paid off in future years, either from depreciation, net income, or grants and contributions. In effect, this meant that over two-thirds of the total capital requirements of the voluntary nonprofit hospitals included in the study were obtained from operations. Primary reliance on operations is also noted in data available on hospitals in the Cleveland and Chicago areas.

It should also be pointed out that this method of financing capital needs through the retention of income from operations is widely used in the rest of the free market economy. In the 12-year period from 1954 to 1965, corporate investment in capital was one-and-a-half times greater than capital consumption. Reinvested corporate income supplied this additional 50 percent, that is, one-third of corporate investment came from the reinvestment of operating profits and provisions for depreciation amounted to only two-thirds of capital investment.

In summary, the hospitals have historically recovered from operations all of their out-of-pocket costs plus their depreciation, based on the historical costs of plant and equipment.

In addition, hospitals also recovered amounts which, while often showing up as "net income" on their financial statements, tended to compensate for the declining purchasing power of the dollar—demands of inflation—and the needs of the hospital to improve itself and maintain itself as an up-to-date institution—demands of medical technology.

THE EFFECT OF MEDICARE REIMBURSEMENT

The current medicare reimbursement principles, in my opinion, have placed this basic pattern of financing the hospital system's capital needs in dire jeopardy. Permit me to give you just a couple of examples.

One serious deficiency in the current procedures has to do with the method called for in the regulations of apportioning patient costs between individuals covered by the program and those not covered. Such apportionment is, I presume, intended to be responsive to section 1861(v)(1) of Public Law 89-97, which states in part that—

> Such (reimbursement) regulations shall * * * take into account both direct and indirect costs of providers of service in order that * * * the costs with re-

spect to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs.

The methods of apportionment specified by the administration employ the hospital's charge structure as a means of measuring the performance of service to these two groups of patients. This method has been perpetuated in the face of much contradictory evidence concerning the method's basic assumption that the hospital's charge structure provides a reasonable measure of the relative cost of providing hospital services.

For example, studies were conducted in New York by three independent public accounting firms in which they analyzed all of the elements of the costs of patient care. From this study, they concluded that the present method of apportioning costs to medicare patients will not accurately measure the cost of caring for patients either over or under 65 years of age.

Part of the reason for this finding is that approximately 50 percent of the hospital's cost is billed to patients in the form of a daily charge for routine services. This daily service charge is intended to reimburse the hospital for costs such as patient rooms, meals, and nursing service. These daily service charges are universally established on the basis of the type of accommodation occupied by the patient; in no instance, that I know of at least, do these charges reflect the cost of the specific array of services rendered to each individual patient. In other words, if two patients occupy a two-bed room, one may receive as much as five times the service his roommate receives; however, the daily routine service charge to each of them will be identical, because they both occupy the same type of accommodation. Studies indicate that the cost of routine services is usually higher for the medicare patient because of his age and the infirmities typically brought about by age. Therefore, the application of cost allocation procedures based on rates does not reflect properly the cost of services rendered to the medicare patient. Cost accounting systems designed to cope with this problem presently are being studied, but I venture to say that it will be many years before they are both perfected and made operational in hospitals; it probably will be many years more before the average hospital will be able to incorporate such changes in its rate structure in an equitable manner. Even then, value judgments as to the patient's equitable share of such costs as standby facilities, public service facilities, experimental procedures, and certain high-cost procedures will make such a solution questionable.

Not only does Social Security Administration's methods of apportionment mean that the medicare program is not paying an equitable share for the patient costs of its beneficiaries, but the continued use of these reimbursement techniques provides a strong source of temptation for other third-party payers to adopt similar inequitable programs.

In addition to the problems inherent in the inequities of the apportionment methods, hospitals will have considerable difficulty in generating capital requirements from operations because current medicare reimbursement principles do not, in fact, cover all of the hospital's out-of-pocket costs. One of the significant costs of operating a hospital is the cost of rendering free care to certain categories of

noncovered patients. In general, such free care relates to two types of patients: One is the patient who is, at least presumably, able to pay his bills, but for some reason or another does not pay and becomes a credit loss; and the other is the patient who is medically indigent and unable to pay his bills. Such bad debts and other free cases cannot be included as reimbursable costs under the regulations adopted for the medicare program.

Caring for patients who eventually become credit problems is a cost of operating any hospital whose doors are open to the public. Providing care for such patients is as much a cost of maintaining an open institution as is the cost of the telephone operator, or the nurse, or the maintenance man. It is a cost that must be borne on a proportionate basis by the paying patient whether that paying patient be sponsored by the U.S. Government or by any other third-party payer or whether he be one who pays his own bills out of his own pocket.

The only alternative to considering bad debts as an overall hospital cost to be borne proportionately by all paying patients is to operate a closed institution, which will only admit patients who are sponsored by some third party with unquestioned credit and which will turn away all others who might become credit problems. This alternative is in conflict with all the moral concepts underlying the hospital field in this country and, as a matter of fact, in some jurisdictions is probably illegal. To attempt to finance this not inconsiderable cost by continuing to increase rates for the relatively small portion of direct pay patients not sponsored by a third party is certainly unjust and cannot be tolerated much longer.

Hospitals, as a matter of public policy, admit patients who, they realize, cannot pay their bills. In many cases, these patients are not qualified for public assistance, and the cost of their care must be borne by the hospital; and, in many instances, these patients are admitted on an emergency basis. The cost of these patients then becomes a part of the overall cost structure of the hospital—it is a cost of maintaining an open institution.

I have been speaking thus far about the serious effects of the medicare reimbursement system on the hospitals' traditional dependence on day-to-day operation as a primary source of financing capital needs. However, I believe that the medicare program may also adversely affect the hospital's ability to raise community contributions. There is certainly much confusion on the part of the public as to just what role the Federal Government has assumed in the financing of hospitals, but there is undoubtedly a strong belief by many that part or all of the community's traditional responsibilities will now be shouldered by the Federal Government.

Not only has the advent of medicare raised the specter of "look to Washington" as the solution of the community's hospital needs, but additionally the Federal program has commandeered past contributions to hospitals through Principle 1–6: Grants, Gifts, and Income from Endowments (Reg. Sec. 405.423), which in part states that "grants, gifts or endowment income designated by a donor for paying specific operating costs should be deducted from the particular operating cost or group of costs." This means they are not reimbursable. The grants and endowments consist of special-purpose donations

that had not been expended as of June 30, 1966, or endowments given to the hospital many years ago with income restricted for use in offsetting operating expenses. It could never be construed that it was the intent of these long-gone benefactors that their donations be used to subsidize hospital payment programs which would otherwise be the Government's responsibility. To offset these items against "reasonable cost" is in effect taxation without representation. Consequently, I would certainly recommend that, as a minimum, all special-purpose donations made before the enactment of this legislation be automatically excluded from its provisions.

THE CURRENT REIMBURSEMENT AMENDMENTS

The picture I have painted of the effects of medicare reimbursement is gloomy, to say the least, but I cannot emphasize too emphatically that the Congress of the United States has a very grave responsibility for developing a reimbursement plan that not only meets the needs of this Federal program but can also serve to strengthen the other institutional components of the Nation's hospital financing system.

With such a conviction, you can no doubt understand my great disappointment when I examined H.R. 12080 and found that not one of these deficiencies had been corrected. In fact, the bill is strangely silent on virtually every question concerning hospital reimbursement.

The only reference to reimbursement, aside from the procedural billings changes for outpatient care, is in section 402, which authorizes the Secretary of Health, Education, and Welfare to conduct reimbursement experiments on incentives for lowering costs while maintaining quality and increasing efficiency in the provision of health services. Frankly, I am quite apprehensive about this section of the bill because I do not believe that the language of the bill bears out the interpretation placed on it in the report of the House Committee on Ways and Means. One statement in that report especially impressed me and I quote: "* * * the success of the experiments will be measured by improvement in efficiency and increase in output per dollar of expenditure * * *." I fully concur with the committee statement of the goal for the program; we should be seeking to maximize the benefit to the Nation of each dollar of expenditure on health services. However, I'm not sure that the current version of section 402 clearly states that objective, nor does it encompass the full implications of such a program of experimentation.

From my reading of section 402, I believe that the phrase "incentives for lowering costs while maintaining quality" implies that the purpose of the experiments is to minimize expenditures for a given level of quality. If the Federal Government only wishes to purchase a given level of quality of care, I think that it is encumbent upon Congress to clearly tell the Nation that it cannot afford to pay for more than that level. However, it should not foster a program which seeks to produce a system that does not permit the hospital, in one way or another, to meet its financial needs without seriously reducing its patient care services. If, for example, a hospital has average operating costs of $75 per day and the Federal Government is only willing to pay $60, the hospital must have the right to recover the additional

$15 from the patient. The only other alternatives are for the hospital to reduce its patient services or charge other patients for the difference. I hope that the Congress does not wish to encourage the acceptance of either of these alternatives—even though today, as I have suggested earlier, the private patients are being forced to subsidize the medicare beneficiaries.

Perhaps the cost minimization objective will not produce such a direct result, but an incentive approach, coupled with cost minimization, suggests to me a system of economic bribery in which the Federal Government will make it "worthwhile" for a hospital to do things it would not ordinarily desire to do. For example, such a program might encourage hospitals to reduce the number of nursing hours per patient day from 5 to 3 or to cut back on housekeeping and sanitation. The basic principle of gearing incentives to reimbursement formulas, which would require a particular course of action is, I believe, highly undesirable.

Therefore, I would recommend that section 402 be modified to make the purpose of these experiments more in keeping with those envisioned in the House report on the bill; the goal of the experiments should be the maximization of public benefits derived from each dollar of health services expenditure. Such a goal not only implies the development of objective measures of quality and efficiency, as the report suggests, but also the development of reimbursement methods which relate adequately to the true costs of hospitalization and fairly compensate the hospital for free care, inflation, and the other elements discussed previously herein. In addition, if the experiments are to be truly dedicated to improving the system's efficiency in the provision of health services, the experiments must be related to the total health care system. That is, the program must be based on the recognition that hospitals and other health care institutions are only a part of the total health care system in this country. The benefit structure of prepayment and health insurance surely influences the way individuals seek to use these institutions and the economic relationship between the doctor, patient, and hospital are also an integral part. Nor can we fail to include the cost of administering the various alternative reimbursement methods. Consequently, it would seem that the goal of maximizing health care benefits would imply a much broader form of experimentation in which all aspects of the medicare program would be included in the program of experiments. The expansion of this program should, and I stress this, continue to be a voluntary basis; that is, participation in the experiments would be mutually agreed upon by the Secretary and the organization, institution, or individual.

The report on section 402 also called the House's attention to another factor that is not specifically included in the bill; it states that "the Secretary would be required to report annually to Congress on the experience in carrying out the experimentation in incentive reimbursement." Such a requirement clearly implies a rather lengthy period of experimentation. Perhaps 5 to 10 years will be required; for the development of a totally new payment system must be accomplished slowly and carefully. The significance of a national fiscal system for the health services industry is far too great to choose any other method of development. However, recognition of the time required for the neces-

sary experiments suggests to me that the deficiencies in the current reimbursement formula should not be perpetuated in anticipation of any quick, "magical" or inexpensive solutions resulting from the authority to experiment granted by the proposed section 402. Such a course of action—or more accurately, inaction—would allow the inequities in the current medicare program to fester and grow into an even greater injustice through a disruption of the whole hospital financing system.

The action which should be taken is clear. It is recommended, therefore, as a minimum that—

(1) The medicare program should include a revision of the method of apportioning costs between program beneficiaries and the rest of the public; average cost per diem is the simplest and most equitable method.

(2) The program should agree to assume its fair share of the hospital system's free-care and bad-debt costs.

(3) Principle 1–6 of the principles of reimbursement for provider costs, expropriating past contributions to hospitals, should be altered to exempt all pre-July 1, 1966, contributions.

These amendments along with the current 2-percent factor would bring the medicare reimbursement system up to a minimum level. However, I would hope that Congress would not choose to permit the national program to accept minimal financial standards. Instead, medicare should assume the lead in raising the standards of third-party responsibilities to the Nation's hospital system. That is, the medicare reimbursement system should serve as a positive incentive for other third-party payers, rather than an inducement for these other third parties to reduce their support of hospitals. I believe that such a positive incentive could be accomplished by appropriately increasing the program's 2-percent factor to one which adequately recognizes the ongoing capital requirements of hospitals. I do not know what percentage would be appropriate in all cases, but I am convinced that 2 percent is pitifully inadequate. Perhaps a partial alternative would be to reimburse hospitals for depreciation on a replacement cost basis.

As I mentioned earlier in my statement, hospital construction costs have been rising much more rapidly than changes in either the general price level or other construction costs. Consequently, the inequities of payment between hospitals are extreme. A survey of Chicago hospitals revealed that the amount of depreciation costs ranged from 6 cents to $3.89 per patient day. The primary cause of the difference is the age of the institution; older hospitals were built with much lower capital costs. Replacement cost depreciation would not only eliminate these gross inequities between institutions, but it would also produce a flow of additional funds to exactly the right kinds of institutions. That is, it would provide an additional flow of funds from the day-to-day operations of older hospitals, which are badly in need of capital for modernization and replacement of facilities.

SUMMARY

As I believe I have at least implied in this statement, hospitals are not perfect; they suffer the same problems that all other organizations

suffer. They are not as efficient as they might be and neither are other organizations. Their operating costs may on occasion be higher than they should be, but so are probably other organizations. They are sometimes guilty of having duplications of facilities which are expensive, and so do other organizations.

In spite of all of their admitted imperfections, hospitals have done an incredibly good job of providing health services to the United States public. They are staffed today by true professionals in all of the health fields; their administrators are more and more becoming university-trained professionals; their paramedical personnel is increasing in quality day by day; the nurses have always been great, and they continue to become better; the attending staffs of our hospitals are the best in the world, bar none; hospitals have a lot to be proud of.

But, because they are good does not mean that they cannot improve, and certainly hospitals should do everything they can to "get their own house in order;" they should work hard on efficiencies; they should attempt to increase individual employee productivity through use of the many sound and tested management devices, including productivity measurement, which are available today; they should install sound accounting methods and procedures and inaugurate tight budgetary controls and responsibility accounting; they should work closely with their voluntary planning agencies in the avoidance of duplicate facilities.

I believe that most hospitals are doing these things, and, as they do them, they will get better, and better, and better.

There is one thing else they should do, however, which they have not done well enough in the past: That is that they should insist on sensible payment for services rendered; their trustees should insist they show an adequate operating surplus which will provide them, together with anticipated donations and such grants as are available, with adequate amounts of capital to meet their long-range financial needs. They must insist that third-party payers, regardless of who they may be, pay them adequate amounts so that they can meet these financial needs. It is my considered opinion that if third-parties will not do this, the hospitals must of necessity stop doing business with them. The Federal Government must admit to the desirability of this undeniable requirement for adequate compensation and take the lead in dealing with hospitals on a fair and business-like basis. There is no other responsible alternative.

I appreciate the opportunity of appearing here today and presenting these views on the medicare program.

The CHAIRMAN. Thank you. I will just ask one question and then I am going to submit a number of others to you for later reply and after you provide the answers to us, we will print those in the record.

(The chairman's questions, with answers supplied, follow:)

Question 1. How much more money are hospitals getting than they previously received for part-paid or free patients who are now covered under Medicare or Medicaid? (Last year estimated at more than $500 million)

Answer. We are unaware of the basis for your statement as to the $500 million and, therefore, cannot substantiate such an amount. In answering this question,

it must be clear that prior to the passage of he Medicare legislaion, large numbers of hospitals throughout the country were paid their full charge for services rendered elderly patients. These hospitals did not suffer serious financial losses for such care. The hardship where one existed was, of course, borne by the elderly patient and their family. In many instances private insurance assisted materially in financing the cost of care. Therefore, it is a complete misnomer to think that all hospitals in the country were suffering substantially financial losses resulting from the care to elderly persons.

There are certain groups of hospitals which have benefitted materially from the Medicare financing. These are the large teaching hospitals which had substantial numbers of part-pay or no-pay elderly patients. Also, generally speaking, hospitals operated by local units of government are benefitting from this Social Security financing.

Prior to the passage of Medicare, various estimates were made on the basis of studies in individual institutions. However, no nationwide figure has even been developed indicating the total loss resulting from treatment rendered to part-pay and no-pay patients. It has been generally seen that elderly persons are unusually conscientious about meeting their obligations and were inclined to underwrite fully the cost of health services received even though it may often have been with considerable hardship. This, of course, was one of the basic arguments for the Medicare program.

Question 2. How many Blue Cross plans pay hospitals *less* per day than does Medicare?

Answer. We do not believe that any Blue Cross subscribers pay hospitals less per day than the hospitals receive for the care of Medicare patients, but many Blue Cross plans pay less. The distinction between subscriber and plan payment arises because few Blue Cross plans provide completely comprehensive service benefits.[1] On the items included on the subscriber's Blue Cross benefit coverage on an indemnity basis, hospitals are permitted to collect the difference between the Blue Cross indemnity payment and the hospitals' full charges from the subscriber. Since the Medicare Program, with the exception of some minor deductibles and copays, has a full service benefit contract, the hospital must accept the SSA payment as full payment for patient care services performed. Consequently, any comparison between Blue Cross and Medicare payments per patient day must include the additional cash payments for patient care made directly by the Blue Cross patients themselves.

The empirical evidence to support our belief that Blue Cross patients are paying significantly more than Medicare patients requires extremely detailed accounting studies,[2] which are currently being conducted under the encouragement of the

[1] In 1966 only one Blue Cross plan reported that it covered 99.8 percent of its subscribers' hospital bills; this level of coverage probably approximates the Medicare Program's service benefits to the elderly. The complete distribution of plan benefit coverage in 1966 was as follows:

PERCENT OF HOSPITAL BILL COVERED

Percentage range	Number of plans	Percent U.S. membership	Total U.S. membership	Accumulated membership
All ranges	76	100	61,938,401	61,938,401
95 to 100	12	38	23,536,593	23,536,593
90 to 95	16	15	9,290,760	32,827,353
85 to 90	18	17	10,529,528	43,356,881
80 to 85	24	27	16,723,368	60,080,249
75 to 80	6	3	1,858,152	61,938,401

[2] The principal problem in measuring the total amount of Blue Cross patient payments is that hospitals only classify accounts receivable by the institution or individual, who owes the hospital for services performed. The identification of total Blue Cross payments would additionally require the identification of individuals who are Blue Cross subscribers and, then, an analysis of the actual collections from these individuals.

Blue Cross and American Hospital Associations. We can assure the Committee that if these studies result in the discovery of any instances in which Blue Cross patients are paying amounts as low as the current Medicare payments, the American Hospital Association and its allied state hospital associations will vigorously press the Blue Cross plan to correct this basic inequity. In the words of Mr. Mueller, already entered in our formal testimony, hospitals "must insist that third party payers, regardless of who they may be, pay adequate amounts so that they can meet these financial needs."

Question 3. How much more money did hospitals receive in federal, state and local contributions to their capital needs? (Hill-Burton, etc.)

Answer.

TABLE 1.—NATIONAL HEALTH EXPENDITURES BY OBJECT OF EXPENDITURE AND SOURCE OF FUNDS, 1965

[Amounts in millions]

Object of expenditure	Total		Source of funds						
			Private				Public		
	Amount	Percentage distribution	Total	Consumers	Philanthropy	Other	Total	Federal	State and local
Total	$40,751	100.0	$30,534	$28,074	$1,459	$1,001	$10,217	$5,262	$4,955
Health services and supplies	37,274	91.5	29,045	28,074	634	338	8,228	3,674	4,554
Hospital care	13,379	32.8	8,432	8,127	305	.....	4,947	1,967	2,980
Federal facilities	1,600	3.9	15	15	.....	.....	1,585	1,566	19
State and local facilities	4,018	9.9	1,352	1,352	.....	.....	2,666	166	2,500
Nongovernmental facilities	7,761	19.1	7,065	6,760	305	.....	696	235	461
Physicians' services	9,003	22.1	8,437	8,428	9	.....	566	137	429
Dentists' services	2,832	6.9	2,800	2,800	.....	.....	32	18	14
Other professional services	896	2.2	842	818	24	.....	54	15	39
Drugs and drug sundries	4,757	11.7	4,617	4,617	.....	.....	140	71	69
Eyeglasses and appliances	1,260	3.1	1,219	1,219	.....	.....	41	17	24
Nursing-home care	1,324	3.2	814	793	21	.....	510	273	237
Net cost of insurance	1,272	3.1	1,272	1,272	.....	.....	.....	.....	.....
Medical activities in Federal units other than hospitals	858	2.1	.....	.....	.....	.....	858	858	.....
Government public health activities	947	2.3	.....	.....	.....	.....	947	318	629
Private voluntary health agencies	275	.7	275	.....	275	.....	.....	.....	.....
School health services	133	.3	.....	.....	.....	.....	133	.....	133
Industrial in-plant health services	338	.8	338	.....	.....	338	.....	.....	.....
Research and medical facilities construction	3,477	8.5	1,488	.....	825	663	1,989	1,588	401
Research	1,490	3.7	163	.....	163	.....	1,327	1,269	58
Construction	1,987	4.9	1,325	.....	662	663	662	319	343
Publicly owned	555	1.4	.....	.....	.....	.....	555	223	332
Privately owned	1,432	3.5	1,325	.....	662	663	107	96	11
Percentage distribution by source of funds:									
Total	100	.....	74.9	68.9	3.6	2.5	25.1	12.9	12.2
Health services	100	.....	77.9	75.3	1.7	.9	22.1	9.9	12.2
Research	100	.....	10.9	.....	10.9	.....	89.1	85.2	3.9
Construction	100	.....	66.7	.....	33.3	33.4	33.3	16.1	17.3

Question 4. How much did hospitals get last year in tax deductible contributions?

Answer.

TABLE 1A.—NATIONAL HEALTH EXPENDITURES BY OBJECT OF EXPENDITURE AND SOURCE OF FUNDS, 1964 (REVISED DATA)

[Amounts in millions]

Object of expenditure	Total		Source of funds						
			Private				Public		
	Amount	Percentage distribution	Total	Consumers	Philanthropy	Other	Total	Federal	State and local
Total	$37,493	100.0	$28,217	$25,928	$1,367	$922	$9,276	$4,693	$4,583
Health services and supplies	34,363	91.7	26,867	25,928	614	325	7,496	3,268	4,228
Hospital care	12,621	33.7	7,902	7,612	290	.....	4,719	1,881	2,838
Federal facilities	1,535	4.1	14	14	.....	.....	1,521	1,502	19
State and local facilities	3,827	10.2	1,262	1,262	.....	.....	2,565	156	2,409
Nongovernmental facilities	7,259	19.4	6,626	6,336	290	.....	633	223	410
Physicians' services	8,065	21.5	7,564	7,554	10	.....	501	116	385
Dentists' services	2,647	7.1	2,620	2,620	.....	.....	27	15	12
Other professional services	885	2.4	843	820	23	.....	42	12	30
Drugs and drug sundries	4,437	11.8	4,315	4,315	.....	.....	122	60	62
Eyeglasses and appliances	1,105	2.9	1,067	1,067	.....	.....	38	18	20
Nursing-home care	1,215	3.2	809	78	20	.....	406	203	203
Net cost of insurance	1,151	3.1	1,151	1,151	.....	.....	.....	.....	.....
Medical activities in Federal units other than hospitals	697	1.9	.....	.....	.....	.....	697	697	.....
Government public health activities	814	2.2	.....	.....	.....	.....	814	266	548
Private voluntary health agencies	271	.7	271	.....	271	.....	.....	.....	.....
School health services	130	.3	.....	.....	.....	.....	130	.....	130
Industrial in-plant health services	325	.9	325	.....	.....	325	.....	.....	.....
Research and medical facilities construction	3,130	8.3	1,350	.....	753	597	1,780	1,425	355
Research	1,322	3.5	157	.....	157	.....	1,165	1,112	53
Construction	1,808	4.8	1,193	.....	596	597	615	313	302
Publicly owned	507	1.4	.....	.....	.....	.....	507	215	292
Privately owned	1,301	3.5	1,193	.....	596	597	108	98	10
Percentage distribution by source of funds:									
Total	100.0	.....	75.3	69.2	3.6	2.5	24.7	12.5	12.2
Health services	100.0	.....	78.2	75.5	1.8	.9	21.8	9.5	12.3
Research	100.0	.....	11.9	.....	11.9	.....	88.1	84.1	4.0
Construction	100.0	.....	66.0	.....	33.0	33.0	34.0	17.3	16.7

Question 5. Could you provide us with a documentation of the basis for the hospital cost estimates you submitted to the Ways and Means Committee?

Answer. The following are the assumptions of the AHA Task Force on Cost Information used in formulating our estimates:

1. Nurses salaries increased 30 per cent from October 1965 to September 1967.
2. Other salaries increased 25 per cent from October 1965 to September 1967.
3. Other expenses increased 11 per cent from October 1, 1966 to September 30, 1967.
4. Full time equivalent employees increased 5.1 per cent from October 1, 1966 to September 30, 1967.
5. Average daily census increased 3.4 per cent from October 1, 1966 to September 30, 1967.

The time periods for the estimates were October 1, 1965 to September 30, 1966 and October 1, 1966 to September 30, 1967. These periods were selected as they have been our traditional Guide Issue year. The data of source that we used was the Hospital Panel in all cases.

The CHAIRMAN. I want to ask you this question. Here is a letter I received from a hospital administrator. It says:

Payment to the hospital for services on the basis of either cost or charges does not provide incentives for hospitals to increase their productivity nor does it provide any penalty to those hospitals which exhibit a relatively poorer quality of care at a relatively higher cost. Inferior hospitals are able to survive and prosper as easily as best under this system.

I want to know if you agree with that statement.

Mr. BERKE. I think in general I probably would, Senator, being quite frank, as obviously I have to be.

While there are no incentives built in, in the sense in which you are talking, in my testimony I presented some seven or eight areas which we believe put incentives into the hospital field, and a good hospital I think will follow all these programs and more also, and will provide care of good quality.

The CHAIRMAN. Even the 2-percent bonus in some respects is an incentive to increase the costs of hospital care; it provides an incentive to run the costs up rather than hold them down.

Mr. BERKE. Of course, Mr. Mueller may be more informed on this than I. I do not feel that 2 percent is a bonus at all or even that it is cost-plus. I think what it is intended to do is to substitute other items of costs which are not included in the reimbursement formula. This would be my view of it, Senator.

The CHAIRMAN. Senator Bennett.

Senator BENNETT. I have two or three questions I would like to ask, Mr. Chairman.

Would your organization favor governmental price fixing or price setting in relation to all health care services?

Mr. WILLIAMSON. No, we wouldn't, Senator.

However, as we look at it, the medicare law and now title 19 does in effect establish price levels as it controls costs or as it applies to given reasonable costs, but in terms of the Federal Government establishing a system that would control prices, no. We hope not.

Senator BENNETT. Then I judge you would not favor having all items in hospital costs so fixed as to price or fix it as to the price that the Government would pay to reimburse the hospitals as distinguished from the present method of cost?

Mr. WILLIAMSON. It is I think the same question. No, Senator.

Senator BENNETT. Would you favor the hospital room costs being predicated on a reasonable cost or on the lowest priced hospital room rates for Government reimbursement?

Mr. WILLIAMSON. Reasonable cost.

Mr. STAGL. I think this leads into another area, Senator. If the Government gets into price setting, and if it gets into a race for a room, that may be all right as long as we can collect from the patient for the balance of the costs.

If the Government should see fit to put limits on what they will pay, we would wish the alternative of collecting the difference from the patients.

Senator BENNETT. That is fine. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much. We appreciate your statement here today.

I will next call the Comptroller General, Mr. Elmer B. Staats. We are happy to have you, Mr. Staats. I am sorry that we could not hear you sooner, because we certainly want to hear your views. We appreciate very much that you did accommodate us, and we are very happy to have you here.

STATEMENT OF ELMER B. STAATS, COMPTROLLER GENERAL OF THE UNITED STATES; ACCOMPANIED BY GREGORY AHART, DEPUTY DIRECTOR, CIVIL DIVISION; AND EDWARD A. J. CHICCA, OFFICE OF GENERAL COUNSEL

Mr. STAATS. Thank you very much, Mr. Chairman. I am happy to be here today. I would like to introduce my colleagues here. To my right is Mr. Gregory Ahart, Deputy Director of our Civil Division, who has devoted a great deal of time and attention to the particular subject we are addressing ourselves to today. To my left Mr. Edward Chicca, of our Legal Division.

I have a brief statement, Mr. Chairman. With your permission I would like to read this statement.

The CHAIRMAN. Would you, please?

Mr. STAATS. I am pleased to have this opportunity to appear here today to comment upon an amendment which would add to H.R. 12080, the social security amendments bill passed by the House of Representatives, a title V entitled "Quality and Cost Control Standards for Drugs." Amendment No. 266 is intended to serve objectives closely related to, and we believe consistent with, certain conclusions and the objectives of recommendations which we in the General Accounting Office have formulated on the basis of our reviews of activities relating to payments for prescribed drugs under federally aided State public assistance programs. These conclusions and recommendations were included in our reports to the Congress on a review of Federal financial participation in the costs of prescribed drugs for welfare recipients in the State of Pennsylvania (B–114836; Feb. 3, 1966) and a review of pricing methods used by various States in the purchase of prescribed drugs under federally aided public assistance programs (B–114836; Apr. 28, 1967).

As you stated on August 15 of this year, Mr. Chairman, when you indicated your intention to propose this amendment, the provisions of the amendment are quite similar to those of Senate bill 1303, upon which we furnished a report to this committee on May 16, 1967. We were happy to learn from your letter, requesting our comments on S. 1303, that the results of our reviews had been helpful in formulating the legislative proposal.

We are also pleased that the provisions of amendment No. 266 contain modifications which we believe appropriately recognize the comments included in our report on S. 1303. We have certain additional suggestions of a drafting nature which we have included as an attachment to my statement.

As we stated in our report on S. 1303, the questions of whether legislation in this field is desirable and whether the specific legislative provisions under consideration are the most appropriate means to accomplish the desired objectives are matters of policy for the con-

sideration of the Congress. We would, however, like to summarize, for the benefit of this committee in its deliberations on the amendment, the results of the two reviews by the General Accounting Office to which I have referred.

The Department of Health, Education, and Welfare is responsible for administering Federal financial assistance, under several titles of the Social Security Act, to publish assistance programs operated by the States and territories. Under the public assistance programs of most States, drugs are provided to welfare recipients through prescribed drug vendor payment programs. In general, under these programs, welfare recipients may have drug prescriptions, which have been written by private physicians, filled by private pharmacies. The private pharmacies render bills to, and are paid by, the cognizant State or local welfare agency for the drugs.

The utilization of the services of private physicians and of established drug distribution channels, in providing for the medical needs of welfare recipients under programs administered or supervised by the several States, makes the problem of achieving available economies in drug procurement quite complex. Our work has been directed to a need for greater attention to this area by the responsible Federal agency and to the need for providing program guidance and criteria to the States, which would assist in promoting such economies.

In February 1966, we issued a report to the Congress on the results of our review of expenditures made by the Pennsylvania Department of Public Welfare for prescribed drugs for welfare recipients. In that report, we pointed out that such expenditures could have been reduced through the increased use of less expensive nonproprietary or generic-name drugs, and that savings would have accrued to both the Federal Government and the State of Pennsylvania. We stated that, to avail itself of these economies, the Department of Health, Education, and Welfare should make further effort to have the States encourage physicians and pharmacists to use more extensively the less expensive nonproprietary or generic-name drugs whenever appropriate in lieu of comparable brand-name drugs or the more expensive nonproprietary drugs.

We noted in our report that several States had, on their own initiative, taken certain measures to control drug costs.

Several States utilize for this purpose a drug formulary which is essentially a list of drugs for which the State will pay and in some cases the maximum prices which will be paid. I am happy to say on this now, Mr. Chairman, that the total list is 10, and I will be glad to give you the 10 at the conclusion of my statement if you wish.

The formularies vary considerably from State to State, ranging from relatively few drug items to more than 1,000. Some are restrictive or mandatory in that the State will, in general, pay only for drugs included in the formulary. Others are voluntary in that they are primarily for the information and guidance of the prescribing physician and the State will pay for the drug of the physician's choice even though it is not included in the formulary.

We have not made an examination of the effectiveness of formularies in achieving economies in the public assistance programs, and we have found little in the way of definitive studies that have been made by others in this regard.

We believe, however, that our Pennsylvania study demonstrated that significant and real economies may be possible.

In fiscal year 1964, Pennsylvania spent a total of about $5.3 million for drugs under federally aided public assistance programs. Our examination of a sample of paid-prescription invoices indicated that savings of from about $772,000 to as much as $1,502,000—the amount depending upon whether lower or higher cost generic products were used—might have been possible during that year if all parties concerned had made maximum effort to insure the use of the least expensive available drug consistent with the welfare of the recipient. The Federal share of such savings would have been between $354,000 and $705,000.

In bringing the results of our review to the attention of the Department, we proposed to the Secretary of Health, Education, and Welfare that steps be taken to bring about greater emphasis on the increased use of nonproprietary drugs in the welfare programs.

The Department subsequently enunciated, as its policy, that nonproprietary or generic-name drugs should be used by both constituent operating agencies and grantees whenever practicable and economical. In our final report we recommended that, in implementing the Department's enunciated policy, the Commissioner, Welfare Administration, issue a policy specifically recommending that State agencies administering federally aided public assistance programs adopt policies and procedures designed to encourage physicians to prescribe, and pharmacists to dispense—for the use of welfare recipients—less expensive nonproprietary drugs, whenever practicable and consistent with the recipients' welfare.

We also suggested that, to assist the State agencies in this regard, the Welfare Administration obtain information concerning the steps which may have been taken by State agencies to reduce drug costs, through encouraging or requiring the use of less expensive nonproprietary drugs in appropriate cases, and the results thereof, and, after appropriate evaluation, disseminate this information to all the States for consideration in designing means to achieve economies in the purchase of prescribed drugs in their own public assistance programs.

In May 1966, following the issuance of our report, the Department stated that the Welfare Administration planned to develop a policy along the lines recommended by us. We are aware that considerable attention has been given to this matter within the Department. As of this time, however, a definitive policy statement on the subject has not been promulgated to the States.

Incidentally, we understand that, on July 1, 1966, the State of Pennsylvania adopted the use of a voluntary drug formularly which has as one of its objectives providing physicians with information on the relative cost of available drug products. The State has indicated that this and certain other steps it has taken have been encouraging from the standpoint of economy.

In a report to the Congress in April 1967, we presented the results of our review of prescription pricing methods used by the various States in the purchase of prescribed drugs under the federally aided public assistance programs.

In this report, we pointed out the need for the Department of Health, Education, and Welfare to provide the States with appropriate guidance and criteria to govern the establishment and revision of pricing methods for drugs purchased for use by welfare recipients. Although prescribed drug programs under which payments are made directly to pharmacies had been in existence in many States for several years and involved substantial expenditures, the Department had not provided the States with guidance in the establishment of drug pricing methods.

We found that a majority of the States having vendor payment drug problems utilized pricing methods which included cost plus a percentage of cost features or otherwise provided an incentive to pharmacies to dispense higher cost drug products where suitable lower cost products which met prescription requirements were available.

We stated our view that a pricing system should not make the pharmacy's profit contingent upon the cost of the drug product sold. This creates a situation in which the pharmacy may obtain a greater profit by selecting the most expensive available product to fill the prescription. We stated also that, conversely, the pharmacy should not stand to lose profit if it acts in the financial interest of the purchasing welfare agency by choosing to fill the prescription with the least expensive available products which meet prescription requirements. We stated further that, under a pricing system which makes the amount of profit contingent upon the cost of the product sold, the pharmacy has no incentive to stock less expensive drug products meeting the requirements of frequent prescriptions.

In our report, we expressed the view that the lack of guidance by the Department of Health, Education, and Welfare had been a significant factor contributing to the use of pricing methods not conducive to equitable prescription pricing and economical drug procurement.

We stated that appropriate guidance should be provided and that such guidance should be consistent with, and aimed at facilitating the implementation of, the Department's enunciated policy that nonproprietary or generic-name drugs should be used whenever it is practical and economical to do so and consistent with the recipient's welfare. In this regard, we should point out that, in our Pennsylvania study, we found a significant number of prescriptions had been filled with relatively high-cost brand name products although they were written in generic terms.

In bringing our findings to the attention of the Department, we proposed that the Secretary direct the Commissioner of Welfare to establish a policy providing a guidance and criteria which would (1) prohibit the use of pricing methods based on cost plus a percentage of cost or which otherwise provide an incentive for the dispensing of higher cost products where suitable lower cost products which meet prescription requirements are available and (2) encourage the use of pricing methods based on cost of the product dispensed plus a fixed professional fee.

The Department responded that it was in general agreement that a policy was needed which would prohibit a cost plus a percentage of cost basis of reimbursement. It also stated that the development of any policy should be deferred for a reasonable period of time because of the need to establish certain related controls, which should be

established in consonance with the policy statement to be developed, and the need to further define and explore certain questions concerning the proper composition of a professional fee.

The Department stated, however, that it should provide encouragement to the States to move toward a cost plus a flexible professional fee, rather than a cost plus a fixed fee, basis of payment. A cost plus a flexible fee pricing method provides a fee, increasing with the cost of the product, for each of two or more defined ranges of drug cost—for example, a 50-cent fee for a drug which cost the pharmacy less than $1, a 75-cent fee for a drug which cost from $1 to $2, and so on.

The Department acknowledged that, under the flexible-fee pricing method, pharmacies would still have some incentive to stock and dispense higher cost products but expressed the view that such incentive would be less than under a cost plus a percentage of cost method.

For several reasons which we have discussed in our report, we do not believe that the flexible-fee pricing method is appropriate for use in the public assistance programs. The principal reason is that it provides incentive to the pharmacy to stock and dispense higher cost products.

We therefore recommended that the Secretary take action to cause the establishment of an appropriate policy as early as practicable and that such policy prohibit not only the use of pricing methods based on cost plus a percentage of cost but also any other methods which provide incentive to dispense higher cost products where suitable lower cost products which meet prescription requirements are available. We recommended also that the policy urge the use of pricing methods based on the cost of the product dispensed plus a fixed professional fee.

In subsequently commenting to the Government Operations Committee of the House of Representatives, the Department stated that it remained of the view that States should be permitted, at their option, to utilize a cost plus a flexible fee method of paying pharmacies for drugs dispensed for welfare recipients rather than to provide only for the use of the cost plus a fixed fee method which we favor.

We believe that our reports have served to increase the awareness of officials in the Department that there is need for some definitive policies governing the procurement of drugs for use by welfare recipients.

A number of the States have been active in establishing or revising formularies to encourage the use of drugs sold under their generic names. In addition, certain States have adopted the cost plus a fixed fee method of reimbursement for prescribed drugs. There is a total of nine of these States at the present time.

It is apparent, from the results of our reviews which provided the basis for the previously described reports, that the price aspects of drugs have a significant impact upon Federal expenditures under public assistance programs. We have endeavored in our work to point up means for reducing such costs to the Federal Government without adversely affecting the objectives of the programs involved.

Amendment No. 266 would provide for the development of a formulary of the United States which would have as a principal purpose promoting the use, in federally aided public assistance programs,

of less expensive drug products where of proper quality. It would also call for the establishment of the range of reasonable costs for drugs included in the formulary and for payment for drugs under the federally aided public assistance programs on a cost plus a professional fee basis. As I stated earlier, Mr. Chairman, we believe that the objectives of these provisions are consistent with the views expressed in our reports resulting from our work in this area.

Before concluding my statement, I would like to call attention to other work which we have done, the results of which are relevant to certain other amendments to H.R. 12080 which are being considered by this committee. These amendments are No. 294, proposed by Sentor Moss, and No. 298, proposed by Senator Kennedy of Massachusetts, which are directed principally to the quality of and payment for nursing home care provided in programs carried out under the public assistance titles of the Social Security Act.

On August 8, 1966, we issued a report to the Subcommittee on Health of the Elderly, Senate Special Committee on Aging, on our examination, which was made at the subcommittee's request, into alleged improper practices in providing nursing home care and controlling payments for prescribed drugs for welfare recipients in the State of California.

On March 31, 1967, we issued a report to the Subcommittee on Long-Term Care of the same Senate committee on our inquiry, at the subcommittee's request, into alleged improper practices in providing nursing home care, medical services, and prescribed drugs to old age assistance recipients in the Cleveland, Ohio, area.

We believe that these reports, each of which has been cited during testimony before this committee relating to the Moss and Kennedy amendments, may be useful in considering the need for additional legislation relating to the provision of and payment for nursing home care.

In addition, we will shortly issue to the Congress a report directed to the need for the development of Federal policy and criteria to govern the manner in which amounts to be paid to nursing homes for caring for welfare patients are determined. This report is virtually completed and should be available shortly. On the basis of our work, which included a review of the manner in which payment rates were established in one State, we believe that this area is one which warrants early attention. The State involved in our review was the State of Massachusetts.

We will make every effort to issue this report in time for its use by this committee. In the meantime, if desired, we would be pleased to discuss the results of our review with the committee or the committee staff.

This concludes our statement, Mr. Chairman. We will be pleased to answer any questions you or any members of the committee may wish to ask.

(Attachments to Mr. Staats' statement follows:)

SUGGESTED DRAFTING REVISIONS TO AMENDMENT NO. 266

Section 2002 (e) (3)—page 7 of amendment, lines 15 and 16

Delete the wording "of a request by such person that such product be included in the Formulary,"

Section 2003—page 7, line 23

Revise beginning of opening sentence to read as follows:
"As used in this title, the term 'qualified drug' means a drug or biological
"(a) which (A) is listed in the Formulary, or (B). . . ."
Insert "which" after (b) on page 8, line 9.

Section 2004(a)(1)—page 9

Insert after "drug" on line 1, the parenthetical expression appearing at end of paragraph, and place period after "based" on line 2.

Section 2004(a)(2) A—page 9, line 17

"is" should be "as".

Section 2005(d)—pages 11 and 12

Combine with section 2004(a)(4)—Pages 10, line 9.

STATES WHICH UTILIZE FORMULARIES IN CONNECTION WITH THEIR VENDOR PAYMENT PROGRAMS

1. California.
2. Georgia.
3. Illinois.
4. Kentucky.
5. Missouri.
6. Oregon.
7. Tennessee.
8. Pennsylvania—noncompulsory formulary.
9. Washington.
10. New York—the city of New York only.

New Mexico—recently adopted the *Physician's Desk Reference* which it refers to as its formulary.

The CHAIRMAN. My understanding about these drugs—what you discuss here—proceeds on the theory that, with regard to most of these drugs which we are buying for the benefit of people who are being provided care at public expense, there is not much variation in quality. The whole idea is that we could inspect and test drugs and make sure that each one has the quality that it is supposed to have and having decided that it is properly made, in effect, seek to buy drugs in a competitive market. If someone wants to go ahead and pay a premium, pay two or three times more than necessary in order to buy it by the name of a particular manufacturer who puts a fancy name on it, all right, he can pay that, but we don't plan to pay five or 10 times extra just to have a fancy name put on something that is not a bit different from what the other fellow has to sell on a competitive basis. That is what we are talking about as I understand it.

Mr. STAATS. The procedure as I see it, Mr. Chairman, stems from a very basic principal of Government procurement policy, which is that we should attempt in our procurement to define the specifications of the item that we need, and buy on the basis of specifications rather than on the basis of the name of a particular manufacturer.

This is long established. It has been provided in many, many pieces of legislation by the Congress, going way back in our history, most notably in the Armed Services Procurement Act of 1947, Federal Property and Administrative Services Act of 1949. You can cite many other pieces of legislation on the subject.

The CHAIRMAN. Isn't that about the way that the Department of Defense buys drugs which are provided the President of the United States when he is sick and in Walter Reed Hospital for treatment?

Mr. STAATS. This is true. This is the policy followed by the Defense Supply Agency, the military hospitals, also followed by the Veterans'

Administration, so it is not a new principle. That is the point I believe that you are making, and we are making also in our report.

The CHAIRMAN. In other words, if the President is sick, such as when President Eisenhower had some health troubles or President Johnson had to be operated on, and they go over to Walter Reed Hospital, he does not get any inferior quality of drug.

Those drugs have actually been tested more than those you get if you go to the ordinary drugstore, haven't they?

In other words, my understanding is that when the Department of Defense buys a drug, it also employs greater testing procedure than are used for those drugs you just buy from the druggist. Of course there is a responsibility to try to maintain quality, but the pharmacist usually doesn't have the testing facilities that the Deparment of Defense does.

Mr. STAATS. Others would have to comment on that precise question that you have raised. They would be far more expert than I would be as to the precise quality. But it is my understanding that this has been the practice.

It is working satisfactorily.

But I think the important point that we have made in these reports of the General Accounting Office is that we are stating that a number of jurisdictions—namely, 10 States and the city of New York—have adopted a formulary system. To be sure, as I pointed out, the nature of the formulary from State to State varies a great deal in terms of the coverage. In some cases it limits the reimbursement to the drugs that are in the formulary. In other cases not.

But the principle is well established. The State of Pennsylvania in the first 9 months of its experience, partly due to the formulary system and partly due to other actions it has taken, saved $1 million, and reversed the trend from an upward increase from year to year to a downward movement in the cost of drugs for the State of Pennsylvania.

I think while we can not isolate out the precise amount which resulted from the formulary system here—we are not proposing that our figure does represent that—it has still nevertheless been a substantially contributing factor to the reduction in drug costs in Pennsylvania.

The CHAIRMAN. When I go over to the doctor's office here in the Capitol building, if I have a headache he will give me something for it. As often as not it will be aspirin, an aspirin tablet. And he just puts it in a little box and hands me an aspirin tablet.

Now I don't know which company made the aspirin but the one thing I do know is that it is just as effective as anybody else's aspirin tablet which meets U.S.P. standards. Somebody advertises that there is none better, there is no better aspirin made, and that is right. None better, none worse, all exactly the same.

Just like that premium we used to collect on cane sugar on the theory that cane sugar was better than beet sugar. It is not. It is all the same thing. It is sugar. When you buy the aspirin tablet, if you have the same amount of aspirin in there, let's say five grains, we shouldn't let a fellow sell it to you if it is not of proper quality.

It ought to be aspirin made to official standards. Why should you pay any more to buy it from one manufacturer than another, just in order to get a particular name?

That is the principle upon which the Government buys aspirin tablets, isn't it? We buy it to give to a U.S. Senator, to give to the President or to give to a serviceman who has a headache. That is an aspirin tablet, and in our judgment it is all the same thing. Isn't that about what it amounts to?

Mr. STAATS. That is the way I would see it, Mr. Chairman.

The CHAIRMAN. And we believe that this bill will also assure better quality by providing more testing and inspection of drugs. We provide for that in this bill. It ought to help reduce the cost of somebody having to stock eight or 10 or 15 or 20 different brands of the same drug. Requiring pharmacists to stock a great number of products just in order to satisfy one producer or the other, and help him get a higher price than he could get for it if he had to compete on a realistic basis for the business is just not good sense.

Mr. STAATS. To explain, Mr. Chairman, why we have concerned ourselves with this area, we are all, I believe, concerned with the rising cost of medical care. The witnesses just preceding us I think pointed this out very, very dramatically.

Drug costs are an important part of the costs of medical care. Drug expenditures have been going up.

I am advised that the total cost of drugs in federally aided medical care programs in fiscal 1966 was upwards of around $140 million. Now this is going to increase very substantially over a period of time. I think the committee is very proper in its concern with this subject, and we hope our reports will shed some light on it. We do not contend that we have the final answer on it. What we really are doing is pushing for answers which we believe can best come from the Department or from the Congress through legislation.

The CHAIRMAN. Let me just put the question somewhat as I see it. One of the latest wonder drugs is tetracycline. That is one of the important breakthroughs that has been made. It is just great for killing bacteria. It even kills some good bacteria that you could use, but it kills practically all the bacteria when you take it.

My impression is, just from recollection—and the Nelson committee has been going into this, the same committee of which I was chairman that that drug could be manufactured for about a cent and a half a capsule. Now I should think that if you pay 5 cents a capsule, when buying in quantity, that would be plenty to pay for it. That would be more than three times the manufacturer's cost.

Manufacturers who produce tetracycline have told me that they thought both they and their competitors could make money on it if they could sell it at 5 cents. We have had major companies selling it for a great period of time by various trade names. I think they were selling it for as much as 50 cents a capsule, and they maintained that price for a long time. It might be below that now. Let's say they are selling it for 15 or 20 cents a capsule today.

Now here is something else. If we are going to purchase for our own hospitals, we ought to be able to buy it and provide it for maybe 2 or 3 cents a capsule, but if we buy it from the druggist, the druggist is entitled to make his fair profit on it, whatever that might be.

But the companies would like to sell that for 40 cents a capsule or 50 cents a capsule. In order to get that big price, they have to have it

prescribed by some other name than what it really it, and so they have got to call that tetracycline achromycin, panmycin, or something else, with the result that somebody is going to have to pay about 10 times what they ought to pay for this stuff.

Well, now if it is better than somebody else's that is one thing, but if it is all the same thing, which our tests indicate it is, then we don't see any reason at all to pay 10 times what we could buy it for.

Now this bill doesn't quarrel with some of those who want to go ahead and spend their own money, paying 10 times as much. It is just that if we are going to buy it and pay for it with Government money, we don't see why we ought to pay 10 times as much for that product. That is the logic that you have recommended and that about 10 States have adopted as I understand it.

Mr. STAATS. They have adopted the formulary system.

The CHAIRMAN. Yes.

Now this formulary matter still confuses me a little bit. My impression is that the reason you use a formulary is that you want to put down there what you are willing to pay for and what you are not willing to pay for.

For example, let's take this same tetracycline. Some fellow goes and puts a pinch of baking soda with it and puts his salesmen on the road, and he wants all our doctors to write that name down there and call it something other than tetracycline. Because he has a little baking soda in there, he wants to go back and charge 50 cents all over again for the capsule.

Now my understanding is that in the formulary might say "we never heard of this thing. You call it by some fancy name. We never heard of that stuff and don't know what it is. The nearest thing to it we have over here is tetracycline, if those are the only active ingredients in it, we are not going to pay eight or 10 times as much because you put a drop of soda or a drop of sugar in it. It is essentially the same thing, and this is all that we propose to pay for it. If somebody wants to pay more, just let him pay it with his own money. We are not that foolish."

Now as I understand it, that is about the kind of thing we are talking about here. My impression is that the companies that oppose this the more are often selling the same product under different labels even though it is made in the same plants. Some of them are the biggest sellers of the products. Do you know who the largest manufacturers of these generic drugs are?

Mr. STAATS. I don't know, Mr. Chairman.

The CHAIRMAN. Well, I think you ought to get to know them because they are some of the big companies, those that advertise the most such as Eli Lilly and Squibb. My understanding is that some 80 percent of the companies that belong to the Pharmaceutical Manufacturers' Association who manufacture and sell by trade names, representing that nobody's product can do the job except theirs, also manufacture generic products. When they have got to compete for the business on a price basis, in many instances these same companies sell under its generic name the same drug, manufactured in the same plant for a fraction of the brand-name price. Are you familiar with the number of those companies which sell to the Department of Defense, on that basis?

Mr. STAATS. I believe they are the same companies that sell in the commercial market.

The CHAIRMAN. My understanding is that with the U.S. Government buying, Mr. Staats, for all the servicemen and all the Members of Congress and for everyone we treat in the veterans' hospitals, and for those others to whom we provide drugs, none of the companies decline to sell to the Government on this basis. We just buy it in effect for what the drug is.

Of course that may not be a fair comparison because the laws provide that the United States, if it can't acquire it for a fair price here, can acquire it overseas. There has been no serious problem in acquiring drugs which we need on a competitive basis, and for a reasonable price.

I for one don't blame anybody for making as much money as he can in selling something for as high a price as he can get. I do blame someone however, who has the responsibility for spending the other man's money, as we do in spending the taxpayers' money, who pays a great deal more for something than good solid business practice would dictate. In buying for my business, that is about how I would buy it, and that is how I would suggest you buy it if buying for the Government. Does the GAO believe that the method of payments and reimbursement for drugs under my bill is feasible and in the public interest?

Mr. STAATS. We think so, Mr. Chairman. We think it is feasible. It is not a simple problem, but it is no more difficult than other pricing problems.

The wholesale costs are well known. It involves consideration of different types of outlets. It also involves the geographic price differential, but these are fairly common in both the commercial trade and Government procurement. So I think the answer that we would give to that question is that we do believe that it is feasible.

I don't want to leave the impression that the Department hasn't been at all concerned or interested in this matter. They have had a task force which has been working, I believe, very hard since the first of June on this subject. I believe that a report is nearing completion. I am told it will be made available to this committee. But I certainly don't want in anything I have said to leave the impression that the Department has not been concerned with this subject.

We hope that our reports may have had something to do with this concern, but in any event, we believe that there is a program now that hopefully is leading to some constructive steps.

The CHAIRMAN. The General Accounting Office has issued several reports relating to welfare payments for drugs, and as I understand it, GAO has been critical of the Health, Education, and Welfare's control procedures. Would you say HEW is applying proper controls over welfare payments for drugs now?

Mr. STAATS. I don't know whether I would use the word "controls" in the sense that you would in a direct federally administered program, because these are grant programs to the States. I suppose the thrust of our criticism has been that we felt the Department is a little slow in developing an active program of guidance, standards, and criteria and maybe setting up some demonstrations. These are all things that the Federal Government can do in a State-administered national program, and so perhaps control isn't the proper word, but I think maybe you are getting at the same point I am.

The CHAIRMAN. Thank you very much.

Senator BENNETT. Mr. Chairman, I have listened to this discussion with a great deal of interest. I know of the chairman's interest in trying to beat the drug pattern into what in effect will be a single item for a single purpose and will eliminate quite a variety now available. That is the effect.

If you really want to save money, you will buy this stuff by the carload under your Federal purchasing right and deny the private physician his right to dispense it, and then simply say that all welfare recipients must get their drugs, and if you have this disease, you are going to get this drug.

If you are going to take away from the physician, I think eventually you are going to try to take away from him his right to prescribe something that he thinks may be better for a particular man than a particular drug which is presumed to handle that general disease problem in the formulary.

I have enjoyed very much hearing aspirin and tetracycline used as the examples over and over again. I have in my pocket three drugs which have been prescribed for me by the Senate physician. They are all proprietary. First is empirin rather than aspirin, which is manufactured abroad. The second is maalox, and there is a great variety of drugs available for antiacid purpose, but for my particular purpose I am going to buy maalox. And the third is another antiacid called tetrelac.

Now, if you have carried this thing to its logical conclusion, there will be one antiacid, because you will say why handle three or four. There is only going to be a variation of a few cents a hundred in them anyway. I think that there is a real danger in this of limiting the opportunity of the physician to prescribe for his patient. Maybe there is a pinch of soda in this combination, and maybe that is what the patient needs in this particular situation.

You said on page 5 toward the bottom of the page:

> Adopt policies and procedures designed to encourage physicians to prescribe and pharmacists to dispense for the use of welfare recipients less expensive nonproprietary drugs whenever practicable and consistent with the recipients' welfare.

That leads me to this question that popped into my mind. Are you going to require that pharmacist to refuse the physician's prescription, if it is not a less expensive proprietary drug? Has he got to call the physician up and say, "Now, you can't prescribe this, this particular one costs less, and therefore you have got to prescribe that?"

Mr. STAATS. May I answer?

Senator BENNETT. Yes.

Mr. STAATS. In terms of the examples that we have from different States, the approach has been to limit reimbursement on the basis of a price for the nonproprietary or generic drug rather than to require that it use it. It provides that the payment would be based upon that as the maximum.

Senator BENNETT. Then if in his judgment he thinks sincerely——

Mr. STAATS. He thinks it ought to be something different——

Senator BENNETT. A more complicated combination.

Mr. STAATS. Right.

Senator BENNETT. But he is going to be limited for the treatment of this particular disease to drugs in a certain list.

Mr. STAATS. It will be a list made up of nonproprietary or generic name drugs to the extent appropriate.

Senator BENNETT. I understand that.

Mr. STAATS. I would like to remove some misunderstanding here, that you would limit it to one manufacturer.

Senator BENNETT. No, I don't have that idea, and as far as aspirin is concerned, it is easy to use that as an example, because it is a drug that has been made for a hundred years more or less, and all the bugs have been worked out and it can be supplied on a mass-production basis.

But we haven't come to the end of biologicals, and if you are going to write a formulary which requires a generic name for a particular range of biologicals, then you are going to deny the physican and the patient the opportunity to use something that may be a later, better variation of tetracycline. This is the thing that bothers me.

The other thing you are going to do is you are going to start setting prices. You can't escape it. And when you start to set prices, you are going to encourage the druggist to go out and see where he can get the drug at the cheapest price, and we are moving into the situation where in our free enterprise economy we are having a large segment of it operated on prices that the Government set, not that the free market sets or that do not reflect the variation in costs of an individual purveyor, or the cost of his development for his drug.

My experience, and I have been in business for nearly 50 years, is that when you do that, you always get the cheapest thing that is available, and in many respects, in order to get the price down, somebody starts to cut corners.

I think this attempt to operate on this basis is going to backfire sooner or later to the detriment of the sick person, because you are going to limit the drugs that may be available to him by making it impossible for him to be reimbursed for anything except the drugs that somebody decides shall be placed in the formulary and there be the only ones which the physican can prescribe.

Mr. STAATS. I would like to say this. I respect your concern and your views on this matter. I would like to point out, however, that in many other areas of our grant-in-aid program, the Government has taken the step of limiting the extent of the Federal financial responsibility. This is in the area of administrative costs, personnel costs, many areas of program costs. This is true in many of our grant programs.

Senator BENNETT. But you are not dealing there with products. You are dealing there with services.

Mr. STAATS. You are dealing with the level of care when you set up the rules for hospital costs, for example. We do have that. That is required by law. You have the cost reimbursement principle which has been established and which the gentlemen from the American Hospital Association were talking about just a few minutes ago.

All I am trying to point out, Senator, is that this is not a brandnew principle that we are talking about when we talk about limiting the extent of the Federal financial responsibility for a Federal-State program.

Senator BENNETT. We are trying to limit the extent of the Federal financial responsibility.

Mr. STAATS. That is correct.

Senator BENNETT. But in order to do it, you are injecting the Federal Government into a basic area of the choice of the drug to be made available, and the quality of that drug inevitably in my opinion, and this is what worries me about this concept.

Mr. STAATS. We felt here——

Senator BENNETT. Generic name.

Mr. STAATS. You know that 10 States have adopted formularies, all of them in fairly recent years. To be sure, much experience has to be achieved. Some of them use the formulary system as the basis for reimbursement. There is a limit on the payment.

Senator BENNETT. How many of those are voluntary and how many of them are not?

Mr. STAATS. The only one that I am aware of offhand that is completely voluntary is the one I mentioned which is Pennsylvania, and even under the voluntary system in Pennsylvania, a major reduction in the cost of drug care in the welfare program was achieved. But the Pennsylvania system involves some 1,368 drugs.

It has an alphabetical list, an over-the-counter listing, and therapeutic index which lists the drugs by therapeutic usage, and shows the relative cost of products for the use by the physician.

Now, Pennsylvania is a voluntary system. As far as I know, the other States have not used a voluntary system. New Mexico I guess you would have to regard also as voluntary.

Senator BENNETT. You are talking about a formulary of the United States.

You suggest that it should be developed, and I assume that that could not be voluntary on the very face of it. It is going to be a completely national system. It has got to be mandatory.

Mr. STAATS. I believe you are correct in that the amendment which has been submitted would limit the amount of Federal responsibility, financial responsibility, to a pricing of a drug based to some extent on nonproprietary or generic name bases.

Senator BENNETT. I have no further comments or statements, Mr. Chairman. I think we may be trying to say that the spigot and we are going to lose at the bong hole in terms of the effect on the industry and the collateral effect of this program as I see it, the next stop will be that druggists who are going to be required to carry these formulary drugs and sell them on the generic basis are going to have a demand from the general public: "Well, if you sell it to my father for 5 cents a capsule, why don't you sell it to me?"

So he does, and believe it or not, this can have some rather far-reaching effects on the whole system of the manufacture and distribution of drugs, because everybody's illness is not exactly the same, and if all they had to do was say take two aspirin and go to bed and rest in bed, there would be no problem.

But I think you are limiting not only the freedom of the physician to take care of his patient, but you are also going to have some very drastic effects on the whole drug system in the United States.

Mr. STAATS. We don't minimize the difficulties involved here. We think that they are great. We feel also that this is an area where the

result of the experience of the jurisdictions that have used the formulary system is such that it does perhaps point the way for further developments in this field.

I believe the Secretary of HEW has so agreed in principle at least, and I believe they are trying to work out a system. I can't, however, speak for the Department.

I believe the Commissioner of Food and Drugs is going to be a witness here, and he certainly can speak to this. But it is our feeling that since Federal costs are involved, it is a matter that needs attention by the Congress and the Department to a greater extent than it has had before.

Senator BENNETT. I think you and I are on different sides of the philosophy on this. You want to take the benefit, or the Federal Government is in a postion in its own purchasing to take the benefit, of all the research and all the cost of developing these things and squeeze out of the price any repayment for that, and reduce the production of drugs down to the same basis as the production of paint, which I know something about.

Just take the raw ingredients and figure out how much it cost to put them through the system, and that isn't the way we grow in drug service to the people.

Mr. STAATS. Maybe we are on different sides, Senator, but I believe in the Federal Government's procurement policy, and I believe this is a form of procurement. Our traditional method of dealing with procurement is to use specifications if you can develop the specifications. I grant you in some areas this is not an easy thing to do, but the effort is always to try to get the maximum competition in Government procurement, and you do this in part by buying according to specification.

Senator BENNETT. But this situation does not involve competition. This stifles competition. This says that in the field of painkillers there is one generic drug—that is, aspirin—or two generic drugs.

Mr. STAATS. This is where I don't believe that we are quite on the same wavelength. I think you can get competition when you procure or reimbuse on a generic name or nonproprietary basis where appropriate. I believe you can do this. This is a matter for the Department people to say how far you can do it, but I know that experience has already demonstrated that you can do it in some cases.

Senator BENNETT. But aren't you thinking about Federal procurement in mass lots while every little individual druggist, whether you like it or not, has got to go to a wholesale druggist to get his supplies even of these generic drugs? He can't deal in carload shipments with the original manufacturer.

Mr. STAATS. But he can order on that basis if he has a formulary before him.

Senator BENNETT. The formulary says if you want painkillers, you can only use these particular things, and we won't pay for any variation, so it seems to me that that stifles competition and tends to force the drugs to their lowest common denominator.

Mr. STAATS. I certainly agree that we don't want to stifle competition. I guess our difference is that I don't believe that this approach necessarily will do that.

Senator BENNETT. Mr. Chairman, I have already overstayed my leave.

The CHAIRMAN. Let me just say this, Senator Bennett.

For example, Senator Bennett, you start out by suggesting here that you are against this because these particular drugs that you have in your pocket were what you needed and you don't want somebody to give you something else. Now all those drugs, which you say you got from the Senate physician, were all bought by just exactly the purchasing method I am advocating. They are all bought generically.

Senator BENNETT. No. May I say these came from wholesale druggists.

The CHAIRMAN. I thought you got them from the Senate physician.

Senator BENNETT. The Senate physician got them from the wholesale druggist because he buys them a few at a time. This other antiacid is Tetrelac. I don't know who makes Tetrelac, but it is undoubtedly different from the person who makes Maalox, and they serve a slightly different purpose.

The CHAIRMAN. I hope you won't take it if you don't know what it is, unless the doctor recommends it.

Senator BENNETT. Life and death doesn't lie on an antiacid.

The CHAIRMAN. Let me show you how we would go about buying that. If you went to the Senate physician and said you had a headache, here is how you would get those Empirin pills. He looks down there and he decides what he thinks you need. Now the Government when it buys consults a listing where it looks first to see what this Empirin is.

Now Empirin is one of many products made under a standard formula combining aspirin, phenacetin, and caffein. It has a little stinger to go along with the aspirin in there. You can get that in a cup of coffee. It has a little more than aspirin in it.

To meet that formula—and some folks might think it will serve their purposes better than aspirin—you have a group of different products. Here are some: Ace-Caf-Edine. That is manufactured by the Maney outfit. Acetidine, manufactured by Merck; Analgia, manufactured by Merrell; Ansemco, manufactured by Masengill; Aphodyne, manufactured by Gold Leaf; A.S.A. Compound, manufactured by Lilly; Ascadin, manufactured by Drug Products; As-Ca-Phen, manufactured by Ulmer; Aspirotabs, by Brewer; Aspodyne, by Blue Line; Empirin Compound, by B. W. & Co.; Fenadin, by Burrough Bros.; and P.A.C. Compound, by Upjohn.

Now that is A.P.C. some folks just call it A.P.C. tablets. I will give you a firm assurance they will all do the same thing for you. They will help your headache. It is just the same as aspirin except that it has this phenacetin and caffein added in the same proportions and it is listed in the National Formulary.

Now if you went down there and the doctor gave you that A.P.C. in a little box and didn't tell you which company manufactured it, it would do the same thing for your headaches as if you did know what company made it. The Government now buys this stuff on a best bid basis, but this bill would give more than that.

We would say that here you have got a whole group of companies manufacturing this. One fellow, say, sells his product for 3 cents, another fellow at 5, another at 7, another fellow at 9 and here is somebody who wants 15 and 16 cents for it. We would say all right, we would be willing to pay up to 9 cents for it, but if you charge more than 9, we think that is just too much, it is out of line and we will pay as much as 9 cents of your cost but not more because here are four or five of them available within the 9 cents. If you want to go ahead and pay 16, that is your privilege.

Is that your understanding?

So we don't necessarily take the lowest priced product. You can favor one manufacturer over another until the price just gets to a price that we think is unreasonable and out of line. At that point we would say we are willing to pay up to the price that half these people charge, but if that particularr thing is out of line, we will pay what we think is a fair price, and that is as high as we are going to go.

Now, by using that procedure, anybody who is an efficient producer should be able to produce it and sell it within that price range, should he not?

Mr. STAATS. I should think so.

The CHAIRMAN. If he can't, there are plenty of people in business producing precisely the same thing that can produce it at that price.

If I am buying paint from a paint manufacturer and I am willing to pay him not just what the product is worth on a competitive basis but willing to pay him a price above what the low bidders were bidding, I would be giving him a pretty good deal in the price I pay him for it. All I am suggesting here is that we just pay what would be a reasonable, fair price for this.

Of course, this doesn't have anything to do with what happens when somebody has a patent. If he has a patent, then we are not proposing to do anything about that. He can just charge all the traffic will bear, if that is a patented drug we think a person needs. This bill doesn't touch that, does it?

Mr. STAATS. It is my understanding that it does not cover that.

Senator BENNETT. Mr. Chairman, would you let me clear that up? If a man has a patented drug and it is not listed in the formulary, the physician can't prescribe it anyway. The person ordering it cannot be reimbursed for that patented drug because the physician can't prescribe it.

Mr. STAATS. If it is the only drug of its kind, Senator Bennett, it is my understanding that it would be listed in the formulary.

In other words, if it is designed for a particular purpose, it is patented, it is one of a kind, it would be listed in the formulary.

Senator BENNETT. A formulary with a thousand numbers——

The CHAIRMAN. What we are saying is that with regard to a patented drug, if we think it is good, it would be in there, wouldn't it? If we think a patented drug is good——

Mr. STAATS. That is what I said.

The CHAIRMAN. And under this bill we would pay whatever the company insisted on. If they have that patent, even if they are charging $1 a capsule for something that costs a half cent to manufacture, we would still pay for it, wouldn't we?

Mr. STAATS. That is my understanding.

The CHAIRMAN. But if we don't think the stuff is any good anyway, if we think this is useless, we would advocate you not put it in your bloodstream. We don't care what kind of patent you have on it, we are not going to pay for that. As far as we are concerned if you want to take it, that is all right; but we don't see that that stuff does any particular good.

Now there are some things around that some people think are good and other people don't think are any good. It might probably do more harm than good. We don't propose to pay for it at all, and that is the only reason it wouldn't be in that formulary if it was a patented drug; isn't that correct?

Mr. STAATS. That is my understanding of the bill.

The CHAIRMAN. And what we try to do is use the best medical judgment in setting up the formulary. You might take the illustration my father used to give about the days when he was a patent-medicine salesman. He had these two drugs—two patent medicines. One was named High Popalowrum and the other was named Low Poplahighrum. One sold for $1 and the other for 50 cents in the same sized bottles. Folks practically always bought the dollar bottle. The only difference between these two products was that one was made from the part of the bark that had been skinned down from the tree and the other that had been skinned up from the tree.

What we are suggesting, in effect, is that between the two, if it is all the same thing, we would buy the 50-cent bottle. But if the junk is no good to begin with, we wouldn't buy either one of them. But if we conclude by our best medical advice that this is something that will do you some good, then we are willing to pay for it. If you have a patent on it, we will pay whatever price you have marked on there. If it is something we think we have to have, and if it is patented and we think the patient requires it, why we would pay it, going by the best medical advice that we have. That is how we have been treating the President of the United States and U.S. Senators and Congressmen for a number of years, isn't it?

Mr. STAATS. You are in a better position to speak to that, Mr. Chairman.

The CHAIRMAN. I have been over there to the Senate doctor, and I have enough confidence in the doctors at Bethesda and the President of the United States has enough confidence in Walter Reed and the Department's purchasing policies that he trusts his wife over there, and so does President Eisenhower and other Presidents. They trusted their lives on drugs bought just in that fashion, as I understand it.

If we think we can save money that way, and we think that will be a good way to save money in the future with regard to these same people, we do this. I am not saying that the President of the United States is any better than a welfare client. I am just saying I think he is just as good, at least as good.

Thank you very much, Mr. Staats.

Mr. STAATS. Thank you, Mr. Chairman.

The CHAIRMAN. The next witness is Dr. James L. Goddard, Commissioner of the Food and Drug Administration. I regret having to keep you this long to hear your testimony, but we are very happy to have you.

STATEMENT OF JAMES L. GODDARD, M.D., COMMISSIONER, FOOD AND DRUGS, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY WILLIAM GOODRICH, GENERAL COUNSEL

Dr. GODDARD. I am pleased to be here. I have with me today, Mr. Chairman and members of the committee, Mr. William Goodrich, General Counsel for the Food and Drug Administration. I have a brief statement, Mr. Chairman, that I would like to proceed with, if I may.

The CHAIRMAN. Please do.

Dr. GODDARD. We appreciate this opportunity to appear before this committee to discuss the effects of S. 2299 on the Food and Drug Administration.

On January 23, 1967, the President in his aid for the aged message directed the Secretary of Health, Education, and Welfare to undertake immediately a comprehensive study of the problems of including the cost of prescription drugs under medicare.

The Department immediately began to consider the economic, administrative, and clinical aspects of the problem in an effort to delineate areas for more intensive study. After the collection of some needed preliminary information, the Secretary on May 31 formally announced the creation of the "task force on prescription drugs" to carry out a comprehensive study of the problem areas which had been identified. We hope that the final report of this task force which will be submitted before June 1968 will provide the knowledge necessary to achieve many of the objectives of S. 2299.

The crux of this legislation as it affects FDA is, basically, the quality of drugs. If all drugs were reliable, there would be a concrete basis for price comparison, and drugs could be included in a formularly solely on a cost criteria. Unfortunately, the FDA is not currently in a position to guarantee the purity and quality of every drug on the market. However, we are continually striving toward the goal of absolute assurance in the drug area and several steps have been taken in this direction. The drug amendments of 1962, for instance, instituted provisions designed to improve the quality of our drug supply.

For example, enactment of the 1962 law:

Required new drugs to be proved effective, as well as safe before marketing.

Gave us authority for the first time to make complete inspection of factories making prescription drugs.

Required drugs to be produced under current good manufacturing practice.

Authorized us to establish simple, useful common or generic names for drugs.

Required recordkeeping and reporting of adverse marketing experiences.

Required the registration of all drug firms and inspection of these firms every 2 years.

Extended batch certificates to all antibiotics for humans.

In the 5 years since the enactment of this law, the full impact of its extensive provisions has not been fully achieved. Utilization of all the authority conferred by this statute has involved significant in-

creases in manpower, resources, and expertise. Every possible effort has been made and all avenues explored in our determination to administer all phases of this law. The monumental responsibility which accompanied this legislation precluded rapid implementation and even now we envision 3 or 4 more years before the task can be accomplished.

During inspections of drug plants, pursuant to this law, we check the manufacturing and quality control procedures to determine compliance or deviation from our good manufacturing practices regulations. Although most manufacturers adhere to our regulations, our field investigations continue to reveal numerous violations of current good manufacturing practices. These deviations vary in degree of importance and may be detected in plants of every size and description. We are presently reevaluating the GMP regulations for prescription drugs with a view toward making them more definitive. We feel that this reevaluation is necessary because of the rising number of recalls occurring each year.

In addition, to factory inspections, FDA's 17 district offices maintain constant surveillance over all drugs in the marketplace.

For example, we have established a National Center for Drug Analysis in St. Louis to act as the public's control laboratory. Using automated equipment, the newest assay techniques, and a constantly evolving technology, this national center will help our agency keep abreast of industry's output and assure the consumer that drugs in the marketplace are closer to perfection than ever before. The national center is, however, an end-point; it is after the fact. The samples are collected from commercial channels providing us with a disadvantage of having to go back through the entire drug distribution system, if we find anything seriously wrong with one of them.

We have begun modestly at the national center, checking out our equipment and giving our chemists and pharmacists the experience which the later expanded efforts will necessitate. Our goal is to examine many thousands of samples a year. We are making good progress, but it is too early to draw any conclusions from the relatively few samples that have been tested. In the future, the reports from the national center, combined with those from our 17 district laboratories, will give a good picture of drugs throughout the Nation.

Price, per se, of course, cannot be a measure of quality. The listing of a drug in a formulary must be made on the basis of quality, irrespective of price. A particular drug may be offered at numerous prices by various drug firms; however, the lowest price for a drug of "acceptable quality" will be the basis for the range of reimbursement under S. 2299.

To effectively make this determination there must, of necessity, be a substantial increase in those activities which I have briefly described. An inspection of a plant every 2 years will not provide the necessary data. Inspections will have to be more frequent and as a corollary we will need a larger force of inspectors. Recruiting and training the necessary people will take a substantial period of time, probably at least 3 or 4 years. In fiscal terms, such an enlarged staff would mean greatly increased appropriations.

The activities of the St. Louis laboratory will have to be expanded and perhaps other similar laboratories will have to be established.

Here again additional training, recruiting, and equipment would be necessary.

Another question which is pertinent in considering S. 2299 is that of the therapeutic equivalency of identical drugs. There are, presently, numerous guidelines available for our use in this area. The United States Pharmacopoeia and the National Formulary have for many years set standards for laboratory examination in the expectation that every drug conforming to these standards will produce the required results in patients. The manufacturing and testing procedures contained in new drug applications and the test procedures in antibiotic and insulin regulations also constitute such standards.

In large measure, we believe that these standards serve their intended purposes. This appears to be particularly true for most antibiotics and insulin; as you are aware, the FDA certifies each batch of antibiotics and insulin to be marketed to see that each meets the appropriate standards.

However, the science of drug production and formulation is becoming increasingly complex. The establishment of standards adequate to meet our increasingly complicated needs is a continuing process in which the private organizations maintaining the USP and the NF, and the Government working with them, are constantly striving to keep ahead.

I think it is important, Mr. Chairman, to keep this question of therapeutic equivalency in perspective. There are some who would have you believe that no reliance can be placed on any drug unless it has been produced by a firm that is widely known. There are others who maintain that you can buy any drug in the marketplace and expect it to be therapeutically equivalent to others sold under the same name. I must say that we do not have controlled clinical studies to decide the issue in all cases. We are initiating studies with Georgetown University and others to carry out the necessary research on about 50 widely employed drugs so that we may have a good basis for making such an evaluation.

At the present time, our feeling is that in only a limited number of drug categories will two drug products with the same active ingredients not produce clinically equivalent results. The exact number is now under intensive examination by the Government; but for most drug preparations, the identical dosage forms seem, for practical purposes, to perform the same.

However, we will have to await the results of a number of studies, such as the one now being conducted at Georgetown University, to make any universal statement. The results may or, indeed, may not confirm our beliefs. If therapeutic differences appear between drugs having identical active ingredients, trade name drugs, even if more expensive, would have to be listed in the Formulary to provide the physician with the proper choice of therapeutic agents.

The bill under consideration also calls for a determination by the Formulary Committee of therapeutically duplicative drugs. That is, given two drugs which produce the same effect, a decision would be made by the Formulary Committee as to which was to be included. Such a finding would involve considerable scientific investigations and almost certainly would arouse considerable controversy among scien-

tists, not to mention my brothers in the medical profession. With them if you get three or them together you will find at least three and possibly four different opinions.

In essence the bill would impose upon the Formulary Committee the duty of evaluating every prescription drug used in medical practice today—more than 5,000 chemical entities—approximately 21,000 different dosage forms included; and of providing a formulary of the drugs of choice. It would have to exclude drugs deemed unnecessary, therapeutically duplicative, or of unacceptable quality. The enormity of such a task should be borne in mind. The present review by the NAS/NRC of the efficacy of drugs marketed between 1938 and 1962 can be used as an indicator of the magnitude of the project.

This review was begun a year and a half ago in response to the Kefauver-Harris amendments, which added efficacy as a criteria for approval of a drug. We are expecting the first report from them by the end of the month. However, the length of time needed for this review aptly illustrates the complexity of such areas of scientific inquiry. Furthermore, after the reports are received, extensive administrative action will still be required to review the recommendations and put them into effect, and to deal with the challenges which will be made with regard to the effectiveness claims of some of the drugs.

It is evident that any review of drugs, including review of both promotional claims being advanced and the scientific data to support these promotional claims, calls for the efforts of the most highly qualified medical scientists. Any large-scale effort of necessity must extend over a period of several years at the very least.

Under this bill all drugs—not only those cleared through the new drug procedures since 1938—would have to be reviewed. For many of these drugs there are no adequate, well-controlled scientific data on which the claims of therapeutic effectiveness could be properly evaluated. This is true even for a number of drugs which are widely accepted among physicians as apparently valuable in the treatment of disease.

In addition to considering the quality of drugs and the necessity of including a particular drug, the Formulary Committee would also have to promulgate regulations designed to assure the orderly, efficient, and proper usage of drugs and biologicals. This provision will necessitate a scientific determination of the precise therapy for a particular indication.

The Food and Drug Administration is presently carrying out programs required to achieve the level of quality controls which would be expected under this bill, and it will be at least 3 years before we can assure a complete reliability of all drugs on the market. It should be emphasized that the benefits of such a program would not only accrue to recipients under this bill but to the general public as well.

In addition to an improved inspection system, the clinical tests and research implicit in the provisions of S. 2299 would demand even greater financial outlays.

Compilation of a comprehensive formulary would be further complicated by administrative and judicial appeal afforded parties adversely affected by the exclusion of a particular drug. Most of the judgments of the Formulary Committee would center on the exclu-

sion of drugs as being unnecessary, duplicative or of unacceptable quality. These judgments could be subjected to extensive litigation, especially in view of the availability of a trial de novo. The requirement that the formulary be kept current could be severely hampered by such appeals.

The administrative authority to revoke the use of registration numbers would also provide for a hearing. As such, there would be a substantial administrative workload placed on FDA. If, however, this is to be done, the basis for revocation should be broadened to include violations of the requirements for production under sanitary conditions and the requirements for adequate directions for use.

The objectives of S. 2299, to introduce a greater rationality into the practice of drug therapy and to apply restraints to excessive costs, are obviously highly desirable. Some elements of this proposal may be susceptible of reasonably prompt achievement, and to the extent that is possible, would be helpful even though they would not accomplish all that the bill seeks to accomplish. Other elements raise such grave problems as outlined above. We believe extended consideration and opportunity for discussion with the many affected groups is needed before decisions can properly be made.

The creation of a National Formulary of the United States, as contemplated by the bill, poses profound issues of policy as well as such difficulties of effectuation as to rule out the possibility of early accomplishment. Some part of the purpose, however, could be achieved by a compendium which would make available to physicians much information about drugs which is not available to them today in readily usable form. This would include the proper prescribing information for drugs which is now disseminated in package inserts; it would also include the means of identifying the several names under which a single drug may be available. The latter item is important to enable physicians to write prescriptions with an informed concern for their patient's pocketbook.

The expanded quality control program which the bill envisages, if it could be effectively carried out, would redound to the benefit of the entire population by speeding the day when we can assure the quality of all drugs available on the market. Our basic problem here is not the cost, considerable as it would be, but the question of whether FDA could expand its organization so rapidly without impairing its effectiveness. Difficulties of recruitment and training, and of rapid absorption of so large a new staff have led us regretfully to postpone until 1971 our target date for attaining so universal an assurance of quality.

In conclusion, Mr. Chairman, the Food and Drug Administration joins the Department in agreeing with the basic principle enunciated by Chairman Long; that is, the Government should strive for the greatest possible economy consistent with quality in the payment for drugs dispensed in Government-sponsored programs. At the same time, we recognize the numerous and complex factors involved in the development of any specific legislation proposal. Basically, in view of the many formidable difficulties presented by S. 2299, I would be extremely reluctant to see any action taken on this proposal prior to the completion of the task force study.

Thank you, Mr. Chairman.

I would be happy to attempt to answer questions.

The CHAIRMAN. As I understand your statement, Doctor, you say that you think the purpose is good, and you agree with what I would seek here, but that to achieve it, would be difficult prior to 1971 due to technical problems that you just don't think could be overcome during the next 4 years?

Dr. GODDARD. I want to be completely accurate, Mr. Chairman. Not all aspects could be implemented prior to 1971 in my opinion. Certain things could be accomplished rather quickly.

The CHAIRMAN. We have here a list of drugs covered under medicare, and it is a rather extensive list of them. These are listed alphabetically. It is a tremendous number. The Department of Defense seems to have been able to make themselves up a list and say what they thought they could buy and what they couldn't buy. Ten States in addition to the Department of Defense, the Veterans' Administration, have all been able to meet that problem. Hospitals all over the country have been able to do the same thing. Why is it so difficult to do what literally hundreds of others have been able to do, just to say, "Here are the things that we think have some value. These things we think have therapeutic value, and we believe they are useful, and here are the various forms of it in these various things, and here is what we think is a fair price to pay for them."

These manufacturers appear to be competent to produce it, and here is what we think would be a fair price to pay. We are willing to pay that much, but we think to pay any more than that would be going too far, paying them an outrageously high profit. Why can't we proceed now? If we can get the Department of Defense and 10 States to do it and it can be done under medicare, why can't you do it under the medicaid program?

Dr. GODDARD. Senator, I think it is clear that drawing up a formulary in itself is not a difficult task. There are problems, to be sure. But to draw up a national formulary would require, by the terms of your bill, the establishment of a committee made up of five appointed physicians, the Commissioner of Food and Drugs, the Commissioner of the Bureau of Narcotics, the Surgeon General, and the Director of NIH. They would be asked not only to devise a formulary, but to do so in such a way that they would eliminate therapeutic duplication, at the same time protect the business rights of firms by affording opportunities for hearings, and do so in such away that it would insure proper and efficient usage. Requiring all these things, I think, is asking a committee to carry out a task which would occupy them full time for at least several years if they were to really work toward the spirit of this bill.

Now, I think I could personally draw up a formulary between now and the 1st of January, but not at the same time accomplish these other requirements that are present.

The CHAIRMAN. Well, the Department of Defense did it a long time ago. They have one you can look at right now which will save you an awful lot of work.

Dr. GODDARD. Yes, sir; I have looked at it.

The CHAIRMAN. Wouldn't that be a decent starting point? All we are talking about under the medicaid program, is those drugs we are

willing to pay for and what we think they are worth. As a matter of fact, why not look at the formulary for the city of New York for their medicaid program? They have some good doctors up there.

Dr. GODDARD. I have not looked at theirs, but I am familiar with the Department of Defense list.

Senator Long, starting with their list would not meet the provision in the bill which says, "is prescribed or furnished in such quantities and under such conditions as are necessary to meet requirements established by the formulary committee under regulations designed to assure the orderly, efficient, and proper usage of drugs and biologicals."

Now, therein lies the difficulty, at least one of them.

Senator BENNETT. Anybody can make a list. It is a question of being sure what you put on it.

The CHAIRMAN. I understand that that particular provision relates to matters such as minimum and maximum quantities of drugs—as to how many pills you provide for a given illness, the dose that you provide. I don't see that it refers to quality among manufacturers; not that provision.

Dr. GODDARD. Senator, I know you want me to get down right to the guts of my objection. My problem with this bill is that the practicing physicians in this country have characteristically selected the drugs they are going to use for their patients. Now, at this point in time, to begin with the formulary I think you would impose serious difficulties on accomplishing the two major objectives that you set forth in this bill.

I think we would make a better beginning if we could establish a drug compendium which covered all drugs in the marketplace available on generic-name basis with the trade names listed, the dosage form, and the price. In Pennsylvania it wasn't just the establishment of the formulary, but was also the education of the physician that went along with it. Perhaps we could find that a national formulary might not be necessary. Under the strictest terms of interpretation of this bill, I believe we are encroaching upon the practice of medicine in such a way that the physicians would rise up in wrath.

Now, I am only sensing what my brother physicians' reaction will be. This is based on discussions and meetings with those who are familiar with the bill. But I think we can accomplish these objectives which are desirable and worthy of accomplishment, but should be met in another fashion.

The CHAIRMAN. The people on my staff have undertaken to work with you and the people on your staff in working up this bill. Why didn't the folks on your staff indicate that that was a problem when they discussed this matter with the committee staff?

Dr. GODDARD. Senator, I will take the burden of blame for that, because I have been the one representing the Food and Drug Administration on the task force that the Secretary appointed. I have been the one that has been educated as to the complexities involved. I have been looking at all of the activities that are underway, and I am afraid that I have not transmitted back to my immediate staff all of the things that the task force has underway, all the information that it has received.

I regret that, because I have a good staff. We did attempt to provide technical assistance to your staff on this bill. I first met—I think in January—with members of your staff, and I have learned a great deal in that period of time. Now, I don't swallow, hook, line, and sinker, every statement that I have heard made about brand name drugs. I am confident that we have a good drug supply, and I am anxious that as quickly as possible we establish that physicians can prescribe any drug in the marketplace without regard to its source. That should be our job, and we ought to be able to do it, and I can assure you that we will take every step that we can.

But there are some uncertainties, and there are some difficulties, and that is what I am trying to reflect to you here today.

The CHAIRMAN. It is my understanding that under the proposal we have here—and your staff at least advised on this—if the formulary committee found any of those problems you cite, they could agree that the drug could be prescribed by the trade name. Where they have any doubt about therapeutic equivalence or if there was a question concerning necessary quality, they could permit the trade names to be used.

Dr. GODDARD. I understand that, sir. I am not quite certain, I must say, or clear in my own mind about the example you used with respect to ASA, or Empirin and Empirin-like compounds, ACP's. My understanding would be all of the products except one would be therapeutically duplicative by the terms of this bill.

The CHAIRMAN. The APC would be the drug covered and then all the products listed there that I listed would be covered, which could meet the standards for APC.

Dr. GODDARD. May I call upon my general counsel, because we have had considerable debate about this point alone, Senator.

Mr. GOODRICH. We consider that if the drug is therapeutically duplicative, and the major fact of therapeutic duplication would be the same composition, the drug should not be put on the list, in the formulary.

Now, there may be other products that are therapeutically duplicative. But we have not only found difficulty in deciding whether a drug of a different chemical composition would be covered in that category, we also weren't sure that that is what you had in mind. But we were pretty sure you did have in mind the same identical product as being therapeutically duplicative.

The CHAIRMAN. What we are talking about is, there is no point in listing two different drugs if they both do the same thing. But that doesn't keep you from having any number, 50 or 100 products of the same drug manufactured by different manufacturers which do exactly the same thing as that drug. That is just like saying that you don't list the same think twice. You are talking about tetracycline. You list it once, and then all the different tetracyclines are converted to a greater or lesser extent.

Suppose you are talking about tetracycline. Well, if that is what you are talking about, you have Achromycin, Panmycin, Polycycline, and Tetracyn. Those are all trade names for tetracycline. And, they are all covered also. You can either buy tetracycline or you can buy any one of those.

Now, if some of those are being sold at prices altogether too high, and the others are being sold at a reasonable price, why, you would say, here is a reasonable price for the product and that is what we are willing to pay. There are plenty of people manufacturing it at that price.

Mr. GOODRICH. The bill provides on p. 5 a national formulary committee may include in the formula, that is a combination provision, the Formulary Committee can include a trade name product provided it is cheaper than the generic name, or provided it is different than the product already in the formulary. It has to either be cheaper or have a distinctive advantage before it can be put in the formulary.

So those products could not all be on the list as we read it. This is just one of the points that would have to be fully understood by us, Senator, before we could make a start with selecting the drugs that should be available to the physician and specifying the conditions under which he should use them.

The CHAIRMAN. Your people helped, as long as they wanted to help, they did, and my impression was they were helpful in indicating what the problems were here, and not just throwing sand in our eyes, may I say, but saying here is what we think the answer to this problem will be. And so far as I know, every suggestion which they have advanced to us as to how you would meet that problem was included in the bill. And may I say that when the Government itself has been doing this type of work with its own agencies for a great number of years, and you have 10 States doing it and a great number of hospitals across the country that are able to do it and then come here and throw sand in my eyes and tell me it cannot be done, and present some of the kinds of objections I see here. For example, in your statement you say that "We have not been able to adequately test all these drugs that are being put on the market."

You have had that job as long as there has been FDA, to test drugs and see what they are selling people; whether it is something that is doing them good and is safe. But to say at this late date that you cannot do what the law had required you to do all the time, and to propose that as a reason why we should not simply try to give the public the benefit of price competition in the purchasing of drugs just strikes me as throwing sand in our eyes.

Dr. GODDARD. Senator, I am sorry you view it as throwing sand in your eyes. It is not intended to do so at all, but rather, it is a reflection of the rather marked change that has occurred in the sophistication of our drug supply. Accompanying that change unfortunately, we have many examples of lack of therapeutic effectiveness because of minor differences in the method of manufacture, the size of the particle, the excipient used, the kind of coating used on a tablet, the pressure on a tablet in the machine—I could go through a whole host of these things which have been written up in the scientific literature.

Now, admittedly, this is not on a great many products, but it happens just enough of the time to give you concern and pause that no longer do you rely upon the laboratory testing program in toto. The laboratory testing program was once the main source of defense of the FDA; did a drug meet U.S.P. standards? We tested it in the laboratories for dissolution or disintegration times and measured it in beakers with hydrochloric acid. These methods were found to be en-

tirely accurate. We now know a great deal more about drug absorption. We know that before the drug can get into the body the particle size may alter its availability. The actual form of the drug, whether it is in an acid form or whether or not it has a different radical on it may be important. The Department of Defense had to learn this the hard way. It has had examples of it.

So I am not trying to throw sand in your eyes. I am trying to be responsive, and at the same time help you to accomplish the objectives.

The CHAIRMAN. Doctor, why can't we just list for generic payment those drugs about which we have no doubt? Here are the drugs about which we don't have any doubt. We know what this will do. For example, we know what an aspirin tablet will do. We understand what this will do. We understand what most of these things are.

Dr. GODDARD. I am sorry, Senator, we don't. I don't wish to contradict you on this point, but this is a technical field and we don't know.

The CHAIRMAN. You say you don't. How did the Department of Defense ever find out?

Dr. GODDARD. They actually had to do testing. They are buying the drug. They require a sample to be submitted in advance of a bid. They go out and visit the factory. They have had episodes in the Department of Defense where the drug has not performed the job clinically, and they have had to do clinical testing. Now, sure, with the drugs marketed since 1962 I have little doubt, because these have had to demonstrate their effectiveness. We are currently evaluating the drugs that were marketed between 1938 and 1962, to determine their effectiveness. But there are a host of other products.

The CHAIRMAN. Doctor, let me ask you this: If you don't know the stuff is any good anyway, why should you pay 10 times as much for it?

Dr. GODDARD. Sir, I wish I could answer that. I can't argue that point with you.

The CHAIRMAN. Well, as between two things that are both the same, why would you want to pay 10 times as much for it if you don't know whether it's any good or not? It seems to me that is part of what we are trying to get at here. It may be you don't think some of the stuff is any good, but I don't see why you would pay a ridiculously high price for it because you can't assure someone that it is good or that it isn't.

Dr. GODDARD. I understand.

The CHAIRMAN. Doctor, thank you very much for your statement. I appreciate it. I regret that your people have not been able to be more helpful to us in drafting the bill. May I say that I heard some of those arguments from some very good doctors on occasion, that this and that, and "Oh, my goodness, you just cannot afford to legislate in this area that has something to do with the practice of medicine."

I find myself wondering after we spend all this money, and, goodness knows, we are spending a lot of it——

Dr. GODDARD. Yes, sir.

The CHAIRMAN (continuing). On trying to test whether a drug is what it is supposed to be or not. Now, who ought to know more about that drug, this Government which has spent a fortune to try to see what that drug will do and testing it when it comes from various manufacturers, or a doctor who merely hears a seller's talk—that

traveling salesman coming there with free samples? Which one should know more about it?

Dr. GODDARD. Under the conditions you describe, the Government should. But we haven't done an extensive program of testing.

The CHAIRMAN. Thank you very much.

Dr. GODDARD. Thank you, sir.

The CHAIRMAN. I am going to have to ask for a 10-minute recess.

(A short recess was taken.)

The CHAIRMAN. Mr. Lawrence Speiser, of the Washington office of the American Civil Liberties Union.

Mr. Speiser, we appreciate your joining with the New York group to help expedite the hearing.

STATEMENT OF LAWRENCE SPEISER, DIRECTOR, WASHINGTON OFFICE, AMERICAN CIVIL LIBERTIES UNION

Mr. SPEISER. Mr. Chairman, because of the lateness of the hour, I would like to ask that my complete statement be submitted in the record, and I will summarize points that I would like to make.

The CHAIRMAN. All right.

Mr. SPEISER. There are two civil liberties issues that we feel at present in H.R. 12080. Most of the provisions of the act fall outside of the purview of the American Civil Liberties Union whose sole purpose is to safeguard the protections guaranteed all Americans by the Constitution. The two issues that I will address myself to are the loyalty provisions in four sections of the Social Security Act which would be continued under this bill, in spite of the request and urging by the administration that they be deleted; and, secondly, the question whether the poor are being deprived of some basic constitutional rights of equal protection of the law of privacy and the freedom to travel by the provisions of title II of the public welfare amendments.

The loyalty provisions that exist under the present Social Security Act are four. The fifth is one that was included in the Medicare Act, section 103(b)(1), which denied medicare benefits to individuals who are members of organizations required to register under the Internal Security Act of 1950.

This specific provision was declared unconstitutional by a three-judge court, a statutory three-judge court in California.

The Department of Justice, and the Department of Health, Education, and Welfare made a decision not to appeal that decision which held this provision unconstitutional, and which specifically enjoined the Secretary of Health, Education, and Welfare from enforcing it.

In a similar case, the case of *Weiss* v. *Gardner*, the Solicitor General of the United States in a memorandum he filed with the Supreme Court conceded the invalidity, the unconstitutionality of this particular provision.

Now, it would seem that Congress should clean up the law if nothing else. The Department of Health, Education, and Welfare has fallen back to recommending this one provision be eliminated. It has been declared unconstitutional. It would seem to me that Congress should not defy the Court, the Court's determination in this case, and should eliminate this clearly unconstitutional provision.

The second provision has not been tested. We feel it is unconstitutional. It is section 104(b)(2) of the Medicare Act, which precludes individuals who have been convicted of certain crimes from participating in the supplementary benefit program.

Third is a provision under the Social Security Act, section 202(u), which provides that persons who have been convicted of certain offenses may as an additional punishment imposed by a judge be barred from receiving social security benefits.

The last is a provision which is covered under both the Internal Revenue Code and the Social Security Act, which bars employees of organizations that are required to register under the Internal Security Act of 1950 from participating in the social security benefit. Its intent, I think, is clearly a punitive one, but the interesting phenomenon is that it is a group that is given almost a special privilege. There are some people who do not want to come under social security and complain about it, and here the employees of such organizations are barred from coming under it.

We feel that although Government benefits such as social security and medicare are not constitutionally required, they can be subjected to reasonable qualifications, but they cannot be withheld merely by governmental fiat or with the purpose of punishment. The whole concept of social security is to provide care throughout our society. Judgments such as certain individuals are undesirable, this is hardly the way to win them to democratic institutions. It is hardly the way to take care of social problems by cutting them off, by letting them starve, by denying them medical benefits that are available to all others.

Generally, these provisions are enforced with some kind of Communist disclaimer, but the decision in the Court barred the loyalty oath in medicare, and I think it is clear that it would bar other attempts to enforce it in that fashion.

There have been other cases that have arisen throughout the country involving some of the same kinds of issue in which individuals and members of organizations have been barred from certain kinds of Government welfare benefits, particularly in the public housing field.

There was a provision called the Quinn amendment which was added as a rider on an appropriation bill for public housing back in the early 1950's which barred any member of organizations that were on the Attorney General's list from living in public housing. This was tested all over the country, and in California there were four cases; New York had one; Illinois had one; Wisconsin had one; and although the Supreme Court refused to hear any of these cases, all of the lower court decisions held the provision to be unconstitutional, and eventually that particular provision expired.

One of the courts holding it unconstitutional, I think said it most eloquently when they said, and this is in the *Cordova* case, a Los Angeles case:

> Obviously, the government is under no duty to provide bounties in the form of low rent housing accommodations for its citizens. If it elects to do so, however, it cannot arbitrarily prevent any of its citizens from enjoying these statutorily created privileges. Nor can it make the privilege of their continuance dependent upon conditions that would deprive any of its citizens of their constitutional rights.

We believe that these provisions that I have mentioned would be declared to be bills of attainder. They are intended to punish. The

Supreme Court has held recently that you should not construe the bill of attainder clause in any narrow technical sense. Three of those provisions are automatic, in which there is no judicial determination as to whether the punishment is warranted in a particular case. These provisions all would violate the kind of law, of ruling, the Supreme Court has made in many of the loyalty oath cases recently. There is no attempt to distinguish between the kind of membership, whether it is an active or a nominal membership. There is no attempt to decide whether the individual has an illegal intent or what his purpose was with joining the organizations, to try to change the organization. There is no attempt to see whether the individual's contact is so tenuous that you really couldn't consider that there is membership in any meaningful sense.

There is no attempt in any of these provisions to make this kind of distinction which is the basis for the Supreme Court declaring similar provisions unconstitutional in State loyalty oath cases.

There is also the question as to whether these provisions are really enforceable now. Many of them are based on the membership in organizations required to register under the Internal Security Act. The Supreme Court has held that that registration provision is unconstitutional in infringing on the privilege against self-incrimination.

Health, Education, and Welfare has urged the repeal of all of these provisions in a letter that Secretary John Gardner and Commissioner of Social Security Robert Ball made. The letter was sent to you, Senator Long, and stated:

> We believe that the provision denying noncontributory insurance benefits to persons who are members of specified organizations is undesirable in principle and should be repealed. We believe that it is not desirable to have a provision of law under which a person's membership in some specified organization—however repugnant that organization might be to Americans generally—will cause him to be denied the benefits of hospital insurance, perhaps with the result that he does not get hospital care when he needs it.

The Commissioner of Social Security, Robert Ball, in a letter to Senator Philip Hart, said:

> It is quite anomalous to require just about every employed person in the country to contribute toward his own protection under Social Security but to relieve employees of these organizations from this responsibility—

The ones that are required to register—

> since when they are in need they will generally be eligible for public assistance supported by general taxation.

Secondly, we are urging the elimination of title II, the public welfare amendments. We believe that the freeze of Federal participation in the aid to families with dependent children program is unconstitutional in denying equal protection of the law. There have been recent cases holding that residence requirements, for example, in Delaware and Connecticut are unconstitutional because there is no rational basis for distinguishing people who need public assistance from those who live in the State and have established a certain degree of residence and those who have come in more recently.

Similarly, the distinction that is drawn between aid to needy children that got on the rolls before a certain date and those after seems to be equally irrational.

The Supreme Court has upheld the right to travel and it is clear that the freeze would inhibit the right to travel as these residence requirements do. The right to travel is a constitutionally protected right. Individuals should be free to go throughout the country. Indigents are subject to selective service. They are sent throughout the country. They equally have a right to participate in whatever benefits exist.

The compulsory work-training program for adults and out-of-school children over 16 we believe would violate the 13th amendment provision against involuntary servitude. There are certainly individuals on welfare who can be encouraged to seek work, but the use of compulsion, the use of coercion under the threat of cutting off the payments is the very kind of prohibition that is inimical to a free society.

There have been instances that show how State employable-mother rules have been used. For example, in a case filed in the Northern District of Georgia last year, challenging the State of Georgia's employable-mother rule, it alleged that in practice the policy has the intended effect of depriving large numbers of Negro families of AFDC benefits and of maintaining an available supply of Negro laborers for agricultural employment in Georgia. County boards in rural areas terminate AFDC eligibility for Negro mothers as of a certain date each year regardless of whether employment is actually available. White mothers are usually exempted from the work obligation because farm labor traditionally is not suitable for them.

The provision for foster homes to increase the removal of children in AFDC programs and place them in foster homes infringes on the right of a mother to raise her child. This should be a choice of hers and it is not a function of the State. When the State starts determining that children would be better off in foster homes, then it seems to me we have gone a long way toward a totalitarian society. The right of individuals to raise their children, even under very tough economic circumstances is still a right of the individual. This is certainly contrary to the whole concept of continuing the family unit.

We urge the members of this committee to reject title II of H.R. 12080 and to devise a new program without the degrading limitations that are placed on staying on AFDC. I will be happy to answer any questions, Mr. Chairman.

The CHAIRMAN. Thank you very much.

(The prepared statement of Mr. Speiser follows:)

STATEMENT OF LAWRENCE SPEISER, DIRECTOR, WASHINGTON OFFICE, AMERICAN CIVIL LIBERTIES UNION

I am Lawrence Speiser, an attorney and Director of the Washington office of the American Civil Liberties Union. I am testifying on behalf of the ACLU on H.R. 12080. Although of great value, most aspects of this legislation fall outside the purview of the American Civil Liberties Union, whose sole purpose is to safeguard and extend the protections of liberty guaranteed all Americans by our Constitution.

There are, however, two very large civil liberties issues presented by H.R. 12080: the loyalty provisions in four sections of the Social Security Act which would be continued under this bill, and the question whether the poor are being deprived of the same basic constitutional rights of equal protection of the laws, and privacy and the freedom to travel and settle throughout the country, that other Americans possess.

As to the first, we urge that Section 110[1] of the Administration bill—H.R. 5710—which was deleted by the House Ways and Means Committee in H.R. 12080, be restored. Section 110 provided for the "elimination of provisions denying benefits to individuals because of membership in certain organizations."

As to the second, we urge the Committee to reject Title II of H.R. 12080—the Public Welfare Amendments—and, in the words of Senator Robert Kennedy, adopt instead "a constructive set of proposals which the Senate can be proud to enact."

I. THE LOYALTY PROVISIONS

Section 103(b)(1) of the Social Security Act, disqualifying members of certain organizations from Medicare benefits, was declared unconstitutional by a statutory three-judge federal court on First Amendment grounds. See *Reed* v. *Gardner*, C.D. Cal. No. 66-1224 TC Civil. The unconstitutionality of this section was also conceded by the Justice Department in the United States Supreme Court by the then Solicitor General Thurgood Marshall. He filed a suggestion of mootness in the case of *Weiss* v. *Gardner*, 35 U.S.L.W. 328 (1967), in which he stated:

"Although the judgment in that case invalidates, on constitutional grounds, an Act of Congress—a result which ordinarily would warrant an appeal to this Court—we have concluded that the decision of this Court in *Elfbrandt* v. *Russell*, 384 U.S. 11 (1966), decided almost nine months after the enactment of Section 103(b)(1), forecloses any argument that the challenged provision is constitutional."

The Administration recognized that the issue had been foreclosed by the Courts when it included in H.R. 5710—the bill displaced by H.R. 12080—Section 110, repealing this provision and other similar sections denying benefits to individuals because of organizational membership. It would be an act of pointless defiance for Congress to ignore the judgment of the Courts and the Executive, and fail to eliminate these lame-duck provisions.

Section 110 of H.R. 5710 consisted of four subsections, which served to repeal existing law and a fifth subsection that merely stated when the repealing amendments were to become effective. The substantive changes envisioned by Section 110 are as follows:

Subsection A

Section 103(b)(1) and (2) of the Medicare Act, P.L. 89-97, 79 Stat. 286, denying Medicare benefits to individuals who are members of organizations required to register under the Internal Security Act of 1950, is repealed.[2]

Subsection B

Section 104(b)(2) of the Medicare Act, *supra*, precluding persons convicted of certain crimes from participating in a supplemental benefit program, is repealed.[3]

---

[1] This section is similar to S. 3678 (89th Congress, 2nd Session) introduced by Senator Javits and co-sponsored by Senators Clark of Pa., Kennedy of N.Y. and Young of Ohio; and H.R. 41 of the 90th Congress, introduced by Congressman Ryan of N.Y.

[2] Section 103(b), applicable only to those who are over 65 and are not covered by social security or railroad retirement, states that:

"(b) The provisions of subsection (a) shall not apply to any individual who—

"(1) is, at the beginning of the first month in which he meets the requirements of subsection (a) a member of any organization referred to in section 210(2)(17) [reprinted in footnote 5] of the Social Security Act.

"(2) has, prior to the beginning of such first month, been convicted of any offense listed in section 202(n) [reprinted in footnote 4], or".

[3] This section applicable to all Medicare participants whether or not covered previously by social security or railroad retirement, states as follows:

"(2) An individual who has been convicted of any offense under (A) chapter 37 (relating to espionage and censorship, chapter 105 (relating to sabotage) or chapter 115 relating to treason, sedition, and subversive activities) of title 18 of the United States Code, or (B) section 4, 112, or 113 of the Internal Security Act of 1950, as amended, may not enroll under part B of title XVIII of the Social Security Act."

Subsection C

Section 202(u) of the Social Security Act, 42 USC § 402(u) providing that a person convicted of certain offenses may be denied social security benefits if the court as an individual penalty so provides, is repealed.[4]

Subsection D

Sections 210(a)(17) of the Social Security Act, 42 U.S.C. § 410(a)(17), and 3121(b)(17) of the Internal Revenue Code of 1954, 26 U.S.C. § 3121(b)(17), barring employees or organizations required to register under the Internal Security Act of 1950 from participation in the social security program, are repealed.[5]

The above sections in addition to being unwise, are unconstitutional under the First and Fifth Amendments and the Bill of Attainder provisions of Article I, Section 9.

A. THE LOYALTY PROVISIONS ARE UNCONSTITUTIONAL IN INFRINGING ON LIBERTY AND PROPERTY WITHOUT DUE PROCESS OF LAW

Although governmental benefits such as Social Security and Medicare are not constitutionally required and can be subjected to reasonable requirements, benefits cannot be withheld by mere governmental fiat. The withholding of benefits available to all citizens from some citizens based on political, associational or religious considerations, can be an infringement on the liberty of those so deprived. *Speiser* v. *Randall*, 352 U.S. 531 (1958) and *Sherbert* v. *Verner*, 374 U.S. 398 (1963). A legitimate governmental objective must be present before the liberty of a citizen can be thus restricted. *Bolling* v. *Sharpe*, 347 U.S. 497.

Communist disclaimers have been incorporated time and again in all manner of programs as a condition for the granting of privileges, awards and employment, yet to this day there remains no evidence that they have safeguarded the nation from subversion.

The due process clause was held to be violated in the case of *Aptheker* v. *Secretary of State*, 378 U.S. 500, involving the denial of a passport to a member of the Communist Party. Section 6 of the Internal Security Act of 1950 (64 Stat. 993 50 U.S.C. 785) precluded a member of a "Communist-action," "Communist-front" or "Communist-infiltrated" organization from obtaining a passport.

The Court said that:

"Section 6, however, establishes an irrefutable presumption that individuals who are members of the specified organizations will, if given passports, engage in activities inimical to the security of the United States."[6]

---

[4] Section 202(u) provides that:

"(u) Conviction of subversive activities, etc.

"(1) If any individual is convicted of any offense (committed after August 1, 1956) under—

"(A) chapter 37 (relating to espionage and censorship), chapter 105 (relating to sabotage), or chapter 115 (relating to treason, sedition, and subversive activities) of Title 18, or

"(B) section 783, 822, or 823 of Title 50, then the court may, in addition to all other penalties provided by law, impose a penalty that in determining whether any monthly insurance benefit under this section or section 423 of this title is payable to such individual for the month—in which he is convicted or for any month thereafter—and in determining the amount of any such benefit payable to such individual for any such month, there shall not be taken into account—

"(C) any wages paid to such individual or to any other individual in the calendar quarter in which such conviction occurs or in any prior calendar quarter, and

"(D) any net earnings from self employment derived by such individual or by any other individual during a taxable year in which such conviction occurs or during any prior taxable year.

"(2) As soon as practicable after an additional penalty has, pursuant to paragraph (1) of this sub-section, been imposed with respect to any individual, the Attorney General shall notify the Secretary of such imposition.

"(3) If any individual with respect to whom an additional penalty has been imposed pursuant to paragraph (1) of this subsection is granted a pardon of the offense by the President of the United States, such additional penalty shall not apply for any month beginning after the date on which such pardon is granted."

[5] Sections 210(a)(17) and 3121(b)(17) are identical and provide as follows:

"[The terms wages and employment do not include]

"(17) Service in the employ of any organization which is performed (A) in any quarter during any part of which such organization is registered, or there is in effect a final order of the Subversive Activities Control Board requiring such organization to register, under the Internal Security Act of 1950, as amended, as a Communist-action organization, a Communist-front organization, or a Communist-infiltrated organization, and (B) after June 30, 1956."

[6] 378 U.S. at 511.

Although denial of a passport might conceivably bear some tenuous relationship to national security, not even such a relationship can be discovered here that would in any way warrant denial of Social Security or Medicare benefits.

The Court in *Aptheker* made extended inquiries into the purpose of the Act. Several defects were uncovered, all of which are here present. Both knowing and unknowing membership in the proscribed organizations comes within the purview of the statute. No reference is made in the statute to the degree of activity in the organization or commitment to its purposes. The statute is applied regardless of the purpose of travel or the place of travel. The objective of the Act could have been achieved through less drastic means.[7]

In previous cases where attempts have been made to bar members of proscribed organizations from the benefits of social legislation, constitutional infirmities have been found. In *Housing Authority* v. *Cordova*, 130 Cal. App. 2d 883, 279 P. 2d 215, *cert. den.* 350 U.S. 969, the court held, among other things, that it was arbitrary to deprive one of governmental benefits solely on the basis of membership in proscribed organizations, i.e. organizations on the Attorney General's list. The court quoted from a previous New York case, *Peters* v. *New York Housing Authority*, 128 N.Y.S. 2d 224, 236 to the effect that:

"Obviously the government is under no duty to provide bounties in the form of low rent housing accommodations for its citizens. If it elects to do so, however, it cannot arbitrarily prevent any of its citizens from enjoying these statutorily created privilliges. Nor can it make the privilege of their continuance dependent upon conditions that would deprive any of its citizens of their constitutional rights. A government is without power to impose an unconstitutional requirement as a condition for granting a privilege, even though the privilege may have been the use of government property."[8]

B. SEVERAL PROVISIONS ABOVE CONSTITUTE BILLS OF ATTAINDER CONTRARY TO ARTICLE 1, SECTION 9 OF THE CONSTITUTION

In determining whether a bill of attainder is present courts are guided by this statement from *U.S.* v. *Lovett*, 328 U.S. 303 (1946): "legislative acts, no matter what their form, that apply either to named individuals or to easily ascertainable members of a group in such a way as to inflict punishment on them without a judicial trial are bills of attainder prohibited by the Constitution."[9]

All of the above provisions except 42 U.S.C. §402(u) provide for such punishment. These provisions are very similar to Section 504 of the Labor-Management Reporting and Disclosure Act of 1959 (73 Stat. 536, 29 U.S.C. §504), held invalid as a bill of attainder in *United States* v. *Brown*, 381 U.S. 437, in which members of the Communist Party were barred from holding union office.

As the Court itself in *Brown* stated:

"[The] bill of attainder clause was intended not as a narrow, technical (and therefore soon to be outmoded) prohibition, but rather as an implementation of the separation of powers, a general safeguard against legislative exercise of judicial function, or more simply trial by legislature."[10]

Under three of the provisions in the Social Security Act, the imposition of punishment is automatic, without any judicial intervention as to whether such punishment is warranted in the particular case. The denial of medical or social security benefits is a sufficient deprivation to constitute punishment, necessary for a finding of violation of the bill of attainder provision.

In no sense can a mere regulation, preventive rather than retributive, be said to be present here.[11] The history of these provisions reveals punitive desires were the sole motivation for their enactment.

C. SEVERAL OF THE ABOVE PROVISIONS VIOLATE THE FREEDOM OF SPEECH AND ASSOCIATION PROVISIONS OF THE FIRST AMENDMENT

In several recent cases, the Supreme Court has invalidated loyalty oaths required of teachers on grounds of penalising mere knowing membership in the

---

[7] 378 U.S. at 514.
[8] 130 Ca. App. 2d 888. See also *Lawson* v. *Housing Authority of Milwaukee*, 70 N.W. 2d 605 (1955) cert. denied, 350 U.S. 822 (1955); *Chicago Housing Authority* v. *Blackmon* (1955).
[9] 328 U.S. at 315.
[10] 381 U.S. at 442.
[11] Cf. annotation—What Constitutes a Bill of Attainder, 90 L. ed 1967.

Communist Party without a specific showing of intent to support the unlawful ends of the Communist Party.[12]

As the Court itself said in *Elfbrandt* v. *Russell*, 384 U.S. 11 at 19:

"A law which applies to membership without the specific intent to further the illegal aims of the organization infringes unnecessarily on protected freedoms. It rests on the doctrine of 'guilt by association' which has no place here."

As we said earlier, no decision was rendered by the Supreme Court on the loyalty provisions in the Social Security Act, as the first case before the Court, *Weiss* v. *Gardner*, 35 U.S. L.W. 3281 (1967), was dismissed upon a suggestion of mootness filed by then Solicitor General Thurgood Marshall in January of this year. The Solicitor General said:

"Although the judgment—in that case invalidates, on constitutional grounds, an Act of Congress—a result which ordinarily would warrant an appeal to this Court—we have concluded that the decision of this Court in *Elfbrandt* v. *Russell*, 384 U.S. 11, decided almost nine months after the enactment of Section 103(b)(1), forecloses any argument that the challenged provision is constitutional. This Court held in *Elfbrandt* that the State of Arizona could not constitutionally bar from public school employment any person who refused to swear that he would not knowingly become or remain a member of an organization one of whose purposes was the violent overthrow of the government so long as the State oath was not construed as requiring specific intent to further the organization's unlawful purposes and active membership in such organization. We recognize that the public policy in disqualifying all members of Communist organizations (whether or not they are active and adhere to the organizations' unlawful purposes) from receipt of medicare benefits must be deemed less substantial than was Arizona's interest in disqualifying such members from employment in the public schools. Consequently, we feel that whatever litigable doubts may have existed regarding the constitutionality of Section 103(b)(1) at the time of its enactment have been resolved against its validity by this Court's subsequent decision in *Elfbrandt*."[13]

In addition to the conflict with freedom of association upon which *Elfbrandt* was based, these provisions also conflict with the First Amendment's freedom of expression. These objections were well stated in a report by a New York State Bar Association committee in urging repeal of § 103(b)(1) and § 104(b)(2):

"Faced with loss in his old age of essential medical care who can say how many people may choose to 'play it safe' rather than join a political group of a controversial nature? Such a result would only lead to dampening of freedom of thought and association, both so essential to a democratic society."[14]

Further, the Supreme Court itself recognized inhibitory-effect provisions like the ones being considered here have on the exercise of First Amendment freedoms in the case of *Sherbert* v. *Verner*, 374 U.S. 398, a case involving the denial of unemployment benefits to a Seventh-Day Adventist fired because of a refusal to work on Saturdays:

". . . [C]onditions upon public benefits cannot be sustained if they so operate, whatever their purpose, so as to inhibit or deter the exercise of First Amendment freedoms. We there [*Speiser* v. *Randall*, 357 U.S. 518] struck down a condition which limited the availability of a tax exemption to those members of the exempted class who affirmed their loyalty to the state government granting the exemption. While the State was surely under no obligation to afford such an exemption, we held that the imposition of such a condition upon even a gratuitous benefit inevitably deterred or discouraged the exercise of First Amendment rights of expression and thereby threatened to 'produce a result which the State could not command directly.' 357 U.S. at 526. 'To deny an exemption to claimants who engage in certain forms of speech is in effect to penalize them for such speech.'"[15]

---

[12] Cf. *Elfbrandt* v. *Russell*, 384 U.S. 11 (1966); *Baggett* v. *Bullitt*, 377 U.S. 360 (1964) (vagueness of oath); *Keyishian* v. *Board of Regents*, 385 U.S. 589.

[13] Solicitor General's suggestion of mootness in *Weiss* v. *Gardner*, 35 U.S.L.W. 3281 (1967), *vacated as moot*, pp. 3–4.

[14] New York State Bar Association, Report of the Committee on Federal Legislation, "Recommendations for Elimination of 'Non-Communist' Certificates in the Administration of the Medicare Program and Repeal of Disqualifications for Medicare Benefits Because of Membership in 'Communist' Organizations and Convictions for Political Offenses." March 21, 1966, pp. 6–7.

[15] 374 U.S. at 405–406.

D. THESE PROVISIONS ARE UNENFORCEABLE, UNNECESSARY AND UNWARRANTED

The legal validity of many of the provisions of the Internal Security Act itself are in doubt. Under recent decisions of the Supreme Court and lower federal courts, no organizations are presently required to register, so that the provisions here considered are in actuality unenforceable.[16]

Sections 103(b)(1) and (2) were inserted into Medicare draft legislation only because HEW believed Congress wanted such provisions. Wilbur Cohen, the Assistant Secretary of HEW, said:

"In view of this expression of current legislative policy with respect to noncontributory benefits, *we have supposed* that Congress would be unwilling to extend the noncontributory benefits of section 103 of S. 880 to members of the organizations in question. This is the *sole* reason that the exclusion was made in the draft which we submitted to the sponsors of S. 880." [17] [Emphasis added.]

There was no apparent justification for such a belief, and particularly in view of congressional repeal of the Communist disclaimer affidavit in the National Defense Education Act and the Office of Economic Opportunity Act, a contrary belief is more likely to be presently warranted.

H.E.W. itself favors repeal of these provisions as testified by these statements of H.E.W. Secretary John W. Gardner and Commissioner of Social Security Robert M. Ball:

"We believe that the provision denying non-contributory insurance benefits to persons who are members of specified organizations (section 103(b)(1) of the amendments) is undesirable in principle and should be repealed. We believe that it is not desirable to have a provision of law under which a person's membership in some specified organization—however repugnant that organization might be to Americans generally—will cause him to be denied the benefits of hospital insurance, perhaps with the result that he does not get hospital care when he needs it." [18]

"It is quite anomalous to require just about every employed person in the country to contribute toward his own protection under social security but to relieve employees of these organizations from this responsibility since when they are in need they will generally be eligible for public assistance supported by general taxation." [19]

Although we are quite sure that if this committee fails to repeal these provisions, they will eventually be declared by the courts to be unconstitutional, we believe that it is the function of the legislature to avoid, in the first instance, passage of legislation of doubtful constitutionality. In a situation like this, when the legislation is already on the books, the remedy is repeal. As stated by a California Assembly Committee:

"Our Constitutions, State and Federal, prescribe the minimal requirements of the mantle of civil liberty; it is the legislature which cuts the cloth; the courts are limited to a search for basic flaws in legislative workmanship. The courts may not question the wisdom of legislative action, but only the power of the legislature to act in a given situation. *For the great protection* of civil liberties as well as for the maintenance of our traditional separation of powers, the legislature *must not abdicate* to the courts its duty to 'secure the Blessings of Liberty to ourselves and our Posterity.'" [20] [Emphasis supplied.]

We hope that such abdication will not occur in this situation. In conclusion, because of the defects in the existing law, the Senate Finance Committee should remedy the omission of the House Ways and Means Committee by inserting a counterpart provision to Section 110 of the Administration's bill (H.R. 5710) when it marks up the House-passed bill (H.R. 12080).

II. THE PUBLIC WELFARE AMENDMENTS

The President's Advisory Council on Public Welfare recommended last year "a nation-wide comprehensive program on public assistance based upon a single criterion: need."

---

[16] *Albertson and Proctor* v. *S.A.C.B.*, 382 U.S. 70 (1965) and *Communist Party* v. *United States* (D.C. Cir., No. 19,8808 and 19,881, decided March 3, 1967).

[17] Letter of Wilbur Cohen to Congressman Robert Kastenmeier, April 3, 1968.

[18] Letter of John W. Gardner to Senator Russell Long, June 30 1966, reprinted in 112 *Cong. Rec.* 16909 (daily ed. Aug. 1, 1966).

[19] Letter of Robert M. Ball to Senator Philip Hart, February 9, 1966, reprinted in 112 *Cong. Rec.* 7706 (daily ed, April 18, 1966).

[20] California Assembly Interim Committee Reports Vol. 20, No. 7, March 1959, Report of the Subcommittee on Constitutional Rights of the Committee on Judiciary Pertaining to Loyalty Oaths, p. 16.

The House passed bill departed from this criterion by imposing new restrictions on recipients of public assistance—restrictions which we believe rises to constitutional dimensions in depriving many of the poor of their rights under the United States Constitution. Some of the most flagrant examples are:

A. THE "FREEZE" OF FEDERAL PARTICIPATION IN THE AID TO FAMILIES WITH DEPENDENT CHILDREN PROGRAM (AFDC)

In the words of the Committee report (H. Rept. 2544), the bill would "impose a limit on Federal financial participation designed to freeze the present situation with respect to that category *which is growing most rapidly*. Specifically, the bill would not allow Federal participation in the future for a higher proportion of children than is now on the rolls."

If a greater public awareness of the program or economic depression, or an increased migration from other states presents a state with a higher proportion of eligibles for AFDC, it is faced with the choice of tightening its eligibility standards or arbitrarily denying aid to those who apply after the cut-off figure has been reached, regardless of their condition. Pressure of course is then placed on the states to trim existing rolls to the bone and to allot additional "vacancies" stingily. The arbitrary denial of assistance to persons as fully qualified as other persons receiving assistance constitutes a denial of the equal protection of the laws as guaranteed against federal action by the Fifth Amendment's due process clause and against state action by the Fourteenth Amendment.

A three-judge federal court in a decision rendered June 28, 1967 declared the Delaware residence requirement for receiving public welfare unconstitutional under the equal protection clause.[21] The Court found that the Delaware law's principal purpose, protection of the public purse, was not a "permissible basis for differentiating between persons who otherwise possess the same status in their relationship to the state of Delaware." We submit that the same legal reasoning applies with equal force to this "Freeze".

In addition, if this denial is directed against an in-migrant who has left a state in search of better life, including even a more liberal and humane welfare program, there arises the question of his freedom to travel and settle in the various states. This taken-for-granted right was recognized by the U. S. Supreme Court in *Edwards* v. *California*, 314 U.S. 160 (1941). The Court reversed the conviction of a California man for having assisted in bringing into the state an indigent non-resident. The Statute under which he was convicted was declared unconstitutional under the Commerce Clause.

In a concurring opinion, however, Mr. Justice Douglas said "the right to move freely from State to State is an incident of national citizenship protected by the 'privileges and immunities' clause of the Fourteenth Amendment against state interference," *supra*, 178.

In another concurring opinion, Mr. Justice Black joined by Mr. Justice Jackson expanded further:

"The right of the citizen to migrate from state to state which, I agree with Mr. Justice Douglas, is shown by our precedents to be one of national citizenship, is not, however, an unlimited on. . . ."

"It is here that we meet the real crux of this case. Does 'indigence' as defined by the application of the California statute constitute a basis for restricting the freedom of a citizen, as crime or contagion warrents its restriction? We should say now, and in no uncertain terms, that a man's mere property status, without more, cannot be used by a state to test, qualify, or limit his rights as a citizen of the United States. 'Indigence' in itself is neither a source of rights nor a basis for denying them. The mere state of being without funds is a neutral fact—constitutionally an irrelevance, like race, creed or color. . . ."

"Any measure which would divide our citizenry on the basis of property into one class free to move from state to state and another class that is poverty-bound to the place where it has suffered misfortune is not only at war with the habit and custom by which our country has expanded, but is also a short-sighted blow at the security of property itself. Property can have no more dangerous, even if unwitting, enemy than one who would make its possession a pretext for unequal or exclusive civil rights. . . ."

---

[21] *Green* v. *Department of Public Welfare*, Civ. No. 3349 (D. Del., June 28, 1967).

"If I doubted whether his federal citizenship alone were enough to open the gates of California to Duncan, my doubt would disappear on consideration of the obligations of such citizenship. . . . A contention that a citizen's duty to render military service is suspended by 'indigence' would meet with little favor. Rich or penniless, Duncan's citizenship under the Constitution pledges his strength to the defense of California as a part of the United States, and his right to migrate to any part of the land he must defend is something she must respect under the same instrument. Unless this Court is willing to say that citizenship of the United States means at least this much to the citizen, then our heritage of constitutional privileges and immunities is only a promise to the ear to be broken to the hope, a teasing illusion like a munificent bequest in a pauper's will." *supra* at pp. 184–186.

A Connecticut residency requirement was stuck down by a three-judge federal court, the court relying on, in addition to the equal protection clause, the right of interstate travel.[25] The court cited *Edwards*, *supra*, then said that *United States* v. Guest, 383 U.S. 745 (1960), a case which listed the right to travel from one state to another among the federal rights protected against criminal conspiracy, went beyond *Edwards* in holding that the Constitution not only militates against absolute proscriptions on interstate travel, but that it also forbids state action which does no more than *discourage* such travel.

The court in the Connecticut case concluded that to deny plaintiff "even a gratuitous benefit because of her exercise of her constitutional rights effectively impedes the exercise of that right."

The court in *Edwards* rejected the economic arguments that seek to justify travel restrictions, such as residence tests and which could be similarly made in seeking to uphold this freeze on the AFDC program. Of course, states with such liberal programs may be, and have been, subjected to heavy and financially-burdensome in-migrations. We submit that the proper response to this is that, as put by Professor Bernard Evans Harvith, "Hopefully, the federal union rationale which has been accepted by the Supreme Court will also find favor with Congress, and fair provision will be made to alleviate unusual burdens borne by those states which attract large numbers of new residents."[26]

B. COMPULSORY WORK-TRAINING PROGRAMS FOR AFDC ADULTS AND OUT-OF-SCHOOL CHILDREN OVER 16

Section 204 of H.R. 12080 requires the states to set up work-training programs for the "appropriate" adults and children over 16 who are not in school. In the words of the Committee report, "If, without good cause, any appropriate child or relative refuses to accept a work or training assignment, or refuses to accept employment or training offered through the state employment service (or that is otherwise offered by an employer) he will have his assistance discontinued upon verification that of this refusal and specific evidence that the offer of training or employment is a bona fide one."

We feel, fundamentally, that the very power to arbitrarily compel a person to accept employment, is inimical to a free society and in conflict with the Thirteenth Amendment prohibition against involuntary servitude and a denial of the equal protection of the laws.

Mothers, in a program so heavily involved with fatherless homes, are heavily affected by Section 204. We insist it is a denial of equal protection and due process either to withhold aid from a needy family where the mother refuses to leave her young children to work or to compel her to work in order to receive aid. The condition of poverty is not a reasonable basis to deprive a mother of the right to remain with her children if she feels they need her and we must recognize that the right of a mother to rear her children *is* a right.

Nor can we appropriately empower the state to make the decision whether a particular mother's determination not to leave her children is "good cause" for refusing employment. Section 204 lends itself to the same implementation as state "employable mother" rules such as the Georgia act now being challenged on equal protection and due process grounds in *Anderson* v. *Schafer*, Civil No. 10443, N.D. Ga., Sept. 20, 1966.

The complaint alleged that "in practice, the policy has the intended effect of depriving large numbers of Negro families of AFDC benefits and of maintaining

---

[25] *Thompson* v. *Shapiro*, Civ. No. 11821 (D. Conn., June 19, 1967).
[26] *The Law of the Poor*, Chandler Publishing Company, p. 517 (1966).

an available supply of Negro laborers for agricultural employment in Georgia. County boards in rural areas terminate AFDC eligibility for Negro mothers as of a certain date each year regardless of whether employment is actually available. White mothers are usually exempted from the work obligation because farm labor traditionally is not 'suitable' for them." [34]

The hearing of the Mississippi Advisory Committee to the U.S. Commission on Civil Rights held early this year in Jackson further illustrated the dangers of this section. The hearings delved into the operation of Mississippi's public assistance, food stamp, commodity distribution and work experience programs. In general, the hearings supported the conclusion that the administration of such programs were discriminatory and arbitrary.

As far as the Work Experience Program under Title V of the Economic Opportunity Act, a parallel program to the one put forth under Section 204, the hearings showed that "it failed to provide on the job training and experience to the poor. Instead of increasing jobs for poor people, Work Experience was used to provide employment to workers from the Department of Public Welfare and to subsidize public agencies by offering a supply of free labor. The few private employers who participated used the program to increase janitorial and maid service, including work done in their own homes, without incurring any expense. Complaints were voiced by many Negroes that they were not receiving training in the jobs which they sought, such as nurses aides or dieticians, but were placed in menial positions. Moreover, when the program ended, most trainees were not employed, and those who were suffered a large wage decrease." [35]

C. FOSTER HOMES

Several provisions offer encouragement to states through financial incentives, to increase the frequency of removing children in the AFDC program from their homes and placing them in foster homes. The House Committee states in its report, p. 100, "Your Committee believes that some children now receiving AFDC would be better off in foster homes or institutions than they are in their own homes." It also observes that "there is some evidence that courts may be reluctant to place a child in foster care because Federal funds are not available." The Committee then makes available federal funds on a more liberal basis for state foster care programs.

As a matter of policy, we can only repeat what Senator Robert Kennedy pointed out to this Committee in his testimony, that study has shown that the worst thing that could happen to a child is to consign him to an institution.

As a matter of law, we believe again that the condition of being poor is used to discriminate in the application of child custody laws, with mothers on the AFDC program being singled out for punitive treatment. This denies them equal protection of the laws.

We urge members of this Committee to reject Title II of H.R. 12080 with its trying and degrading conditions and to adopt instead a comprehensive program ever-mindful of the overriding criterion: need, and without the imposition of unconstitutional conditions.

STATEMENT OF I. LEON GOODMAN, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HOSPITALS, INC.

Mr. GOODMAN. My name is I. Leon Goodman. I am executive director of the Federation of American Hospitals, Inc., the executive offices of which are located at 1450 Broadway, New York City.

I appreciate the opportunity to appear before you today to express federation's comments on H.R. 12080.

The federation has served the proprietary hospitals of the Nation for a little over 1 year. Members now number 160 hospitals in 19 States.

These hospitals importantly contribute to the health of the American people. Last year, federation hospitals treated approximately

[34] Welfare Law Bulletin, No. 5, October 1966, p. 2.
[35] Welfare Law Bulletin, No. 9, July, 1967, p. 13.

350,000 patients. The 14,179 beds of the federation member hospitals have a capacity of 5,175,335 patient-days per year.

Many of the Nation's proprietary hospitals have long histories—and great traditions of excellence. More typically, however, proprietary hospitals are young—founded by physicians or civic leaders to meet the health needs of the new communities that grew up during the postwar period.

In Nassau and Suffolk Counties in New York State, for instance, proprietary hospitals have been created to fill the vacuum in health care that arose with the huge population growth of these suburban areas.

Today, nearly five out of every 10 Nassau and Suffolk hospitals are proprietary institutions. In the New York City metropolitan area, as a whole, proprietary hospitals comprise one-quarter of all hospital facilities. Large concentrations of proprietary hospitals are also found in such fast-growing areas as California, Texas, and Tennessee. Nationally, approximately one out of every 10 hospitals is a proprietary institution.

Proprietary hospitals are highly significant to the economies of their communities. Last year, federation hospitals employed 18,451 persons, and maintained payrolls of $63,898,869. Local taxes came to $7,962,783. Moneys paid into the economies of the local communities served totaled $141,082,613.

The proposed implementation of Public Law 89-97 last year made clear to the proprietary hospitals that the needs of the free enterprise sector of the hospital industry had not been effectively presented to Congress or the administration. The payments formulas promulgated for titles 18 (medicare) and 19 (medicaid) would have actually prejudiced the continued existence of the proprietary hospitals.

The first, most urgent, order of business was for proprietary hospitals to make it understood that they could not long work with the proposed payments formulas—and stay out of bankruptcy. And it was for that reason that a few proprietary hospitals took the initiative of forming the Federation of American Hospitals, Inc.

Our problems are today better understood on Capitol Hill and within the Department of Health, Education, and Welfare. Although further improvements must be achieved, the first, grossly unfair payments formulas have now been modified.

But the fact that many public officials remain unaware of the actual financial needs of hospitals still underlies federation's difficulties. It is in this regard that I shall today discuss H.R. 12080.

WHAT ARE PROPRIETARY HOSPITALS?

First, we must understand what proprietary hospitals really are. Proprietary hospitals are developed by the investment of private capital. Substantial investment is required. The capital invested generates borrowing power for long-term debt for either building or acquiring these institutions.

Proprietary hospitals must repay their obligations. They are in business and are subject to the rigors of the capital market. They must be self-supporting. They are taxpaying and support the communities

that they serve, and in no way are they a burden to the communities. They contribute substantially to the labor market of the communities they serve, and bolster the economy by their purchases in the community.

PROPRIETARY HOSPITALS AND THE MEDICARE ACT

Frankly, gentlemen, we in the proprietary hospital field are at a loss to understand what actually transpired when Congress adopted the Medicare Act. Under the act, specifically section 1814(b), the amount to be paid to providers of service was designated to be "the reasonable cost" of the services provided to beneficiaries.

The first regulations published by the Social Security Administration took the position that "reasonable cost" did not contemplate the inclusion in payments of any amounts to providers of services which were under proprietary ownership above bare cost.

Although briefs were filed with the Social Security Administration, they consistently maintained that any allowance based on invested capital would be deemed profit and thus not an element of cost, and they persisted in this interpretation of the law until section 1861(v)1 of the Social Security Act was amended by the Miller amendment which added the following new sentences:

> Such regulations in the case of extended care services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services in lieu of other allowances to the extent that they reflect similar items. The *rate of return* recognized pursuant to the preceding sentence *for determining the reasonable cost* of any services furnished in any fiscal period shall not exceed one and one-half times the average of the rates of interest, for each of the months any part of which is included in such fiscal period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund. [Emphasis supplied.]

Although the above amendment, known as the Miller amendment, referred specifically to extended-care proprietary facilities, the conference report of the Senate and House contained the following statement:

> The conferees expect that the Secretary of Health, Education, and Welfare will apply similar or comparable principles in determining reasonable costs for reimbursement of proprietary hospitals for services furnished by them.

Social Security Administration has computed the return to be allowed on equity capital at approximately 7 percent for the initial period.

The unfair discrimination against proprietary hospitals by the reduction of the 2 percent in lieu of specific allowances for other costs to 1½ percent:

However, the 2 percent of operating costs which was to be allowed before the amendment, in lieu of specific allowances for other costs, has been reduced for proprietary hospitals to 1½ percent of the operating costs.

This reduction was promulgated, despite the testimony before your committee by Commissioner Ball, that no portion of the 2 percent was in payment of any profit, but rather was given as "a recognition in a broad and general way, that the specific elements of the formula did not openly recognize some of these elements of true cost that perhaps should have been in the formula so that we felt and the council

felt that this 2 percent is not a bonus, not a profit, is not over and beyond the cost, but it is an essential part of the basic cost—recognizing the deficiencies elsewhere." (Mr. Ball, pp. 107–108, hearing before Committee on Finance, 89th Cong., second sess. May 25, 1966.)

Despite the above quoted testimony, the administration arbitrarily reduced the 2 percent for proprietary hospitals to 1½ percent of the operating costs.

The effect of the Miller amendment has been to clarify that "reasonable cost" in the case of proprietary hospitals includes an amount equivalent to interest foregone on invested capital. There has been no change, however, in the basic philosophy that no profit is to be allowed for providers of services which are under proprietary auspices.

THE APPROPRIATION OF PROPRIETARY HOSPITALS' PROFITS WITHOUT JUST COMPENSATION

It is the contention of the proprietary hospitals that the Federal Government is appropriating the profits of proprietary hospitals to the extent that such hospitals serve the beneficiaries under the health insurance program for the aged, without just compensation therefor.

It is particularly difficult for us to understand the rationale behind this action. In all Government contracts there is a cost-plus factor. This factor is not computed on the equity capital, but rather on the cost of producing the product, and the skill and know-how of the contractor.

Furthermore, the quality of the product produced by the hospital; namely services, is not proportionate to the equity capital invested in hospitals, but rather to the experience and reputation of the hospitals in its services to the community built up over a period of years.

We feel, therefore, that it is only just and proper that owners of proprietary hospital facilities be compensated for services purchased by the Government in amounts which are given due recognition to their contribution to their business, besides the amount of equity capital only.

Proprietary hospitals are not public utilities. They do not have a vested monopoly. The proprietary hospital business, and it is a business, involves risk capital, and by reason thereof its return above operating costs should not be limited to return on capital invested in an amount which is available without any risk with high grade bonds.

Where else can proprietary hospitals receive the funds necessary to continuously improve their facilities and services?

THE FREE ENTERPRISE SYSTEM AND PROPRIETARY HOSPITALS

Our Government has been based on the free enterprise profit system.

I believe what our Vice President, Hubert H. Humphrey, said in a letter to U.S. News & World Report, which was published in its issue of October 25, 1965, best exemplifies the feelings of most of the people in Government today:

> I have always been an advocate of the competitive enterprise system. I come from a business family. I do have investments in business. My family has investments in business. We live off the profit system . . . I believe in our private enterprise system. I believe in expanding and growing economy, and I believe

that it is to the good of that economy to have it identified not only with economic growth and profits, but also with an interest in the welfare of people—yes, the education, the health, the working conditions, and the happiness of the people. This is the American way. It is the difference between our capitalism and that of some of the other areas of the world.

If we examine the reason why proprietary hospitals came into being, we will note that private capital in the form of investment by the doctors and civic leaders who were left without facilities to treat their patients, because of the refusal of their community to shoulder their responsibilities and supply these needed medical facilities, was the impetus for their construction. Thus, in those areas of the United States where there were tremendous population explosions and the communities could not afford, or did not wish to provide these needed medical facilities, they sprang into being. As I said before, in New York, in Nassau County, 50 percent of the beds are in proprietary hospitals. In California, Texas, and Tennessee, and in many other States, there would be complete chaos without the proprietary hospital beds.

Furthermore, proprietary hospitals are subject to all taxes to the same extent as other business. They pay Federal, State, and local income taxes, real estate taxes, as well as taxes such as franchise tax, etc.

THE SLOW DEATH OF PROPRIETARY HOSPITALS DUE TO THE METHOD OF REIMBURSEMENT

Another unique anomaly of the medicare reimbursement formula with respect to the return on vested capital, is that the dollar amount of such return will decrease in each and every year in the future, unless additional capital is required and contributed by the owners. This is so because the depreciation taken for tax purposes, reduces the amount of the equity in the hospital's plant and equipment. This result is contrary to the objectives of private business in general, for increased profits year after year to attract capital and to plow back into the business part of the profits to create more and better products and improve efficiency.

The same is true of the hospital business. Without surplus earnings above cost hospitals cannot pay off their mortgages and other indebtedness and the opportunity does not exist to improve facilities and service and to keep abreast of the dynamic and expensive developments in the health field.

THE UNFAIRNESS IN REIMBURSEMENT TO LEASED FACILITIES

The Medicare formula is even more unfair to proprietary hospitals which do not own but rather lease the hospital plant. They receive no return above operating costs because they are deemed to have no investment. No matter that the rental under the lease is far below the fair rental at current values, no allowance is given to such hospitals. A lease may have been negotiated long before Medicare came into being, yet no consideration is given to the increase in the value of such leasehold.

CURRENT VALUE AS A BASIS FOR DEPRECIATION

The most unjust element in all of this return on equity capital, is the failure to recognize the current value of the hospital's plant and

equipment in determining the return on invested capital. The invested capital at the time the Medicare Act became effective was the value on that date—not the historical cost. When property is condemned by the Government for public purposes, current values are considered in determining the compensation to the owners thereof. Why should not the current values be considered when the Government "condemns" the property of proprietary hospitals for Medicare purposes. Let there be no mistake about this. There is a condemnation of property here. It is not an answer to say that the hospital is not compelled to contract with the Government. A hospital cannot exist if it excluded Medicare patients because its medical staff would seek other facilities for their patients.

The restrictive payments in Medicare cases have now been extended also to public assistance patients under title XIX since the Social Security Administration has stated that the Social Security Act provides that the Medicare reimbursement formula applies to title XIX. If, as and when a compulsory health program for all citizens comes into being, proprietary hospitals will cease to exist under the present reimbursement formula.

HOW TO CURE THE INEQUITIES OF THE PRESENT REIMBURSEMENT FORMULA

The inequities of the Medicare provisions of the Social Security Act with respect to reimbursement to proprietary hospitals must be remedied by amendment to provide that:

1. Proprietary hospitals should receive a reasonable profit in Medicare cases.
2. Such profit should be based on a combination of a cost-plus factor and a return on invested capital computed at current values of the plant and equipment and necessary working capital.
3. In the case of leased premises, the current value of the leasehold should be computed on the current value of the plant and equipment.

THE RISING COST OF MEDICAL CARE

All of us in the health care field, and those in government, are particularly anxious and concerned about the increasing rise in medical care costs. At the National Conference on Medical Care Costs, held on June 27 and 28, 1967, at the direction of President Johnson, the keynote speaker, Victor H. Fuchs, Ph. D., associate director of research of the National Bureau of Economic Research, made the following observations:

Most industries in the United States consist of profit seeking firms actively engaged in competition with one another. The fundamental rationale of the American Economic System is that the hope of profit (and fear of loss), under conditions of open competition, are the best guarantees of efficiency, an appropriate price and rate of output and the fair return to the various factors of production.

We, the proprietary hospitals, believe that this is the dominant factor that has controlled prices in our hospitals to the general public. It has been established by all the indexes ever published that proprie-

tary hospitals charge less for the same quality of care as hospitals not engaged as profit-seeking enterprise.

Dr. Fuchs further goes on in his address as follows:

> The common practice of reimbursing hospitals on the basis of their costs, as under Medicare and many other private and public programs, appears to be an open invitation to inefficiency. At best, the ability of hospital management to improve productivity is imperfect because of the independence of the attending staff. Under present arrangements, almost no one has any incentive to be concerned with the efficiency of the hospital as a whole.

In private enterprise hospitals, for which I speak, the incentives of ownership—the difference between profit and loss—provide all the necessary incentives for efficiency.

In further expanding his thesis, Dr. Fuchs states:

> An analysis of the supply of capital to the medical care industry is much more difficult to undertake because most capital is used in hospitals, and most hospitals are non-profit. Thus, the flow of capital is not determined by the rate of profit (as it is in most industries), but by government decisions and philanthropies.

In our hospitals the flow of capital is determined by the rate of profit. It would be impractical and impossible for our hospitals to continue to keep stride with the current rapid pace of the technological improvements, unless the flow of capital into our institutions was encouraged rather than discouraged by the present method of reimbursement. Why should any investor in a proprietary health institution invest his capital when the present outlook for its return is very gloomy? Would it not be more practical and feasible for this investor to allow his money to accumulate growth and interest by putting it into secure guaranteed investments, such as savings banks or Government bonds, or high price yield bonds?

CONCLUSION

If it is the intention of Congress to encourage the investment of private capital to construct, maintain, and utilize facilities for participation in the health needs of the country, then it is distinctly your obligation to understand their distinct responsibilities, and needs. If it is the intention, however, that Congress does not desire the continuation of the free enterprise system in the health care field, then it should arrange for the orderly purchase of proprietary hospitals in accordance with the applicable provisions of law—not starve them or use attrition as a means of accomplishing this purpose.

Gentlemen, proprietary hospitals offer outstanding hospital services to a significant proportion of the Nation's ill. Their dynamic is that of free enterprise, and if they are to expand—even survive—they cannot bear more restrictions than those who operate in other free enterprise sectors. Until such time as Congress recognizes the essentials required by the laws of free enterprise, and the laws of the capital market, as well as a record of services to the community, proprietary hospitals will remain in jeopardy.

Thank you Mr. Chairman and gentlemen for the opportunity to present this testimony.

The CHAIRMAN. Mr. George Young, senior vice president of the Connecticut General Life Insurance Co., and chairman of the American Life Convention and Life Insurance Association of America.

STATEMENT OF GEORGE W. YOUNG, SENIOR VICE PRESIDENT, CONNECTICUT GENERAL LIFE INSURANCE CO. OF HARTFORD, REPRESENTING THE AMERICAN LIFE CONVENTION, THE LIFE INSURANCE ASSOCIATION OF AMERICA, AND THE LIFE INSURERS CONFERENCE, ACCOMPANIED BY JOHN MILLER

Mr. YOUNG. Mr. Chairman, appearing with me is John Miller. We, as you mentioned, are appearing on behalf of the American Life Convention, the Life Insurance Association of America, and the Life Insurers Conference.

I have a prepared statement which I will file.

Over the years it has been widely accepted that the role of OASDI is to provide a floor of economic security for retired and disabled workers and their dependents, with both room and incentive for supplementation through voluntary private means. Life insurance companies agree with this principle. It is their role to provide additional life, disability, and pension benefits to enable individuals and groups to improve their economic security.

I don't know if you have my statement here, sir, but I will skip through it.

Undue expansion of the social security system would have a far-reaching impact on voluntary private security mechanisms in our economy. Savings and thrift institutions are essential to our society. They permit the individual to invest in American business and to help build a supply of capital needed for the continued health and growth of our economy. A high rate of savings through pension funds and other private savings media will be necessary if our economy is to grow in the years ahead on a sustainable basis without chronic inflation.

In contrast, the social security system does not generate capital, but redistributes each year most of the tax revenue received. For this reason it becomes critically important that the role of the Government system be concentrated on clearly established social need.

Attached to this statement is a memorandum showing the need for a vigorous increase in savings in our economy.

We believe this is a particular important point.

I now turn to some specific provisions of the bill. First, on proposed changes in the benefit formula. While we believe that a reasonable across-the-board benefit increase is justified, we are of the opinion that a 12½-percent increase as proposed in H.R. 12080 is not warranted by the experience of the economy since the last increases were made in 1965.

As noted in the report of the Ways and Means Committee, the Consumer Price Index has risen only about 7 percent since the 1965 increases.

The increases of 1965 represent a very substantial change as borne out by the attached exhibit 2. This exhibit shows that the average monthly cash benefits paid in 1966 to retired workers were higher than in any previous year in terms of both actual dollars and purchasing power except for 1965. The same amendments also added medi-

care, which, in view of rapidly rising health costs, has become an increasingly more valuable benefit to the aged. We see no justification for a benefit increase of the size now recommended, just 2 years later.

Minimum benefits: We support the provision of H.R. 12080, which would raise the flat minimum benefit from $44 to $50. As stated in the Ways and Means Committee report, at page 24, such a minimum appears appropriate in maintaining a wage-related system.

The administration would increase this flat minimum benefit to $70, and would also provide a sliding minimum benefit of $4 for each year of significant covered employment up to a maximum of $100 for an individual with 25 or more covered years. We believe that a flat minimum of $70 would be unsound, in that it would give undue benefits to intermittent or part-time workers. If any increase in the minimums beyond that adopted by the House were to be considered necessary, the $4 sliding minimum would be more appropriate.

To illustrate the defects in the administration proposal, an individual retiring in 1967 with his last 18 years' covered employment would have to pay taxes on credited wages of $19,650 in order to qualify under the sliding scale for a minimum benefit of $72—18 years times $4 per year.

In contrast, an individual receiving $50 in covered wages from incidental employment in one quarter out of each of the years since 1950 would have to pay taxes on only $800 of wages to qualify for the flat minimum of $70. Thus, it becomes apparent that the flat minimum proposed by the administration is inconsistent with the wage-related character of the system.

Proposed increase in earnings base—section 108:

We oppose the suggested earnings base increase. The present base of $6,600 is adequate under current conditions. To raise the base at this time would extend the social security system into income areas which can be better and more appropriately served by voluntary private programs.

The earnings base should not exceed average earnings. We believe that the average earnings of regularly employed male workers represents an appropriate dividing line between the area in which the Government should have responsibility to provide basic benefits and the area in which the individual and his employer should have responsibility to provide security through private media.

The Social Security Amendments of 1965 increased the earnings base from $4,800 to $6,600, effective in 1966. This $1,800 increase was three times as great as any prior increase and equal to the total of all increases since the beginning of the program in 1935. Now, 2 years later, H.R. 12080 would provide an additional increase of $1,000 in 1968. This, added to the 1966 increase, would total an increase of $2,800 in 2 years, as contrasted with an increase of $1,800 in the preceding 30 years.

This chart shows the relationship between average earnings of regularly employed male workers and the social security earnings base, both historically and under H.R. 12080, and the administration proposal—H.R. 5710. This chart shows that, in the case of every prior

increase in the earnings base, including the one effective in 1966, the average earnings of regularly employed male workers exceeded the base before the increase was enacted. Each increase brought the base slightly above average earnings, except for the 1966 increase, which took the base almost $1,000 above average earnings. We estimate that the average earnings of regularly employed male workers will not reach the present $6,600 base until about 1970, and will not reach $7,600 until about 1973.

(The chart referred to appears at p. 1250.)

Mr. YOUNG. Thus the earnings base increase proposed by H.R. 12080 represents a sharp departure from this historical pattern in two important respects. First, the base would be increased while still substantially in excess of the average earnings of regularly employed male workers. Second, the base would substantially exceed estimated average earnings over a long period of time. The administration proposal, H.R. 5710, would, of course, be even more extreme.

We recognize that other standards for testing the adequacy of the earnings base have been suggested. For example, the 1965 Report of the Advisory Council on Social Security refers to three possible standards—the percentage of total earnings of covered workers subject to tax, the percentage of all workers whose entire earnings are subject to tax, and the percentage of regularly employed male workers whose entire earnings are subject to tax.

As shown by exhibit III, the 1966 increase in the earnings base has already brought all of these percentages into line with the corresponding percentages resulting under all wage base increases beginning with 1951.

We start with 1951, the year in which the first earnings base increase was effective, rather than going back to 1935, the year of inception, because 1935 was a year of very depressed earnings and a substandard economy. As the economy has improved, a smaller share of the increased earnings should be required for compulsory social security and a larger share should be available for individual self-provision and for growth investment through savings.

Thus all of these comparisons lead to the same conclusion—the earnings base increase proposed in H.R. 12080 is not warranted. The increases proposed by the administration would be even more unsound.

Younger workers with earnings at or above the proposed earnings base would be seriously disadvantaged. Exhibit IV compares (*a*) the additional retirement benefits provided by H.R. 12080 and H.R. 5710 for younger workers with earnings equal to or greater than the proposed earnings bases, with (*b*) the private plan retirement benefits that could be purchased for those workers with the increase in taxes attributable to retirement benefits under those bills. The exhibit shows that in the case of the earnings base increase under H.R. 12080—and, of course, to a much greater extent in the case of the earnings base increases proposed in H.R. 5710—the worker would do much better with a private plan.

For example, under H.R. 12080, the increase in the monthly social security retirement benefit for a career worker age 25 in 1968 with

earnings equal to or greater than $7,600 a year would amount to $44. A private plan retirement benefit of nearly $68 a month could be provided at current group annuity rates for the same worker from that portion of the proposed increase in employee-employer OASDI taxes which is allocable to retirement benefits.

Under H.R. 5710, the increase in the monthly social security retirement benefit for a career worker age 25 in 1968 with earnings equal to or greater than the proposed earnings bases would amount to $115. A private plan retirement benefit of nearly $220 a month could be provided at current group annuity rates from the projected increase in employee-employer OASDI taxes allocable to retirement benefits.

Under H.R. 12080, OASDI taxes for the younger worker with earnings at or above the earnings base would reach an ultimate level in 1973 which would be over 18 percent higher than the level which would be reached under existing law. Under H.R. 5710, this figure would be over 68 percent in 1974. Tax increases of this magnitude would constitute a severe burden. A large portion of these tax increases would go toward providing benefits for workers not affected by the wage base increase. The balance of the increase would provide additional social security benefits to younger workers at or above the proposed earnings base, which would be incompatible with the floor of protection principle.

At the same time, the latter workers would be deprived of the opportunity of obtaining greater benefits for the same amount of money under voluntary private plans. In sum, the floor of protection principle would be breached, and at the same time younger workers with earnings at or above the wage base would be disadvantaged.

The serious results just described are essentially the product of the proposed earnings base increase. Accordingly, we recommend that any increase in social security benefits be financed through the favorable actuarial balance in the present program together with whatever increase in the tax rate may be necessary. The wage base should not be changed at this time. The present wage base of $6,600 still exceeds average earnings by a substantial amount, and any higher base will be unfair to many younger workers.

Benefits for disabled widows, section 104: We support the provisions of H.R. 12080 granting severely disabled widows under age 62 cash benefits under specified conditions.

Liberalization of the retirement test, section 107: We support the proposed increase in the amount an individual may earn without a reduction in social security benefits. We believe that a sound retirement test should be retained at all times, but the proposed increase is modest and would not in our opinion unduly weaken that test.

This concludes my statement, Mr. Chairman, and Mr. Miller and I will be glad to answer any questions the committee may have.

(Mr. Young's prepared statement, with exhibits attached thereto, follows:)

PREPARED STATEMENT OF GEORGE W. YOUNG ON BEHALF OF THE AMERICAN LIFE CONVENTION, LIFE INSURANCE ASSOCIATION OF AMERICA, AND THE LIFE INSURERS CONFERENCE

My name is George W. Young. I am Senior Vice President of the Connecticut General Life Insurance Company of Hartford. I appear today on behalf of the American Life Convention, the Life Insurance Association of America and the Life Insurers Conference, three associations with an aggregate membership of 401 life insurance companies accounting for approximately 92 percent of the life insurance in force in the United States. These companies also hold over 99 percent of the reserves of insured pension plans in the United States. I am accompanied by John H. Miller, formerly Executive Vice President of the Monarch Life Insurance Company of Springfield, Massachusetts, who has appeared before you on prior occasions on behalf of the three associations. We appreciate this opportunity to express our views on H.R. 12080.

Social Security's Role

Over the years it has been widely accepted that the role of OASDI is to provide a floor of economic security for retired and disabled workers and their dependents, with both room and incentive for supplementation through voluntary private means. Life insurance companies agree with this principle. It is their role to provide additional life, disability, and pension benefits to enable individuals and groups to improve their economic security.

This basic nature of OASDI is confirmed by its benefit pattern. While benefits bear a relationship to a worker's average taxable earnings, the benefit formula is heavily weighted in favor of workers with low average earnings. Thus the OASDI system assures a level of economic security for all covered individuals without strict regard for individual equity.

The voluntary insurance system affords the individual the opportunity to create flexible contractual arrangements under which individual equity is preserved at all times. These arrangements are valuable property rights which greatly strengthen the individual's security program and provide him with a share in our economy. In contrast, the Social Security system seeks to achieve goals for society in general, as distinguished from goals of the individual. Thus proposals to increase OASDI benefits must be considered not only in terms of broad social need but also in terms of the proper relationship between public and private programs. Consideration must also be given to the effect of resulting tax increases on the ability of individuals to make their own security arrangements.

We believe that Congress should review from time to time the benefit levels under the OASDI system to determine whether intervening price increases warrant a change, particularly at the lower levels. Current conditions call for a benefit increase but, in our opinion, not of the magnitude proposed by this bill. Also, the proposal to raise the earnings base above its present level would result in an unwarranted and unnecessary increase in taxes for those who are trying to provide for themselves.

Undue expansion of the Social Security system would in addition have a far-reaching impact on voluntary private security mechanisms and our economy. Savings and thrift institutions are essential to our society. They offer the individual the opportunity to invest in American business and to help build the supply of capital needed for the continued healthy growth of our economy. A high rate of savings through pension funds and other private savings media will be necessary if our economy is to grow in the years ahead on a sustainable basis without chronic inflation. In contrast the Social Security system does not generate capital, but redistributes each year most of the tax revenue received. For this additional reason, it becomes critically important that the role of the government system be concentrated on clearly established social need. Exhibit I attached to this statement is a memorandum showing the need for a vigorous increase in savings in our economy.

Within this frame of reference, I now turn to the provisions of the bill.

Proposed Changes In Benefit Formula (Section 101)

While we believe that a reasonable across-the-board benefit increase is justified, we are of the opinion that a 12½ percent increase, as proposed in H.R. 12080, is not warranted by the experience of the economy since the last increases were made in 1965. As noted in the Report of the Ways and Means Committee (at page 22), the Consumer Price Index has risen only about 7 percent since the 1965 increases.

The increases of 1965 represented a very substantial change, as is borne out by the attached Exhibit II. This Exhibit shows that the average monthly cash benefits paid in 1966 to retired workers were higher than in any previous year in terms of both actual dollars and purchasing power, except for 1965. The same amendments also added Medicare, which, in view of rapidly rising health costs, has become an increasingly more valuable benefit to the aged. We see no justification for a benefit increase of the size now recommended, just two years later.

Minimum benefits.—We support the provision of H.R. 12080 which would raise the flat minimum benefit from $44 to $50. As stated in the Ways and Means Report (at page 24), such a minimum appears appropriate in maintaining a wage-related system.

The Administration would increase this flat minimum benefit to $70, and would also provide a sliding minimum benefit of $4 for each year of significant covered employment up to a maximum of $100 for an individual with 25 or more covered years. We believe that a flat minimum of $70 would be unsound, in that it would give undue benefits to intermittent or part-time workers. If any increase in the minimums beyond that adopted by the House were to be considered necessary, the $4 sliding minimum would be more appropriate.

To illustrate the defects in the Administration proposal, an individual retiring in 1967 with his last 18 years in covered employment would have to pay taxes on credited wages of $19,650 in order to qualify under the sliding scale for a minimum benefit of $72 (18 years x $4 per year). In contrast, an individual receiving $50 in covered wages from incidental employment in one quarter out of each of the years since 1950 would have to pay taxes on only $800 of wages to qualify for the flat minimum of $70. Thus it becomes apparent that the flat minimum proposed by the Administration is inconsistent with the wage-related character of the system.

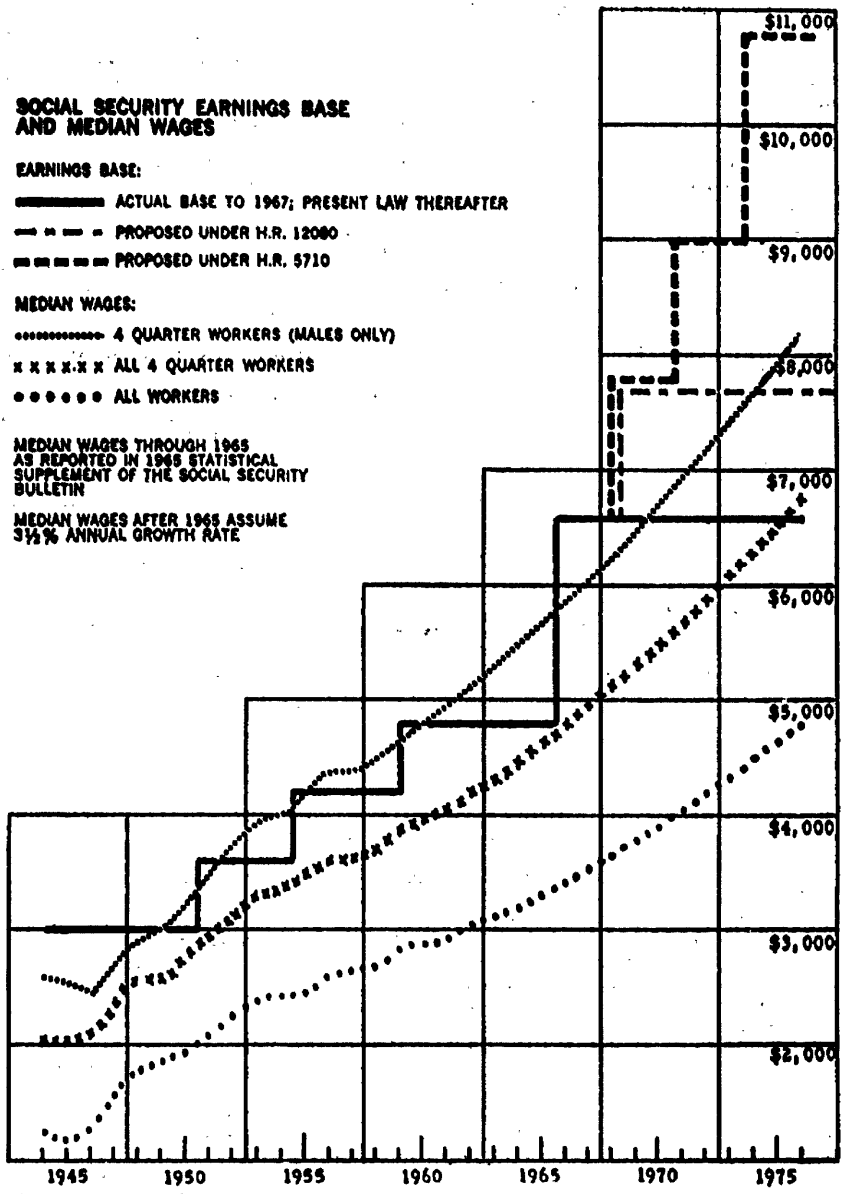
Proposed increase in earnings base (sec. 108)

We oppose the suggested earnings base increase. The present base of $6,600 is adequate under current conditions. To raise the base at this time would extend the Social Security system into income areas which can be better and more appropriately served by voluntary private programs.

The earnings base should not exceed average earnings.—We believe that the average earnings of regularly employed male workers represents an appropriate dividing line between the area in which the Government should have responsibility to provide basic benefits and the area in which the individual and his employer should have responsibility to provide security through private media.

The Social Security Amendments of 1965 increased the earnings base from $4,800 to $6,600, effective in 1966. This $1,800 increase was three times as great as any prior increase and equal to the total of all increases since the beginning of the program in 1935. Now, two years later, H.R. 12080 would provide an additional increase of $1,000 in 1968. This, added to the 1966 increase, would total an increase of $2,800 in two years, as contrasted with an increase of $1,800 in the preceding thirty years.

The Chart on page 6 shows the relationship between average earnings of regularly employed male workers and the Social Security earnings base, both historically and under H.R. 12080 and the Administration proposal (H.R. 5710). This Chart shows that, in the case of every prior increase in the earnings base, including the one effective in 1966, the average earnings of regularly employed male workers exceeded the base before the increase was enacted. Each increase brought the base slightly above average earnings, except for the 1966 increase, which took the base almost $1,000 above average earnings. We estimate that the average earnings of regularly employed male workers will not reach the present $6,600 base until about 1970, and will not reach $7,600 until about 1973.



Thus the earnings base increase proposed by H.R. 12080 represents a sharp departure from this historical pattern in two important respects. First, the base would be increased while still substantially in excess of the average earnings of regularly employed male workers. Second, the base would substantially exceed estimated average earnings over a long period of time. The Administration proposal (H.R. 5710) would of course be even more extreme.

We recognize that other standards for testing the adequacy of the earnings base have been suggested. For example, the 1965 Report of the Advisory Council on

Social Security refers to three possible standards—the percentage of total earnings of covered workers subject to tax, the percentage of all workers whose entire earnings are subject to tax, and the percentage of regularly employed male workers whose entire earnings are subject to tax. As shown by Exhibit III, the 1966 increase in the earnings base has already brought all of these percentages into line with the corresponding percentages resulting under all wage base increases beginning with 1951. We start with 1951, the year in which the first earnings base increase was effective, rather than going back to 1935, the year of inception, because 1935 was a year of very depressed earnings and a substandard economy. As the economy has improved, a smaller share of the increased earnings should be required for compulsory Social Security and a larger share should be available for individual self-provision and for growth investment through savings.

Thus all of these comparisons lead to the same conclusion—the earnings base increase proposed in H.R. 12080 is not warranted. The increases proposed by the Administration would be even more unsound.

Younger workers with earnings at or above the proposed earnings based would be seriously disadvantaged.—Exhibit IV compares (a) the additional retirement benefits provided by H.R. 12080 and H.R. 5710 for younger workers with earnings equal to or greater than the proposed earnings bases, with (b) the private plan retirement benefits that could be purchased for those workers with the increase in taxes attributable to retirement benefits under those bills. The Exhibit shows that in the case of the earnings base increase under H.R. 12080—and of course to a much greater extent in the case of the earnings base increases proposed in H.R. 5710—the worker would do much better with a private plan.

For example, under H.R. 12080 the increase in the monthly Social Security retirement benefit for a career worker, age 25 in 1968 with earnings equal to or greater than $7,600 a year would amount to $44. A private plan retirement benefit of nearly $68 a month could be provided at current group annuity rates for the same worker from that portion of the proposed increase in employee-employer OASDI taxes which is allocable to retirement benefits.

Under H.R. 5710, the increase in the monthly Social Security retirement benefit for a career worker age 25 in 1968 with earnings equal to or greater than the proposed earnings bases would amount to $115. A private plan retirement benefit of nearly $220 a month could be provided at current group annuity rates from the projected increase in employee-employer OASDI taxes allocable to retirement benefits.

Under H.R. 12080, OASDI taxes for the younger worker with earnings at or above the earnings base would reach an utlimate level in 1973 which would be over 18% higher than the level which would be reached under existing law. Under H.R. 5710 this figure would be over 68% in 1974. Tax increases of this magnitude would constitute a severe burden. A large portion of these tax increases would go toward providing benefits for workers not affected by the wage base increase. The balance of the increase would provide additional Social Security benefits to younger workers at or above the proposed earnings base, which would be incompatible with the floor of protection principle. At the same time, the latter workers would be deprived of the opportunity of obtaining greater benefits for the same amount of money under voluntary private plans. In sum, the floor of protection principle would be breached, and at the same time younger workers with earnings at or above the wage base would be disadvantaged.

The serious results just described are essentially the product of the proposed earnings base increase. Accordingly, we recommend that any increase in Social Security benefits be financed through the favorable actuarial balance in the present program together with whatever increase in the tax rate may be necessary. The wage base should not be changed at this time. The present wage base of $6,600 still exceeds average earnings by a substantial amount, and any higher base will be unfair to many younger workers.

Benefits for disabled widows (sec. 104)

We support the provisions of H.R. 12080 granting severly disabled widows under age 62 cash benefits under specified conditions.

Liberalization of the retirement test (sec. 107)

We support the proposed increase in the amount an individual may earn without a reduction in Social Security benefits. We believe that a sound retirement

test should be retained at all times, but the proposed increase is modest and would not in our opinion unduly weaken that test.

This concludes my statement, Mr. Chairman, and Mr. Miller and I will be glad to answer any questions the Committee may have.

EXHIBIT I

THE NEED FOR A VIGOROUS INCREASE IN SAVING THROUGH PRIVATE PENSION FUNDS TO AID IN FINANCING SOUND GROWTH OF THE UNITED STATES ECONOMY

If the economy of the United States is to grow strongly in the years ahead, and on a sustainable basis without inflation—objectives widely accepted—there will be an urgent need for a high rate of saving to finance the production of capital goods—industrial plant and equipment, housing, public utilities, transportation and communication facilities, and the many other capital projects. A high rate of saving and economic growth is required to provide job opportunities for our rapidly growing labor force and to improve our living standards.

The private pension system is a major source of saving for the financing of capital projects of all kinds, whereas the Federal social security system does not produce savings. To the extent that a sharp increase in social security benefits should curb the healthy expansion of the private pension system, the aggregate rate of saving to finance sound economic growth would be reduced and the capacity of the economy to provide job opportunities and rising living standards would be limited. In the light of the need for a high rate of saving in the years ahead, proposals for undue expansion of the Federal social security system, with a consequent reduction in the role of the private pension system, present a serious problem of public policy.

THE CONTRIBUTION OF PENSION FUND SAVING TO THE ECONOMIC GROWTH OF THE UNITED STATES

Using the national income accounts prepared by the U.S. Department of Commerce, the following picture of the importance of pension fund saving emerges:

(Dollar amounts in billions)

	Average per annum			
	1946–50	1951–55	1956–60	1961–65
Personal income [1]	$203.0	$283.4	$366.0	$471.2
Personal saving [1]	11.7	17.2	20.0	22.6
Pension saving [2]	2.7	4.6	7.2	9.9
Personal saving as percent of personal income	5.8	6.1	5.5	4.8
Pension saving as percent of personal income	1.3	1.6	2.0	2.1

[1] National income accounts of the U.S. Department of Commerce, Survey of Current Business.
[2] Flow-of-funds accounts of the Board of Governors of the Federal Reserve System. This figure measures the increase in assets held by private pension plans, pension programs administered by State and local government units, and the Federal employee and railroad retirement benefit programs. It includes both insured and noninsured plans. It excludes OASDI.

Note: If personal saving is expressed as a percent of disposable personal income (after Federal income tax payments), the savings ratios for the 4 5-year periods are 6.4, 6.9, 6.2, and 5.5 percent, respectively. The use of the ratio of saving to personal income is considered more relevant here since most of the pension saving is, in effect, from pretax income; i.e., employer contributions to private and public pension plans are not treated as taxable income to the employee.

As shown in the table, the annual amount of saving through private pension funds (including those administered by state and local government units) has increased markedly since 1946 both in absolute dollar amount and as a percentage of total personal income. It is significant that total personal saving as a percent of personal income has declined during the past fifteen years from an average of 6.1 percent in 1951–1955 to an average of 4.8 percent in 1961–1965. Thus the increase in the rate of pension saving has been an important factor in checking the decline of the aggregate rate of personal saving.

The savings accumulated through private pension funds have been invested in corporate securities, mortgages, state and municipal bonds, and U.S. Government obligations. They have thus provided financing for the construction of in-

dustrial plant and equipment, single-family homes, apartment buildings, commercial properties of all kinds, public utilities, transportation and communication facilities, roads and other public facilities, and many other kinds of capital projects. The capital expenditures made possible by pension savings have provided increasing job opportunities in our economy and have contributed heavily to improved productivity and thus higher living standards.

Studies conducted by the National Bureau of Economic Research indicate that in coming years the rate of increase of private pension saving is likely to slacken because, with a rising percentage of our people moving into the retirement age group, benefit payments are likely to be increasing at a more rapid rate than the sum of contributions and investment earnings.[1] This is a disturbing prospect in view of the need to finance the heavy demands for capital formation which the country faces in the years ahead. This is an additional reason to encourage expansion of the private pension plan system.

THE URGENT NEED FOR A HIGH RATE OF SAVING IN THE YEARS AHEAD

In looking to the future, the majority of economists are projecting a stronger rate of economic growth—say 4–5 percent—than we have experienced in the past. This expectation is based on the following reasoning:

1. There are a number of factors in our economy which will provide a favorable climate for strong growth such as (a) a sharp increase in the labor force; (b) a marked increase in the rate of family formations; (c) a very rapid rate of technological innovation abetted by a large increase in research and development expenditures; (d) the need for heavy and rising public and private expenditures to meet the problems of our cities—urban renewal and rehabilitation, air and water pollution, transportation, and the like; and (e) the drive for stronger economic growth in other countries and the leverage which this will exert upon our own desire and capacity to grow.
2. Both political parties and the public at large agree that fiscal, monetary and other Government policies must be directed toward encouraging full employment and faster economic growth.

To achieve a stronger rate of economic growth there will have to be a very high rate of investment spending, and, of course, a very high rate of saving.

To illustrate the above point, it will be helpful to review three recent projections of the growth of the U.S. economy in the next decade: (1) *U.S. Economic Growth to 1975: Potentials and Problems*, a study prepared for the Subcommittee on Economic Progress of the Joint Economic Committee of the Congress; (2) Albert T. Sommers, "The Economy in the Next Decade", *The Conference Board Record*, December, 1965; and (3) Leonard A. Lecht, *Goals, Priorities and Dollars—The Next Decade*, a study prepared under the auspices of the National Planning Association. These studies are typical of the thinking of most economists about the prospects for growth of the American economy in the years ahead.

The projections of GNP and national income developed in the study made by the staff of the Joint Economic Committee have built into them a number of assumptions about Federal fiscal aimed at maintaining full employment.[2] Their "Projection A" is based on the assumption that during the next decade the real GNP will grow at a 4.5 percent annual rate, and also assumes an average unemployment rate of 3 percent. Their "Projection B" is based on the assumption that during the next decade the real GNP will grow at a 4 percent annual rate, and assumes an average unemployment rate of 4 percent.

It is significant to note that their projection A (in current dollars) calls for a rise in gross private domestic investment from $106.6 billion in 1965 to $142.9 billion in 1970 and to $201.4 billion in 1975, an increase of nearly 90 percent by 1975. Excluding the change in business investories, the increase in fixed investment would be from $97.5 billion in 1965 to $185.7 billion in 1975, or an increase of just about 90 percent. These figures suggest that there will be a great demand for capital funds generated by savings during the next decade. The figures in project B, although somewhat lower, also suggest an enormous rise in capital demands.

The projection of GNP in 1975 prepared by Albert T. Sommers of the National Industrial Conference Board assumes an average unemployment rate of 4.5

[1] Daniel M. Holland, *Private Pension Funds: Projected Growth*, Occasional Paper 97, National Bureau of Economic Research, New York, N.Y., 1966.

[2] For a discussion of these assumptions, see *U.S. Economic Growth to 1975: Potentials and Problems*, pp. 29–47.

percent and a 4.85 percent increase per annum in real output. Again, it is interesting to observe that under his projections gross private domestic investment in current dollars would rise sharply from $92.9 billion in 1964 to $171.9 billion in 1975, an increase of about 85 percent. A marked increase in personal saving is also projected by Sommers, from $26.3 billion in 1964 to $48.5 billion in 1975, with the rate rising from 6 percent to 6.2 percent of disposal personal income.

Commenting upon his projection, Sommers stated:

"Up ahead, nevertheless, appears to lie a further vigorous expansion in the rate of investment. Indeed, vigorous growth in investment is an essential requirement if the substantially faster rate of growth of employment envisioned here is to be accompanied by an appropriate increase in the total stock of capital.

"The annual rate of new fixed investment in 1975 may approach $118 billion, in prices then prevailing; this is almost double the gross investment rate of 1964."[3]

In his concluding remarks about his projection of the growth of the American economy in the next decade, Sommers states:

"In the first instance, the challenge posed by the trillion-dollar potential of the U.S. economy is job creation. The bumper dimensions of the 1975 potential arise largely because the American economy of 1965 is on the threshold of a great wave of growth in its human resources, unequalled since the days of heavy immigration to America many decades ago. The great challenge in the next decade is to create the jobs to fully engage this surging tide of manpower.

"The creation of jobs means, of course, investment; and investment, of course, depends upon saving. Given the increments to the labor force that seem to lie ahead, it would be hard to envision any ten-year projection of the American economy that would not focus on a compelling need to achieve and sustain a high rate of capital formation, to equip the increments to the labor force, and to improve the efficiency of the labor force as a whole."[4]

A similar conclusion was reached by Leonard A. Lecht, a member of the staff of the National Planning Association, in his study *Goals, Priorities and Dollars—The Next Decade*. Lecht's projection calls for a GNP of close to one trillion dollars in 1975, expressed in 1962 dollars. He assumes a 4 percent increase per annum in real GNP, based on full employment and a 3 percent per annum increase in productivity of labor. Lecht has studied what the "costs" (in terms of GNP growth) would be to fulfill the goals which have been advanced by the Administration in such fields as urban development, health, education, housing, and the like. To satisfy these goals, he has estimated that by 1975 GNP would have to rise to $1.5 trillion (in 1962 prices). Concerning this output, he comments:

"Creating sufficient output to realize the aspiration standards for the 16 goals would entail a GNP growth rate approaching 5.5 per cent a year between 1962 and 1975 (measured by GNP in constant prices from the full capacity level of production in 1962). This compares with an increase in GNP averaging 3 per cent a year in the past generation and 3.5 per cent between 1948 and 1962. Sustaining a 5.5 per cent annual growth rate for over a decade would require technological changes leading to massive increases in productivity, considerably beyond the 3 per cent growth in GNP per manpower anticipated in the next 10 years."[5]

Aside from the "aspiration" level of GNP (i.e., $1.5 trillion), Lecht's projection of a $1.0 trillion GNP provides that private expenditures for business and industrial plant and equipment would have to rise from $48.9 billion in 1962 to $102.3 billion in 1975 (all expressed in 1962 dollars). This more than doubling of capital expenditures by business and industry is a measure of the great need for savings in the years ahead if capital formation is to be financed soundly.

The most comprehensive study of capital requirements in the United States in the years ahead has been made by Harvard Professor Simon Kusnets.[6] In his

---

[3] Albert T. Sommers, "The Economy in the Next Decade", *The Conference Board Record*, December, 1965, p. 8.

[4] Ibid., p. 28.

[5] *Goals, Priorities and Dollars—The Next Decade*, p. 43.

[6] *Capital in the American Economy—Its Formation and Financing*, a study by the National Bureau of Economic Research, published by Princeton University Press, 1961. The Kusnets monograph was the summary volume in a project financed with a grant of $460,000. Other monographs, all published by the Princeton University Press, were: (1) *Capital Formation in Residential Real Estate: Trends and Prospects* (Leo Grebler, David M. Blank, and Louis Winnick); (2) *Capital in Agriculture: Its Formation and Financing Since 1870* (Alvin Tostlebe); (3) *Capital in Transportation, Communications, and Public Utilities: Its Formation and Financing* (Melville Ulmer); (4) *Capital in Manufacturing and Mining: Its Formation and Financing* (Daniel Creamer, Sergei P. Dobrovolsky, and Israel Borenstein); (5) *Trends in Government Financing* (Morris A. Copeland); and (6) *Financial Intermediaries in the American Economy Since 1900* (Raymond Goldsmith).

monumental study. Kuznets concluded that during the preceding twenty years (1941–1960) the rate of economic growth of the United States had been held considerably below its potential because of too low a rate of saving. He found that the demands for capital financing will be very large in coming years, and that high levels of consumption are likely to continue. Therefore, he concluded, the supply of savings in the years ahead will be inadequate, and he strongly recommended measures to encourage a higher rate of saving. Kuznets' principal conclusions are well summarized in the following quotation:

"The above treatment of conditions for the future, far too brief and dogmatic, may carry a sense of firmer conviction than is intended. The discussion reflects conclusions suggested by the record of this country's economy—an economy geared for a long-run rise to increasingly high levels of consumption per capita, and one in which savings and capital formation, though large and sustained, nevertheless have been kept within moderate proportional limits by the secularly high propensity to consume. It is also an economy in which the recently increasing diversion of product to current consumption by governments, combined with high levels of consumer demand, has limited capital formation and savings proportions and brought about, under conditions of full employment, rising price levels which have persisted even through the 1958 recession. Against this background, consideration of the prospective large rise in population numbers—particularly of new family makers, entrants into the labor force, and of the school-age groups—the prospective acceleration of potential technological change and the prospect of continued international competition and strain suggest the following prospects. First, the demand for capital over the coming two and a half to three decades is likely to be large. Second, drains upon the national product for current consumption by governments will continue to be proportionately sizable and may well rise. Third, high levels of consumption and the high secular propensity to consume by individuals and households are likely to continue. Fourth, under the circumstances, the supply of voluntary savings may not be adequate. Finally, inflationary pressures may well continue, with the result that part of the savings needed for capital formation and government consumption will be extracted through this particular mechanism. Yet, extrapolation of inflationary pressures over the next thirty years raises a specter of intolerable consequences, making the policy solutions adopted critically important; and those solutions, in turn, will affect the structure and pattern of financial intermediaries and their role in financing."[1]

The views of Sommers, Lecht, and Kuznets, as well as those in the Joint Economic Committee study, are characteristic of the great majority of economists today. The American economy has great potential for vigorous growth in the years ahead. Public policies will be directed to maintaining full employment and faster growth. If growth is to be realized soundly and without a sharp rise in the general price level, the rate of saving will have to be high. This is why it is important to ask what the effect of OASDI is upon saving and capital formation.

THE IMPACT OF OASDI UPON SAVING AND CAPITAL SPENDING

Inasmuch as the Federal social security system is financed on nearly a pay-as-you-go basis without an appreciable accumulation of investment funds, it is clear that OASDI does not perform the vital function of the private pension funds as a source of saving for the financing of capital spending.

Beyond this, what effect does the OASDI program have upon the overall rate of personal saving? The effect is to reduce the aggregate rate of personal saving below what it would otherwise have been. This arises because of the redistributive effect of the system. The taxes are levied on persons who tend to be savers and benefits are paid to retired persons who on the whole are not savers but who are dependent for their livelihood on past savings. Roger Murray, who has headed the pension fund study of the National Bureau of Economic Research, has the following observations upon the redistributive effects of the Federal social security program:

"The redistributive effects of the growing stream of transfer payments also are in the direction of depressing the saving ratio. The operation of tax-supported programs at present moderately increases consumption at the expense of saving if one presumes—as seems reasonable—that pension beneficiaries save smaller fraction of their incomes than do contributors to pension programs. A more pronounced effect of income redistribution on saving is indicated for the future." (43d Annual Report of the National Bureau of Economic Research, p. 23)

[1] Kuznets, pp. 459–460.

SUMMARY AND CONCLUSIONS

The foregoing analysis may be summarized as follows:

1. The savings generated by private pension funds, as well as by pension funds administered by state and local government units, have contributed importantly to the financing of capital spending in the United States and hence to the provision of job opportunities and to the encouragement of national economic growth and rising living standards.

2. If the economy of the United States is to grow strongly in the years ahead, and on a sustainable basis without inflation, there will be a pressing need for a high rate of saving to finance capital spending.

3. The Federal social security system is not generating any appreciable amount of saving because it is being financed upon nearly a pay-as-you-go basis. In fact, the social security system acts to depress the overall rate of personal saving because the taxes are levied on persons who tend to be savers and benefits are paid to retired persons who on the whole are not savers but rather dissavers.

4. The public interest requires that a vigorous expansion of private pension saving be encouraged in order to provide financing for a strong rate of growth of the American economy on a sustainable basis free of inflationary excesses. This means that social security benefits should not be increased so sharply that they curb the healthy growth of private pension savings.

EXHIBIT II.—COMPARISON OF AVERAGE MONTHLY BENEFITS IN CURRENT PAYMENT STATUS TO RETIRED WORKERS IN ACTUAL DOLLARS AND IN TERMS OF 1966 PURCHASING POWER, DECEMBER 1940-65[1]

December—	Average monthly benefit in—		December—	Average monthly benefit in—	
	Actual dollars	1966 purchasing power[2]		Actual dollars	1966 purchasing power[2]
1940	$22.60	$52.79	1954	$59.14	$72.78
1941	22.70	48.31	1955	61.90	75.93
1942	23.02	44.91	1956	63.09	75.22
1943	23.42	44.26	1957	64.58	74.75
1944	23.73	43.90	1958	66.35	75.50
1945	24.19	43.77	1959	72.78	81.60
1946	24.55	37.60	1960	74.04	81.74
1947	24.90	34.96	1961	75.65	83.04
1948	25.35	34.65	1962	76.19	82.60
1949	26.00	36.24	1963	76.88	81.95
1950	43.86	57.76	1964	77.57	81.77
1951	42.14	5[illegible] 3	1965	[3] 83.92	[3] 86.72
1952	49.25	6[illegible].74	1966	[3] 84.35	[3] 84.35
1953	51.10	62.62			

[1] Social Security Bulletin, June 1967.
[2] Calculated by dividing the benefit amount by the consumer price index (1966=100).
[3] Excludes medicare. If provision were made to include the value of medicare, the corresponding figures would be about $12 higher.

EXHIBIT III.—PROPORTION OF WORKERS WITH TOTAL EARNINGS COVERED BY WAGE BASE AND PROPORTION OF TOTAL EARNINGS IN COVERED EMPLOYMENT TAXABLE IN SELECTED YEARS

Year	Wage base	Proportion of workers with all earnings taxable (in percent)		Proportion of total earnings taxable (in percent)
		All covered workers[1]	Regularly employed men[2]	
1950	$3,000	71	43	79.7
1951	3,600	76	53	81.7
1954	3,600	68	40	77.7
1955	4,200	74	50	80.9
1958	4,200	70	44	77.8
1959	4,800	73	50	79.7
1965	4,800	64	35	71.7
1966	6,600	78	56	80.4

[1] Includes both employed and self-employed.
[2] Includes men who were paid wages in each calendar quarter or acquired 4 quarters of coverage by being paid maximum taxable wages.

Source: Department of Health, Education, and Welfare.

EXHIBIT IV

COMPARISON OF ADDITIONAL SOCIAL SECURITY RETIREMENT BENEFITS UNDER H.R. 12080 AND THE ADMINISTRATION'S PROPOSAL (H.R. 5710) WITH RETIREMENT BENEFITS THAT COULD BE PURCHASED UNDER PRIVATE GROUP ANNUITY PLANS USING AMOUNTS CORRESPONDING TO TAX INCREASES UNDER H.R. 12080 AND H.R. 5710

The following tables compare (a) the increases in retirement benefits provided under H.R. 12080 and H.R. 5710 with (b) retirement benefits which could be purchased privately with amounts corresponding to the portion of increases in taxes which may be allocated to retirement benefits under H.R. 12080 and under H.R. 5710. Benefit comparisons are shown for workers age 25 in 1968 who will have earnings equal to or greater than the proposed wage base. In all cases, the taxes used are limited to those amounts attributable to the cost of retirement benefits. A detailed description of the methods and assumptions underlying the tables follows Table 2.

In the case of H.R. 12080, the additional benefits which could be provided under private plans using the proposed increase in taxes for the employer and the employee would be substantially greater than the increase in benefits provided under the bill. If the retirement benefits were purchased privately using the amounts corresponding to the increase in taxes from the self-employed, they would not exceed the additional retirement benefits provided by H.R. 12080.

With respect to H.R. 5710, the tables show that under private plans, retirement benefits which are nearly double the additional retirement benefits provided by the bill could be purchased using the proposed increase in taxes on the employer and employee. For the self-employed, the additional retirement benefits so purchased would be substantially greater than the increase in retirement benefits provided by H.R. 5710.

It should be noted that the increases in monthly Social Security benefits shown in the two tables are the full increases resulting from H.R. 12080 or H.R. 5710. However, an increase in current benefits of about 7½% could be provided by the reported current actuarial surplus without any increase in taxes. This corresponds to an increase of about $12.60 per month in the retirement benefits of a worker age 25 in 1968 with monthly earnings of $550, and about $6.30 per month additional in the wife's old age benefit. These amounts might be appropriately removed from the Social Security benefit increases shown in order to arrive at the increase in benefits corresponding only to the increase in taxes under H.R. 12080 or H.R. 5710.

TABLE 1.—COMPARISON OF ADDITIONAL RETIREMENT BENEFITS UNDER H.R. 12080 AND H.R. 5710 WITH BENEFITS WHICH COULD BE PURCHASED UNDER GROUP ANNUITY PLANS AT CURRENT RATES WITH THE INCREASES IN TAXES UNDER H.R. 12080 AND H.R. 5710 WHICH ARE ATTRIBUTABLE TO RETIREMENT BENEFITS, FOR A WORKER AGE 25 IN 1968 WITH EARNINGS AT LEAST EQUAL TO THE PROPOSED WAGE BASES

Bill	Monthly retirement benefits which could be purchased under group annuity plans with tax increases for—		Increased monthly [1] social security retirement benefits
	Employer-employee	Self-employed	
H.R. 12080	$67.34	$41.51	$44
H.R. 5710	219.73	149.21	115

[1] Amounts shown are not reduced by the approximately $12.60 of increase which, it might be argued, could be provided with current actuarial surplus without an increase in taxes.

Basis for group annuity benefits

1951 Group Annuity Table with Projection C, which assumes substantial future reductions in mortality, for males attaining age 25 in 1968. Provision for administrative expenses is made by reducing to 4¾% investment returns, which currently range from 5 to 5½%. Monthly retirement benefits are what would be purchased by the amounts from age 25 to age 65 which equal the portion of the proposed tax increases which is attributable to worker's retirement benefits. It is assumed that 62.4% of taxes are needed for worker's retirement benefits.

TABLE 2.—COMPARISON OF ADDITIONAL RETIREMENT BENEFITS, INCLUDING WIFE'S BENEFIT, UNDER H.R. 12080 AND H.R. 5710 WITH BENEFITS WHICH COULD BE PURCHASED UNDER GROUP ANNUITY PLANS AT CURRENT RATES WITH THE INCREASES IN TAXES UNDER H.R. 12080 AND H.R. 5710 WHICH ARE ATTRIBUTABLE TO RETIREMENT BENEFITS, FOR A WORKER AGE 25 IN 1968 WITH EARNINGS AT LEAST EQUAL TO THE PROPOSED WAGE BASES

Bill	Monthly retirement benefits which could be purchased under group annuity plans with tax increases for—		Increased monthly social security retirement benefits, including wife's benefits [1]
	Employer-employee	Self-employed	
H.R. 12080	$72.98	$44.97	$65
H.R. 5710	238.02	161.65	121

[1] Amounts shown are not reduced by the approximately $18.90 which, it might be argued, could be provided with current actuarial surplus without an increase in taxes.

Basis for group annuity benefits

Mortality, investment and expense assumptions are identical to those in Table 1. Monthly retirement benefits are what would be purchased by amounts from age 25 to age 65 which equal the portion of the proposed tax increase which is attributable to worker's retirement benefits plus wife's old age benefits. It is assumed that 67.6% of taxes are needed for these two benefits.

METHODS AND ASSUMPTIONS UNDERLYING TABLES 1 AND 2—COMPARISON OF RETIREMENT BENEFITS ONLY

There are two reasons for limiting the comparison to retirement benefits. First, the survivor benefits and disability benefits under Social Security do not have any exact counterparts under private plans. Private plans offer essentially fixed benefits—without regard to how many dependents a worker may have or whether the beneficiary has other earnings—and charge premiums that reflect closely the value of the protection provided. In contrast, the taxes collected under Social Security are based solely upon taxable wages and the survivor and disability benefits reflect family status and a number of other factors. The second reason for limiting the comparison to retirement benefits is that the disability and survivor benefits under Social Security are analogous to term insurance coverage. The costs of providing such benefits through private group plans, to the extent it is feasible to do so, would be basically the same as providing the coverage through a government program; any differences in cost would be relatively small and would arise from differences in expenses. On the other hand, private retirement benefits may be funded and variations in investment returns can cause very substantial differences in the cost of providing such benefits which far overshadow any differences in administrative costs.

ASSUMPTIONS REGARDING SOCIAL SECURITY TAXES AND BENEFITS UNDERLYING COMPARISONS

Only retirement benefits are being compared and, therefore only a corresponding portion of OASDI taxes is used in the comparison. In Actuarial Study No. 63, the most recent study of its kind prepared by the Social Security Administration, the cost to provide retirement benefits to workers represents approximately 62.4% of the cost of all OASDI benefits. The inclusion of old age benefits paid to wives of workers increases the portion to 67.6%.

ASSUMPTIONS REGARDING GROUP ANNUITY BENEFITS

The basis for mortality used in the calculations is that in current use by most insurance companies. However, it is projected assuming very substantial improvement in mortality. If the emerging mortality proved to be higher than projected, larger retirement benefits could be provided for the same amount of premiums.

The interest rate used is a net interest rate after making provision for administrative expenses. For most insurance companies, the return on new investments made during 1966 exceeded 5½% after investment expenses. At the beginning

of this decade the correpsonding rate was over 5¼%. A fairly recent development which could increase investment returns is the establishment of separate accounts for pension business with substantial investment in common stock. It is, of course, impossible to predict investment returns far into the future, but it is unlikely that the abnormally low rates of the 1930's and 1940's will return, barring a corresponding depression or war.

The relationship between expenses and investment income will vary from plan to plan depending on size of plan, degree of funding and services rendered. For current levels of funds for all insured plans combined, an investment return of ½% corresponds to an expense charge of more than 5% of premiums. As funds mature, ½% of income would be equivalent to an expense charge of a correspondingly greater proportion of premiums.

On balance, it seemed appropriate to use 4¾% to represent investment returns at current levels, after allowance for administrative expenses, in Table 1. Table 2 is based on the same assumptions as Table 1 except that the wife's benefit under Social Security is included.

TAXES TO BE USED IN COMPARISONS

In each table, columns have been prepared showing the benefits which could be privately purchased with the appropriate portions of the taxes on the employee and the employer and on the self-employed individual. The enactment of H.R. 12080, H.R. 5710, or comparable legislation would mean that the self-employed would have a reduction of their income by the amount of the tax increase and that there would be a corresponding reduction in the amount available to provide for their own retirement. In the case of employees, the amount available to provide private retirement benefits is reduced by the additional taxes on employees and employers as well. If the taxes were not increased, the employees and employers would have the option to use an equivalent amount of money to provide additional private plan retirement benefits. It is particularly appropriate to take into consideration the proposed increase in employer tax, as well as that of the employee, since private plans are largely financed with employer contributions.

AGES AT WHICH BENEFITS COMMENCE

In all of the tables the benefits shown are the full benefits which would be paid only after reaching age 65. The average age at which benefits are actually first paid is currently age 67 for Social Security beneficiaries, largely because of the earnings test. The benefits shown for private plans begin at age 65. If they were calculated to begin at age 67, they would be about 20% higher than the amounts shown in the tables. If the increases in Social Security benefits were calculated to begin at age 67, they would be no higher under H.R. 12080 and slightly less than 8% higher under H.R. 5710.

The CHAIRMAN. Thank you very much.

The next witness is Mr. Clarence Mitchell, director of the Washington bureau of the National Association for the Advancement of Colored People.

Mr. Mitchell, I am sorry to have kept you so long today.

STATEMENT OF CLARENCE MITCHELL, DIRECTOR, WASHINGTON BUREAU OF THE NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE

Mr. MITCHELL. Thank you, Mr. Chairman, for your fortitude. You have been under quite a siege here.

With your permission, I would like to file my statement and summarize it. I appear primarily, Mr. Chairman, to express objection to the amendment which was added in the House committee that freezes the number of children who would benefit under the AFDC program. I think the amendment was handled in a way that we usually handle

things around here in Washington. People began to get nervous about complaints from the taxpayers on the large number of people on this program. There was sent out a big chart showing how the number of children had increased over the years. I think it has a little of a racial overtone, too. You know, sometimes people drive through colored neighborhoods and they see a whole lot of colored people standing around on corners and assume they are all idlers and are just on relief and that kind of thing. So that it is my judgment that the House more or less was forced into a position where it had to pass the bill in this form or not get anything.

As you know, it was handled under a closed rule.

I would just like to point out what I consider one of the absurd possibilities that can happen if we don't do something about this.

On page H10669 of the Congressional Record of August 17, the authors of the bill—in an attempt to justify what they had done—the authors of the amendment pointed out that in New York under their plan, it might be entirely possible for 6,200 more children to go in under this freeze than they now have, because of the population increase. My question would be: What happens to the 6,201st child?

You get into a situation where maybe you can have an increased number, but it is unjust because inevitably some child is left out.

Then over on page H10780 of the Record, that same page, there is a very interesting colloquy between Chairman Mills and Congressman Burton of California. Mr. Burton points out that under the arrangement here which requires that the parents of children in this category accept work, it is entirely possible that the parent might be required to work for as little as 75 cents an hour.

In other words, undercutting the minimum wage law. In the colloquy, Mr. Burton asked the question of the chairman, isn't it quite likely that the parent might be required to work at a learner's rate of 75 cents an hour, and the answer given by the chairman of the committee is, "Yes, that is possible."

Well, I think we don't want that kind of situation to develop in this country where we undercut the minimum wage law in trying to meet some other kind of a problem.

I know, Mr. Chairman, you have a very deep interest in these matters, and I urge that you look at it with your usual humanitarian concept. I would like to point out that in my testimony, I mentioned that in this country we are very careful to make sure that we don't do hazardous experimenting with things that affect the welfare of our farm animals, pigs, cattle, things of that sort. We don't even do a whole lot of experimenting with our pets, dogs, canaries, and that kind of thing.

After I wrote that testimony, this morning as I was leaving home, I happened to remember that I had better feed the dog and I opened one of these real pretty packages, I think they are called Gaines Burgers, or something like that. I don't know whether you have ever seen them, but they are real nice looking stuff. It looks like hamburger. Well, on this package there was the statement which said:

This is processed under the continuous examination of the United States Department of Agriculture.

I am sure if somebody started experimenting with that dog food and saying that you don't give it to brown dogs or dogs of uncertain ancestry and that kind of thing, you would have a big hullabaloo in this country. I think that we ought to be just as concerned about experimenting with the lives of our children and the future of our children as we are about experimenting with the welfare of pets, and even more so.

I want to thank you very much for giving me this opportunity to appear, Mr. Chairman.

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

One thought that occurs to me is that there are things we could do at the Federal level to help see that fathers discharge their duty toward their children, rather than simply calling upon the mothers to try to find the father, and to sue him for support. They are things we could do ourselves. Tax him and use that money to help the mothers and children, particularly that man's own children. Do you have any objection to that type of approach?

Mr. MITCHELL. As a lawyer, I couldn't object to it. As you know, it is the weight of authority in the common law States and I suppose it is so in your State. The father is responsible for taking care of his minor children, and I certainly think we ought to do everything possible to hold the father to his responsibility. I don't think we ought to do anything to let fathers get out from under that, but as you know, under the existing law, at least the way the existing law is administered, and under this proposal to some extent, there are various kinds of escape hatches for the father.

For example, in this law it is suggested that if the father doesn't do his duty, that there is an emergency arrangement under which the children can be taken care of. Well, I think there would be a whole lot of fathers who are irresponsible who will take advantage of that emergency procedure.

I think also that while you wait for that emergency procedure to go into effect, you might very well have a lot of suffering among the children.

The CHAIRMAN. My thought is that between the two approaches, rather than having a cutoff of assistance for a child because his father is irresponsible and leaves the State, it leaves us no other choice but to: one, say that the mother must make every effort to make the father do his duty; and, two, to say that if she is unable to do so and society pays, we might want to put the Government in the business of finding those fathers and collecting either what they owe, or a substantial portion of it, and providing for the children or working out some scale by which those funds could be used to supplement the assistance available to those children. That way we are not left with two answers, neither one of which is satisfactory.

Now when I was a young lawyer practicing law, on occasion I tried to chase down a father to try and get some money out of him for his wife with very little success. All he had to do was leave town and it just didn't cover the expenses of a private lawyer to try to follow him around. It seems to me that through the Social Security Administration we can set up a system where we can find these people and tax them if we cannot do any better, to get some money for their children.

Another thought that occurs to me is that we can work out a better provision, I think, to help make use of people who are unemployed, who cannot find work, to provide some jobs for them on the basis that they won't lose their welfare payments entirely, if they supplement them one way or the other.

You can look upon it as supplementing their private earnings with welfare payments or supplementing their welfare payments with private earnings. I think there is a possibility that we ought to explore those ideas so as to encourage people to work; to find jobs for them, and put them in the best jobs we can find at the time and hope that we will get something better.

Mr. MITCHELL. I think that point came up this morning. I was very interested in your exchange with Mayor Lindsay about supplementing the income, and I agree with the idea. One of the things that we are troubled with today is the honest person who wants to work, but who cannot make enough to support her family or his family. Therefore he or she has to be on relief. Then you do have a situation where they actually cannot take jobs for fear that they will lose relief, or if they take a job and get off relief temporarily, they have so much trouble getting back on that it is a real hardship. Now, that happens right here in Washington.

I have felt as I listened to your discussion that surely there must be a solution if we approach it in the spirit that you are approaching it, in which we make it possible for honest people to work to get an income and at the same time not place their families in jeopardy because they aren't making enough money.

I think also we don't want to open the door for unscrupulous employers who might be just trying to take advantage of somebody because he is down on his luck and that kind of thing. But as I say, if we approach it in the spirit that was evidenced this morning, I would think we ought to be able to settle it.

The CHAIRMAN. Thank you very much.

(The prepared statement of Mr. Mitchell follows:)

STATEMENT OF CLARENCE MITCHELL, DIRECTOR, WASHINGTON BUREAU OF THE NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE

Mr. Chairman and members of the Committee, I am Clarence Mitchell, director of the Washington Bureau of the NAACP. When H.R. 12080 was before the House our organization expressed strong opposition to Section 208 which freezes, for the purpose of Federal matching, the rate of dependency for children with a parent absent from the home. As you know, the House considered this bill under a closed rule. This prevented the offering of amendments to strike out the freezing provision. We strongly urge that the Senate eliminate the freezing language.

As we understand the House bill, it contains a number of measures designed to reduce dependency through employment. The three most important of these are requirements that the States provide work training, day care and work incentives through earned income exemptions. States are encouraged by favorable Federal matching to use these new provisions to full advantage.

It is our understanding that the limitation on Federal participation in AFDC is aimed at providing an additional, much stronger incentive for states to reduce dependency through a constructive employment program. Under the bill, the proportion of all children under age 21 who were receiving AFDC in each state in January 1967 because of the absence of a parent could not be exceeded for Federal participation after 1967.

As our population increases and our society becomes more complex, it is increasingly difficult to provide remedies for the numerous social problems that

affect the poor. It is also more difficult for the poor and the deprived to express their grievances and obtain redress for such grievances.

Faced with the mounting costs of public welfare programs, our country is confronted with irate taxpayers who demand that the costs be cut. The freezing amendment in this bill is a response to that demand. On the other hand there is also a growing demand from those who have long suffered in silence because they did not know how to express themselves. These are the victims of overzealous social work investigators, the persons whose homes are invaded by amateur sleuths in search of adult male residents or who are deprived of their self respect through unwarranted probes of their private lives.

We can set up an arbitrary system of saving money as has been done in the House passed bill. This will satisfy some of the tax payers, but it may cost more in the long run because of increased tensions nad frustrations among the poor and the deprived. Surely, it is better to carry on our experiments in cost reduction in a manner that will move the poor back into the main stream of prosperity without causing undue hardship in the process.

The House amendment to H.R. 12080 denies assistance to those least responsible for their plight—the children who happen to be in the class covered by the cut-off formula.

A very sensible observation on this point was made by Representative Charles Vanik of Ohio. The following is his comment which appears on page H 10698 of the *Congressional Record* for August 17, 1967:

"Coupled with the planning for employment is a limitation that I believe is most unfortunate. This says flatly to the states that if the number of children with absent parents who require assistance grows at a more rapid rate than the child population of a state, the Federal government will not participate on behalf of the additional children. This arbitrary cut-off penalizes states and will probably be most acutely felt in the large cities where this type of dependency occurs. If the training and job placements work, then there should be a leveling off and possibly a decline in the number of recipients of aid. In this event, the limitation is unnecessary and would be inoperative."

If we follow Mr. Vanik's reasoning we avoid the risk of having children suffer from hunger and other kinds of privation while some well meaning but unproductive experiments on employment are being tried out. We are a great and a rich nation. We spend millions on research and experiments in government and in private industry to improve the living conditions of farm animals and even domestic pets. However, we do not stop existing expenditures or programs for the care of these creatures until we know that the proposed ideas will work. The children of our country do not deserve to be handled more arbitrarily and callously than we handle our cattle, pigs, dogs, cats and pet canaries.

The lives of Americans who will help to guide the future of our nation are too valuable to be left to develop under harsh and unfavorable conditions that will be created by regulations and requirements that arbitrarily reduce benefits to children who have the misfortune of being in a home where a parent is absent. We ask that the House amendment be deleted.

(Whereupon, at 6:05 p.m., the committee adjourned until Monday, September 18, 1967, at 10 a.m.)

SOCIAL SECURITY AMENDMENTS OF 1967

MONDAY, SEPTEMBER 18, 1967

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

The committee met, pursuant to notice, at 10 a.m., in room 2221, New Senate Office Building, Senator Fred R. Harris, presiding.

Present: Senators Harris, Talmadge, Williams, Carlson, and Curtis.

Senator HARRIS. The committee will be in order.

Today we begin the final week of hearing public witnesses on H.R. 12080, the Social Security Amendments of 1967. This phase of our work ends on Friday, September 22.

Next week, the Secretary of Health, Education, and Welfare, and his staff returns for a wrap-up round of questioning by committee members before we move into closed-door session and begin our mark-up of the bill.

We have quite a lengthy witness list for today, and indeed for the rest of the week. All witnesses are under time limitation on their oral statements; and out of respect for later witnesses and for the committee, I hope that all statements will be carefully confined to the time limits allotted.

Our first witness this morning is Paul P. Henkel, chairman, Social Security Committee Council of State Chambers of Commerce. Mr. Henkel, we are glad to see your organization represented at this hearing. You may have a seat, sir, and we will be glad to hear from you at this time.

STATEMENT OF PAUL P. HENKEL, CHAIRMAN, SOCIAL SECURITY COMMITTEE, COUNCIL OF STATE CHAMBERS OF COMMERCE, ACCOMPANIED BY WILLIAM F. BROWN, ASSOCIATE RESEARCH DIRECTOR

Mr. HENKEL. Mr. Chairman, and members of the Senate Finance Committee. My name is Paul Henkel. I am manager of payroll taxes of Union Carbide Corp. of New York. I am chairman of the Social Security Committee of the Council of State Chambers of Commerce, and I am appearing on behalf of 29 members State chambers which are listed at the end of our statement as endorsing our statement. Appearing with me is Mr. William R. Brown the associate research director of the council.

We thank the committee for the opportunity to appear at these public hearings on H.R. 12080, and we request permission to offer our full statement for the record and to compress our oral presentation within the allotted time.

Senator HARRIS. Without objection that may be done.

Mr. HENKEL. Thank you, sir.

At the outset we wish to state that the Council of State Chambers of Commerce believes that some increase in social security benefits should be enacted and that a new and different approach should be adopted in an attempt to solve our nationwide public welfare problems.

In appearing before the House Ways and Means Committee on the matter of H.R. 5710, we stated that benefits should be increased no more than 8 percent, without adopting a cost of living automatic escalator, and without increasing the maximum taxable wage base about $6,600. We expressed our opposition to—

(1) the enactment of greater benefit increases which could lead to annual appropriations being required from general revenues;

(2) the extension at this time of Medicaid Health Insurance to disabled persons under age 65;

(3) the Federal income taxation of social security benefits; and

(4) the further extension of Federal financial aid and control of benefits levels in Federal-State categorical aid programs.

The overwhelming House vote of 415 to 3 in passing H.R. 12080 in our opinion represents due regard for some of the criticisms and objections voiced by us. H.R. 12080 is in most respects more acceptable than was H.R. 5710; however, we continue to oppose those aspects of the current bill which are not in accord with our views and objectives.

H.R. 12080 would provide a 12½-percent benefit increase which does more than take into account the 7.7-percent increase in prices or the 10-percent increase in wages that have taken place since benefits were last adjusted in 1965. We do not agree that the benefit increase should exceed the relative increase in prices or cost of living. Also, we do not agree that the relative increase in wages should be a valid measure for a proposed benefit increase.

In our prepared statement on pages 4 and 5 and in exhibits I to III, we estimate that an 8-percent benefit increase would add $9.9 billion in costs over the next 5 years ending in 1972. H.R. 12080, providing a 12½ percent benefit increase, would add $17.9 billion in costs over that period. It would raise $8.5 billion new social security taxes, and yet, because of the $17.9 billion in new costs, it would reduce the excess social security tax collections over that period from $31.5 billion to $22.1 billion. We contend that an 8-percent benefit increase and a retained $6,600 taxable wage base would effect the same reduction in excess tax collections and would avoid raising $8.5 billion in new social security taxes. We ask why $8.8 billion in new social security taxes are being sought at the same time when Federal income tax surcharges and other tax changes amounting to $17 billion are being sought and when there appears to be a mere token administration and congressional action to reduce Federal spending?

We object to the proposed 0.4-percent reduction in the OASDI combined employer-employee tax rate in 1969 and 1970. A decrease in the tax rate and an increase in the taxable wage base is the reverse of the policy espoused by the Council.

We continue to maintain that an 8-percent benefit increase is reasonable at this time, and that it can be financed under the $6,600 taxable wage base, and we object to its being raised to $7,600.

We do not oppose the disability insurance amendments proposed in H.R. 12080. We support the concern of the House Ways and Means Committee over the extension by judicial decisions of the definition of disability. We agree there is need for a stricter definition.

In our prepared statement on pages 5 through 8, we have discussed the effect of H.R. 12080 on young and high-wage employees and on business and industry. We contend that although H.R. 12080 is not as costly or disadvantageous as H.R. 5710, it may still lessen the popularity of the social security program among these employees. The added tax costs of H.R. 12080 will continue to fall more heavily upon the younger people, and this burden will increase with each successive benefit increase that will be enacted in the future.

We believe that a private retirement annuity could be more advantageous to a single person than would social security benefits as proposed in H.R. 12080. We also believe that many younger persons—even those with families—would rather have the options of obtaining greater cash wages, or the equivalent in fringe benefit private retirement annuity purchases, or more disposable income, rather than having the additional tax burden mandated by H.R. 12080. In comparing private retirement annuities with social security, the fact that H.R. 12080 is less disadvantageous should be a caution against adopting the benefit increases proposed in H.R. 5710.

After 1970, the major share of the added burden of H.R. 12080 will be borne by those earning more than $6,600—those whom we feel not reap a commensurate benefit.

The 1965 amendments to the Social Security Act lifted the 1966 maximum tax per employee 60 percent over 1965. If H.R. 12080 is enacted, by 1969—a little more than a year away—the maximum tax per employee will be increased 109 percent over 1965. We feel this is a significant and vital comparison, especially as wage increases are bringing so many employees to or above the maximum taxable earnings. This can mean an alarming jump in employer costs, especially for those employers paying high wages.

We do not agree with those who claim that social security taxes are an insignificant portion of an employer's total costs. Total costs have been mounting because of an aggregate of "insignificant" as well as significant increases in virtually all components of costs. We do not share the view held by others that employers will be able to pass all of the cost increases to the consumer. We believe they more probably will offset earnings and profits and will reduce incentives and the ability to expand business and create jobs.

We wish to reiterate our apprehension expressed to the House Ways and Means Committee that some social security and tax planners seem to be working—perhaps unwittingly—toward the objection of replacing private pension plans with a single overall social security program. In this respect, we would call attention of this committee to the views of Mr. Robert Tyson, chairman of the finance committee of United States Steel Corp., as expressed in his address to the Council of State Chambers of Commerce last Wednesday, September 13. A copy of his address will be attached for the record if it is satisfactory, sir.

Senator HARRIS. Without objection that will be done. (See p. 1283.)

Mr. HENKEL. In it he voices the same apprehension over the growing competition between private programs and social security, over

mounting social security tax costs, and over the diminishing value of social security to the young people.

In our prepared statement on pages 8 and 9, we again voice two concerns which we expressed to the House Ways and Means Committee. The first relates to the combined effect of a social security and an income tax increase on the middle-income taxpayers, and to our contention that certain segments of this vast group will lose the effect of the 1964 Federal income tax reduction. The second relates to the alarming increase in State and local taxation and to our contention that its burden again falls heavier on the middle-income taxpayers. In support of our concerns, we have attached hereto as appendixes A and B, two relevant and cogent articles from the U.S. News & World Report. One article published August 28, 1967, is entitled "Tighter Squeeze Ahead on Middle Incomes." The other, published August 21, 1967, is entitled "The Big Tax Spree in the United States." We believe these two concerns cannot and must not be ignored by the Congress.

Senator HARRIS. Without objection both articles will be made a part of the record. (See p. 1278.)

Mr. HENKEL. Thank you, Mr. Chairman.

The public assistance amendment of title II of H.R. 12080 impose new Federal controls and expand the scope of Federal financial participation under the AFDC program. Although we deplore this extension of control, we support wholeheartedly the new thrust and direction in public welfare programs developed by the House Ways and Means Committee. We recognize that the tremendous and unexpected growth in numbers of AFDC program recipients—particularly in our large urban centers—justifies to some extent the need for such controls for the immediate future.

The training of employable welfare recipients has long been considered by employers to be more desirable than the mere continuation of assistance payments. Throughout the country, employers already will be found cooperating with and aiding authorities and other groups in training and basic education programs.

Criticism has been leveled at the new direction as being repressive and at the appropriations as being inadequate. We suggest this criticism may not be in line with the mainstream of public opinion. The earnings offset against public assistance payments has been criticized as promoting a disinclination to work. We would mention that with the total tax burden approximating 30 percent of income—and destined to increase substantially—the same disinclination to work or the disinclination to support public welfare appropriations may occur among the taxpayers.

The proposal to deny public assistance if work or training is refused or avoided also has been criticized. We see nothing wrong in this proposal. Its counterpart is found in every State unemployment insurance law. If assistance can be denied a person normally in the labor force, it should be denied a person who prefers to remain on welfare rolls. We believe this proposal is a refreshing change. We see it as a negation of the attempt to establish an absolute or constitutional right to welfare payments or to a guaranteed income.

The proposed new safeguards for children in undesirable homes, their protection against wayward parents, the provisions for day care

centers to help employable mothers on AFDC rolls, the earnings incentive for working mothers and children under age 21, the community work and training programs—all are experimental but laudatory objectives. We recognize that there will be increased costs and appropriations needed at both Federal and State governmental levels; but we feel the objectives and the additional human value to be achieved outweigh these costs.

We believe the House Ways and Means Committee has taken bold and meaningful action in these problem areas and has taken precautions to contain costs and appropriations within reasonable limits.

We support section 208 of H.R. 12080 which will limit Federal financial participation in the AFDC program to the proportion of each State in January 1967 of children under age 21 receiving aid on the basis of an absent parent to all children under age 21.

We also support section 220 of H.R. 12080 which will limit Federal participation in State medical assistance programs to families whose income does not exceed applicable income levels.

Both sections 208 and 220 of H.R. 12080 have formulas which have provoked criticism. Modification of the formulas may be appropriate, but we hope that any modification will not destroy the import and intent of these sections.

To summarize, we support an 8-percent social security benefit increase. We oppose a greater percentage increase at this time and we oppose an increase in the maximum taxable wage base. There are other tax and non-social-security problems that cannot be ignored and social security benefits and financing cannot be considered in a vacuum. We are concerned about compounding the future tax liabilities upon future generations without their consent. We are vitally concerned with the growing overall tax burden on our present taxpayers. We feel our concern is direct—not remote—for these taxpayers are our customers, our clients, our employees, and stockholders. We urge this committee to support the decision of the House of Representatives that more tax money is not the only viable solution to our public welfare problems.

Thank you, gentlemen.

Senator HARRIS. Thank you, Mr. Henkel, you have set forth your position very well.

Senator Williams?

Senator WILLIAMS. Mr. Henkel, just one question: We all recognize that as we increase the benefits under the social security program we automatically increase the costs, and the costs are financed by taxes—by increased taxes.

Now my question is: To the extent that it is decided that an increase in tax is necessary to finance whatever increased benefits may be agreed upon, would you recommend that the tax increase be effective the same date as the benefits?

Mr. HENKEL. I believe so, Mr. Williams. We feel they should be currently funded.

Senator WILLIAMS. The practice has been for it too often, as you well know, to increase the benefits ——

Mr. HENKEL. And to postpone the increase in taxes.

Senator WILLIAMS. And to postpone the increase in taxes; and I won't say with any intent necessarily, but it just so happens that the

benefits always go into effect before the election and the tax increasings into effect after the election. Don't you think it would be a healthy situation to have whatever tax is going to be necessary to finance the benefits that are going to be approved by the Congress that all of the people, the taxpayers and the beneficiaries, all know exactly what the cost is and have all of that effective the same date?

Mr. HENKEL. I agree, sir. It is most important that they correlate benefits to taxes.

Senator WILLIAMS. Thank you.

Senator HARRIS. Senator Carlson?

Senator CARLSON. Mr. Henkel, I want you to know I appreciate very much your statement here this morning. I think you called our committee's attention this morning to some problem we should stop and take a look at before we enact the proposed legislation and particularly some of the proposed amendments, and I want to commend you particularly for this section you wrote on the possible effect of H.R. 12080 on young and middle-income employees.

I find among our young people there is getting to be ever-increasing concern about the increase in rates, the tax base, and so I think that it is time we stop and look at this in order that we do not get a program here that will not at least bring benefits to these young people, who are at the age of raising families, educating families, who will not be discouraged and they will want to be removed from the program. Did you hear any of that where you meet people?

Mr. HENKEL. Sir, in my capacity I have quite an opportunity to talk to employees at all levels, all echelons, and I am particularly concerned with the expression of frustration that I hear from them at the mounti g tax problem. I can't accentuate it enough. I think, Senator, that it is a tremendous problem, and it can't be overlooked.

Mr. BROWN. In this connection, Senator, I think we might add that when you increase payroll taxes you add pressure on the part of employees to try to offset that with increased wages, and this adds further inflationary pressure, and the whole thing accentuates the vicious circle we are in in this country today with our economic problems.

Senator CARLSON. Mr. Brown, I had, last week, a petition from a junior chamber of commerce at Derby, Kans., 92 members, in which they were wondering if it would not be possible to have a voluntary type of insurance program providing some of those younger folks did not want to participate in the Federal social security program, and that was one of the things that led me to make this statement. I think that the junior chamber of commerce is beginning to get concerned nationally, as this one locally did, with 92 members, and that we ought to take a second look at it.

I would ask, Mr. Chairman, that Mr. Henkel's statement on page 7 of two paragraphs be made a part of these remarks at this time. I won't read it into the record at this time

(The information follows:)

We find that 72 percent of the additional combined taxes payable under H.R. 12080 would amount to $3,721.29. This would accumulate at 4 percent interest to $9,984.37 in the year 2013. This accumulation would provide a private lifetime benefit of $81.18 per month. This is almost double the increase in Social Security benefits of $44 per month that would be provided under H.R. 12080. We recognize that, given the same accumulation, a monthly benefit under a private joint

and survivor annuity would be less than the increase in the man and wife's benefit provided in H.R. 12080.

Certainly, when compared with private retirement annuities, H.R. 12080 is less favorable to a single individual, but it is more favorable in such a comparison than was H.R. 5710. We believe that many younger persons—even those with young families—might rather have the options of obtaining either greater cash wages or the equivalent in private retirement annuities rather than having the additional tax burden that would be mandated by H.R. 12080. As H.R. 5710 is more disadvantageous than H.R. 12080 in these comparisons, we submit this should be a caution against adopting the benefit increases proposed in H.R. 5710.

Mr. HENKEL. Thank you, Senator.

Senator HARRIS. Senator Curtis has just come in. I wonder if you would have any questions of Mr. Henkel, who is chairman of the Social Security Council of the State Chambers of Commerce?

Senator CURTIS. I have none, but I assure you I will read your statement.

Senator HARRIS. Thank you.

(The prepared statement of Mr. Henkel, with attachments referred to, follows:)

SUMMARY OF TESTIMONY BY PAUL P. HENKEL FOR THE COUNCIL OF STATE CHAMBERS OF COMMERCE

1. *Support of benefit increase.*—Sufficient to compensate for the increased cost of living. An 8% increase will do this and will require no increase in the taxable wage base because of greater than anticipated revenues from current tax schedules. Any increase in benefits greater than 8% should be limited to that which can be financed through an increase in tax rates rather than an increase in the taxable wage base. Care should be taken to avoid benefit increases that will lead to general revenue financing which would be contrary to the basic wage-related social insurance principles of Social Security. These basic principles should not be endangered by making the Social Security Program into another "poverty" effort.

2. *Support House approved disability definition.*—Agree that there is a need for a stricter definition of disability, as a result of judicial decisions.

3. *Taxable wage base increase discriminates against middle income taxpayers.*—No increase in the taxable wage base is necessary or desirable at this time. The $7,600 proposed in the House is less objectionable than the $7,800, $9,000, and eventual $10,800 proposed by the Administration. But any increase in the taxable wage base would discriminate against middle income taxpayers who are being hit hard by increased and new State and local taxes and now face the prospect of increased Federal income as well as payroll taxes. While the middle income taxpayers would potentially be entitled to greater benefits as a result of increasing the taxable wage base, the increased benefit is not proportionate. This is especialy true when the tax the employer pays is also taken into consideration and it should be since the employer logically considers this an employment cost which might otherwise be spent on wages or other fringe benefits. Young families especially might well prefer greater wage and private fringe benefits to increased taxes.

4. *Increasing the taxable wage base would adversely affect the economy.*—Business is facing a worsened cost-price squeeze which is forcing up the prices of consmer goods. Not only will increasing the taxable wage base at this time add to the pressure for increased prices directly through higher tax costs, but it also will add to the wage demand pressure in order to offset increased employee tax costs. Also to the extent that business is not able to pass the increased cost on the consumer, there will be less money for business expansion to create more jobs.

5. *Danger of discouraging private pension plans.*—Too inclusive, generous, and costly Social Security liberalizations can lead to the replacement of private pension plans by a single overall Social Security Program. This would result if Social Security taxes should become so burdensome and the benefits so generous as to discourage private plans.

6. *The combined effect of proposed Social Security and income tax increases would be especially hard on middle income taxpayers.*—Some middle income tax-

payers would lose all benefit of the 1964 Federal income tax reductions which in many cases have already been more than offset by moves into higher tax brackets and increased State and local taxes.

7. *Regret the necessity for extension of Federal controls over State Welfare Programs.*—But, support wholeheartedly the objectives of H.R. 12080 in aiming to make welfare recipients more self-sufficient through training and employment. The requirement for appropriate recipients to accept jobs has a long time precedent in every State unemployment benefit law in the country.

8. *Support provisions in H.R. 12080 limiting Federal financial participation in State Medical Assistance.*—

The following State Chambers of Commerce have endorsed this statement:

Alabama State Chamber of Commerce
Arkansas State Chamber of Commerce
Colorado Assn. of Commerce & Industry
Connecticut State Chamber of Commerce
Delaware State Chamber of Commerce
Florida State Chamber of Commerce
Georgia State Chamber of Commerce
Idaho State Chamber of Commerce
Illinois State Chamber of Commerce*
Indiana State Chamber of Commerce
Kansas State Chamber of Commerce
Kentucky Chamber of Commerce
Maine State Chamber of Commerce
Michigan State Chamber of Commerce
Mississippi State Chamber of Commerce
Missouri State Chamber of Commerce
Montana Chamber of Commerce
New Jersey State Chamber of Commerce
Empire State Chamber of Commerce
Ohio Chamber of Commerce
Pennsylvania State Chamber of Commerce
South Carolina State Chamber of Commerce
Greater South Dakota Association
East Texas Chamber of Commerce.
West Texas Chahmber of Commerce
Lower Rio Grande Valley Chamber of Commerce
Virginia State Chamber of Commerce
West Virginia Chamber of Commerce
Wisconsin State Chamber of Commerce

Cooperating Organization: Utah Legislative Conference.

STATEMENT OF PAUL P. HENKEL ON BEHALF OF THE COUNCIL OF STATE CHAMBERS OF COMMERCE

Mr. Chairman and Members of the Senate Finance Committee, my name is Paul Henkel. I am Manager of Payroll Taxes for Union Carbide Corporation. I am Chairman of the Social Security Committee of the Council of State Chambers of Commerce and I am appearing on behalf of the member State Chambers of Commerce of the Council which are listed at the end of this statement as having endorsed our statement. Accompanying me is Mr. William R. Brown, Associate Research Director of the Council.

We thank the Committee for the opportunity to appear at this public hearing on a matter of such broad scope and importance.

At the outset, we wish to state that the Council of State Chambers of Commerce believes that some increase in Social Security benefits should be enacted and that a new and different approach should be adopted in an attempt to solve our nationwide public welfare problems.

It might be helpful to summarize the position of the Council stated before the House Ways and Means Committee when it was studying the Administration's Social Security proposals in H.R. 5710. We stated that benefits should be raised

---

*In general agreement with statement. Plans to file a supplemental statement on certain public assistance provisions.

not more than 8% without adopting an automatic "cost of living" escalator and without raising the maximum taxable wage base above $6600. We stated further that any greater increase in benefits at this time should be limited to that which could be financed through an increase in tax rates rather than an increase in the taxable wage base. We expressed opposition:

—to the enactment of greater benefit increases which could lead to annual appropriations being required from general revenues;

—to the extension at this time of Medicaid Health Insurance to disabled persons under age 65;

—to the Federal income taxation of Social Security benefits; and

—to the further expansion of Federal financial aid in and control of benefit levels in existing Federal-State categorical aid programs.

The House Ways and Means Committee made an exhaustive study of H.R. 5710, holding three weeks of public hearings and sixty-four executive sessions. That Committee performed a remarkable task in developing H.R. 12080 and we are mindful and appreciative of that fact. The overwhelming House vote of 415–3 in passing H.R. 12080 in our opinion represents due regard for some of the cautions and objections voiced by us. H.R. 12080 is in most respects more acceptable and palatable than was H.R. 5710. However, we continue to oppose those aspects of H.R. 12080 which are not in accord with our viewpoints, policies and objectives.

Increases in social security benefits

H.R. 12080 would provide a 12½% increase in benefits. This does more than take into account the 7.7% increase in prices or the 10% increase in wages that have taken place since benefits were last adjusted in 1965. We do not agree that the proposed increase in benefits should exceed the relative increase in prices or costs of living. Moreover, we do not agree with the contention that benefit increases should equal or exceed relative wage increases. H.R. 12080 would accomplish the latter. It has been contended that the past employment of the current beneficiaries has contributed to the affluence of our present society and they therefore should share in this affluence through excessive increases in Social Security benefits. This contention does not square with the wider-held view—which we share—that benefits should be related to past earnings, and if necessary, should be adjusted periodically to reflect changes in living costs.

We are not unaware of the claim that Social Security benefits are inadequate in many instances. We believe that there are other existing programs that should be relied upon for supplementation, viz.: the Old Age Assistance Program and state welfare programs.

There is attached to our statement Exhibit I which presents a summary of the short range estimates—for years 1968 through 1972—of the OASI and DI trust fund operations.[1] It shows that the 12½% benefit increase will add $17.9 billion to present costs over the next five years.

We estimate that an 8% increase in benefits would increase the benefit and administrative expense costs by only $9.9 billion over the next five years—a reduction in costs of approximately $1.6 billion a year. We believe an 8% increase could be accomplished with an approximate benefit formula of:

68% of the first $110 of the average monthly wage,
24.5% of the next $290,
23.1% of the next $150.

We have attached Exhibit II which displays a comparison of the effect of an 8% and a 12½% benefit increase on the benefit formula and on the 5-year costs. We have also attached Exhibit III which displays selective monthly primary insurance amounts obtainable under an 8% and 12½% benefit increase. You will note that an 8% benefit increase would provide a currently available range in the monthly primary insurance amount from a minimum of $50 to a maximum of $153.40. The ultimate maximum monthly benefit of $181.50 would be obtainable in the year 2005. We believe this would be a reasonable benefit increase at this time.

Social security disability insurance benefits

We do not oppose the disability insurance amendments proposed in H.R. 12080. We are particularly interested in the concern of the House Ways and Means Committee over the extension by judicial decisions of the definition of disability.[2] We agree that there is a need for a stricter definition.

[1] Source: Tables IV and V, pages 90–91 and page 131, House Report No. 544.
[2] Pages 28–31, House Report No. 544.

The taxable wage base

We continue to maintain, as we did before the House Ways and Means Committee, that the taxable wage base need not be increased above $6600 in order to finance an 8% benefit increase. We do not agree that a $7600 wage base proposed in H.R. 12080 is necessary at this time.

We wish to mention, too, our objection to the proposed .4% reduction in the OASI combined employer-employee tax rate in 1969 and 1070. This of course will postpone the impact of a $7600 wage base. Perhaps, too, this move has been made in anticipation of, and to mitigate the effect of, the expected temporary Federal income tax surcharges. In any event, concerning the financing of social security, an increase in the wage base and a decrease in the tax rate is the reverse of the policy of the Council.

You will note on our Exhibit I that over the next 5 years the present law will provide $155 billion in taxes and will pay $123.5 billion in benefits. This will result in $81.5 billion excess Social Security tax revenue that will be used for other governmental spending purposes.

Over the next 5 years, H.R. 12080 will provide $163.5 billion in taxes—an increase of $8.5 billion; it will pay $141.4 billion in benefits—an increase of $17.9 billion; and excess Social Security tax revenue will be $22.1 billion—a reduction of $9.4 billion.

We have indicated on Exhibit II that an 8% benefit increase might cost $9.9 billion more over the next 5 years. If the taxable wage base of $6600 were to be retained, and the benefit increase were to be held to 8%, this combination would also reduce excess Social Security tax collections over the next 5 years to $21.6 billion.

Essentially, therefore, H.R. 12080 collects $8.5 billion more in additional taxes (and relies in part on present taxes to the extent of $9.4 billion), to provide $17.9 billion in additional benefits. Yet there is still a $22.1 billion cushion remaining at the end of the 5-year period. The same result could be obtained under our recommendations—increasing benefits by 8% and retaining the $6600 taxable wage maximum.

We ask why $8.5 billion additional excess Social Security taxes are being sought under H.R. 12080 when Federal income tax surcharges and other tax increases totaling $17 billion are being sought at the same time, and when there appears to be mere token action by the Administration and the Congress to reduce Federal spending?

Possible effects of H.R. 12080 on young and middle-income employees

We believe that the tax costs of H.R. 12080 may tend to lessen the popularity of the Social Security program among the young and middle-income employees.

Under H.R. 12080, the additional taxes to be collected through 1970 will be derived solely from wages and self-employment income in excess of $6600. The major advantage will not be reaped by those who will bear the added tax burden. Thereafter, the added tax costs under H.R. 12080 will continue to fall more heavily upon the younger people—and this burden will increase with each successive increase in scheduled benefits which will be enacted in the future. This is why we continually have urged moderation in liberalizing benefits under the Social Security program.

The proponents of Social Security tax increases are prone to accentuate the accompanying increase in benefits but they minimize the postponement of such increases to the remote future. They minimize, too, the disparity in the benefit-wage replacement percentage which is advantageous at the lower end, and disadvantageous at the higher end, of the benefit schedule. The disadvantage at the higher end will be accentuated by the proposal to limit a wife's benefit to a stated dollar amount—$105. This proposal we oppose.

When we testified before the House Ways and Means Committee on H.R. 5710, we included data designed to show that disregarding disability and survivorship protection, a younger employee might accumulate a greater retirement through private annuities rather than through the payment of additional taxes. We cited this in line with our apprehension that H.R. 5710 tax costs could make the program less popular with the young people.

We found that the Social Security Administration considers disability and survivorship benefit protection to account for 28% of the costs of the OASDI program. Accordingly we have made a recomputation of the comparison between private retirement annuities and Social Security benefits—using for accumulation purposes only 72% of the additional combined employer-employee taxes that would be payable under H.R. 12080. We know the Social Security Administration takes the position that the employer tax does not accrue to a given employee's

benefit but it is considered to be paid to provide benefits generally. We disagree strongly with this position. Any employer can testify that an employee looks upon the employer Social Security tax as a payment to purchase his own "fringe benefit", and if this were not so, the employee would want the equivalent of the tax as a wage payment.

In making a recomputation, we assumed a person aged 21 in 1968 had maximum taxable earnings throughout his career until he attained age 65 in the year 2013.

We find that 72% of the additional combined taxes payable under H.R. 12080 would amount to $3721.20. This would accumulate @ 4% interest to $9,084.37 in the year 2013. This accumulation would provide a private lifetime benefit of $81.18 per month. This is almost double the increase in Social Security benefits of $44 per month that would be provided under H.R. 12080. We recognize that, given the same accumulation, a monthly benefit under a private joint and survivor annuity would be less than the increase in the man and wife's benefit provided in H.R. 12080.

Certainly, when compared with private retirement annuities, H.R. 12080 is less favorable to a single individual, but it is more favorable in such a comparison than was H.R. 5710. We believe that many younger persons—even those with young families—might rather have the options of obtaining either greater cash wages or the equivalent in private retirement annuities rather than having the additional tax burden that would be mandated by H.R. 12080. As H.R. 5710 is more disadvantageous than H.R. 12080 in these comparisons, we submit this should be a caution against adopting the benefit increases proposed in H.R. 5710.

The effect of H.R. 12080 on business and industry

The 1965 amendments to the Social Security Act lifted the 1966 maximum tax per employee 60% over the maximum in 1965. If H.R. 12080 is enacted, by 1969—a little more than a year away—the maximum tax per employee will have been increased 100% over 1965. We feel this is a vital and significant comparison—especially as wage increases are bringing so many employees to or above the maximum taxable earnings. This can mean an alarming jump in employer costs—particularly for the employers and industries paying high wages. We do not agree that it is valid to contend that Social Security tax costs are an insignificant portion of an employer's total costs and thus are bearable. Total costs have been mounting because of an aggregate of "insignificant", as well as significant, increases in virtually all components of costs. In fact, increases in payroll taxes of themselves create pressures for further wage increases.

We do not share the view held by some that employers will be able to pass all of the Social Security cost increases to the consumer. It is our view that they more probably will offset earnings and profits and will reduce incentives and ability to expand business and create jobs.

The effect of H.R. 12080 on private pension plans

We wish to reiterate our apprehension expressed to the House Ways and Means Committee that some tax and social security planners seem to be working—perhaps unwittingly—toward the objective of replacing private pension plans with a single, overall Social Security program. An overly-liberal Social Security program can endanger private pension plans whether or not they are integrated with the Social Security program. Integrated plans can be forced to provide greater pension benefits for the lower-paid employees at the expense of reducing benefits for higher-paid employees. Non-integrated private plan costs and rising Social Security taxes could become so burdensome that such plans might have to be discontinued. We contend this was not the original purpose, and should not be the future purpose, of the program.

The combined effect of social security and income tax increases

We pointed out to the House Ways and Means Commitee that the middle-income taxpayers would be the most disadvantaged group under H.R. 5710 and a 6% Federal income tax surcharge. The tax effect under H.R. 12080 is not as extreme as that under H.R. 5710; however, the income tax surcharge now being considered is 10%. Our contention is verified and updated by a recent article entitled "Tighter Squeeze Ahead On Middle Incomes" in the August 28, 1967 issue of the *U.S. News and World Report*. A copy of that article is attached as Appendix A for this Committee's consideration. The updated article also confirms our contention before the House Ways and Means Committee that certain middle-income taxpayer groups will have lost the benefit of the 1964 Federal income tax reductions.

State and local tax burdens cannot be ignored

We also indicated to the House Ways and Means Committee that the increasing burden of state and local taxation on the middle-income taxpayer must not be ignored by the Congress. The U.S. Bureau of the Census has just published State and local tax data for the fiscal year 1966. Per capita State and local taxation is at a national average of $290 and is increasing at rate of 10% per year. The State of New York leads the states with a per capita figure of $410! The Census Bureau figures, please note, involve only taxes—not other types of governmental revenue which are becoming more important, too.

State and local taxation is assuming alarming proportions. This growth is due in part to the expanding economy, but it is also due in considerable part to constant and widespread increases in tax rates and the imposition of new taxes at both state and local levels.

In support of our concern over growing state and local taxation, we have attached as Appendix B another article entitled "The Big Tax Spree in the U.S.", from the August 21, 1967 issue of the *U.S. News and World Report.*

Public welfare program changes

The public assistance amendments of Title II of H.R. 12080 impose new Federal controls and expand the scope of Federal financial participation under the AFDC (Aid To Families With Dependent Children) program. Although we regret the necessity for this extension of Federal controls, we support wholeheartedly the new thrust and direction in public welfare programs developed by the House Ways and Means Committee. We recognize that the tremendous and unexpected growth in numbers of AFDC program recipients—particularly in our large urban centers—justifies to some extent the need for such controls for the immediate future.

The training and retraining of employable welfare recipients has long been considered by employers to be more desirable than the mere continuation of assistance payments. Throughout the country, employers will be found cooperating and aiding authorities and other groups in employment training as well as basic education programs. Three sources of concern to employers, however, are: (1) to avoid training for useless or obsolete employment skills; (2) to maintain the ability to furnish job opportunities to an expanding labor force, and (3) to foster and preserve the incentive to work.

We note that many well-meaning public welfare officials have criticized both the proposed new directions and limitations on Federal financial support. They consider the new directions to be repressive and the financial support to be inadequate. In this respect, we suggest they may not be in the main stream of public opinion. They have called attention to the disinclination to work that springs from the offset of earnings against assistance payments. We, in turn, would call attention to a parallel and more critical problem. As the total tax burden approximates 30% of income—and seems destined to increase substantially—the same disinclination to work or the disinclination to support public welfare appropriations may occur among the taxpayers. We suggest, further, that these officials bear in mind that they are not talking about the Government's money, they are talking about the people's money.

Criticism has been leveled against the proposal to deny public assistance if work or training is refused or avoided. We see nothing wrong in this proposal. Its counterpart is found in every state unemployment insurance law. If assistance can be denied a person normally in the labor force, it should be denied a person who prefers to remain on the welfare rolls. We believe this proposal is a refreshing change. We see it as a negation of the attempts to establish an absolute or constitutional right to assistance payments or to a guaranteed income—independent of the ability or desire to work.

The proposed new safeguards for children in undesirable homes, their protection against wayward parents, the provisions for day care centers to help employable mothers on AFDC rolls, the earnings incentive for working mothers and children under 21, the community work and training programs—all are experimental but laudable objectives. We recognize that there will be increased costs and appropriations needed at both Federal and State government levels; but we feel the objectives and the additional human values to be achieved outweigh these costs.

We believe the House Ways and Means Committee has taken bold and meaningful action in these problem areas and has taken precautions to contain costs and appropriations within reasonable limits.

We support Section 208 of H.R. 12080 which will limit Federal financial participation in the AFDC program to the proportion in each state in January

1967 of children under age 21 receiving aid on the basis of an absent parent to all children under age 21.

We also support Section 220 of H.R. 12080 which will limit Federal participation in state medical assistance programs to families whose income does not exceed applicable income limitations.

Both Sections 208 and 220 of H.R. 12080 have formulae which have provoked criticism. Modifications of the formulae may be appropriate, but we hope that they will not destroy the import and intent of these sections.

Conclusion

To summarize, we are not opposed to a reasonable increase in Social Security benefits when they are, in our opinion, properly funded. We believe that there are other tax problems that must be considered in determining the wisdom of increasing Social Security taxes. We have stressed the point that the problem of Social Security benefits and financing cannot be viewed in a vacuum. We oppose liberalization of benefits that will compound future tax liabilities to be borne by future generations. We have emphasized our concern over the total tax burden on citizens. Our concern is direct—not remote—for they are our customers, our clients, employees and stockholders.

In closing, we wish to answer those who are critical of our society as being apathetic, uncommitted, uninvolved and unfeeling in matters of public assistance. They have failed to consider the countless billions of total Federal, State and local tax appropriations that have been ratified and endured by the people since World War II for the purpose of curing our society's ills—and those of other countries as well. Rather than accept this indictment, it seems appropriate for our citizens to ask for a better accounting as to why this staggering past tax burden has not produced better results. We think it is time to support the decision of the House of Representatives that more tax money is not the only viable solution to our public welfare problems.

SUMMARY OF SHORT-RANGE ESTIMATES OF OASI AND DISABILITY INSURANCE TRUST FUNDS

[In billions]

	Present law			Proposed in H.R. 12080			H.R. 12080 over present law—	
	Taxes	Benefits [1]	Difference	Taxes	Benefits [1]	Difference		
OASI PROGRAM								
1968	$24.1	$20.6	+$3.5	$24.3	$23.6	+$0.7		
1969	28.0	21.4	6.6	27.3	24.6	2.7		
1970	29.3	22.3	7.0	28.5	25.5	3.0		
1971	30.1	23.2	6.9	32.1	26.5	5.6		
1972	30.9	24.1	6.8	33.5	27.6	5.9		
Total.	142.4	111.6	30.8	145.7	127.8	17.9	In taxes	+$3.3
							In benefits	+16.2
							In excess taxes	−12.9
DISABILITY INSURANCE PROGRAM								
1968	2.4	2.1	+.3	3.2	2.5	+.7		
1969	2.4	2.3	.1	3.5	2.6	.9		
1970	2.5	2.4	.1	3.6	2.7	.9		
1971	2.6	2.5	.1	3.7	2.8	.9		
1972	2.7	2.6	.1	3.8	3.0	.8		
Total.	12.6	11.9	.7	17.8	13.6	4.2	In taxes	+5.2
							In benefits	+1.7
							In excess taxes	+3.5
OASI AND DISABILITY INSURANCE PROGRAMS								
1968	26.5	22.7	+3.8	27.5	26.1	+1.4		
1969	30.4	23.7	6.7	30.8	27.2	3.6		
1970	31.8	24.7	7.1	32.1	28.2	3.9		
1971	32.7	25.7	7.0	35.8	29.3	6.5		
1972	33.6	26.7	6.9	37.3	30.6	6.7		
Total.	155.0	123.5	31.5	163.5	141.4	22.1	In taxes	+8.5
							In benefits	+17.9
							In excess taxes	−9.4

[1] And administrative expenses.

Source: p. 90–91, H. Rept. 544, Aug. 7, 1967.

EXHIBIT II.—OASI AND DI PROGRAMS

PRESENT AND PROPOSED PIA BENEFIT FORMULA AND BENEFIT COSTS[1]

[In percentage of average monthly wage; dollar amounts in billions]

	Present law[2]	8 percent benefit increase	12½ percent benefit increase[3]
Benefit formula:			
The first $110 of the AMW	62.97	68.0	70.84
The next $290 of the AMW	22.7	24.5	25.76
The next $150 of the AMW	21.4	23.1	24.08
The next $83 of the AMW	.....	.....	21.40
5-year OASI and DI benefit costs:[1]			
1968	$22.778	$24.600	$26.050
1969	23.717	25.614	27.173
1970	24.684	26.659	28.265
1971	25.674	27.728	29.391
1972	26.683	28.817	30.547
5-year total	123.536	133.418	141.426
Increase	.....	+9.882	+17.890

[1] Including administrative expenses.
[2] P. 131, H. Rept. 544.
[3] Tables IV and V, pp. 90-91, H. Rept. 544.

EXHIBIT III.—MONTHLY PRIMARY INSURANCE AMOUNTS[1] UNDER SELECTED AVERAGE MONTHLY WAGES

Average monthly wage	Present law	Benefits increased— 8 percent	12½ percent (H.R. 12080)
$67	$44.00	$50.00	$50.00
68	45.00	50.00	50.70
80	51.00	55.00	57.40
90	57.00	61.60	64.20
100	63.20	68.30	71.10
150	78.20	84.50	88.00
200	89.90	97.10	101.20
250	101.70	109.90	114.50
300	112.40	121.40	126.50
350	124.20	134.20	139.80
400	135.90	146.80	152.90
427	142.00 (1967)	153.40 (1967)	159.80 (1967)
450	146.00 (1971)	157.70 (1971)	164.30 (1970)
500	157.00 (1987)	169.60 (1987)	176.70 (1975)
550	168.00 (2005)	181.50 (2005)	189.00 (1987)
600	.....	.....	203.00 (1997)
633	.....	.....	212.00 (2006)

[1] Assuming maximum taxable earnings during career from age 21 through age 64.

[From U.S. News & World Report]

TIGHTER SQUEEZE AHEAD ON MIDDLE INCOMES

It's the middle-income family that gets pinched hardest by rising prices and proposed higher taxes.

Even now, middle-class people are hard-pressed, many having to economize.

What worries business is the threat to a prime market for goods.

A point that is beginning to worry business: Millions of people in the middle ranges of income are caught in a squeeze, and this squeeze is going to get worse if federal taxes are raised as now proposed.

The double blow of higher income taxes and higher Social Security taxes would fall relatively harder on this middle-income group than on any other.

This is also the group in which the typical family is most likely to feel the worst pinch of inflation. Some of the sharpest price increases of all show up in the very items that dominate the spending of many middle-income families.

Vast but vulnerable market

What worries business is that this vulnerable group makes up a vast and vital market for goods and services of all kinds. In many key lines of business, the middle market is so important that any sizable reduction in the group's buying power spells trouble.

In the income group from $7,500 to $15,000 are one third of all American families, and they get 45 per cent of the country's total family income.

These people buy 46 per cent of all the new cars sold in this country, and 40 per cent of the used cars. Three out of four buy some appliance or major item of furniture each year. About 75 per cent own their homes, and 95 per cent own at least one car.

These figures, from the University of Michigan Survey Research Center, demonstrate why business views the middle-income squeeze with some alarm.

Note what the tax proposals now in the works in Congress would do to a middle-bracket family.

The Social Security tax, now $200 a year at the top, would rise to $334 for anyone earning $7,600 a year.

This is just as steep a dollar increase as would apply to a man earning $25,000 or $50,000 a year. At lower levels of pay, below $6,600 a year, there would be no increase in Social Security tax at all until 1969.

As for the federal income tax, once more those in lowest brackets would be spared any increase. All others, including people in middle brackets, would pay a surtax of 10 per cent.

Take a family of four with an income of $15,000. Social Security tax would go up $44. Income tax would rise from $2,002 to $2,208, an increase of $206. Total hike in federal taxes: $250.

On top of that, this family's State and local taxes are almost sure to be going up. A typical increase here would be at least $50 to $60, probably more if the family owns a home and pays property taxes.

All told, this family faces increases adding up to $300 or more. For a family at that income level, probably already straining a bit to make ends meet, an extra $300 in taxes comes as a major blow.

Prices rises, too

The squeeze will hurt especially when the tax increase is piled on top of a succession of price increases.

To hold his own, a family man in these circumstances must have a substantial raise in pay. In fact, as shown by the chart on page 31, a pay raise of 5 per cent is not enough. The proposed hikes in federal taxes alone—income and Social Security—are more than enough to wipe out all the benefit of the tax cut voted by Congress in 1964 in the case of families earning $7,500 to $11,000 a year.

Other families—those below $7,500 and those above $11,000—generally would retain part of the benefit of the tax reduction of three years ago.

Widespread complaints

From all over the country come complaints from middle-income people who are already feeling the squeeze and are worrying over the additional pinch of higher taxes. Congressmen's mail from home is filled with protests against rising prices and rising taxes.

A random sampling of the mood of people reveals growing worry over the income squeeze. Taxes and prices and the strained family budget, more and more, dominate ordinary conversation.

Many people contend the prices they pay are obviously rising much faster than the 3 per cent yearly rate shown by the cost-of-living index, and are puzzled by the official figures.

It is true that, for millions of people in the middle and upper brackets, the official index does understate the rise. That index is based on only a "modest" standard of living, and thus does not reflect many of the "extras" for which people spend their money.

Take, for example, the family with a child or two in college. Here the squeeze is probably worst of all.

Such a family, if in the middle-income range, is likely to find college cost the biggest item in the budget. Yet, on the official index, education cost accounts for an almost negligible fraction of the cost of living.

Late surveys show another hike in college fees starting in September. Charges well above $3,000 a year are widespread. Few items of family cost have risen so

sharply. And scholarship aid is limited for the children of middle and upper-income families.

That is just one item that tends to fall heavily on the middle group. There are many others.

In growing family, many costs

Typically, the middle-income family is headed by a youngish white-collar worker with the extra expense of providing for children in a range of ages.

Medical expenses for this family are a considerable item. These costs are climbing much more sharply than the general cost of living.

Shoes are way up in price, and it takes a lot of them for growing children. Auto insurance is skyrocketing, and just about every middle income family owns a car or two. The occasional dinner out is a treat that some families report they have given up. Prices in better restaurants are jumping.

With youngsters coming along, the family begins to need a home of its own. House prices are always a shock, and the trend is still sharply upward. Building costs are rising. So are land prices. Mortgage costs are at or near the highest in many years. Often the buyer must pay "points" to get a loan. And this means an added cash cost. Settlement charges are up. Required down payments have been rising.

An analysis of department-store ads in newspapers, just completed by George Neustadt, Inc., of New York, shows that goods in the middle-price range have tended to rise more sharply than those in lower and upper ranges. Items covered by the analysis included men's summer suits, women's wash dresses, living room suites, lamps, air conditioners.

A common complaint is that the sharpest price rises have seemed to center in the kind of items that people cannot very well avoid buying—that is, unless they are willing to change their way of living.

On the other hand, purchases of some of the items most stable in price can be deferred. Refrigerators and other major appliances are examples.

"Let's hold off."

A report from Los Angeles on the attitude of consumers:

"The most fundamental effect of rising living costs here appears to be that most people are making do with what they have. The favorite expression today is, 'Let's hold off until next year.' Most people are putting off such major purchases as a new car, living-room carpeting, kitchen range, or professional landscaping of their yards."

From a family man in Houston: "One thing we're doing these days is avoiding charging at stores. It's almost too convenient, and before you know it, you've run up big bills. Also, we're finding we can delay purchases of clothing and the trade-in of a car."

From Detroit comes the word that a buyer waiting for the 1968-model cars will pay price increases averaging $75 to $100.

Detroiters complain of a whole rash of price increases. Haircuts are going up a quarter to $2.75 weekdays and $3 on Saturdays. City water, milk, cigarettes and orange juice are all up. Shoeshines have been increased to 35 cents, and a bootblack commented: "It's a real cheapskate who can't give me a 15-cent tip."

The pinch is hurting in Chicago, where people complain about increases in cigarettes, gasoline, rent, food, utilities, bus fares, other things. Apartment dwellers typically are having to pay about 6 per cent more when their leases expire. For new tenants, rents are up around 10 per cent over a year ago.

In New York, apartments in desirable areas are being offered on new leases at rents up 20 per cent or more.

It's getting so people have to think twice before going to a movie. Said a New York movie-goer: "The least you pay to see a good movie in New York in a decent neighborhood is $2.50."

Small businesses and property owners are squeezed, just as are consumers. In San Francisco, the owner of a 30-unit apartment house reports that his taxes are up 20 per cent in just the last year, and adds: "I have not raised rents for some time, but now I'm going to raise them." Another apartment owner: "Repairs of all kinds are prohibitive."

One State's "Black Tuesday."

Californians, in particular, are complaining about State taxes. The legislature has just adopted the biggest tax increase ever voted in any State.

On August 1, the day a first large portion of the California tax increases took effect, a family man in Los Angeles wrote a friend in the East: "This is my mad-at-the-world morning—Black Tuesday, I guess it could be called. Governor Reagan's 943-million-dollar tax increase goes into effect. Sales tax up 1 point to a total of 5 per cent, State and local—a sizable increase for a five-member family—cigarettes up 4 cents a package to be increased another 3 cents in October, State income tax up an average of 60 per cent. On top of that, I face a healthy increase in property taxes. Guess I'll have to quit smoking, and if I had not already stopped drinking, that would go too. I'm seriously thinking of asking for either a raise or a transfer to some Micronesian island."

That same attitude, in varying degrees, shows up among consumers across the country, especially those in the hard-pressed middle group.

Many, of course, are getting pay raises sufficient to stay ahead. Other millions are falling behind in this race with inflation and taxes. Big question: Will the squeeze on middle incomes slow or reverse the current pickup in total consumer spending?

[From U.S. News & World Report]

THE BIG TAX SPREE IN THE U.S.

When the President called for higher federal taxes, he joined a parade already rolling in statehouses, courthouses, city halls. Nothing like this proliferation of taxes has ever been seen before. A report on new levies—and a look ahead.

REPORTED FROM ACROSS THE COUNTRY

From one end of the United States to the other, a scramble is on for new tax money.

Nothing to equal this tax-raising spree has ever been seen before.

It is going on in statehouses, city halls, courthouses, and in the U.S. Capitol in Washington.

All told, based on the federal tax hikes now proposed plus a succession of State and local tax increases, the rise in total tax collections is estimated at 14.5 billion dollars this year and a record 23.5 billion next year.

Thus, there is the prospect of increases adding up to 38 billion dollars in just two years. This rise in collections will result partly from expected growth in the U.S. economy, which means an expanding tax base, and partly from new taxes and increased rates on existing taxes.

This is the story that emerges from a check across the country and from a new study by the Economic Unit of "U.S. News & World Report."

Even without the current round of tax increases, it was estimated by the Economic Unit study that, out of a family income of $10,000 a year, roughly 30 per cent, or $3,000, is drained off in taxes of all kinds, both direct and indirect, open and hidden.

In addition to all that, people's incomes right now are being hit by a new rash of price increases. Some experts say that inflation is the severest tax of all.

"Profound danger." The Bank of America, taking note of the repeated tax hikes and proposals, warned of the "profound danger" of "spiraling tax increases."

In Washington, the House Ways and Means Committee set hearings to begin August 14 on President Johnson's plan to add a 10 per cent surcharge to the taxes of individuals and corporations.

The same Committee had just approved a bill to raise Social Security benefits and the payroll tax to support them.

These two tax proposals alone would add up to increases of 11.5 billion dollars a year.

At the same time, Congress is getting ready to raise postage rates—in effect, one more tax that will add to personal and business costs.

State income taxes are going up, and some new ones are being added. Local income taxes are spreading. Sales taxes are up in many places. Property taxes keep going up year after year, and 1967 is no exception. Fees and charges of many kinds are being raised.

This year, 21 States have imposed new taxes or materially increased old ones. Literally thousands of cities, towns, counties, school districts and other units are raising taxes.

All told, there are 80,000 taxing jurisdictions in the United States, and a substantial number of them raise taxes every year.

Signs of revolt. This year, the increases have been so stiff that, in some jurisdictions, there have been evidences of a taxpayer revolt. Many bond issues have been voted down. In a few places, there have been demonstrations to protest increases.

In Texas, two mayors who supported a bill in the legislature to authorize city sales taxes were subsequently defeated for re-election.

Yet the drive for more and more tax money to finance a rise in spending goes on, with no end in sight.

California's legislature, at the urging of Governor Ronald Reagan, has just passed the biggest tax increase ever imposed by any State.

Income taxes for some Californians are doubled. Rate of the State sales and use tax went from 3 to 4 per cent on August 1. The cigarette tax was raised August 1 from 3 cents to 7 cents a package, and will rise on October 1 to 10 cents.

That's the story in a State where all the emphasis of a new Administration has been on holding down spending.

Michigan, under Governor George Romney, has adopted a State income tax for the first time. The rate is 2.6 per cent on personal income. It is 5.6 per cent on corporations and 7 per cent on financial institutions.

These income taxes were added to a sales tax of 4 per cent on goods and many services in Michigan. State fees of various kinds are being marked up—drivers' licenses, marriage licenses, admission fees for State parks.

Nebraska has added an income tax for the first time, as well as a new sales tax of 2½ per cent. The income tax, effective January 1, will fluctuate from year to year, depending on revenue needs.

West Virginia, as well as Michigan and Nebraska, has added a tax on corporation incomes. With these three additions, 40 of the 50 States now tax corporations on their earnings.

As for personal income taxes, the addition of Michigan and Nebraska means that 38 States are drawing on this source of revenue.

Five States have raised personal income taxes this year—Maryland, Vermont, Montana, Iowa and California.

Corporation taxes have been raised by six States—Maryland, Montana, Tennessee, Iowa, California and Minnesota.

Two more States have adopted sales taxes—Nebraska and Minnesota. There are now only six States left that do not have sales taxes. Eight States have raised sales taxes this year. A good many localities have adopted new sales taxes or raised old ones.

The typical State sales tax is 3 per cent, but rates go as high as 5 per cent in Rhode Island and Pennsylvania.

All States tax gasoline at rates that go as high as Washington's 9 cents a gallon. Eight States have raised gasoline taxes this year.

Cigarettes are taxed in all States except North Carolina, where a proposed tobacco tax was narrowly defeated recently. Seven States raised cigarette taxes this year. Rates go as high as 11 cents a pack in New Jersey, Texas, and Washington. In New York City, the combined State and city tax is 14 cents a pack.

Illinois has raised a whole assortment of taxes, including those on sales, gasoline, cigarettes, utilities and corporate franchises.

North Carolina, in an unusual move for 1967, cut the income tax by raising exemptions for dependents. Kansas reduced the bottom-bracket rate. Missouri cut the State property tax.

Taxes on top of taxes

In a good many areas, income taxes are being doubled up, with both State and local taxes being piled on top of the federal tax.

A striking example is Maryland, where the 1967 legislature not only raised the State income tax sharply but also tacked on local income taxes.

The old Maryland tax was 3 per cent. The new tax begins at 2 per cent, rising to 5 per cent on all over $3,000. In addition, local governments were required to impose taxes of their own equal to one fifth of the State tax, and were authorized to go as high as one half of the State tax. The city of Baltimore is imposing the full one half. This means the total tax is more than doubled.

New York, a city in trouble, has stacked a local income tax on top of the State tax, which itself is one of the highest in the country.

The Los Angeles city council on August 8 rejected, for a second time, a proposal by Mayor Sam Yorty to impose a payroll tax on both residents and com-

muters. The mayor had hoped to cut the property tax, which he considers too high. Now there is speculation that the property tax will have to rise.

The property tax in many areas is the one that produces more citizen complaints than any other.

In New Jersey, local property taxes are reported by the New Jersey Taxpayers Association to have jumped from 646 million dollars to $1.45 billion in just 10 years.

In Newark, a house worth $20,000 on the market pays a real estate tax of $1,552. That is an increase of 34 per cent in just three years.

Newark's Robert Treat Hotel in 1964 completed an expansion that increased the number of rooms from 272 to 438. The hotel's real estate tax had been $96,454. This year, a tax of $411,280 was assessed. The hotel is appealing.

Newark's problem, like that of many cities, is primarily the skyrocketing cost of welfare. Negroes have flooded into the city in recent years.

Lid on property taxes?

Local governments still have to get along primarily on the property tax, although more than 2,000 cities, towns, counties and other local units have adopted income taxes to provide additional revenue.

Now the word from many areas is that local officials are warning there is a practical limit to the yearly rise in property taxes.

In Montgomery County, Maryland, adjacent to Washington, D.C., homeowners are complaining that not only are they hit by a higher State income tax and new county income tax, but also by property taxes that rise year after year.

One Montgomery County homeowner dug out his old tax bills to show that the tax on his house, which cost about $20,000 in 1942, had climbed over the years from $261 a year to $1,422.

One-third increase in year

In Atlanta, it is estimated that the average homeowner will pay one third more tax this year than last.

In San Francisco, there is such a stir over property tax increases that there are demands for a special session of the State legislature to vote relief.

One San Francisco homeowner who paid $276 last year will pay about $490 this year. Another owner's bill is up from $1,204 to $2,386.

Near Seattle, a dairy farmer complains that his tax was $35 an acre in 1965, $43 last year, and probably $50 or above this year. He reports that the going rental fee on land in the area is $50 maximum, just covering the tax.

In some places, property taxes are being reduced. DeKalb County, Georgia, next to Atlanta, has reduced taxes. Minnesota property owners are promised a cut next year. These places are in the minority. The broad trend is still strongly upward.

The Tax Foundation reports that State and local general spending has more than quadrupled since 1948, and will nearly double again by 1975.

Federal aid can pinch

On top of everything else, the States and localities are hard pressed to raise funds for matching federal aid programs. Medicaid, for example, is causing severe problems in some States.

In New Mexico, Governor David F. Cargo put his State's problem this way: "I'm not sure we can take much more by way of gifts from the Federal Government when they involve matching funds, because many times we don't have the ability to match. It's a funny way to put it, but 20 percent of nothing is nothing."

The Governor said New Mexico faced tax increases in the next year or two.

New York's Governor Nelson Rockefeller has issued a similar warning. Texas faces tax increases next year. So do many other areas.

The big tax parade of 1967, thus, will continue into 1968 and beyond. There is no end in sight to the rise in public expenditures—or in the taxes to support them.

PRIVATE PENSION PLANS AND PUBLIC POLICY

(An Address by Robert C. Tyson, Chairman, Finance Committee,, United States Steel Corporation, before the Council of State Chambers of Commerce, New York, New York)

I am honored to speak before the Council of State Chambers of Commerce. Your outstanding organization, founded in 1932, has long rendered fine public

service in exploring issues and problems involved in your three main areas of concern—Social Security, labor-management relations, and Federal spending and taxation. Appropriately, my topic today of private pension plans and public policy is very much involved in all three areas as well as in, I may add, our heritage of free enterprise and limited government.

My message to you in these remarks is, I trust, simple and to the point: Now is the time for all good men in private and public life to preserve and promote America's dual retirement system. For I believe that the drift of public policy is endangering that duality and jeopardizing the future of private pensions—the very pensions to which millions of workers and their families are looking to provide more adequate retirement security.

All of us, I am sure, accept the role of Social Security in supplying retirement income. But all of us should accept the role of private pension plans in also supplying retirement income. Yet even these two parts do not necessarily add up to the whole of retirement security. For workers in our free society seeks to build security with still such other retirement blocks as savings accounts, common stocks, bonds, real property, insurance policies and annuities.

Certainly this highly individualistic security-building—this nest-egg-building—differing as it does workers by worker, family by family, is part of the American dream. It is part of that heritage of free enterprise and limited government to which I just referred. For let it not be forgotten that this heritage is primarily responsible for the world's highest standard of living. And let it not be forgotten that income—private or public, retirement or pre-retirement—originates solely from production, from our free enterprise system. Finally, let it not be forgotten that this marvelous free enterprise engine of production is built and expanded by investment, and sparked and guided by profit.

Now consider some revealing trends in private and public pensions. Aggregate employe-employer taxes for Old Age and Survivors Insurance started out in 1937 modestly enough (at least by today's standards), with a total of $576 million, equivalent to 1.4% of total private compensation of employes. There was little change in that effective tax rate until 1950, when it rose to 2.0%. By 1966, however, these taxes, reflecting wider coverage plus Medicare, totaled over $25 billion, or 7.3% of aggregate private compensation. Meanwhile, employer contributions to private pension funds have risen from around $2 billion or about 1.6% of total compensation in 1950 to around $8 billion or about 2.4% of compensation in 1966. From a benefit standopint, total private pensions have increased about eightfold since 1950, while total Social Security benefits have increased about twentyfold, or more than twice as fast.

Thus, as I see it, the future of our private pension plans is in jeopardy, even though private pension plans are an integral part of the free enterprise system, even though they have distinctive advantages in furnishing a voluntary system, in financing retirement security, in providing retirement flexibility, in providing incentives, in promoting savings and capital formation, and coping with inflation.

The jeopardy comes from the drift of public policy in two directions. In one direction sharply rising Social Security costs and benefits threaten to put the private pension system out of business. In the other direction, under a smog of misunderstanding and misinterpretation about the facts and nature of private pension plans, proposed restrictive legislation similarly threatens the private system.

Let us explore each of these threats, beginning with the threat of runaway Social Security. Social Security is becoming more and more costly, perhaps prohibitively so. While its benefits have more than doubled in the past 18 years, the combined employe-employer maximum tax has increased from $60 per employe in 1949 to $581 today, and is scheduled to go to $746 by 1987, quite apart from the even higher taxes scheduled in the Social Security bill passed last month by the House of Representatives. And while today's Social Security recipients will receive benefits far greater than they and their employers paid in, many of today's newcomers to the labor force might just be better off if Social Security taxes could be diverted to private annuities.

So we see why there is growing talk in Congress that Social Security may be reaching the end of the road as a self-supporting payroll tax system. Both employe and employer are beginning to wince. Does this wincing preclude further cost and benefit escalation? Admittedly, the bill passed by the House scaled down the Administration's recommendations for further Social Security escala-

tion. Still, some in Congress are talking of dipping into general revenues to finance the difference between Social Security taxes and expanding benefits. For example, last year one senator proposed that the amount coming from general revenues to finance Social Security would progressively increase until it would reach 60% of the combined employe-employer tax.

The danger to private pension plans from such a proposal is clear. Once Social Security has ceased to be work-related, once it is freed of directly taxing employe and employer, benefits would no longer be restricted to the limit of payroll taxation. Then private pension plans could hardly compete with such a welfare system because of accelerating benefits—and accelerating income taxes required to finance them, which would in turn impair corporate ability to finance future private pensions. At that point, private pension plans could well be on their way to the dustbin of history.

Again, while the word "insurance" still clings to the public system of old age benefits, the fact is that it is no such thing. It is a tax on today's productive workers to pay benefits to those who are no longer productive. It is threatening to become another welfare system. It is on a compulsory basis. It is dependent on future legislative disposition. And it discourages enterprise: The man between 65 and 72 years of age who is regularly employed and earns more than a minor monthly stipend forgoes part or all of his public pension.

On these scores note how private pension plans stand in sharp contrast: They are adaptable to individual personnel needs and company situations; they are heavily funded, almost completely actuarially determined, entirely on a voluntary basis and entirely on a contractual basis between the employer and employe, or his agent.

Fortunately, the employes' stake in private pension plans is heavy and the number of workers participating in these plans is large. While Social Security now covers about 86 million persons and has about $23 billion in reserves, private pension plans have grown more rapidly on both counts. Take 1950 as a benchmark. Then such plans covered about ten million employes and had reserves of about $12 billion; now they cover almost 30 million employes and have reserves approaching $100 billion. Based upon this growth, I think it fair to say that all employes have much to lose in any falling-behind of private pension plans.

Let us see why this is so before we discuss the other threat to private pension plans from excessive regulation. First, I think it behooves us to remind ourselves that whole Social Security funds are entirely "invested" in U.S. Government securities, private pension funds are mainly invested in free enterprise activities through such vehicles as corporate securities and real estate mortgages. Hence, while Social Security reserves are practically immediately spent in all the pursuits of the Federal Government, private pension reserves are generally adding to capital formation and therefore to the economic growth of the nation. So we see that private pension funds serve as a means of accumulating private savings and investment. And, since one new job requires a capital investment of up to as much as $100,000 or more, these savings provide a source of job creation and wage improvement as well as of retirement security.

There are other important advantages of private pension plans to employes. While Social Security must ever remain a monolithic uniformity, private pensions can be tailor-made to meet differing situations and conditions. Thus, there is not "one private pension plan" but literally thousands, each one adapted to meet the conditions of specific employe-employer relationships—relationships that differ with each company, industry, location, time of installation, time of operation and specific requirements of specific personnel. In view of the infinite variety of such changing conditions across our land, private pension plans offer abundant opportunities for evolutionary experiments and dynamic innovations.

And, perhaps most important of all, private pension plans tie in with the free enterprise precept of incentives. Being pretty fully work-related, private pensions recognize the importance of individual incentives to produce more and save more—the social need for retirement incomes to differ from one individual to another in accordance with each individual's employment contributions to society.

So much for the threat to private pension plans from runaway Social Security.

Now let us explore the other threat to private plans—excessive and restrictive Federal regulations. Already too many Washington monkey wrenches are poking into the private pension motor. Consider some of the high-powered Government committees that have been studying or investigating private pension plans. Among them are the President's Committee on Corporate Pension Funds

and Other Retirement and Welfare Programs including its Interagency Staff Committee, the Senate Subcommittee on Employment and Retirement Incomes of the Special Committee on Aging, the Senate Permanent Subcommittee on Investigations, and the Subcommittee on Fiscal Policy of the Joint Economic Committee. One upshot: In this session of Congress alone more than 30 bills have been introduced to restrict or regulate private pension plans.

The nub of these studies and investigations to date seems to be a general charge of inadequate public control of private pension plans, frequently coupled with charges that the plans are recipients of tax subsidies. The thrust of these bills is, hopefully, to render more adequate protection to the employe and thereby to the public interest. But if these bills were passed, would not the employe be more hurt than protected?

For instance, the charge of tax subsidy reflects the premise that the Government tends to control that which it subsidizes. I do not here question the premise, but I do question the subsidy and hereby submit that there is none. To be sure, the employer obtains tax deductibility for his contributions to a qualified pension trust fund. In addition, pension trust fund income in such form as dividends on common stocks and interest on loans and mortgages is not taxable until disbursed as retirement payments to pensioners. Similarly, employes do not have to pay taxes on their pension credits until they retire when very likely their benefits will be taxed at lower rates.

I fail to see any subsidy in these arrangements. Tax deductibility for pension fund contributions is no different from tax deductibility allowed for any other form of deductible employe compensation. Indeed, pension costs are simply another ordinary and necessary cost of doing business. Again, payment of taxes by the pensioner when he receives his pension is not tax exemption but only a matter of tax timing. For in the case of compensation in wages or salaries, the employe is the recipient of highly spendable—and taxable—cash income. In the case of employer contributions to the pension fund, however, the employe receives concurrently no such spendable—or taxable—income. It is true that when he retires his income bracket is generally lower, but this situation in no way obviates a cardinal principle of income taxation—namely, that a tax is not incurred until income is received.

In fact, it is my considered opinion that over the full pension cycle—from the active service years through the retirement period—the Government can be better off financially from present funding arrangements and tax treatment than it would be from non-funded pay-as-you-go plans, and that there is no tax subsidy whatsoever.

So much for the charge of tax subsidy, which I further submit is a myth intended as an attempt to justify Government control of private pension plans.

The charge of inadequate public control of private pension plans also calls for a rebuttal. This charge should be considered in the light of all the compliance already required by agencies checking on private pension plans—agencies such as the Labor Department, Securities and Exchange Commission and Internal Revenue Service.

The charge frequently details such allegations as inadequate vesting and funding, and insufficient disclosure and fiduciary responsibility. On this latter point, let me say that I firmly believe in the principle of fiduciary responsibility. And, in my judgment, virtually all of the established plans are exercising full fiduciary responsibility and are managing pension fund investments as would a prudent man with his own funds. Look at the record. Cases of irresponsible fiduciary management turned up so far are few in number, minor in extent, and most if not all of these cases are in welfare plans—not pension plans.

Thus the wording and implementation of the fiduciary responsibility section in any private pension bill before the Congress should be closely watched. For talk of fiduciary responsibility may imply fiduciary irresponsibility which, although unfounded, tends to undermine confidence in the private pension system.

On the other allegations of inadequate vesting, funding and disclosure, I have even stronger reservations.

On vesting, we see further attempts on the part of the Government to impose arbitrary vesting standards—standards as to eligibility, age and years of service, etc. Here, again, the necessarily great variety of plans to meet different needs throughout our complex economy seems to have been ignored.

Without any mandate from Government, the actuality is that various vesting provisions have increasingly been incorporated into private pension plans. U.S.

Department of Labor surveys of 300 large plans, for example, indicated that 25% of the plans in 1952 already had some vesting provisions; in 1958 the percentage had climbed to almost 60%; the percentage is probably much higher today. As a matter of fact, a more recent Labor Department study of a greater number of plans found that some two-thirds carried vesting provisions.

But advocates of compulsory vesting argue, why not raise the percentage to 100%? The answer is simple. Priorities and voluntary choices are involved: Vesting is not inexpensive—the broader and sooner the vesting, the greater its preemption of other forms of employe compensation improvement perhaps more desired by employes and employers. More desired improvements, for example, could take the form of higher wages, shorter hours, greater vacation time, better incentive payments, other fringe benefits, or even other pension benefits. Overruling such desire by law strikes me as being neither democratic nor economic.

Critics of private pension plans also argue that non-vested or inadequately vested plans impede labor mobility—the ability to switch from one job to another. These critics charge that the employe's private pension credits serve as an impediment to his free choice to take another job. This charge of being "locked in" by pension credits, however, does not stand under scrutiny. According to a 1964 study published by the Bureau of Labor Statistics, seniority rights and other employment practices may be greater impediments to labor mobility. Also, the very service-required vesting rights sought by private pension plan critics may themselves impede mobility. Moreover, private pension plans serve as a way to compete for experienced skilled employes. Lastly, these plans are a voluntary arrangement, a matter of employe and employer choice and accommodation.

Or take the allegation of inadequate funding. Being against adequate funding is like being against motherhood or morality. But adequacy has to be correlated with feasibility, and on feasibility reasonable men can differ. Yet clearly whatever the funding requirement—if indeed any fixed requirement can really be imposed by law—it could only be done by a rigid and highly restrictive rule, which could not possibly take into account the vast variety of pension plans, vesting provisions and actuarial methods in use.

Flexibility is the key. The present Internal Revenue rule for qualified plans requires, as a minimum, funding equal to current service costs plus interest on the unfunded cost of past service. But stipulating funding beyond this involves the danger of slowing down pension plan improvements, discouraging new plans from coming into existence, or driving old plans out of business.

On the allegation of inadequate disclosure, I believe private pension plans already operate in a goldfish bowl. But even goldfish need a degree of privacy. For I believe there is need to distinguish between a fishing expedition and meaningful disclosure. Disclosure through current reporting requirements is already very heavy. Further requirements would further bulge the Government's already bulging files—burdening Government, business and hence taxpayers generally, without providing, in my judgment, any real benefit to the pension plan participants themselves—and might, in fact, even reduce benefits.

Moreover, some disclosure proposals would call for financial information that is inherently confidential and competitive. Such information also could tend to generate unfair hindsight criticism in Washington and elsewhere of financial practices and particular investments by pension fund trustees. Moreover, information on pension cost determination and investment portfolios could fall into the hands of competing companies. Pension costs are just as much a part of production costs as any other cost. Similarly, disclosure to others of a long-range investment program by any fund could force up the market price of the investment before completion of the program or disclosure of portfolio changes could be misconstrued as an expression of confidence or lack of confidence in particular companies or industries. In all these cases the employes participating in the plan could be hurt instead of helped.

So I hope that it is evident that fast and easy demands for restrictive legislation and control of private pension plans may well not be in the public interest, that they can bring about a state of affairs less satisfactory to the pension plan participants than exists today, that they can interfere with employe and employer choices and accommodations on how the production pie is to be cut. For the record show that there is just so much pie to be cut no matter how you slice it—and not just for employes, but also for consumers, suppliers, governments and investors. In the problem of private pension determinations, or in the broader problem of total employe compensation determinations—including public pensions—we must ever keep our eye on expanding the pie of production.

And, let the record also show that private pension plans have come a long way toward meeting retirement security in America. U.S. Steel's plan, I believe for one, has been fairly and equitably administered, has flexibly met particular pension needs, has maintained the work-related principle of pension credits, has improved steadily over the years, has fully informed employes of their benefits, has kept promises made to employes, has been adequately funded, and has various vesting and early retirement provisions; also, its funding costs have been actuarially determined; its trustee has acted in a proper fiduciary capacity in all respects; and its fund is yearly audited and reported upon by independent public accountants. This is true of the U.S. Steel Fund; I am sure it is equally true of most other funds.

The private part of our dual retirement system has proved its worth, and we would be derelict in our duty if we did not protest against its being placed in a straitjacket of controls. Yet both the private and public parts of the dual retirement system are being short-changed by that artful silent thief, inflation. Inflation robs those who can afford it least—low income groups, those living on fixed or relatively fixed incomes and, perhaps most pertinent to our discussion today, pensioners under private pension plans and Social Security. To be sure, private pension plans, unlike their public counterpart, may cope with inflation to some extent by investments in common stocks and real estate, which in their market values may hedge against inflation.

Now can it be that the same Government calling for Social Security escalation and tighter controls over private pension plans is the same Government whose inflationary policies are hurting both private and public pensions? I say, it can be, and is. Public policies are contributing to demand-pull and cost-push inflation —inflation via nondefense expenditure acceleration and excessive expansion of the money supply, via wage-pushes far beyond productivity and tax increases further pyramiding costs.

Permit me to expand on the last point. For all the talk about the deflationary effects of the tax increase now under consideration, I wonder if sufficient consideration has been given to the inflationary potential of a tax increase. I cite three reasons for this potential. First, the increase may encourage the Parkinsonian spending tendencies of Government (recall Parkinson's Second Law: expenditures rise to meet income). Second, it may add to cost-push inflation as labor leaders seek to maintain take-home pay levels and as businesses seek to recoup tax costs. Third, it may have a negative impact on the anti-inflationary incentives to save and invest. In addition, let me suggest that present tax rates are already oppressive, that Congress and the Administration should redouble the effort to reduce or defer nondefense and unessential defense spending, and that a tax increase be authorized only if the remaining deficit is of unmanageable proportions and if the increase in uniformly distributed over all taxpayers, individual and corporate.

To sum up: Destructive public policy can snuff out private pension plans through over-regulation and runaway Social Security; it can also erode private and public pensions by inflation. Constructive public policy will seek to avoid inflation and will recognize and safeguard the dual nature of our private and public retirement system. Thus I would hope that the role of Government would be limited to fostering a climate for the fulfillment of private pension promises made and not to specifying what those promises should be nor how they should be fulfilled.

Senator HARRIS. Mayor Dumas.

The chairman of this committee, Senator Long, regrets he is not able to be here to introduce the next witness. He has asked me to extend a warm welcome the the Honorable Woodrow Dumas, who is the mayor-president of East Baton Rouge Parish, La. Mayor Dumas is a long-time friend of Senator Long's. He is past president of the National Association of Counties and is appearing here today on behalf of that organization. He is also, as I have just indicated, the mayor of the chairman's hometown. It is a pleasure to have you here today.

Before you proceed, Senator Long also wanted me to express to you that he has prepared an amendment to the social security bill to enlarge the role of the Federal Government in providing assistance to

children in foster homes, something I understand the National Association of Counties and you have taken a leading role in advocating. We will be pleased to hear you at this time.

STATEMENT OF W. W. DUMAS, PAST PRESIDENT, NATIONAL ASSOCIATION OF COUNTIES, ACCOMPANIED BY WILLIAM R. MacDOUGALL, SECRETARY, COMMITTEE ON WELFARE

Mr. DUMAS. Thank you, Mr. Harris, Mr. Carlson, Mr. Curtis. I am sorry Senator Long is not here. Of course the Saints were beaten by the Rams and I imagine it is quite a setback for the Senator. He is a terrific fellow and we have a great deal of respect for him in our great State of Louisiana.

Mr. Chairman, Senator Williams, and members of the committee, my name is W. W. Dumas. I am the mayor-president of East Baton Rouge Parish, La., and a past president of the National Association of Counties. I am accompanied today by Mr. William R. MacDougall, secretary of the National Association of Counties' Committee on Welfare and the general counsel of the County Supervisors Association of California. In my opinion and that of our association, Mr. McDougall is unquestionably one of the most informed individuals in the Nation with respect to local government's relationship and responsibility in the area of welfare. I hope that you gentlemen take full advantage of Mr. MacDougall's knowledge and experience in examining the merits of the proposed legislation currently before you.

Here in Washington, in December of 1966, the National Association of Counties held its first national conference devoted exclusively to the subject of welfare. This conference's purpose was to consider our Nation's welfare efforts and their relationship to the overall problem of poverty.

Two basic concepts clearly emerged from the conference.

One was the restatement of our basic philosophy as to county government's welfare role, which reads as follows—gentlemen, I am not going to go through all of this, we are going to submit most of this for the record. I am only going to go about five pages and then give Mr. MacDougall the rest of the time.

Senator HARRIS. Without objection the entire statement will be inserted in the record to the degree it is not covered in your oral testimony.

Mr. DUMAS. Thank you, sir.

The National Association of Counties believes the responsibility of alleviating and eliminating poverty is a principal function of county government, and therefore urges the respective states to provide counties with broad legal powers to accomplish such objectives. Additionally, we urge the respective states and the Federal Government to participate financially in these programs, but urge that any accompanying state and federal regulation be such as to maintain the maximum degree of initiative and responsibility at the local level.

The other concept was this—nothwithstanding county government's desire to retain and to increase its role in our Nation's welfare efforts, this will be difficult, if not impossible, unless the Federal Government initiates a more flexible general policy with respect to local welfare administration. Local elected officials have neither the desire, nor is it feasible, to have the responsibility for a program in

which they have virtualy no authority. Increased flexibility at the county level will require Federal administrative and legislative action.

I have included at the conclusion of my statement the recommendations of this National Welfare Conference, as well as the recommendations adopted at our very recent National Legislative Conference. In view of our time limitation, we have selected certain recommendations to discuss in greater detail because of their high priority in county thinking.

I feel it is important to bear in mind that welfare, nationally speaking, is county government's largest budgetary item and accordingly one of its principal responsibilities. Thus, you can understand our abiding concern that our views be given the maximum possible consideration.

Prior to detailing our observation, I should first like to state that except for several aspects of H. R.12080, which we shall elaborate on, we feel it is an excellent bill.

We do feel it is possible that some of the new provisions of H.R. 12080 could be administered in such a way as to justify the criticisms that have been made of them. This is especially so with respect to the provisions dealing with training and work placement. On the other hand, these provisions can also be administered in such a way as to bring unlimited benefits to welfare recipients and the Nation as a whole.

We feel it is important to note a strong endorsement with respect to the ability and integrity of the thousands of Federal, State, local elected and nonelected officials who have the responsibility of carrying out in a partnership arrangement the present and future Federal-assisted welfare programs. They are capable, competent, and properly motivated to carry out the new and revised provisions of H.R. 12080, and in doing so, we fully expect them to bring credit to our welfare efforts.

There exists in our Federal welfare program, one of the least known and least justifiable omissions one might imagine. That omission is the Federal Government's failure to make available anything other than token assistance to that pitiful group of needy children who, for reasons beyond their control, have neither a mother or father or relative of the required consanquinity with whom they may reside, in order to meet the Federal eligibility requirements for assistance—the "foster children." The seriousness of this omission, in the view of our association, is of such magnitude that our National Welfare Conference, determined that the attainment of Federal assistance for foster care programs must be our top-priority legislative objective. It is now so designated.

Although the Federal Government has long recognized that it must bear a part of the responsibility for the welfare of our needy dependent children, it has, through an arbitrary distinction in the law, for all practical purposes, ignored the plight of the foster child. The only exception of note is one grudging provision of the aid to family of dependent children's program, which does provide assistance to a foster child who is placed in a foster home by a court order, but only if the child was receiving AFDC aid in and for the month court action was initiated. The rationale of this distinction has always escaped us.

This provision did provide assistance to approximately 5,780 foster children, as of June 1965. However, it is our understanding that there are currently 300,000 children in approved foster homes and institutions recognized by the States for public aid purposes.

In 1962 President Kennedy successfully recommended to Congress that the aid to dependent children program—currently entitled "aid to families with dependent children"—be amended to include the needy children of the unemployed. He stated:

> Under the aid to dependent children program, needy children are eligible for assistance if their fathers are deceased, disabled, or family deserters. In logic and humanity, a child should also be eligible for assistance if his father is a needy, unemployed worker.

We have agreed—and hundreds of counties have broadened their child aid programs accordingly, under their own State legislation.

NACO contends that this same logic and humanity is a compelling force to include children in foster homes. For reasons beyond their control, they have neither mother, father, nor even a relative of the required consanguinity with whom they may reside in order to meet the Federal requirements.

It is our view that if we must limit our welfare efforts, the last place we should do so is with respect to children, especially needy ones who have the added handicap inherent in foster children.

As you know, H.R. 12080 as enacted by the House further expands the Federal Government's participation in foster home care of dependent children. The legislation provides that, although a court order is still required for placement, the child need not have received AFDC aid during the month in which he or she were placed in a foster home. Rather, it provides that in the 6 months before proceedings started in the court, they would be eligible for AFDC if they had lived in the home of a relative.

Unfortunately such a requirement, although aiding some additional children, works further inequities on a great many more than it aids. In the first place, you have a situation where approximately 22 States have adopted the AFDC–UP program while 28 States have not. Consequently, foster children in 22 States will have a different set of criteria as far as potential eligibility for Federal assistance than those in the 28 other States. We urge this committee to provide for uniform assistance to all needy children. I will turn over to page 13 and then we will give to Mr. MacDougall.

We are extremely gratified that the chairman of this committee once again plans to introduce legislation which would truly bring equity to the Federal Government's treatment of these foster children. In the past, we have endorsed Senator Long's efforts to remedy the unfortunate limitations for persons in tubercular institutions, and we strongly support his efforts to correct the situation as with respect to the Federal program's aid for foster children.

In essence, his bill will in thousands of cases make the difference in providing proper and wholesome foster family homes, where such are not now available, due to the financial inability of many couples qualified and desiring to care for a foster child. Because of low foster payments they are now unable to do so.

Secondly, it will increase the financial assistance to our foster care child institutions, thereby improving their ability to provide an

environment offering the foster children a better opportunity of making the difficult adjustment to the circumstances with which they are confronted.

Lastly, it will provide aid for professional services, and for the training of appropriate personnel necessary to deal with the problem of our foster care programs.

It is important to point out that we are all in full agreement that, if possible, a child should be in his natural home—and every effort should be made to keep him there if such is in his best interest. The fact remains that there are thousands of cases where it is either impossible or undesirable for a child to remain in his natural home and there is no alternative other than a foster home. Surely, that child deserves the same Federal consideration as any other.

Mr. Chairman, I would like to submit for the record a copy of information that I have received from Mr. Garland L. Bonin, commissioner of public welfare in the State of Louisiana, for the record.

Senator HARRIS. Without objection the statement will be inserted in the record.

(The document referred to above follows:)

STATE OF LOUISIANA,
DEPARTMENT OF PUBLIC WELFARE,
Baton Rouge, September 15, 1967.

Hon. W. W. DUMAS,
Mayor-President,
Municipal Building, Baton Rouge, La.

DEAR MAYOR DUMAS: The attached information has been prepared by the Department of Public Welfare at your request for presentation to the Senate Finance Committee. This information reflects the position of the Department in relation to Child Welfare Services included in H.R. 12080.

We hope it will be helpful to you.

Sincerely yours,

GARLAND L. BONIN,
Commissioner of Public Welfare.

CHILD WELFARE SERVICES AS AFFECTED BY H.R. 12080

We believe there should be sound federal financing for comprehensive child welfare programs which should be available for *all* children in need of care and services regardless of their socio-economic condition or their ethnic background. If H.R. 12080 becomes law in its present form, it will be more difficult to achieve this goal. Section 205 amends and improves the provision for matching funds for foster care children who were receiving AFDC. However, we in Louisiana believe that the Child Welfare Program including foster care services would be improved if there would be provision for Federal matching for the entire program similar to the matching for AFDC. There are many children in foster care who were ineligible for AFDC or whose families were not known to the Department of Public Welfare before the court committed them to the care of the Department. For example, at the end of the fiscal year on June 30, 1967 there were 5,491 children in foster care in Louisiana and only 760 of this total number had been included in AFDC grants before placement.

In the fiscal year 1966-67 the Department of Public Welfare paid $5,298,597.25 for children in foster care. We received $611,015.57 in federal funds for foster care payments for AFDC-Foster Care children. The total program of Child Welfare Services (including foster care payments) cost $8,020,183.00 of which amount only $1,752,559.00 came from federal funds.

At the end of the fiscal year on June 30, 1967 there were 458 children in foster care in East Baton Rouge Parish. Of this number only 42 had been included in AFDC grants prior to placement and were therefore eligible for federal matching funds. Expenditures for children in foster care in this Parish amounted to $485,058.11 for the fiscal year 1966-67.

We also hope that Senate Finance Committee will carefully review the proposals to restrict the AFDC Program as they could mean more expenditures for Child Welfare Services. Ultimately they could result in removal of children who might be better cared for in their own homes if lack of money is the basic problem. Child Welfare caseloads will then increase. It will be the children who will suffer as a result of circumstances of their birth, the behavior of their parents or economic conditions—all matters beyond their control. Louisiana already has a suitable home policy to provide for children who are truly neglected.

Under H.R. 12080 seventy-five percent federal matching would be available to states for Child Welfare services provided to AFDC children, but this matching would *not* be available for Child Welfare services to non-AFDC children. We believe there should be federal matching not only for personnel providing services to AFDC families but for all Child Welfare personnel without distinction as to the caseload they are serving.

In our opinion H.R. 12080 concentrates on services for AFDC children. We believe that Child Welfare services should exist for all children in need of such services without regard to financial need.

Mr. DUMAS. I would like to thank you very much for allowing me here and at this time I would like to present to you Mr. MacDougall, as I introduced him early, to present the remaining portion of this testimony. I hope to be in your State in the next 2 weeks. I have a meeting.

Senator HARRIS. What are you going to be doing in Oklahoma? You have sort of intrigued my interest.

Mr. DUMAS. Well, we have a few water problems in Louisiana and several years ago a gentleman from Oklahoma came to Baton Rouge about the canals and waterways and we assisted them and they were so successful in getting financial aid we thought we would go back and find out and have you teach us how to do it.

Senator HARRIS. Mr. MacDougall.

Mr. MACDOUGALL. Mr. Chairman, I think in the interest of conserving time in the minutes available here I would like your permission to submit which you have already accepted the written statement and comment to you extemporaneously on the position of the counties particularly on the public welfare portions of H.R. 12080.

Senator HARRIS. Very well, without objection that may be done. And also we will have inserted in the record, we haven't done so previously, the written recommendations of the First National Association of Counties Welfare Conference that is attached to your statement, Mr. Mayor. Go ahead Mr. MacDougall.

(The prepared statement of Mr. Dumas and attachments previously referred to appear at p. 1299.)

Mr. MACDOUGALL. Mr. Chairman, first let me get on then with the dismal side of our testimony. The things in H.R. 12080 on the public welfare side that counties nationally would like to see changed. Improvement in the bill. This is not meant to derogate the general excellence of the bill and we will get to the good point in the bill in a few moments, but specifically we would ask these changes: First, that the arbitrary limitation on the number of absent parents cases in child aid that the bill contains in section 208 be changed. We can see in every State trouble there that will just be no way of avoiding if such an arbitrary limitation is put on. These are the children whose need may be greatest, and we have no way of controlling absolutely the number of derogations or abandonment in our State or in any State, and we certainly join in the concern of the Congress and the House Ways and

Means Committee about the growth of this part of the child aid program, but we do ask some other device than an arbitrary ceiling on the number of cases that may be recognized federally in any State be the answer, and we do think that this committee, and its staff will be able to come up with a substitute provision that will not work the hardship that present section 208 would, and forcing us to either deny aid to those children or to levy additional property taxes in a situation where there is already a burdening of that base to take care of them.

Senator HARRIS. What would you have to do in your State, in regard to those people who otherwise would be cut off under the House bill provisions, section 208—with the population of California going up like the population of the country, this seems a likely possibility.

Mr. MACDOUGALL. Well, under our basic law, and this is true in most States, I think they would go back on the basic obligation of the counties, to render general assistance and there is a very limited base and payments are very limited. In some States they aren't even in cash, and it would make really second-class children out of these children, when their only crime, if it is that, their only difficulty is that, they came along a little bit late.

There will be groups of children under this kind of a limitation if they had come along—if pop had run away a month earlier they would be all right, but if he runs away a month later they would be denied aid. That is the kind of situation that this arbitrary limit gives. It doesn't fit the overall tone of the bill which is a balanced bill designed for, we think, the first time to tackle some of our worse problems of welfare abuse while at the same time maintaining a very liberal public assistance payment operation, and in fact going into those portions of the case load that the Federal Government has previously neglected, such as the foster home situation.

This is by and large a good bill, and this particular device of frustration, shall we call it that, on limiting absent parents cases just isn't the kind of devise that fits this situation.

We hope all of the other good things that are in the bill will create a situation where the caseload won't grow that way. But after all, neither the Congress nor the counties can guarantee the moral climate in America, let alone the economic situation, and this is what motivates parents either to leave the home, desert or abandon children and, as I said before those are probably the most unfortunate children of all and their need is immediate, and since they have been recognized for years, we have a difficult situation there and we hope that this committee will look at it.

Mr. DUMAS. May I inject one thing there?

Senator HARRIS. Yes, sir; Mr. Mayor.

Mr. DUMAS. It seems in a lot of ways we seem to put a lot of emphasis upon the desertion of the parents of these children, but by the same token many of these children are left on the public welfare by the tremendous accidents we have, like the last year 52,000 people were killed on the highways. Many of these children were sent into the homes by, just by, death, rather than by desertion and those should be considered the same way. I just thought I would bring it aught because it is strictly just not people who have left home. There are many reasons why these kids are there.

Mr. MACDOUGALL. Another problem we have, gentlemen, is with respect to the definition of unemployment in the child aid situation where you are granting aid to an unemployed father and his family.

At the moment the States define unemployment or employability with respect to this particular type of aid. Admittedly the situation is neither uniform nor terribly satisfactory nationally. For one thing all of the States aren't in the program. But the proposal now in the bill that a Federal definition of unemployment be made mandatory throughout the Nation and it be implemented by a very difficult mechanical situation where you must examine the last 13 months of every one of these people's lives and determine whether or not they had six covered quarters of employment, where you have to go through their unemployment compensation history, all to decide whether or not they are truly unemployed, is going to not only be an administrative monstrosity, but it is going to leave us in a situation of a limbo land of children for whom there is no recognition.

In other words, if a parent, a father is out and out unemployed under all standards, he just lost a steady job, he will get eligibility. If the children have an incapacitated parent who is physically disabled there will be eligibility, but under this bill there is a large middle ground there of thousands and thousands of children whose father isn't disabled enough to be permanently disabled and isn't employed enough in recent history to be called unemployed right now and our problem, and it will be the Nation's problem of what to do about those children.

Now, in programs like we have now in California and other States those children are recognized as children of unemployed parents even though there is the question in many cases as whether the unemployed parent is actually employable, can fit into the labor force, because of his own problems for long periods of time.

But again we are creating here under this bill an interim zone where there is no Federal coverage for children, where there is now and where there needs to be. These are small changes, but we do ask you to consider them.

Senator HARRIS. Could that be taken care of by rewriting that into some kind of Federal minimum?

Mr. MACDOUGALL. Possibly could. It could be taken care of by continuing the present law which permits the States to write a definition, and possibly then tightening up on the Federal approval of that definition. So that the Federal authorities here in Washington will have the last say as to whether or not the States definition is realistic. But what we are all concerned with, I think, is coverage of all children vary in like circumstances.

Senator CURTIS. May I ask right there——

Mr. MACDOUGALL. Yes.

Senator CURTIS (continuing). If the States have the right to write their own definition.

Mr. MACDOUGALL. They do under the present law. The bill before you, Senator, would change that.

Senator CURTIS. But I understood you were critical of the present law.

Mr. MACDOUGALL. No, not at all. No, I said from the standpoint of obtaining what some think is great uniformity on a national basis it

hasn't produced, but each State is now doing what that State thinks is proper and best, and we have no complaints with that situation whatever. There are those outside of the welfare administration or county government who do have complaints and they will be voiced to you, but we have none.

We are having problems with the medical aid program, too. I think those are national in title XIX of the bill, and we ask you if you would just take a look at two things there: One, are what I think are becoming known as the anti-New York-California provisions to set family income limits beyond which a family cannot be called medically indigent. New York is the outstanding example. You will be hearing from them this week. We, in California, are a reluctant runner-up, not reluctant because we are not the champion, but reluctant because we are that high in the list to New York.

We are having vast problems with this problem in our State itself running to $800 million this year. But the answer to that problem is not an arbitrary Federal sliding rule that will take a family on and we ask you to continue the present law in this respect, let New York and California sweat their problems out, and believe me they are doing it in the next year and then look at whether or not we have been able to wrestle with these things successfully and if not then I think we would be the first to come in and invite you to lower the boom on us at this time.

Senator CURTIS. May I ask, what is the maximum income permitted to be medically indigent in California?

Mr. MACDOUGALL. We are below New York. It is on a sliding scale. It runs basically about one and a half times to one and maybe two-thirds times what the comparable child aid budget situation would be for each family. Of course, it depends on the size of the family and the income.

Senator CURTIS. In dollars tell me how much it is.

Mr. MACDOUGALL. Well, Senator, it varies with each case. The beginning of eligibility is at a point that is above what child aid eligibility would be. It is, I can't describe it without reading to you an entire table. But I will be glad to submit that for the record.

Senator CURTIS. What is it for a family of four, at what point would their income be such that they wouldn't be considered for medicaid?

Mr. MACDOUGALL. I couldn't precise that either without referring, and I would like to submit that, too, if I may, sir. As to the exact number of dollars, and I will do that.

Senator HARRIS. All right, without objection that will be included in the record when it is received.

(Data referred to may be found at p. 317.)

Mr. MACDOUGALL. We are also interested in title XIX in the proposal of Senator Ribicoff that the requirement that medical program be the same for people in all types of welfare categories be modified so that we can have a special classification for children. We find that there are certain needs, particularly dental and optical needs that children have that arrive at a higher priority than some of the residual needs of the other types of people, and we would support Senator Ribicoff's proposals in that regard.

Now, so much, Mr. Chairman, for the things in this bill that we would like to see improved.

I would just very briefly now like to run over some that they will be balanced in this testimony the very good features of the bill, the entire thrust of the bill is one which is meeting county approval across the Nation, and we say this as the basic administrators of welfare in half of the States.

We are extremely pleased with the devices that the bill is making possible to eliminate abuses of welfare particularly in the child aid field. The extension of vendor payments, the broadening of the concept of protective payments. These are things that we have needed for a long time, things that we have asked for for a long time. It is a great source of satisfaction to sound welfare administration to find those in the bill.

Also, the fact that a work and training program will be made mandatory, that each State will be required to look at every recipient of child aid, the parents in that situation, to determine employability to be given meaningful work and training. These are things we have been trying on our own in the progressive counties in the Nation. Some of the State programs are helping us. We were tremendously happy to see that made a Federal requirement.

Senator HARRIS. Will you take a position on whether welfare aid ought to be made conditional upon going into that program?

Mr. MACDOUGALL. Yes.

Our position is this: That there is no justification for penalizing children for the, shall we say, indolence, laziness, or insolence of their parents. On the other hand, if, and this is where this bill does offer a solution we have never had before, if a father is, we call them just plain lazy and will not react to work training, will not embark on a program, we believe the provision of the bill is sound that says that that father should be excluded from the budget. On the other hand, we know from years of experience in welfare administration that they are all going to eat out of the same beanpot. Taking Pop out of the budget may be fine for the welfare case record because it shows his blank, but he is going to get his hands or she, if it's a mother, on that welfare check in its reduced form so in that sense you penalize the children. The answer we suggest there and that is one of the set of recommendations of the bill is to use one of the other provisions in the bill on vendor payments and place that particular family on a type of regulated payments where they don't get the cash in hand so that the money surely goes to the children. Now, if the father sees fit to lay around home in that atmosphere, being kind to his children so that there is no problem there of abuse, if they need a foster home situation at least we are one up on the present situation. So we do feel this is a good feature of the bill. But that we must be realistic in knowing that just taking him out of the budget and paying, say, $50 a month less in the welfare check is going to come out of the children just as much as it does out of him and this has to be faced. So we think the indirect payment idea there is a meaningful answer, and we would like to try it.

We are very happy, too, in this child aid situation to see further recognition of exempting the earnings of those in the child aid family. There are some in county circles who feel that H.R. 12080 is too lib-

eral with that respect, that you could tighten the dollars and cents figures in the limitations now in the bill. But the general idea of more recognition of earnings in the family is a very fine thing.

We are also very happy to see the recognition of our law enforcement activities in desertion cases and in parental nonsupport cases. This is something we have pleaded for for years as some recognition of the work done in the district attorney's, the county attorneys with respect to law enforcement, and in some of the States, particularly in our own State of California, we are financing that at 100 percent county expense just to get the job done. But to have the Federal Government now require that there be this cooperation between the welfare department and local law enforcement, and recognition of that is a very wonderful thing, and we are very happy to see it.

We think with those safeguards and others in the bill, it is safe to make the unemployed parents program a permanent one, and we are happy to see that the bill does that.

We are happy, too, to see another little vacuum filled in here which has been, I think, a problem to every State, and that is what do you do about temporary emergency assistance? A family comes in, and they are completely destitute. This has gone all the way from State aid in States like New York, county aid in States like California, Salvation Army aid in States that don't have any basic governmental setup for those people, you finally in this bill are moving in and recognizing, limited, it is true, 30 days in each year is all that is permitted, but that the Federal Government will say that these kids are just as hungry today as they will be 6 weeks from now is what it amounts to and if you meet today's empty stomach with Federal funds too and we appreciate that.

I think this should conclude my testimony, Mr. Chairman. We are very happy with the general thrust of the bill.

Senator HARRIS. Mayor Dumas, did you have anything further?

Mr. DUMAS. I have one further comment to make based on the question asked by Senator Williams, that NACO, the National Association of Counties and I as the mayor of Baton Rouge, I think I speak for many other elected officials throughout the country, realize when you increase benefits that the money has to come from somewhere, you just can't manufacture it. It has got to be a justifiable reason for increasing it. We want you to know we are aware of the situation and we do, would do anything in the world to work with the Congress, the Senate to help in any situation we can, increase in benefits means increase in some other branch of the Government. So we are all aware of that, sir.

Senator HARRIS. Anything further, Senator Curtis?

Senator Talmadge?

If not, thank you very much, gentlemen.

Mr. DUMAS. Thank you very much.

Senator HARRIS. We will tell the chairman his hometown was represented very well.

Mr. DUMAS. Thank you, sir.

(The prepared statement of Mr. Dumas and Mr. MacDougall, with attachments, follows:)

STATEMENT ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES BY W. W. DUMAS, MAYOR-PRESIDENT, EAST BATON ROUGE PARISH, LOUISIANA, AND WILLIAM R. MACDOUGALL, GENERAL COUNSEL, COUNTY SUPERVISORS ASSOCIATION OF CALIFORNIA

Mr. Chairman, Senator Williams, members of the Committee: My name is W. W. Dumas, and I am the Mayor-President of East Baton Rouge Parish, Louisiana and a Past President of the National Association of Counties. I am accompanied today by Mr. William R. MacDougall, Secretary of the National Association of Counties' Committee on Welfare and the General Counsel of the County Supervisors Association of California. In my opinion and that of our Association, Mr. MacDougall is unquestionably one of the most informed individuals in the nation with respect to local government's relationship and responsibility in the area of welfare. I hope that you gentlemen take full advantage of Mr. MacDougall's knowledge and experience in examining the merits of the proposed legislation currently before you.

Here in Washington, in December of 1966, the National Association of Counties held its first national conference devoted exclusively to the subject of welfare. This conference's purpose was to consider our nation's welfare efforts and their relationship to the overall problem of poverty.

Two basic concepts clearly emerged from the conference.

One was the restatement of our basic philosophy as to county government's welfare role—which reads as follows:

"The National Association of Counties believes the responsibility of alleviating and eliminating poverty is a principal function of county government, and therefore urges the respective states to provide counties with broad legal powers to accomplish such objectives. Additionally, we urge the respective states and the federal government to participate financially in these programs, but urge that any accompanying state and federal regulation be such as to maintain the maximum degree of initiative and responsibility at the local level."

The other concept was this—notwithstanding county government's desire to retain and to increase its role in our nation's welfare efforts, this will be difficult, if not impossible, unless the federal government initiates a more flexible general policy with respect to local welfare administration. Local elected officials have neither the desire, nor is it feasible, to have the responsibility for a program in which they have virtually no authority. Increased flexibility at the county level will require federal administrative and legislative action.

I have included at the conclusion of my statement the recommendations of this National Welfare Conference, as well as the recommendations adopted at our very recent National Legislative Conference. In view of our time limitation, we have selected certain recommendations to discuss in greater detail because of their high priority in county thinking.

I feel it is important to bear in mind that welfare, nationally speaking, is county government's *largest* budgetary item and accordingly one of its principal responsibilities. Thus, you can understand our abiding concern that our views be given the maximum possible consideration!

Prior to detailing our observation, I should first like to state that except for several aspects of HR 12080, which we shall elaborate on, we feel it is an excellent bill.

We do feel it is possible that some of the new provisions of HR 12080 could be administered in such a way as to justify the criticisms that have been made of them. This is especially so with respect to the provisions dealing with training and work placement. On the other hand, these provisions can also be administered in such a way as to bring unlimited benefits to welfare recipients and the nation as a whole.

We feel it is important to note a strong endorsement with respect to the ability and integrity of the thousands of federal, state, local elected and non-elected officials who have the responsibility of carrying out in a partnership arrangement the present and future federal assisted welfare programs. They are capable, competent, and properly motivated to carry out the new and revised provisions of HR 12080, and in doing so, we fully expect them to bring credit to our welfare efforts.

There exists in our federal welfare program, one of the least known and least justifiable *omissions* one might imagine! That omission is the federal government's failure to make available anything other than token assistance to

that pitiful group of needy children who, for reasons beyond their control, have neither a mother or father or relative of the required consanguinity with whom they may reside, in order to meet the federal eligibility requirements for assistance—the "foster children." The seriousness of this omission, in the view of our Association, is of such magnitude that our National Welfare Conference, determined that the attainment of federal assistance for foster care programs must be our top priority legislative objective. It is now so designated.

Although the federal government has long recognized that it must bear a part of the responsibility for the welfare of our needy dependent children, it has, through an arbitrary distinction in the law, for all practical purposes, ignored the plight of the foster child. The only exception of note is one grudging provision of the Aid to Family of Dependent Children's Program, which does provide assistance to a foster child who is placed in a foster home by a court order, but only if the child was receiving AFDC aid in and for the month court action was initiated. The rationale of this distinction has always escaped us. This provision did provide assistance to approximately 5,780 foster children, as of June 1965. However, it is our understanding that there are currently 300,000 children in approved foster homes and institutions recognized by the states for public aid purposes.

In 1962, President Kennedy successfully recommended to Congress that the Aid to Dependent Children Program (currently entitled Aid to Families with Dependent Children) be amended to include the needy children of the unemployed. He stated, "Under the aid to dependent children program, needy children are eligible for assistance if their fathers are deceased, disabled or family deserters. In logic and humanity, a child should also be eligible for assistance if his father is a needy, unemployed worker." We have agreed—and hundreds of counties have broadened their child aid programs accordingly, under their own state legislation.

NACO contends that this same logic and humanity is a compelling force to include children in foster homes. For reasons beyond their control, they have neither mother, father, nor even a relative of the required consanguinity with whom they may reside in order to meet the federal requirements.

It is our view that if we must limit our welfare efforts, the last place we should do so is with respect to children, especially needy ones who have the added handicap inherent in foster children.

As you know, HR 12080 as enacted by the House further expands the federal government's participation in foster home care of dependent children. The legislation provides that, although a court order is still required for placement, the child need not have received AFDC aid during the month in which he or she were placed in a foster home. Rather, it provides that in the six months before proceedings started in the court, they would be eligible for AFDC if they had lived in the home of a relative.

Unfortunately such a requirement, although aiding some additional children, works further inequities on a great many more than it aids. In the first place, you have a situation where approximately 22 states have adopted the AFDC-UP program while 28 states have not. Consequently, foster children in 22 states will have a different set of criteria as far as potential eligibility for federal assistance than those in the 28 other states. We urge this Committee to provide for uniform assistance to all needy children.

As is evidenced by the requirement of a "court order," there is an apparent feeling that such is a necessary procedure prior to federal participation. If the court order is used as a mechanism to hold down the federal government's participation, then it is understandable and an effective device. We do not feel that is the intention.

If it is the contention of the federal government that the court order is an essential requirement solely to protect the rights of the child and his parents, then we contend this requirement is in itself an injustice. Our contention is supported by 35 out of the 36 states responding to a survey we conducted on this very subject. The survey was answered by those state officials having the primary and ultimate responsibility for foster care programs within the respective states.

We have received an unofficial estimate from some informal sources that HR 12080 might assist up to 50,000 foster children. This leaves 175,000 needy foster children still unaided by federal participation. The financial lure to go the court route in the future, regardless of the situation, will be difficult to resist and with it, unfortunate results for many children as well as their parents.

I think the various responses of our survey make the best possible care for federal participation for all needy children placed in a foster home by an approved state procedure. Such eligibility is embodied in S. 1186 introduced by Senator Fulbright and Senator McCarthy of this Committee.

Of the 50 questionnaires which were sent to each of the state agencies with primary responsibilities for placing needy children in foster homes, 38 have been returned. Each state which answered the questionnaire, except Arizona, indicated that they were in favor of federal participation for needy children in foster homes placed there under approved state procedure rather than preference for the requirement of a court order prior to federal participation. Eveyone of the states which responded, except that of Arizona, maintains an approved, voluntary procedure in addition to a court order in admitting children to foster homes. In every case, again with the exception of Arizona, it was felt that children placed in a foster home other than by a court order have their rights, as well as those of their parents, adequately protected.

The voluntary placement technique generally follows the same lines in all states in that it involves a contractual agreement between parents, or persons standing in place of parents, and the relevant social service agency.

In Louisiana, such voluntary placement can be accomplished through a surrender for adoption by the parents or by contract with the parents for a limited time.

In the state of Maine where voluntary placement is used, the plan is devised jointly by the parent and the agency with final decision and approval residing with the parent. Social and financial need determine the nature and scope of the agency service.

In the state of Oregon where children may be placed in foster care on the basis of a written voluntary consent of the parents as well as by a court order, between 10 and 20 percent of the foster home placements are voluntary.

In Delaware, the following procedures, in addition to a court order, are used in placing children in foster homes: (1) direct application of a parent or relative, (2) referral from Protective Service in the Child Welfare Division of the Department, (3) referral from another agency within the state, (4) referral from the Public Assistance Division, (5) referral from anyone regarding a child who has been placed with a non-relative and is without legal protection. Delaware indicated "a very small percent" of its 1,200 foster children would be assisted by the restrictive House version.

The state of Texas has offered a well expressed observation regarding voluntary placement. Here casework analysis establishes the need of the child and considers the rights of all parties concerned. *This method involves the active participation of the parent in planning for the child and builds upon the parental strengths for those cases in which this is appropriate. They further observe that to remove custody of some children from their natural parents by court action fosters their dependency and contributes to the inadequacy and irresponsibility of the parents rather than assisting the parents in being more responsible for adequate child care and growing into more adequate parenthood through the aid of social and rehabilitation services.*

In the state of New York, which has 44,000 children under foster care, and therefore the larger number of any of the states, more than 80 percent of the children *do not* come into foster care through the court.

In Los Angeles County, only 25 percent of the Department of Public Social Services placements have involved court action. Seventy-five percent result from cooperative planning by parents and the agency for the best interest of the child.

In Los Angeles County, the present law provides assistance to 1% of the foster home placements because (a) court action was not needed, or (b) the child was not receiving aid to families with dependent children when court action occurred. Los Angeles County observes that the Juvenile Court should be used for the protection of children and not as a means for obtaining federal participation in foster care. Los Angeles County further notes that when the large majority of dependent, neglected children can be placed and protected by mutual agreement between the parents and the child welfare agency, there is no basis for petitioning the court. *Court proceedings involve judges, probation officers, and other related personnel, and are extremely costly. The Director feels that there is no justification for local governments to finance this costly and unnecessary procedure.* One compromise which might be offered should the administration be willing to support the elimination of requiring court involvement for federal participation

would be: federal participation be available for children placed by order of a court and for children placed by a state or local agency that has an approved professional protective services program.

The following are several answers to the question regarding the reasons or circumstances why it is preferable to place a needy child in foster homes other than by a court order. The state of Georgia observed that there is no need to subject an already distressed parent or guardian to court action unless the circumstances require it. A parent who is ill, temporarily destitute, etc., need not have to go to court. Many people are afraid of court procedures and would choose not to take an otherwise desirable action if it meant going to court.

The state of Maine felt that the avoidance of court action where possible improves chances of family rehabilitation. The higher percentage of children placed under the voluntary program are replaced in their own homes with obvious long-run financial savings. If court order requirement is dropped from HR 12080, safeguards to protect voluntary nature and parental rights should be written into the law.

The state of Mississippi observes that if financial need is the problem and if parents do consent to placement, they feel the signature on the parental consent form is preferable to court order. A child should not have to experience a court hearing situation because of financial needs that exist in his family.

In Pennsylvania it is felt that placement under a court order implies an adversary proceeding and this is distasteful and demeaning when there is no issue of neglect, abuse or unwillingness to exercise parental responsibility. Parents should be encouraged to discharge their responsibilities in a responsible way, and reliance upon court procedure and court order takes this responsibility for them.

In the state of Nevada, the Welfare Division feels there are selected cases in which a voluntary agreement with the natural parents is preferable to a court order. These cases include the unwed mother who is undecided about relinquishing her child for adoption; the child for whom foster care is needed for a brief period of time because of some temporary family problem; and the child with a physical or mental handicap for whom care outside his own home is indicated, perhaps to take advantage of special medical and education facilities not available in his own community. The important determining factor in accepting a child on a voluntary agreement versus a court order is the strength of the parent and his ability to work cooperatively with the agency in the best interest of the child.

In the state of New Jersey, it is felt that the necessity for appearance in court could frequently be misinterpreted by the child and the necessity for court action could frequently result in unnecessary delays in imperative or desirable placement.

The state of New York observes that in many cases of children going into foster care placement, neglect or potential neglect which might indicate the advisability of court action is not present. For example, a child may be emotionally disturbed, his parents recognize the need for foster care and cooperate fully with the placing agency, or foster care may be necessary for a temporary period because of illness of a parent and it is not possible to keep a child in his own home through the provisions of a homemaker service or day care. Where the parents are cooperative, and are not neglecting the children, it does not appear that the authority of the court needs to be invoked in order to effect necessary foster care for their children.

North Carolina feels there are frequent situations where a child needs an interim living arrangement while his own home is receiving social services which will preserve and strengthen the home. The child's right to receive AFDC should not be jeopardized by his need for foster home care. In North Dakota, it is felt that a court procedure should not be required of responsible parents to be eligible for foster care services. *They want the parents to carry the maximum responsibility in planning for their children. Placement by a court order would shift the responsibility from parents to the court, and undermine rather than strengthen parental responsibility for children.*

In the state of Ohio where the voluntary agreement under which a child is placed in the temporary custody of an agency often follows extensive casework service to the family. Because the family has thus been enabled to share in the decision for placement, a continuing relationship can be preserved with the ultimate result of rehabilitation of the natural home. The court procedure, on the other hand, often engenders hostile and offensive feeling resulting in loss of

meaningful contact between agency and parent and between parent and child. The state of Ohio observes that the court order specifically for placement or specifically requiring that physical custody be removed from the parent is considered by the better child welfare agencies to be a deterrent to the agency's provision of the optimum service. In most instances, the county-agency relationships are such that the court commits the child to the agency's custody but leaves to the agencies decisions regarding the kind of care (own home under supervision as against foster care) most beneficial to the child and family at any particular time. This very flexibility might preclude eligibility of some children under HR 12080.

The state of South Dakota makes a simple observation that people usually can do voluntarily anything a court can force them to do involuntarily and as a result, it is easier to plan with natural parents and the children for their return to their own home.

In Tennessee, it is observed that the focus in utilizing foster care placements is toward serving the total family and with the conviction that the majority of children can best be served in their own homes. Voluntary placements enhance casework planning and rehabilitation. If required to bring all placements before the court for adjudication, it will decrease the effectiveness and bring undue pressure and responsibility on the court.

In West Virginia, it is felt that a responsible parent or parents should be able to request voluntary placement of their child for a temporary period of time because of such problems as hospitalization, absence, marital problems, or other family crises that interfere or prevent the parent from the caring for the child temporarily. Under these circumstances, a parent should not be charged with neglect and lose legal custody of his child which is necessary before a child can be placed on the basis of a court order and be eligible for AFDC foster care.

We are extremely gratified that the Chairman of this Committee once again plans to introduce legislation which would truly bring equity to the federal government's treatment of these foster children. In the past, we have endorsed Senator Long's efforts to remedy the unfortunate limitations for persons in tubercular institutions, and we strongly support his efforts to correct the situation as with respect to the federal program's aid for foster children.

In essence, his bill will in thousands of cases make the difference in providing proper and wholesome foster family homes, where such are not now available, due to the financial inability of many couples qualified and desiring to care for a foster child. Because of low foster payments they are now unable to do so.

Secondly, it will increase the financial assistance to our foster care child institutions, thereby improving their ability to provide an environment offering the foster children a better opportunity of making the difficult adjustment to the circumstances with which they are confronted.

Lastly, it will provide aid for professional services, and for the training of appropriate personnel necessary to deal with the problem of our foster care programs.

It is important to point out that we are all in full agreement that, if possible, a child should be in his natural home—and every effort should be made to keep him there if such is in his best interest. The fact remains that there are thousands of cases where it is either impossible or undesirable for a child to remain in his natural home and there is no alternative other than a foster home. Surely, that child deserves the same federal consideration as any other.

I would at this time like to request Mr. MacDougall to present the remaining portion of our testimony.

FEDERAL STANDARD OF "NEED"

One of the most significant portions of the President's welfare proposal would have Congress establish a minimum standard for public assistance payments according to each state's definition of "need." If this measure was adopted, every state would be required to pay 100 percent of its own definition of "need" to welfare recipients before July 1, 1969. In the interim, no state would be permitted to pay a lower standard than it had in 1966, at the risk of forfeiting all federal funds. Thus, the federal government would establish a floor under which no state could go in its cash grants to public assistance recipients. An appropriation of only $60 million accompanies this major proposal, to be used by those states with real financial "hardships." Presumably, *no* additional federal funds

would be available for the "richer" states who would nevertheless be bound by the same provisions.

We do not dispute the fact that the goal of meeting a public assistance recipient's full needs is laudable. Neither do we contest the statement of the Federal Advisory Council on Public Welfare, in its discussion of this issue, that recipients "are not dependent through choice, but are victims of economic, social, or health circumstances beyond their control . . ." We cannot be accused of favoring low grants as a means of punishing the unfortunate. What *is* in dispute is the method by which the welfare system—federal, state and county—can best provide for the needy.

In California, for example, only *one* program in which the federal government shares—the Aid to Families with Dependent Children Program—falls below the state's definition of full "need." Our blind, aged, and disabled programs meet the definition of need. But I must emphasize that this is *not* the case in most other states. Indeed, 31 states pay below their standard and 8 pay less than a half! And it is this regrettable situation that concerns you, just as it concerns every state and county official who has the awesome responsibility for establishing public assistance standards.

If unlimited funds were available, I might not be here before you today on this issue, although I do have some reservations about the advisability of the federal government moving into as traditional a function of state government as that of establishing welfare grant standards.

But, regrettably, money *is* our problem in this issue, just as it is in *every* issue with which you gentlemen of this Committee must deal.

If I may be permitted to refer again to California's statistics: For the *one* category which does not presently meet the state's definition of need, it is estimated that it would take an additional *$33.2 million* to meet full need. As presently phrased, HR 5710 would provide little or no increased federal sharing to meet this extra financial burden. Thus, the counties and state of California would be forced to meet an additional cost of $33.2 million, and that is an amount which can only *grow* between now and 1969 and for each year after that. Indeed in 1968, if present trends continue, our State Department of Social Welfare has estimated that 10 percent of *all* children under 18 years of age in California will be eligible to receive AFDC payments!

An insistence upon a federal standard of grant payments could have the adverse effect upon California by forcing the state to equalize its standard of aid so that all cases would get the same treatment, but all would generally receive *less* money than they now receive. In other words, it is possible for the State of California to consider an assistance standard that is well within its maximum payment base that would equitably apply to all persons but will allow *less* money for a vast number of cases. This adverse effect is certainly not the intent of the measure before you, but financial necessity could easily force any state to resort to such a practice.

It is the National Association of Counties firm belief that any federal requirements in this area should be accompanied by corresponding federal financing of the additional costs. As the Advisory Council on Public Welfare so correctly observed, ". . . strong federal leadership, combined with greater federal financial responsibility, are absolutely essential to bringing substandard public assistance payments up to a proper and decent level."

WELFARE ABUSES

From the standpoint of the elected county official, one of the most difficult problems confronting the administration of our welfare programs is the inability to adequately control the problems arising from those welfare recipients who are unable to properly manage their financial affairs. This situation seriously jeopardizes the local elected official's efforts to secure the needed local public support for an adequately financed program, not to mention the more important aspect of thwarting the intent and purposes of its program.

This problem was recognized in the 1962 Amendments to the Social Security Act, by the enactment of what is referred to as "third party protective payments." Although this provision has now been in existence for almost five years, it has proven to be ineffective in handling the problem. According to our latest information, only five jurisdictions have been fit to implement the provisions—and even in those five jurisdictions the situation appears to be not very satisfactory.

We feel that it is vital that some new mechanism be provided in order to allow a greater local flexibility in money management of welfare payments. It is equally important to stress that our purpose is *not* to jeopardize the basic concept of unrestricted cash payments. Rather, it is to correct those abuses that, in effect, are greatly damaging the entire welfare program.

We therefore strongly endorse the Section 207 of the bill which provides for vendor payments and discontinues the requirement that a state must meet need in full in order to utilize protective or vendor payments.

Section 207 brings to mind a problem caused by one provision of H.R. 12080, a problem which the use of vendor or protective payments can help solve. As you know, the proposed work and training program, a provision we strongly support, provides that those members of the family who refuse without good cause to accept training or employment would be cut off the rolls. (Children would not have to be cut off the rolls but the adults would not get payments.)

The problem is that despite the fact that the adult is cut off the rolls, he is still in the home and will continue to share with the children whatever they are still entitled to receive. Unless there would be justifiable reasons for removing the children from the home, and a refusal on the part of the parent to work would hardly be so, you are penalizing the child as well as the parent. We suggest that in such a case, protective or vendor payments be utilized and the adult or adults still be computed in determining the total grant.

INCENTIVE PAYMENTS (SEC. 202)

As you will note by the attachment setting forth our Welfare Conference recommendations, there are a number of other items in the bill which we are totally in sympathy with. One I should like to particularly point out is the one dealing with incentives for employment. Its merits have been adequately covered by other witnesses; however, we join in support for its enactment.

WORK AND TRAINING PROGRAM (SEC. 204)

As previously mentioned, we endorse the work and training program, and we welcome the correction of the previous problem in the existing program by allowing the federal sharing in the cost of training, supervision, and materials.

PARENTAL DESERTION

The bill provision to allow federal sharing in the reasonable expenses of the law enforcement agencies with respect to welfare recipients as a usual administrative expense of the welfare program is desirable and another we feel will provide significant assistance in rendering the problem it is designed to correct, that is, problems caused by the desertion of parents. Notwithstanding the fact that this provision will result in some, and hopefully many cases going off the public rolls, and that our work and training programs will soon also start accomplishing the same objective, we do not feel it is realistic to expect that the total number of cases of aid to children with a parent absent from the home will stabilize, or start diminishing, as of January 1968. The result will be a larger burden being placed on the state and local governments, a burden which is already very significant and one that will increase by virtue of H.R. 12080. However, we feel that the added cost to be incurred by county government as a result of this bill is money well spent in that we consider it more of an investment than a typical grant.

AID TO NEEDY CHILDREN WITH UNEMPLOYED PARENTS

Another of NACO's recommendations resulting from our Welfare Conference was that of making this program permanent and we are pleased that H.R. 12080 would do so. However, we feel a federal definition of unemployment, especially the one outlined in the bill, will result in a very difficult and unworkable administrative problem. We would urge that the definition be left to the states or at the very minimum some broader federal guidelines than those presently proposed.

TEMPORARY EMERGENCY ASSISTANCE

We find this portion of the legislation to be one of its most constructive ingredients. Surely the process of determining eligibility and authorizing payments should not preclude the meeting of emergency needs when they are required. We are hopeful that the legislation will be broad enough in this area to include a wide variety of emergency situations.

RECOMMENDATIONS
OF THE
FIRST NATIONAL ASSOCIATION OF COUNTIES WELFARE CONFERENCE

RECOMMENDATION I—SINGLE PUBLIC ASSISTANCE CATEGORY

The National Association of Counties urges the creation of a new federal category of Public Assistance based upon the single criterion of need and with a single formula for federal financial assistance. Conversion to this new category would be optional, therefore permitting those states who desired, to continue under the existing categories.

RECOMMENDATION II—AID TO NEEDY FAMILIES WITH UNEMPLOYED PARENT

The National Association of Counties urges that federal aid to needy families with an unemployed parent be made a permanent part of the aid to families with dependent children program.

RECOMMENDATION III—THIRD PARTY, VOUCHER, DIRECT VENDOR PAYMENTS

The National Association of Counties encourages the programs and policies that prepare welfare clients to be self-sufficient and there is in favor of the principle of the unrestricted cash payment. We do recognize, however, that there are individuals who are not able to properly manage their own financial affairs, and for such clients, welfare departments should be given the authority to use either third party payments, voucher payments or direct vendor payments, whichever is most appropriate.

The National Association of Counties further recommends that the present 5% ceiling on protective payments be abolished.

RECOMMENDATION IV—IMPROVEMENT OF WORK AND TRAINING PROGRAMS

The National Association of Counties suggests that legislation which provides federal participation in costs of community work and training programs designed to conserve and develop work skills of the unemployed parent receiving AFDC should be improved and made permanent and that the federal government share in all staff, training, and maintenance costs of such programs.

RECOMMENDATION V—NEW WELFARE EMPLOYMENT CRITERIA

Whereas the present federal and state classification and qualification staffing requirements for welfare and social workers often result in the wasteful application of professional talent to sub-professional tasks and often precludes the employment of competent persons to perform many welfare tasks, the National Association of Counties urges and recommends that the federal government foster and encourage the states to experiment in the use of sub-professional classifications.

Whereas it is difficult to obtain necessary caseworkers under the present mandated classifications and qualifications, we recommend in the interest of home rule and greater efficiency that the fixing of such classifications and qualifications be vested in the local unit of government administering such relief, consistent with Civil Service as established in each state.

Senator HARRIS. Mr. Green.

Our next witness is the Honorable S. William Green, assemblyman of the State of New York.

We welcome you here and we will be pleased to hear from you at this time.

STATEMENT OF S. WILLIAM GREEN, MEMBER, NEW YORK STATE ASSEMBLY

Mr. GREEN. Thank you very much, Mr. Chairman. Out of deference to the requests that have previously been made by the committee staff to make my remarks short, I have abbreviated my full statement to a very short digest, but I hope my full statement will be included in the record.

Senator HARRIS. Very well. We apologize to you for your time limitations. Your statement will be printed in full.

Mr. GREEN. I do want to state that, when I am referring to the fiscal projections for my State, the documentary backup that it is not just out of the air, it is in my full statement.

Senator HARRIS. The insertion will include the tables.

Mr. GREEN. Thank you, sir.

As a member of the New York Legislature, I want to thank you for permitting me to tell you today some of the problems that the ADC ceiling and the medicaid income limits proposed by H.R. 12080 would create for us on a State level. The gravity of the problem to us can be seen from the fact that by 1970 these two measures could cost my State, New York, $172 million a year in lost Federal reimbursements.

Let me begin with the January 1967 base ceiling which section 208 of the bill imposes upon the absent parent category of aid to dependent children cases which in any State amount to two-thirds of the total ADC caseload.

We, in New York, have experienced a continuing rise in our ADC caseload over the last several years. In the most recent 12-month period for which statewide data have been distributed this increase was an appalling 22½ percent. We, in New York, have not been delinquent in trying to meet this situation. First, we have provided 50 percent State reimbursement for the operation of local day care centers where mothers could leave children in order to take jobs.

Second, to the extent permitted under Federal law we have encouraged welfare recipients to seek jobs by reducing welfare payments less than the wages received.

Third, we have established a program to make birth control information and supplies available to welfare recipients. I am sure you will recognize in these programs steps similar to those where H.R. 12080 proposes Federal action. So we ask you to work with us in trying to meet the problem instead of imposing an arbitrary ceiling on us which can only aggravate our difficulties.

Indeed, as far as we are concerned the ceiling is already obsolete. By May 1967, the last month for which statewide data have been distributed, we, in New York, exceeded the ceiling by almost 28,000 persons. Moreover, even if the bill has all the answers to our welfare problem it will take time to put its various programs into effect. Thus the bill itself gives States until July 1, 1969, to get community work and training programs going. In the meantime our caseloads must inevitably be rising. If this growth continues at our most recent rate a January 1967 based ceiling will cost us $40 million in the State's 1968–69 fiscal year.

What if the bill's solutions fail? For example, the bill relies heavily on foster home programs to break the cycle of dependency by which successive generations continue on welfare.

In New York, the bulk of our ADC children are of Negro and Puerto Rican origin and we already have a shortage of foster homes willing to receive Negro and Puerto Rican children under existing programs.

Going beyond this, I fear that the basic cause of our swelling welfare rolls is the migration to the cities resulting from the technological revolution in American agriculture, which has drastically reduced the need for farm labor. This migration is coming at a time when automation is ending the era when any man, regardless of how scanty his education or training, could earn a living for his family by the strength of his back and the sweat of his brow. The result is that our economy is simply not producing enough of the kinds of jobs that these rural migrants to our cities can do.

If this is the case, the program proposed in H.R. 12080 will not halt the growth in ADC caseload. In this event the ADC caseload ceiling would work a major injustice on States like New York which are on the receiving end of this migration. It in fact, our ADC caseloads should continue to rise at its present rate, by 1970, we, in New York, will have an ADC caseload more than 360,000 persons in excess of the proposed ceiling, and we will be losing Federal reimbursements at the rate of, almost $117 million per year.

I do not think that State and local governments should be called on to bear fiscal risk of this magnitude when the risks do not arise from conditions of their own making. The fact is that this migration from rural to urban areas is a national problem. The National Government ought to be assuming more of the responsibility for this problem. H.R. 12080, in effect, moves in exactly the opposite direction and will impose more of the costs on those particular areas of the country which are already bearing the greatest burden of these changes.

I strongly urge you to recognize the national responsibility to meet this challenge. We in the cities, and in the great urban States have already pressed to our fiscal limits in trying to cope with this situation.

For example, in my few years in our State legislature, I have twice had to vote for major tax increases, in 1965 for New York State and in 1966 for New York City. We face every prospect of having to go through this at our session next year, another time for both.

To throw more of the fiscal burden on the cities and ask us to raise our local taxes still more simply drives away the very industry we must keep to create the jobs to take these families off the welfare rolls. The problem is not an easy one, but surely its solution is not to be found by transferring more of the fiscal burden away from the Federal Government, which has the ability to distribute it equitably throughout the country and imposing it instead on those urban centers already reeling under the load and thereby losing in the competition for employment giving getting industry and business.

Let me now turn to section 220(a) of the bill which would impose an income limit on families receiving federally reimbursed medicaid and which would, by 1970, in New York State, impose an income limit

of $4,300 a year for a family of four compared with our present ceiling of $6,000 a year for a comparable family.

By 1970, this provision would cost New York State more than $55 million per year.

The proposal to place a Federal income limit on families eligible for federally reimbursed medicaid appears to be based on the assumption that a few States have taken advantage of medicaid by imposing unexpectedly high income limits. In fact, this is not the case. Nor is it true that the proposed income limits affect only a few States.

Since New York has the highest medicaid income limits, I suppose the charge of abuse is intended to be made with particular force against us. Yet, the fact is that in 1965 when medicaid was adopted, income limits for our medical assistance programs were $4,700 for medical care and $5,200 for hospital care—that is for the same family of four. These income limits were already in the process of being increased because of increasing living and medical costs at the time when medicaid came into effect. So our $6,000 medicaid income limit for a family of four is scarcely out of line with our preexisting program.

Under these circumstances it is hard to see how our income limits can have come as such a shock, and the proposed income limit in H.R. 12080 which, as I said, would work out in our State to an income limit of $4,300 in 1970 for a family of four is, in fact, lower than the income limits we had when medicaid was adopted.

This is particularly incongruous because Social Security Act section 1902(c) requires that a State medicaid plan continue to provide assistance for those covered by premedicaid medical plans and although H.R. 12080 amends the maintenance of effort provisions of Social Security Act section 1117, which requires total expenditure to be maintained, it does not appear to alter this requirement for an approved State plan under section 1902(c).

This would appear to require us to maintain at least $4,700 and $5,200 income limits we had when medicaid was adopted although reimbursing us only on the basis of a $4,300 income limit which is a manifestly unjust result.

So far I have concentrated on New York because I know its problems best. But I should point out that H.R. 12080 is not limited to New York. It would roll back the income limits on medicaid in 14 States having more than 45 percent of the Nation's population. H.R. 12080 does not affect only a few. It is a serious cutback in a major social program.

Of course, I am aware of the budgetary impact of medicaid, because we are feeling it on the State and local level just as you are on the Federal level. But this impact is only a symptom of the general rise in medical costs far outstripping the cost of living, a 9.2-percent increase last year, for example.

If we are to deal with these rising costs, I believe we must reexamine the whole method by which medical care is delivered in our country.

Section 402(a) of the bill takes a halting step in this direction. It authorizes the Secretary of Health, Education, and Welfare to conduct experiments in payment systems for medical care. I believe that this section should be greatly broadened in scope to deal with all aspects of the delivery of medical care. I believe it should deal with such ques-

tions as, can we transfer a substantial portion of our present hospital patients to nursing homes since nursing home patient care costs are about half those of hospitals itelf? To what extent can paramedical personnel be substituted for doctors in handling routine work? To what extent can an extensive preventive medical program keep people from getting sick and thus cut medical costs? The surprising fact is that, although we spend $2.3 billion a year on medical research—and you in the Federal Government are providing $1.5 billion per year of this—very little is being spent on problems such as these.

I have gone to great efforts at the Federal and State level to try to develop an actual figure and it is apparently so insignificant that no one could give me a number on that, but it is extremely small. I respectfully suggest that if you want to solve the problem of medical costs instead of passing it back to the States and to families without the resources to cope with it, you should establish a major research program to finance study of such questions as I set forth above.

I want to thank you again for fitting me into your busy schedule and for letting me tell you some of the problems that this bill creates for us on the State and local level.

Senator HARRIS. Thank you, Mr. Green.

I think you have put your finger on a national problem we are going to have to face up to. This is the rural-to-urban shift of our population which, unfortunately for so long, many people felt was inevitable and nothing could be done about it. I think we could do something about it and should; but if we don't—and I don't think there is much chance we are going to do much about it immediately—then we are going to have to recognize that whether the birth rate goes up or not we still are going to have people moving into New York and New York City, and that is very much involved in this upper limit set forth in 12080.

Mr. GREEN. Yes, but to give you just an example of how that has affected us. The figures in the census from 1950 to 1960 showed a population change in New York consisting basically of a movement to the suburbs of a net of about 900,000, largely middle-income white families, and there replacement by about 800,000 low-income, largely Negro and Puerto Rican families and, of course, you can see the effect of this on our tax base, and also in terms of our welfare expenditures. This is certainly not a problem we are happy with, but I do ask you to give us a little forbearance because of these serious difficulties we are facing.

Senator HARRIS. Senator Curtis?

Senator CURTIS. How many family units are there in New York State?

Mr. GREEN. Total number of families? We have a total population of about 17½ million, I guess you could divide that by the average size of four.

Senator CURTIS. 4½ million?

Mr. GREEN. In that range.

Senator CURTIS. How many are eligible for medicaid?

Mr. GREEN. Well, I would have to qualify my answer somewhat. I would say that our income limits would create an eligibility potential, although only a small percentage of these people have actually signed up, of something on the order of 8 million. However, although

it has not been as heavily publicized, we also have limits on assets, which I suspect will, in fact, keep this slowed down very substantially, we have an asset limit of $3,000 in terms of cash assets plus insurance or burial reserve of $1,000 per family member.

Senator CURTIS. Is that 8 million people or 8 million families?

Mr. GREEN. No, that is people.

Senator CURTIS. And that is exclusive of medicare.

Mr. GREEN. That would include people of the over 65 bracket in the number of people who are eligible.

Senator CURTIS. Not if they were receiving medicare?

Mr. GREEN. They would have no reason to apply to medicaid, but they are included in that figure of potential income eligibility.

Senator CURTIS. In other words, you have got a standard that takes care of about half of your people?

Mr. GREEN. I would say it could potentially. We had a standard before medicaid came in which took care of about 5½ to 6 million people, but our total number of people using these programs was only about 1½ million.

Senator CURTIS. Who paid for it?

Mr. GREEN. Some of it was under the preexisting Federal programs under the various titles which provided some form of medical assistance and, of course, we had the State and local contributions.

Senator CURTIS. Well, aside from medical assistance to the aging, what other programs did you get?

Mr. GREEN. You had programs for medical aid to the blind; some others covered by welfare for children. I can give you the full titles. There were five titles.

Senator CURTIS. When did medicaid go into effect?

Mr. GREEN. In New York State, May 1, 1966. It was adopted here in 1965.

Senator CURTIS. Yes.

In the year prior to when it went into effect how much Federal money was being spent in New York for medical assistance?

Mr. GREEN. I don't have the exact figure on that, but there is no question but that medicaid increased it quite substantially.

Senator CURTIS. Even with the new limits it will be way more than it was before?

Mr. GREEN. The total amount we in New York State spent on medical assistance including Federal contributions in the last fiscal year was not extraordinarily above what was being spent before, no, sir. There was some increase, and I have every reason to expect there will be a more substantial increase this year.

Senator CURTIS. What is your age limit for providing AFDC care, the upper age limit?

Mr. GREEN. I believe it is 20 years, I would have to check it. I should explain that our State medicaid program goes all the way through.

Senator CURTIS. I am talking about AFDC.

Mr. GREEN. I think that is correct, that 20 years in the cutoff.

Senator CURTIS. 20 years?

Mr. GREEN. Yes.

Senator CURTIS. How many children are there in New York under 20 years of age?

Mr. GREEN. I can dig out those statistics for you. I guess our total population of children in that category was approximately 5,200,000.

Senator CURTIS. And how many were receiving AFDC?

Mr. GREEN. 699,368 in May 1967.

Senator CURTIS. How many?

Mr. GREEN. 699,368 is the total number of people covered under the aid to dependent children in New York in May 1967.

Senator CURTIS. In other words, about one out of six or so?

Mr. GREEN. That includes categories other than the absent parent categories, and also includes parents of children.

Senator CURTIS. Oh, yes, I understand.

I think that is all.

Senator HARRIS. Thank you very much, Mr. Green.

Mr. GREEN. Thank you, sir.

(Mr. Green's prepared statement follows:)

TESTIMONY OF S. WILLIAM GREEN, MEMBER, NEW YORK STATE ASSEMBLY (REP.—N.Y. Co.)

As a member of the New York State Legislature, I want to express my appreciation to the Senate Finance Committee for the opportunity to appear before you today to tell you something of the problems which H.R. 12080 would create for us on the state level. I particularly want to stress the effect of (1) the ceiling on number of dependent children with respect to which Federal reimbursement would be available and (2) the ceiling on Medicaid income limits. I think I can indicate the gravity of these proposals as far as my state is concerned by pointing out that they could cost us in excess of $172 million in lost Federal reimbursement in 1970 and each year thereafter.

1. Aid to Families with Dependent Children

Section 208 of the House-passed bill would add a new subsection (d) to Section 403 of the Social Security Act which would impose a ceiling on Federal reimbursement to states for aid to families with dependent children. The ceiling would apply to those cases where aid is being given on the basis of absence of a parent from the child's home by reason of desertion, separation without a court decree, or non-marriage to the child's other parent. In my state, these categories amount to at least two-thirds of the ADC caseload.

The ceiling to be imposed would be based on the number of children in a state with respect to whom payments for this category of aid were being made on January 1, 1967. If there is no change in a state's under-21 population from January 1, 1967, the number of such children with respect to whom aid was being given on January 1, 1967 becomes the ceiling, and the state loses any Federal reimbursement for any increase in this category of ADC cases. If there is a change in the state's under-21 population, there is a proportionate adjustment in the ceiling.

We in New York have been experiencing a continuing rise in our ADC caseload for the last several years. Until last year, that increase had been some 10% per year—10.6%, for example, between 1965 and 1966. This last year, I am sorry to report, the increase was at a much greater rate, 22.5% between May 1966 and May 1967, the last month for which data was available when I prepared the statistics on which this statement is based.

It is not hard to see that this increase in caseload has already brought us well past the January 1, 1967 ceiling, and, if the proposed ceiling is enacted, it must inevitably create a critical situation in my state and others similarly situated.

Before I present to you the detailed statistics to document this statement, let me state that we in New York share the concern which was expressed by the House Ways and Means Committee at the spiraling increase in our welfare rolls. Nor have we been delinquent in trying to combat this situation. Indeed, we have embarked on programs to meet this situation which in many respects parallel those included in the bill as passed by the House. For example:

1. We have enacted legislation to provide 50% state reimbursement to local governments for the operation of day-care centers where mothers could leave their children in order to hold jobs.

2. To the extent permitted under Federal law, we have enacted legislation so that welfare payments are reduced less than the amount of income received when welfare recipients take jobs, thus providing a financial incentive for welfare recipients to seek employment.

3. Our State Board of Social Welfare, the policymaking head of our welfare operations, has established programs to make birth control information and supplies available to welfare recipients; in 1965 the legislature repealed a 19th Century anti-birth control law in order to remove any statutory impediment to this program.

In short, this is not a problem that the states have ignored. Indeed, the effect of soaring welfare costs on state and local budgets is such that we could not ignore this problem even if we would. But we ask you to work with us in trying to solve the problem, and not to impose on us an arbitrary caseload ceiling which can only aggravate the problem at the state and local level.

I have prepared some statistical studies to demonstrate exactly how critical that situation will be if the ceiling is enacted, and I want to share the results of these studies with you. In preparing these studies, I have made certain assumptions to simplify the calculations, but they are significant assumptions, and candor requires that I make them clear to you:

1. I have assumed that New York's total under-21 population will remain stable over the next few years. I have done so because birth rates have recently been falling, and, starting this year, the first members of the post-World War II baby boom generation will be turning 21. To the extent that total under-21 population instead increases, our problem eases because such an increase proportionately increases the proposed ceiling.

2. I have assumed that the proportion of ADC children who fall within the "absent parent" categories to which the ceiling applies, remains constant at 66.6%. This figure is derived from a study made in New York in 1963, the latest I could find. I should point out that an earlier study—made in 1961—showed a 61% figure. If in fact we are facing an uptrend in this figure, so that an increasing proportion of our ADC children fall in the categories covered by the ceiling, this will of course make the problem created by the ceiling even more acute.

3. I have assumed that despite a steadily rising cost-of-living index the average monthly payment to ADC recipients will remain constant. Any increase in the average monthly payment would increase the fiscal problem created for states by the ceiling by increasing the dollar amount of unreimbursed payments.

I think I am being pessimistic in my first assumption—that total under-21 population in New York will not increase—and optimistic in my last two assumptions—particularly in assuming that cost-of-living increases will not force benefit increases—so that on balance my projections are likely to understate rather than overstate the fiscal problems that the proposed ceilings will create for the states.

Here, then, is what my studies show will be the effect of the proposed ceiling on New York State:

1. Suppose we could freeze our caseload at the actual level in May, 1967, the last month for which data was available when I did these studies. By May, 1967, we in New York already had exceeded our January 1, 1967 ceiling by 27,720 persons. In short, the January 1, 1967 ceiling has been rendered obsolete and unrealistic even before this bill is enacted. Thus, even if we could freeze the caseload at the May, 1967 level, the effect of this bill would be to cost New York State $8,953,000 per year in lost Federal reimbursement. (Table No. 1)

2. But unfortunately we cannot freeze our caseload at the May, 1967 level. Even if this bill has all the answers to our welfare problems, it will take time to put the various programs into effect. Subsection 204(g) of the House bill itself recognizes this with its July 1, 1969, deadline for state implementation of the community work and training programs. What will be happening in the meantime? Unquestionably caseloads will continue rising, and the proposed January 1, 1967 ceiling will be throwing an increasing fiscal burden on the states. Just how much of a burden you can see from the figures for New York State:

a. If the caseload growth continues at the rate we experienced in the several years up to 1966—10.6%—the January 1, 1967 ceiling will cost New York $8,889,000 from October, 1967 through March, 1968, the final six months of its present fiscal year. In the state's next fiscal year, from April,

1968 through March, 1969, the lost reimbursement will amount to $28,472,000. (Table Nos. 2 and 3)

b. If the caseload growth continues at the rate we experienced in the most recent 12-month period for which statistics were available when I made this study, May, 1966 to May, 1967, i.e., a growth rate of 22.5%, the lost reimbursement will be $18,902,000 in the remainder of this state fiscal year, and $50,131,000 in the next state fiscal year. (Table Nos. 4 and 5)

c. Averaging the above—i.e., assuming a growth rate between the lower rate we had been experiencing until 1966 and the higher rate we have experienced since then—the lost reimbursement will be $11,395,000 for the remainder of this state fiscal year and $39,301,000 for the next state fiscal year.

3. Finally, the whole premise underlying the imposition of a caseload ceiling is that the remedies proposed by the bill will in fact end the rising ADC caseload. I would like to think that this will be the case, but I also have reasons to fear that it will not.

For example, the assumption that expansion of foster home programs can be used to break the cycle of dependency by which successive generations continue on welfare, which seems implicit in the House bill (see Report of the Committee on Ways and Means on H.R. 12080, p. 100), runs into the hard fact that in New York State the bulk of our ADC children are Negro and Puerto Rican, and we already have a shortage of foster homes for Negro and Puerto Rican children even under existing programs. Of course, if we want to remove children from their mothers we can place them in institutions, but this is certainly an unhappy alternative.

Going beyond this to the basic philosophy of H.R. 12080, we may well discover, when we seek to implement its provisions, that the reason we are facing ever-mounting ADC rolls is that the technological revolution we have experienced in American agriculture has driven out of rural areas and into the cities millions of families of farm laborers and marginal farmers, and that this migration into our urban areas has occurred just at the same time that the development of automation has brought to an end the era when any man could earn a living for his family with the strength of his back and the sweat of his brow. Further, we may find that our economy, fast growing though it is, simply is not creating enough jobs to absorb both our natural population growth and the influx to our cities from the rural areas.

If this is the case, then the programs proposed in H.R. 12080 will not substantially reduce the expansion of the ADC caseload. And, should this prove to be the case, the Subsection 403(d) ceiling would work a major injustice on states like New York, which are on the receiving end of this migration to our urban areas.

To demonstrate this, let me take the same projections I have been using, and carry them down to December, 1970. By this point, if the growth in our ADC caseload continues as it did in the years up to 1966—i.e., 10.6%—there will be 185,000 persons on our ADC roll for whom we are receiving no federal reimbursement, and they will cost New York's taxpayers almost $60,000,000 a year in lost Federal reimbursement. (Table No. 6) If, however, the 22.5% per annum growth in caseload which we were experiencing earlier this year continues, we shall have more than 861,000 additional persons on our ADC rolls, and the lost Federal reimbursement will amount to more than $116,700,000 per year. (Table No. 7)

I do not think that State and local governments should be called on to bear fiscal risks of this magnitude when the risks do not arise from conditions of their own making. The fact is that this migration from rural to urban areas is a national problem. The fact is that under the decision of the U.S. Supreme Court in *Edwards* v. *California* the states that are receiving this vast flood of unskilled, undereducated, unemployed people cannot turn them back.

What are our alternatives? We could cut welfare benefits, but how much can you cut welfare benefits in these inflationary times when they are already so tightly rationed that, in a typical welfare family, they allow an average of 81 cents for each meal?

Or we could simply refuse to place any new families on welfare. I would hate to be responsible for the consequences of such a Draconian measure.

In short, the problem of our rising welfare rolls is a national problem, resulting from nationwide changes in our economy and from vast nationwide flows of

population. The national government ought to be assuming more of the responsibility for this problem. H.R. 12080 in effect moves in exactly the opposite direction and will impose more of the costs on those particular areas of the country which are already bearing the greatest burden of these changes. I strongly urge you to recognize the national responsibility to meet this challenge.

We in the cities and in the great urban states have already pressed to our fiscal limits in trying to cope with this situation. For example, in my few years in our state legislature, I have twice had to vote for major tax increases, in 1965 for New York State and in 1966 for New York City. We face every prospect of repeating this next year. To throw more of the fiscal burden on the cities and ask us to raise our local taxes still more simply drives away the very industry we must keep to create the jobs to take these families off the welfare rolls. The problem is not an easy one, but surely its solution is not to be found by transferring more of the fiscal burden away from the Federal government, which has the ability to distribute it equitably throughout the country, and imposing it instead on those urban centers which are already reeling under the load and thereby losing the competition for employment-giving industry and business.

2. Medicaid

Let me now turn to the proposed medicaid income limits.

Section 220(a) of the bill adds a new Subsection 1903 to the Social Security Act which would impose an income limit on families receiving Federally-reimbursed medicaid. By 1970 the limit would be one-and-one-third times the state's highest payments under the aid to families with dependent children program or one-and-one-third times the state's average per capita income, whichever is less. Based on June 1, 1967 ADC cash payments, this would result in a $4,300 ceiling in New York for a family of four, compared with our actual ceiling of $6,000. (See Table No. 8)

The decision to place a Federal income limit on families eligible for Federally-reimbursed medicaid is in my opinion based on a serious misconception. It appears to be the view of the House Ways and Means Committee that a few states somehow unexpectedly took advantage of Title XIX and established programs with coverages well beyond what Congress had reason to expect when it enacted the Social Security Amendments of 1965 (Report of the Committee on Ways and Means on H.R. 12080, pp. 117–18). Since my state, New York, has adopted the highest medicaid income limits, I suppose the charge is intended to be made with particular force against us.

The facts simply do not sustain this charge. The fact is that even prior to adoption of the Social Security Act Amendments in 1965, New York's medical assistance program had a ceiling for a family of four of $4,700 for medical care and $5,200 for hospital care. At the time medicaid was adopted, our State Board of Social Welfare, which sets these income limits, had under study an increase in the income limits because of increases in the cost of living and the cost of medical care. As a result, when medicaid became effective, the Board established income limits of $6,000 for a family of four with one wage earner.

In view of the existence of our $4,700–$5,200 income limits at the time medicaid was adopted, limits at these levels should scarcely come as a shock to the Congress. And, in view of the substantial increases in living and medical costs since that date, our present $6,000 limit is certainly not out of line with our 1965 limit. I should point out that although much publicity has been given to the alleged liberality of these income limits, little attention has been paid to the asset limits, which, for the same family of four, would be $3,000 in savings, plus per person insurance or burial reserve of $1,000. In short, the whole point of extending medicaid to persons not on welfare was to prevent medical costs from pauperizing families which are otherwise self-sustaining, and New York's limits are reasonable for this purpose.

Please note also that the proposed income limit of $4,300, as it would affect New York, would be substantially lower than our income limits prior to medicaid; therefore, far from dealing with some unintended post-medicaid abuse, H.R. 12080 actually would deny reimbursement for programs in existence and known to the Congress when medicaid was adopted.

Please note also that although the so-called maintenance of effort provisions in § 1117 of the Social Security Act have been amended by the proposed H.R. 12080, there does not appear to have been any corresponding change in the requirement under § 1902(c) that a state plan for medicaid may not be approved if it results in reduction of aid which a state had been providing individuals

under the previous programs for medical assistance (Titles I, IV, X, XIV, and XVI). Thus, it appears that as drafted the House bill would require us to keep the $4,700 and $5,200 income limits, although reimbursing us only on the basis of a $4,300 income limit. Such a result is manifestly unjust.

The loss to New York from this withdrawal of Federal reimbursement will be substantial. According to our State Department of Social Services, a Federal contribution of $276,900,000 to our state medicaid program is anticipated for our current fiscal year ending March 31, 1967. I estimate that a reduction of the income limits for Federal reimbursement to $4,300 would have the effect of reducing by 20% the portion of our medicaid program that would be Federally-reimbursable. The cost to New York State would therefore be $55,380,000 per year, starting in 1970.

So far I have concentrated on the New York situation, because I know it best, and because some have held up New York—erroneously, as I have tried to show—as a state that has taken advantage of medicaid. But the problems that the medicaid income limits create will not be limited to New York. For, although the Ways and Means Committee Report on H.R. 12080 asserted that it was questioning only "a few" state plans, and that "most of the State plans raise no question at this time" (p. 118), the fact is that the income limit ceiling in H.R. 12080 is lower than the ceilings established under the state plans in fully 14 states.

These states are California, Connecticut, Delaware, Illinois, Iowa, Kentucky, Maryland, Michigan, Nebraska, Oklahoma, Pennsylvania, Rhode Island and Wisconsin, as well as New York. These 14 states represent fully half of the 28 states operating programs under medicaid as of July 19, 1967 and fully two-thirds of the 21 states that had elected to extend their medicaid programs beyond those receiving public assistance. On the basis of 1960 census figures, these states have more than 45% of the nation's population. In short, the roll back in medicaid proposed by H.R. 12080 does not affect only a few; it is a serious cut back in a major social program.

Of course I am aware of the increasing costs of the medicaid program which have led to the response embodied in H.R. 12080. But it should be recognized that these costs are not themselves the fundamental problem; instead, they are symptomatic of a general rise in medical costs, far outstripping the cost-of-living index, which is making it extremely difficult for families of moderate means to pay for medical care. For example, costs of medical care services increased 9.2% last year. This trend has continued for a long time; there is every reason to believe it will continue to do so. For example, expenditures on health services in the United States increased from $12,867,000,000 in 1950 to $40,751,000,000 in 1965. Despite the tremendous growth in gross national product in that period, this represented a one-third increase in the portion of our income we are spending on health services—from 4.5% to 6.0% of gross national product.

To remove families in the $4,300 to $6,000 bracket from medicaid will not solve these cost problems; it will simply face such families with the choice when illness strikes of doing without needed care or of pauperizing themselves with medical payments before they become eligible for help under medicaid.

I believe that if we wish to stem the upward spiral of medical costs, we need to take a look at the entire system by which medical care is delivered to the populace in the United States today. For example, to what extent could we save by transferring patients from hospitals to nursing homes, since nursing homes have a per patient day cost of approximately half that of hospitals? To what extent can paramedical personnel be substituted for doctors in the performance of routine work? To what extent can preventive medicine keep people from getting sick and thus cut their medical care costs?

The surprising fact is that although we are spending in this country $2,300,000,000 annually on medical research—of which about $1,500,000,000 comes from the Federal government—very little is being spent to get the answer to these important questions. May I respectfully suggest that if you want to solve the problem of medical costs, instead of merely passing it back to the states or to families without the resources to cope with it, you should very substantially expand the resources we are devoting to find the answers to questions like these.

For this reason, I should like to urge you to expand the scope of Section 402(a) of the bill. As it now stands, the experiments authorized by this section are limited to payment systems. This is an important area where we should know more, but it is not the only area. I would suggest that in addition this section should authorize the Secretary to develop and engage in experiments dealing

not only with payment methods, but also with the entire gamut of techniques for delivering medical care. In the long run the information we can derive from such experiments could save all of us—the Federal government, state and local governments, and private individuals—untold billions.

SCHEDULES OF TABLES

AID TO FAMILIES WITH DEPENDENT CHILDREN

Table No. and Subject:

1. Calculation of N.Y. Loss in ADC Reimbursement Based on Continuance of May 1967 Caseload.
2. Calculation of N.Y. Loss in ADC Reimbursement to March 31, 1968 Based on Growth in Caseload Comparable to Growth from 1965 to 1966 (10.6%).
3. Calculation of N.Y. Loss in ADC Reimbursement in April 1, 1968—March 31, 1969 Fiscal Year Based on Growth in Caseload Comparable to Growth from 1965 to 1966 (10.6%).
4. Calculation of N.Y. Loss in ADC Reimbursement to March 31, 1968 Based on Growth in Caseload Comparable to Growth from May 1966 to May 1967 (22.5%).
5. Calculation of N.Y. Loss in ADC Reimbursement in April 1, 1968—March 31, 1969 Fiscal Year Based on Growth in Caseload Comparable to Growth from May 1966 to May 1967 (22.5%).
6. Calculation of N.Y. Loss in ADC Reimbursement in December 1970 Based on Growth in Caseload Comparable to Growth from 1965 to 1966 (10.6%).
7. Calculation of N.Y. Loss in ADC Reimbursement in December 1970 Based on Growth in Caseload Comparable to Growth from May 1966 to May 1967 (22.5%).

(In all of the above tables, references to ADC caseload exclude T-ADC caseload, and references to absent fathers include only those absent by reason of desertion, separation without court decree or non-marriage to the mother.)

MEDICAID

8. Calculation of Medicaid Income Limit.

Table No. 1.—Calculation of N.Y. Loss in ADC Reimbursement Based on Continuance of May 1967 Caseload

1/1/67 ADC children	426,871
% of ADC children with absent fathers	.666
Proposed § 403(d) ceiling	284,296
5/67 ADC children	457,512
	.666
5/67 ADC children with absent fathers	304,708
	−284,296
Non-reimbursable children	20,406
Non-reimbursable adults (1 adult per 2.79 children)	+7,314
Total non-reimbursable persons	27,720
Average monthly payment	$53.83
Total monthly payments to non-reimbursable persons	$1,492,167.60
Normal federal reimbursement rate	.5
Monthly loss in federal reimbursement	$746,083.80
To annualize	12
Annual loss	$8,953,005.60
	.5
Loss, 10/67–3/68 (i.e.—remainder of state's fiscal year)	$4,476,502.80

TABLE No. 2.—*Calculation of N.Y. Loss in ADC Reimbursement to March 31, 1968 Based on Growth in Caseload Comparable to Growth from 1965 to 1966 (10.6%)*

5/67 ADC children	457,512
Estimated ADC rate of growth to 10/67	1.044
10/67 ADC children	477,643
	457,512
Estimated ADC growth to 3/68	1.088
3/68 ADC children	497,773
	477,643
	+497,773
	975,416
	.5
Ave. # ADC children, 10/67–3/68	487,708
% of ADC children with absent fathers	.666
Ave. # ADC children, 10/67–3/68, with absent fathers	324,814
Proposed § 403(d) ceiling	−284,296
Non-reimbursable children	40,518
Non-reimbursable adults (1 adult per 2.78 children)	+14,523
Total non-reimbursable persons	55,041
Average monthly payment	$53.83
Total monthly payments to non-reimbursable persons	$2,962,857.03
Normal federal reimbursement rate	.5
Monthly loss in federal reimbursement	$1,481,428.52
	6
Total loss in federal reimbursement, 10/1/67–3/31/68	$8,888,571.12
To annualize	2
Annual loss	$17,777,142.24

TABLE No. 3.—*Calculation of N.Y. Loss in ADC Reimbursement in April 1, 1968–March 31, 1969 Fiscal Year Based on Growth in Caseload Comparable to Growth from 1965 to 1966 (10.6%)*

5/67 ADC children	457,512
Estimated ADC rate of growth to mid-fiscal year	1.146
Ave. # ADC children, 4/1/68–3/31/69	524,309
% of ADC children with absent fathers	.666
Ave. # ADC children, 4/1/68–3/31/69, with absent fathers	349,190
Proposed § 403(d) ceiling	−284,296
Non-reimbursable children	64,894
Non-reimbursable adults (1 adult per 2.79 children)	+23,259
Total non-reimbursable persons	88,153
Average monthly payment	$53.83
Total monthly payments to non-reimbursable persons	$4,745,275.99
Normal federal reimbursement rate	.5
Monthly loss in federal reimbursement	$2,372,638.00
To annualize	12
Annual loss	$28,471,656.00

TABLE No. 4.—*Calculation of N.Y. Loss in ADC Reimbursement to March 31, 1968 Based on Growth in Caseload Comparable to Growth from May 1966 to May 1967 (22.5%)*

5/67 ADC children	457,512
Estimated ADC rate of growth to 10/67	1.094
10/67 ADC children	500,518
	457,512
Estimated ADC rate of growth to 3/68	1.188
3/68 ADC children	543,524
	500,518
	+543,524
	1,044,042
	.5
Ave. # ADC children, 10/67–3/68	522,021
% of ADC children with absent fathers	.666
Ave. # ADC children, 10/67–3/68, with absent fathers	347,666
Proposed § 403(d) ceiling	−284,206
Non-reimbursable children	63,370
Non-reimbursable adults (1 adult per 2.79 children)	+22,718
Total non-reimbursable persons	86,083
Average monthly payment	$53.83
Total monthly payments to non-reimbursable persons	$4,633,847.89
Normal federal reimbursement rate	.5
Monthly loss in federal reimbursement	$2,316,923.95
	6
Total loss in federal reimbursement, 10/1/67–3/31/68	$13,901,543.70
To annualize	2
Annual loss	$27,803,087.40

TABLE No. 5.—*Calculation of N.Y. Loss in ADC Reimbursement in April 1, 1968–March 31 1969 Fiscal Year Based on Growth in Caseload Comparable to Growth From May 1966 to May 1967 (22.5%)*

5/67 ADC children	457,512
Estimated ADC rate of growth to mid-fiscal year	1.309
Ave. # of ADC children, 4/1/68–3/31/69	598,883
% of ADC children with absent fathers	.666
Ave. # ADC children, 4/1/68–3/31/69, with absent fathers	398,556
Proposed § 403(d) ceiling	−284,206
Non-reimbursable children	114,260
Non-reimbursable adults (1 adult per 2.79 children)	+49,953
Total non-reimbursable persons	155,213
Average monthly payment	$53.83
Total monthly payments to non-reimbursable persons	$8,355,115.79
Normal federal reimbursement rate	.5
Monthly loss in federal reimbursement	$4,177,557.90
To annualize	12
Annual Loss	$50,130,694.80

TABLE No. 6.—*Calculation of N.Y. Loss in ADC Reimbursement in December 1970 Based on Growth in Caseload Comparable to Growth from 1965 to 1966 (10.6%)*

5/67 ADC children	457,512
Estimated ADC rate of growth to 12/70	1.380
12/70 ADC children	631,367
% of ADC children with absent fathers	.666
12/70 ADC children with absent fathers	420,490
Proposed § 403(d) ceiling	−284,296
Non-reimbursable children	136,194
Non-reimbursable adults (1 adult per 2.79 children)	+48,815
Total non-reimbursable persons	185,009
Average monthly payment	$53.83
Total monthly payments to non-reimbursable persons	$9,959,034.47
Normal federal reimbursement rate	.5
Monthly loss in federal reimbursement	$4,979,517.24
To annualize	12
Annual loss	$59,754,206.88

TABLE No. 7.—*Calculation of N.Y. Loss in ADC Reimbursement in December 1970 Based on Growth in Caseload Comparable to Growth from May 1966 to May 1967 (22.5%)*

5/67 ADC children	457,512
Estimated ADC rate of growth to 12/70	1.806
12/70 ADC children	826,267
% of ADC children with absent fathers	.666
12/70 ADC children with absent fathers	550,294
Proposed § 403(d) ceiling	−284,296
Non-reimbursable children	265,998
Non-reimbursable adults (1 adult per 2.79 children)	+95,340
Total non-reimbursable persons	361,338
Average monthly payment	$53.83
Total monthly payments to non-reimbursable penalty	$19,450,824.54
Normal federal reimbursement rate	.5
Monthly loss in federal reimbursement	$9,725,412.27
To annualize	12
Annual loss	$116,704,947.24

TABLE No. 8.—*Calculation of Medicaid Income Limit*

ADC CALCULATIONS

6/1/67 ADC monthly cash assistance	$264.00
To annualize	12
6/1/67 ADC yearly cash assistance	$3,168.00
Formula for 1970 on	1.33⅓
Which, rounded upward to next multiple of $100	$4,224.00
	$4,800.00

PER CAPITA INCOME CALCULATION

N.Y. per capita income, 1966	$3,480
	1.33⅓
Which, rounded upward to next multiple of $100	$4,640.00
	$4,700.00

Since $4,300/$4,700, $4,300 is the income limit.

Senator HARRIS. Governor Andersen and Mr. Reid.

Our next witness is the Honorable Elmer S. Andersen, president of the Child Welfare League of America, Inc., and the former Governor of Minnesota.

He is accompanied by Mr. Joseph H. Reid, executive director of that association.

Governor Andersen, we are glad you are here and we will be pleased to hear from you at this time.

STATEMENT OF HON. ELMER L. ANDERSEN, PRESIDENT, CHILD WELFARE LEAGUE OF AMERICA AND ACCOMPANIED BY JOSEPH H. REID, EXECUTIVE DIRECTOR

Mr. ANDERSEN. Thank you, Mr. Chairman and members of the committee. We, too, have testimony that is rather long, and we would like to submit that and summarize it.

Senator HARRIS. All right. That will be done.

Mr. ANDERSEN. I am Elmer L. Andersen, president of the Child Welfare League of America. I am also president of H. B. Fuller Co., St. Paul, and was Governor of Minnesota. I am speaking on behalf of the board of the Child Welfare League of America.

Accompanying me is Mr. Joseph H. Reid, executive director of the league since 1953.

Established in 1920, the league is the national voluntary accrediting organization for child welfare agencies in the United States. It currently has 292 child welfare agencies in membership as well as 59 associate agencies.

The league's prime functions are consultation services to local agencies and communities, standard setting, research and child welfare publications.

We wish to address ourselves to the child welfare and public assistance amendments of title II of H.R. 12080 as they would affect the lives of untold numbers of children in this country. We do not believe that these provisions are in the true tradition of the U.S. Congress which has, over the past decades, expressed its concern for the health and welfare of all the Nation's children.

Although title II of H.R. 12080 presents the illusion of helping children, upon close analysis, it is in fact coercive, punitive, and creates discriminatory conditions hostile to the welfare of children and the promotion of sound family life. Even the positive features of the bill when viewed within the total context of the programs proposed, become negative and hostile to the well-being of children. A bill such as this could only have come from the House of Representatives because those esteemed Members did not fully understand the regressive proposals in this legislation and how they would ultimately harm the lives of millions of our children.

The league, like the Congress, has always been concerned about the factors in our society which lead to such severe social problems as dependency, illegitimacy, delinquency, mental instability, and a lack of proper care and protection for children. We know, as does the Congress, that such social problems are not found just within those families accepting public assistance, but can be found throughout our society whether in the large urban cities, the rural districts, or among the rich or the poor.

The Congress, as well as the league, has therefore recognized the necessity to make public child welfare services available for all children in need of such service, regardless of their financial status.

The Congress has expressed this necessity in the Social Security Act by a broad definition of child welfare services and by a mandate to the States to make comprehensive child welfare services available throughout the States for all children by July 1, 1975.

But in writing H.R. 12080, the Ways and Means Committee seems primarily concerned with the increases in numbers and costs of the AFDC program. It is concerned over the rising numbers of illegitimate children.

I might insert even though among families on AFDC and during the time they are on AFDC, the incidence of illegitimacy is less than that of the general population. They may have had illegitimate children before and after, but during the time they are on AFDC, the illegitimacy incidence is less than that of the general population, contrary to some who feel the program fosters illegitimacy.

Senator HARRIS. Is that, Governor, on percentages of the total population?

Mr. ANDERSEN. Yes.

Gentlemen, I cannot emphasize enough how much the Child Welfare League shares that concern. However, we believe that many of the measures proposed will only aggravate the situation—not relieve it, and tend to vitiate Congress' concern for all children.

Our first objection to the bill is that in part, it relies on coercion to achieve its end. It is excellent to provide job training and increased employment opportunities which the bill seeks. But the effort to force people to accept job training or employment with the threat of cutting off food for their children if they refuse to work is deplorable. I would take exception to Mr. Henkel's likening of this program to unemployment compensation. In unemployment compensation you are dealing with single people, you are dealing with many married individuals without families. Here the impact of the coercion hits the children which, we think, is deplorable.

Not only are such efforts deplorable; they are self-defeating. This is particularly true in the light of the fact that H.R. 12080 greatly enlarges the responsibility for the judgments of welfare workers to determine whether a family receives assistance. It will be the individual welfare workers or local welfare board who will determine whether a mother has a "good cause" in preferring to stay home with her children or whether employment is "suitable."

We believe that it is a drastic mistake to substitute subjective judgment on the part of a welfare worker or county welfare board for objective eligibility criteria; and particularly we feel this is true when

the Congress is seeking to establish minimum standards. We feel the minimum standards ought to be on an objective criteria that apply equally to all children in the country, not vitiated by local subjective action.

We assume that the Department of Health, Education, and Welfare would create sound guidelines as to what constitutes a mother's "good cause" for refusing to accept training or employment, or for defining what constitutes "appropriate" training and employment. Unfortunately, we know from past experience that well-meaning regulations emanating from Washington frequently provide little protection for the individual. And, gentlemen, we must think of this in terms of such individual. There is a vast range of personal situations among all the families that find themselves in the condition which we are treating here.

We cannot let the subject judgment of thousands of individual welfare workers, influenced by local attitudes and prejudices, result in arbitrary, unjust decisions from which appeal is long, costly, and often impossible. Such circumstances severely endanger the rights of people, destroy their dignity, and make the individual subject to such critical abuses of authority and discretion, that they result in severe privation for children.

I think much of the thinking in the House Ways and Means Committee directed itself to the adults involved, and not enough of it is to the secondary impact on the children involved.

Emphasis upon investigations, searches, and referrals to courts produce a climate in which constitutional rights are endangered and welfare workers are alienated from people they are supposed to serve. It is extremely difficult, if not impossible, to offer rehabilitative service to help families who must constantly be in fear of the worker who is serving them.

The Committee has stated that these parents should be referred to the courts for proper action. Neglect and abuse of children are by no means confined to the AFDC family. As the reports of the Children's Bureau indicate, severe abuse of children is widespread and is found in all economic groups. Yet, there is nothing in the bill that would extend protective services to all children.

All States have laws giving courts jurisdiction over the neglecting and abusing parent. Congress adds nothing new when it mandates the States to bring court action against the neglecting AFDC parent, except to single him out as a second-class citizen, while ignoring the others.

The basic reason children are not protected under our present laws is that positive services do not exist to provide that protection. And while it is true that almost all cities in the United States have an organization that is responsible for protecting animals from abuse, extremely few communities in the United States have a comparable system to protect neglected and abused children.

H.R. 12080 seems to reflect the concern for the alleged immorality of persons receiving public support rather than a concern for the welfare of all children. In 1961, only 20 percent of the illegitimate children in the country were on AFDC, but if the House Ways and Means Committee believes that illegitimacy——

Senator CURTIS. At that point, what percent of the total child population is on AFDC?

Mr. ANDERSEN. There are about 4½ to 5 percent, per 100 births, are illegitimate.

Senator CURTIS. No. My question was that 20 percent of the AFDC children——

The league is totally opposed to the provision which would limit the percentage of deserted or illegitimate children who may be on the relief rolls. This ignores all the social and economic realities in the country, and in the end can only hurt children. Obviously, there is no justification for denying aid to certain children because of the time they happen to be born.

The Ways and Means Committee report indicates that children will not be punished for the failure of a mother to work although she may be cut off assistance. This, too, is an illusion, again as the counties so well brought out this morning. If a mother is cut off relief because she sincerely believes she should care for her children and "protective payments" are made only to meet the children's needs, realistically, the mother will either share the child's portion of potatoes, or she will starve. Obviously, neither of these alternatives is sound. Both, in fact, would punish the child despite the committee's good intentions.

The second reason that we oppose title II is that it would result in limiting concern to the child receiving public assistance instead of continuing the Congress' concern for all children who may need care or protection. For example, the Ways and Means Committee is concerned with children on AFDC who are neglected or abused by their parents.

Mr. ANDERSEN. No; 20 percent of the illegitimate children in the country are in AFDC; 80 percent of the children in the country are not in families on AFDC.

Senator CURTIS. What about the total number of children, what percent of the total number of children are on AFDC?

Mr. ANDERSEN. There are 3 million children on AFDC in the country today, and this would constitute——

Senator CURTIS. Ten percent?

Mr. ANDERSEN. Roughly, somewhere in that area. We could get the exact figure and file it with the committee.

Senator CURTIS. The staff tells me it is about 4.7 percent, the children, on the average, of the Nation, who are on AFDC.

Mr. ANDERSEN. Very good; and 20 percent of those children are illegitimate; 20 percent of all the illegitimate children in the country are on AFDC. So the higher percentage——

Senator CURTIS. Do I understand that the Federal law refers to children as illegitimate?

Mr. ANDERSEN. I believe so.

Senator CURTIS. I do not think so.

Mr. ANDERSEN. Maybe no. You would know.

Senator CURTIS. No. We do not in our State.

Mr. ANDERSEN. Other terms are used. It varies from State to State.

Senator CURTIS. But I doubt very much that the Federal law refers to any child as illegitimate.

Mr. ANDERSEN. It is an interesting thing that although the total number of children or the percentage of children on AFDC who are,

if we use the word "illegitimate," it is higher than the national average, yet the families on AFDC, while they are on AFDC, have a lower incidence of illegitimacy than the national average. They may get there as a result of many of those conditions, but the program has been successful in arresting one of the areas of greatest concern.

It is not the program that has caused the illegitimacy that frequently gets them into the program, but the program has been helpful in halting the incidence.

If the House Ways and Means Committee believes that illegitimacy per se is sufficient cause to remove a child from his home and place him in foster care, then what about the other 80 percent of illegitimate children who are not on AFDC? If a family does not need to apply for assistance or removes itself from the AFDC program, are their children to be without care and protection, and must these families do without any help from the community for their children? Are children whose mothers are working but who are not on welfare rolls to be denied the advantages of proper day care? The prospects are, gentlemen, that these things may very well happen if H.R. 12080 is passed in its present form, as it passed the House.

The third reason we oppose title II of H.R. 12080 is that it would greatly weaken, if not destroy, existing public child welfare programs despite provisions which may, on the surface, look like great gains for child welfare. The increased authorizations for child welfare appropriations in section 235(c), for example, may well be meaningless when seen in the operational context of the merger provisions of section 235(d) and the new requirements for the AFDC program as interpreted by the House Ways and Means Committee report.

No reasons have been given by the House Ways and Means Committee for the proposed removal of the child welfare services provision from title V to title IV of the Social Security Act. We can see no logic in putting a service program designed for all children into a public assistance title designed only for those requiring financial assistance. This seems to indicate a major change in congressional intent, to concentrate on services for AFDC children instead of maintaining services available for all children in need of care or protection.

Senator CURTIS. Would you enumerate what services you are talking about?

Mr. ANDERSEN. We are talking about the child welfare services to families where there is abuse, where there is illegitimacy, where there are different needs, where these conditions occur outside of an AFDC family.

The great emphasis of the bill as it comes over is on the——

Senator CURTIS. What are the services?

Mr. ANDERSON. The services would be the consultative services of skilled social workers to help find out the problems generating the conditions in nonpublic assistance families of abuse.

Senator CURTIS. That is all that is involved in the social welfare services?

Mr. ANDERSEN. And the adoption and the foster care program also, is also involved.

You could have just as much need for a foster care program in an abuse situation in a family not on AFDC as one on AFDC, but all the emphasis——

Senator CURTIS. I was not arguing with you. I was just trying to find out what you meant by the general term.

Mr. ANDERSEN. Yes. We mean all of the services of child welfare.

Senator CURTIS. It is the adoptive services——

Mr. ANDERSEN. Foster home care services and counseling services, treatment for disturbed children would be still another; institutions.

Senator CURTIS. Now, does the Federal Government have anything to do with, at the present time, the removal of children from an unfit home if the parents are substantially high income?

Mr. ANDERSEN. Maybe Mr. Reid could comment on that.

Mr. REID. Yes. In 1962 Congress mandated the States in the Social Security Act to extend child welfare services to every jurisdiction in the community, and specifically provided that the services should be available to all people who needed them. This has been the base of the law since 1909 of the Children's Bureau setup.

Senator CURTIS. That includes the social welfare services primarily?

Mr. REID. That is correct, and it includes it for upper income families because the States are permitted to charge fees of the families who can afford to pay them.

Senator CURTIS. Yes. But it did not include any payments.

Mr. REID. The moneys that go to the—the moneys from the Federal Government that go to the welfare services under title V are approximately $50 million at the moment. In other words, grants are made to the States for the general support of child welfare programs.

The amount of Federal moneys, amounts to approximately 10 percent of the total expenditures of the States and Congress——

Senator CURTIS. The Federal Government only contributes 10 percent?

Mr. REID. That is correct. These children are severely penalized by virtue of that fact; that this is the only, in fact, major category of people in the United States, I think of need, in which the Federal Government does not share the costs of the States and the counties.

Senator CURTIS. I thought you said their need was not financed.

Mr. REID. No. These are not families in which they have to receive a money payment in order to survive. However, the programs, themselves, the children in foster care, or the children in institutions, the service programs, the cost of those are borne 00 percent by the States.

Senator CURTIS. That is where the State can collect from the parents if they want to?

Mr. REID. Yes. The income from that, Senator, I should say amounts to a very small percentage of the costs.

These are families that may not be financially indigent. A large percentage of them, however, cannot afford, for example, to pay for the institutional care of their child, which may cost several thousand dollars a year, or they do not pay for, let us say, a mother's releasing her child for adoption; they cannot pay for the $2,000 that it may cost the State to place that child for adoption.

Senator CURTIS. All right.

Mr. ANDERSEN. I guess the main thrust of our comment here is that by merging the services for all children in with the services for the public assistance families, and then putting great emphasis on concern about the public assistance family, the service program to non-

public assistance families could be even less than it is, and it needs to be greatly upgraded.

For example, in the area of illegitimacy, where 80 percent of the births are in nonpublic assistance families, we think this is a dangerous and unwise move, this merging.

Section 235(d)(2) mandates one organizational unit at the State or local level to provide both AFDC and child welfare services. It also mandates one State agency to administer or supervise both the AFDC and the child welfare programs. We oppose these mandatory mergers and believe that States should be permitted to choose their own pattern of organization as long as services are made available both to AFDC and non-AFDC groups. We oppose the merger of AFDC and child welfare services into one organizational unit unless eligibility determination and income maintenance are completely removed from the service programs. This problem has already been recognized at the Federal level where the Department of Health, Education, and Welfare reorganization plan separates out income maintenance programs from service programs.

Existing public child welfare programs are pure service programs. They are quality programs which attract trained personnel and enjoy public support at the local level. Public child welfare agencies serve some 600,000 children per year who need services such as adoption, foster care, day care, and counseling for problems which are not necessarily related to financial need. AFDC, on the other hand, is a massive public assistance program where emphasis is placed on determination of financial eligibility and investigation of the family situation which would be even more stringent under the provisions of H.R. 12080.

The indiscriminate merger of a service program for all children in need of care with the massive AFDC assistance program would greatly jeopardize or even sacrifice child welfare services without the hope of constructive gains.

There is all too common a feeling that somehow many of the social problems relate only to low-income families. The thing we are pleading for is that these needs cut through all economic groups.

Merging the AFDC and the child welfare programs will not provide the solution to the problem of insufficient services for the AFDC child. The basic problem is a lack of sufficient child welfare services for all children in this country, and this problem can only be solved by proper Federal financing of child welfare programs.

The Congress is generous in the Federal matching for other categorical aids. This is the only Federal program, child welfare services, that does not get Federal matching at the local level for the hiring of personnel and this too, we feel discriminates against the services.

More children are in need of service than the current programs can accommodate and since the States and localities already bear 90 percent of the cost of child welfare services, there is a great need to increase the Federal share in financing child welfare.

It may not be directly comparable, but it is interesting to notice that the Congress provides 90 percent of assistance to build the highways, but 10 percent of assistance to give child welfare service.

For these reasons, the League has supported legislation like S. 1116, introduced by Senator Pell, which would provide matching funds to

the States for the costs of child welfare personnel and child welfare services. If sufficient funds were made available to the States, these child welfare programs could serve all children in need of care, whether or not they also required financial assistance.

The League has always urged the availability of comprehensive child welfare services to provide care and protection for children both in their own homes and in foster care, as well as other services to strengthen family life and to prepare individuals for employment and self-support. The League believes that the whole range of family and child welfare services should be widely available to all families and children who need them and should not be confined any one socio-economic group.

Under H.R. 12080, however, services would be limited mainly to AFDC families, omitting the many other poor families not within the AFDC program, as well as other children who are also in need of care and protection.

Moreover, the assistance and services for AFDC families would be given under coercive and discriminatory conditions which might well preclude their usefulness.

For these reasons, we wish to recommend that the Senate substitute the public assistance amendments of title II of H.R. 5710 for the public assistance amendments of title II of H.R. 12080, and substitute the provisions of S. 1116, introduced by Senator Pell, for the child welfare services amendments of H.R. 12080.

If substitution of S. 1116 is not possible, however, we would suggest as an alternative, the substitution of the child welfare services amendments of H.R. 5710. This would provide matching funds for additional child welfare personnel in addition to increased authorizations for child welfare services under part 3 of title V of the Social Security Act.

Increased day care and foster care services, as well as services to children in their own homes, would then be possible and available for all children in need of such care and protection.

We, too, wish to thank the chairman and the committee for their courtesy in permitting us to testify on behalf of the Child Welfare League of America.

Thank you very much.

Senator CURTIS. Governor, thank you.

I am rather astounded that the Child Welfare League of America would brand any child as illegitimate.

How long do you think they should carry that tag? Until they are 10 or 20 or 50, or 70 or 80?

Mr. ANDERSEN. No. I think as a personal tag it should not apply to any child. It is just a means of identification, and if one could use the term "born out of wedlock," I think it is just a matter of terminology, and it could be changed. But the child itself——

Senator CURTIS. I do not think there is any such term in the Federal law, and I doubt very much that this is, under the Minnesota law.

Mr. ANDERSEN. It is in the report of the committee on H.R. 12080, and I suppose that is why we used it, purely to identify the children we are talking about. But we surely would be glad to substitute any other term.

Senator CURTIS. No human being has anything to say about how he is going to be born.

Mr. ANDERSEN. That is right. But some are born under the law and some are not.

The law requires marriage, of course, and so it has come to be children not born under marriage are not born under law, and have become illegitimate.

We are wholly sympathetic to the child, and we are wholly sympathetic to using terms to protect the child. We would never refer to a particular child as illegitimate.

Senator CURTIS. Just as a group.

Mr. ANDERSEN. Just as a group, just as a means of identifying a group of children we are talking about, but never to a particular child.

Senator CURTIS. I think you will find Federal law has very carefully avoided any such branding of even a group.

Mr. ANDERSEN. I think it is a good thing. I would agree with that.

Senator CURTIS. My guess is that the Minnesota law would not use it.

Mr. ANDERSEN. I think mainly we use in Minnesota the term "born out of wedlock."

Senator CURTIS. That is all.

Senator HARRIS. Thank you very much.

(Mr. Andersen's prepared statement follows:)

PREPARED STATEMENT OF ELMER L. ANDERSEN, ON BEHALF OF THE CHILD WELFARE LEAGUE OF AMERICA

INTRODUCTION

I am Elmer L. Andersen, President of the Child Welfare League of America. I am President of H. B. Fuller Company, St. Paul, and was Governor of Minnesota. I am speaking on behalf of the Board of the Child Welfare League of America. Accompanying me is Mr. Joseph H. Reid, Executive Director of the League since 1953. Established in 1920, the League is the national voluntary accrediting organization for child welfare agencies in the United States. It currently has 292 child welfare agencies in membership as well as 59 associate agencies. Represented in this group are voluntary agencies of all religious groups as well as non-sectarian public and private agencies. The League's prime functions are consultation services to local agencies and communities, standard setting, research, and child welfare publications.

We wish to address ourselves to the Child Welfare and Public Assistance Amendments of Title II of H.R. 12080 as they would affect the children of this country. We do not believe that these provisions are in the true tradition of the United States Congress which has, over the past decades, expressed its concern for the health and welfare of all the nation's children. Although Title II of H.R. 12080 presents the illusion of helping children, upon close analysis it is in fact, overall, a potentially harmful measure. Even the positive features of the bill, when viewed within the total context of the programs proposed, become negative and hostile to the wellbeing of children. We can only believe that the House of Representatives did not fully understand the regressive proposals in this legislation and the extent to which they would ultimately harm the lives of millions of children.

The League, like the Congress, has always been concerned about the factors in our society which lead to such severe social problems as dependency, illegitimacy, delinquency, mental instability, and a lack of proper care and protection for children. We know, as does the Congress, that such social problems are found throughout our society and not just within those families receiving public assistance.

The Congress, as well as the League, has therefore recognized the necessity to make public child welfare services available for all children in need of such services, regardless of their financial status. The Congress has expressed this

necessity both by the definition of child welfare services in Section 528 of the Social Security Act and by the language in Section 523(2) which requires a state plan to show progress towards making child welfare services available through the state "for all children in need thereof" by July 1, 1975.

But in writing H.R. 12080, the Ways and Means Committee seems primarily concerned with the increases in numbers and costs of the AFDC program. It is concerned over the rising numbers of illegitimate children. The League shares that concern. However, we believe that many of the measures proposed will only aggravate the situation, instead of relieving it, and tend to vitiate Congress' concern for all children.

Public Assistance Amendments, Part 1, Title II, H.R. 12080

Our first objection to Title II of H.R. 12080 is that, in part, it relies on compulsion and coercion to achieve its end. It is excellent to provide job training and increased employment opportunities which the bill seeks. But we deplore the effort to force people to accept job training or employment with the threat of cutting off food for their children if they refuse. Such efforts are self-defeating.

This is particularly true in light of the fact that H.R. 12080 greatly enlarges the areas where the subjective judgments of welfare workers would determine whether a family receives assistance, for it will be the individual welfare workers who will determine whether a mother has a "good cause" in preferring to stay at home to care for her children, or whether employment is "suitable." We believe that it is a critical error to increase the areas where the subjective judgment of welfare workers is substituted for objective eligibility criteria. We assume that the Department of Health, Education, and Welfare will write sound guides as to what constitutes "good cause" for refusing to accept training or employment, or for defining what constitutes "appropriate" training and employment. However, we know from past experience that well-meaning regulations emanating from Washington frequently provide little real protection for the individual. The subjective judgment of thousands of individual welfare workers, influenced by local attitudes and prejudices, frequently results in arbitrary unjust decisions from which appeal is long and costly and often impossible. Such circumstances severely endanger the rights of people, destroy their dignity, and make the individual subject to critical abuses of authority and discretion that, before they are corrected, can result in severe privation for children.

Emphasis upon investigations, searches, and referrals to courts produce a climate in which constitutional rights are endangered and welfare workers are alienated from people they are supposed to serve. It is extremely difficult, if not impossible, to offer rehabilitative service to help the families who must constantly be in fear of the worker who is serving them.

We believe also that placing limitations on the percentage of deserted children who may be on the relief rolls ignores all the social and economic realities in the country, and in the end can only hurt children.

The Ways and Means Committee Report states that children will not be punished for the failure of a mother to work although she may be cut off assistance. This too is an illusion. If a mother, for example, is cut off relief because she sincerely believes she should care for her children and "protective payments" are then made only to meet the children's needs, that mother will either share the children's portion of potatoes or will starve. Either of these alternatives would, in fact, punish the child, despite the Committee's good intentions.

The second reason that we oppose Title II of H.R. 12080 is that it would result in confining concern to the child receiving public assistance instead of extending concern for all childen in need of services. For example, the Ways and Means Committee is concerned with children on AFDC who are neglected or abused by their parents. It has stated that these parents should be referred to the courts for proper action. Neglect and abuse of children is by no means confined to the AFDC family. As the reports of the Children's Bureau indicate, severe abuse of children is widespread and is found in all economic groups. Yet, there is nothing in the bill that would extend protective services for all children. All states have laws giving courts jurisdiction over the neglecting and abusing parent. Congress adds nothing new when it mandates the states to bring court actions against the neglecting AFDC parent, except to single him out as a second-class citizen. The basic reason children are not protected under our present laws is not that the law is insufficient, but that services do not exist to provide that protection in a positive manner.

Although almost all cities in the United States have an organization that is responsible for investigating reports of abuse or neglect of animals, extremely few communities in the United States have a comparable system for investigating reports of neglect and abuse of children. In a few communities, there are highly experienced organizations that have established what are known as protective services for children. These agencies investigate all reports of child abuse and neglect. They send trained social workers to the child's home to determine whether the child is in need of care or protection, to work with the family to correct the abuse and neglect when possible, and, if necessary, to take appropriate court action.

Police authorities and social work experts agree that precipitous police action is self-defeating and does not produce positive results. When skilled services are not available to help parents take proper care of their children, families are unnecessarily broken up and children are doomed to the limbo of long-term foster care. The taxpayer pays dearly for the cost of that foster care. The League has supported legislation such as H.R. 1977 introduced by Congressman Burke in the House and S. 1116 introduced by Senator Pell, which would provide federal matching funds to the states for comprehensive child welfare services. This would enable all communities to establish protective services which would then be available for all children in danger and would not be limited solely to AFDC children.

H.R. 12080 seems to reflect the concern for the alleged immorality of persons receiving public support rather than a concern for the welfare of all children. In 1961, only 20 percent of the illegitimate children in the country were on AFDC, but if the House Ways and Means Committee believes (as the Child Welfare League does not) that illegitimacy per se is sufficient cause to remove a child from his home and place him in foster care, then what about the other 80 percent of illegitimate children who are not on AFDC? If a family does not need to apply for assistance, or exits from the AFDC program, are their children to be without care and protection, and must these families do without any help from the community for their children? Are children whose mothers are working but who are not on welfare rolls to be denied the advantages of proper day care? The prospects are that these things may well happen if H.R. 12080 is passed in its present form.

We strongly urge this Committee to reconsider the basic philosophy embodied in Senator Pell's bill which would make possible services to all children who need them and not only the child who is a drain on the public purse.

Child Welfare Services Amendments, Part 3, Title II, H.R. 12080

The third reason we oppose Title II of H.R. 12080 is that it would greatly weaken, and in some situations might destroy existing public child welfare programs despite provisions which may on the surface look like great gains for child welfare. The increased authorizations for child welfare appropriations in Section 235(c), for example, may well be meaningless when seen in the operational context of Section 235(d)(2) and the new requirements for the AFDC program as interpreted by the House Ways and Means Committee Report on H.R. 12080.

Section 235(a), (c) and (e)(1) of H.R. 12080 provide for the removal of Part 3, Title V of the Social Security Act to Title IV, and Section 235(d)(2) provides for the mandatory merger at the state and local level of AFDC and child welfare service units. We believe these requirements would jeopardize or even sacrifice the child welfare service programs without the hope of constructive gains. Under Part 3, Title V, child welfare programs in the states are pure service programs and not relief programs. Public child welfare agencies serve approximately 600,000 children per year who need services such as adoption, foster care, counseling and day care, for problems which are not necessarily related to financial need. These are quality service programs capable of attracting trained workers, and they have enjoyed public support at the local level. However, they have been insufficient in quantity because of the lack of adequate federal financing. More children are in need of these services than the current programs can accommodate, and comprehensive child welfare services are not yet fully available throughout the states despite the 1962 Congressional mandate that this should be accomplished by 1975. Since the states and localities bear 90 percent of the cost of these programs, there is a great need to increase the federal financing of the child welfare programs. For these reasons, H.R. 5710 provided federal funds to the states on a matching basis for additional child

welfare personnel and also removed the ceiling from the authorization for child welfare grants as of 1969.

This need for federal financing of comprehensive child welfare services is why the League and many other groups supported legislation like S. 1110 introduced by Senator Pell which would provide matching funds to the states both for the cost of child welfare personnel and child welfare services. If sufficient funds were made available to the states, these child welfare programs would include both AFDC as well as non-AFDC children. Since eligibility for child welfare programs depends on the need of the child for service rather than on his financial eligibility, there are provisions in the states for payment by families who can afford to pay for part or all of this care. These child welfare programs are now in jeopardy. If these true service programs for all children in need of care were to be indiscriminately merged with a mass financial assistance program of AFDC, where the emphasis is on financial eligibility and investigation of the family situation, the child welfare programs might soon lose their effectiveness.

Section 201(c) of H.R. 12080 would provide 75 percent federal matching for the personnel cost of workers serving AFDC or AFDC related cases, but similar matching funds would not be available for the cost of workers serving non-AFDC children. This would further accentuate the current discrimination between the financing of public assistance service workers and child welfare workers. It would accent the hesitancy of the states and localities to appropriate funds for non-AFDC cases since the state dollar would not be matched by Federal funds. Some states are already forfeiting federal matching funds for AFDC because they cannot or do not wish to put up the required state percentage. Under H.R. 12080, there are so many mandated AFDC programs that there may well be no state money available for non-AFDC child welfare services. Even with an increase in federal child welfare authorizations, the states would still have to provide a large percentage of the cost of the child welfare programs. The ultimate result may well be the loss of child welfare services for any child other than an AFDC related case.

No reasons have been given by the House Ways and Means Committee for the removal of Part 3, Title V of the Social Security Act to Title IV, the AFDC title. We can see no logic in putting a service program designed for all children into a public assistance title designed only for those requiring financial assistance. Removal of Part 3 from Title V to Title IV seems to indicate a major change in Congressional intent—to concentrate on services for ADFC children instead of maintaining services available for all children in need of care or protection. We think this is dangerous and unwise.

We oppose the mandatory merger in Section 235(d)(2) and believe that states should be permitted to choose their own pattern of organization as long as services are made available both to AFDC and non-AFDC groups. We are opposed to the mandatory merger of AFDC and child welfare service programs into one unit at the local level, unless eligibility determination and income maintenance are completely removed from the service programs. This problem has already been recognized at the federal level where the Department of Health, Education, and Welfare reorganization plan separates out income maintenance programs from service programs.

Merging the AFDC and child welfare programs will not provide the solution to the problem of insufficient services for the AFDC child. The basic problem is a lack of sufficient child welfare services for all children in this country, and this problem can only be solved by proper federal financing of child welfare programs. We belive that H.R. 12080 ducks this issue by attempting to merge two programs and thus creating a dual financing system which would be administratively unwieldy and would result in the loss of services for those children requiring protection and care but not requiring financial assistance. The League suggests that children and families would be better served by providing funds for child welfare services across the board under provisions of a bill similar to that introduced by Senator Pell and Congressman Burke. However, if this is not possible, then the provisions of H.R. 5710 would be a viable alternative with additional funds to be provided for day care and foster care through the child welfare appropriations.

Comments on Specific Provisions of H.R. 12080

Community Work and Training, Section 204, H.R. 12080.—H.R. 12080 requires states to provide work and training programs which would be mandatory for AFDC mothers as well as other covered relatives and AFDC children over 16

not in school full-time. Failure to participate in these programs without "good cause" would result in the loss of assistance.

Although the Child Welfare League supports provisions to make opportunities and incentives for work and training more available, the League believes that work and training for mothers must be offered on a voluntary basis if the program is to be successful. The Child Welfare League believes that mothers should have a choice between working or caring for their own children full-time. Mothers who choose to work or train have a much better chance of success than those who are forced to do so.

Under the present work and training provisions of Section 409(a) of the Social Security Act, which are voluntary both as to the states and as to the recipients, there is a requirement that the state provide, "(4) . . . for assuring appropriate arrangements for the care and protection of the child during the absence from the home of any such relative performing work under such program *in order to assure that such absence and work will not be inimical to the welfare of the child.*"

The underlined language is omitted from similar provisions in H.R. 12080. If the work and training section of the Social Security Act is amended, we believe that this language should remain in the Social Security Act in order to emphasize concern for the welfare of the children involved.

Day Care.—When mothers wish to work, however, they are often frustrated because of the lack of sound child care services. The League has always held that day care services should be available as part of a total child welfare program so that children in need of service might be properly cared for when their mothers are either unable to do so full-time or are at work.

Day care is not only a service that permits mothers to seek employment; it is also a preventive service which helps keep children in their own homes and out of foster care. Many children who are not on assistance also need care while their mothers work. In some of these cases, though families would be able to pay part or all of the cost of day care, the services themselves are lacking.

It is the League's position that day care services should be available for a wide variety of reasons, in addition to the fact that a mother may be working to support her family. Nor should day care services be required for children when it is not in their best interest as, for example, in the case of the child not ready for separation from his parent for any extensive time.

Because H.R. 12080 would make work and training programs mandatory for most AFDC mothers, the states would also be required to provide child care programs to make this possible. However, no standards are set for these day care services under the AFDC program, and there is no recognition of the need of the child for anything other than custodial care. Moreover, according to the Ways and Means Committee Report, these funds would be restricted to providing day care for only those children whose AFDC mothers were at work or in training. This is in contrast to the magnificent recognition which Congress has previously given to the values of the Head Start program which provides enriching experiences for preschool children. It is also in contrast to the day care provisions now in Section 523(1)(B) of the Social Security Act which sets standards for day care services under a state plan. (These provisions also appear in Section 235(c) of H.R. 12080 and would apply to the use of funds appropriated under the child welfare authorizations in that section.) The state plan must provide:

"(iii) for such safeguards as may be necessary to assure provisions of day care under the plan only in cases in which it is in the best interest of the child and the mother and only in cases in which it is determined, under criteria established by the state, that a need for such care exists; and in cases in which the family is able to pay part or all of the costs of such care, for payment of such fees as may be reasonable in the light of such ability;

"(iv) for giving priority in determining the existence of need for such day care, to members of low income or other groups in the population, and to geographical areas, which have the greatest relative need for extension of such day care; and

"(v) that day care provided under the plan will be provided only in facilities (including private homes) which are licensed by the state, or approved (as meeting the standards established for such licensing) by the state agency responsible for licensing facilities of this type."

The League believes day care facilities for AFDC children should be provided as part of the state's child welfare services and under the same standards and protections as set forth above.

The League believes that day care services should be available for children of non-AFDC as well as AFDC parents, not only because these children need such care, but also because it will avoid the ghettoizing effects of programs run solely for AFDC children. We believe the present language contained in Section 523(a)(1)(B)(iii) of the Social Security Act permitting payment of part of all of the cost of day care according to the ability of the parent is very sound in this respect, and although priority is given to day care for low income groups in the population, it is not limited solely to parents on assistance. We believe the provisions for day care should be kept as part of the child welfare program, Part 3 of Title V, and not made Part A of Title IV.

The Ways and Means Committee estimated that under H.R. 12080 $470 million would be spent on day care under AFDC for working mothers in 1972. We believe that these funds should be made available as part of the child welfare appropriations under Part 3 of Title V and that states should have a single program for day care for both AFDC and non-AFDC children administered by the child welfare program.

Foster Care.—There is a documented and recognized need for federal financing of foster care as the House Ways and Means Committee has pointed out. H.R. 12080 attempts to remedy the present situation in which states and localities pay for 98 percent of the foster care cost which amounted in 1966 to $258 million. This is to be done by expanding the number of children who may be financed in foster care under AFDC provisions by changing the requirement of eligibility to include those children who might have been eligible for AFDC within the past six-month period under certain conditions had application been made on their behalf. The Committee estimates an additional $40 million in federal foster care funds would be spent under this provision in 1972.

The Committee also states its belief that more AFDC children should be in foster care because of poor home environment, including that caused by "multiple instances of illegitimacy." H.R. 12080 retains the requirement of Section 408(a) of the Social Security Act that federal funds for foster care will be available only if such a removal has been made "as a result of a judicial determination to the effect that continuation (at home) would be contrary to the welfare of the child." The League believes that this judicial review protects AFDC children and families from possible coercion and placement contrary to the child's welfare. We therefore urge the Senate to retain this protection in the law.

The Ways and Means Committee Report indicates that, "the increase in the authorization for appropriations for child welfare services . . . will be of substantial help to states in meeting the cost of foster care of children . . . and expect states to use most of their increased allotments of federal funds which result for foster care of children." This would provide the states with additional foster care funds for non-AFDC cases. The 1972 cost estimates of the Committee, however, as revealed in the chart on page 117 of the Committee Report, indicate that *if* the entire increase in child welfare authorizations were appropriated and *if* the entire amount allotted to child welfare services were used for foster care, there would be $40 million federal available for non-AFDC foster care. This would be in addition to the $40 million federal funds for foster care added by the expanded AFDC foster care provisions of H.R. 12080. Even this maximum figure of $80 million would be less than one-third of the foster care expenditures of $258 million spent by the states and localities in 1966 and would preclude any funds for the basic essential for sound child welfare services, namely, child welfare personnel. The Child Welfare League believes that all foster care, whether for AFDC or non-AFDC children, should be funnelled through child welfare funds and that there should be a single foster care program in the state.

Child Welfare Personnel.—It must be re-emphasized that personnel is essential to the provision of sound child welfare services. H.R. 12080 does not provide the funds necessary for additional child welfare personnel, although federal funds would be available for personnel working with AFDC children. State welfare departments have indicated that the need for additional trained child welfare personnel is the highest priority need in their child welfare programs. Without the necessary personnel, children cannot be protected in their own

homes and may end up needlessly (and much more expensively) in foster care. They also stay in foster care for longer periods than necessary when child welfare workers are lacking to help remedy their home situations. In addition without funds for personnel, adoption services are lacking so that children who could have permanent homes of their own at no further expense to the community are kept needlessly in foster care. Without personnel funds, protective services to assist children who are abused or neglected in their own homes will be sorely lacking, and these problems occur in many families not within the AFDC caseload. H.R. 5710 recognized this vital need by providing 75 percent federal matching funds for the cost of additional child welfare personnel. We, therefore, recommend a return to the personnel provisions of H.R. 5710.

Meeting Full Need.—In testifying before the House Ways and Means Committee, the League stressed the basic importance of the provision in H.R. 5710 which would require states to meet the financial needs of families with children as determined by the state's own budgeting standards of minimum need, and to provide for an annual review of the standards to take into account changes in living costs. Unfortunately, this provision of H.R. 5710 does not appear in H.R. 12080. As is well documented, there is a serious discrepancy between what the states determine to be minimal need and the amount they actually pay to recipients on assistance. This discrepancy is widest in the AFDC program and children are, therefore, most affected by it. Meeting the minimal needs of children is essential to any program which seeks to protect them. The best social services in the world cannot feed the hungry child nor provide him with the necessities of life. Living in constant poverty is not the way to promote the healthy physical or emotional growth of the next generation on which this country must depend. For these reasons, we urge the Senate to amend the Social Security Act so as to include the provisions as written in Section 202 of H.R. 5710.

Dependent Children of Unemployed Fathers, Section 203, H.R. 12080

The Child Welfare League believes that the goal of public assistance polices should be to help keep families together rather than to encourage family breakup. The AFDC programs which permit assistance to children who are needy because their father is unemployed, help keep families together. We believe this program should be mandatory upon the states. It is unwise to continue any policy which actually encourages the breakup of families. This is the unfortunate end result of programs which provide assistance only upon condition that the father is absent from the home. New restrictions which would be placed on the AFDC–U programs under Section 203 of H.R. 12080 also tend to encourage family breakup because they cut the number of fathers whose children would be eligible for AFTC. For example, any child whose father received any amount of employment insurance, no matter how small, would be ineligible for AFDC assistance during that month. If the father deserted that family, however, the child would be eligible. A child whose father did not have six or more quarters of work within a prescribed period, would also be ineligible, unless the father disappeared from the home.

This is unsound public policy. It would exclude from AFDC some of the neediest children—those whose families had been hit by a severe or prolonged recession, or those whose father had had a prolonged illness from which he had since recovered. For these reasons, we believe that the definition of "unemployment" should be much more broadly defined than it is in H.R. 12080 and that there should be no restrictions based on the receipt of unemployment compensation which falls below the state's standard of need. In addition, we would urge that the states be required to provide assistance to families with children with an unemployed parent as a basic part of the AFDC program.

Protective Payments and Vendor Payments, Section 207, H.R. 12080

Under present law (Sections 405 and 406 of the Social Security Act, if a state is meeting full need, "protective payments" to a third party may be made in the limited number of cases where AFDC relatives are found to be fiscally irresponsible and assistance payments are not being used in the best interests of the child. Section 207 of H.R. 12080, however, would eliminate all but one of the provisions of Section 406 designed to safeguard the child and his family from possible misuse of protective payments and would also provide for the use of vendor payments. H.R. 12080 would now *require* states to use protective and vendor payments when AFDC relatives were fiscally irresponsible and also whenever there was a refusal to accept training or employment.

Although there are relatively few cases of demonstrated fiscal irresponsibility, this new requirement would open the door to widespread use (and possible abuse) to protective and vendor payments, which would further discriminate against AFDC families. The League is opposed to any use of vendor payments for rent, food, clothing or other goods and services because it is almost impossible to prevent their widespread abuse. This is particularly important if children are not to be further deprived, since AFDC grants are already low and do not meet minimum needs in most states.

The League believes "protective payments" should be permitted to protect the best interests of the child in instances where there has been a state determination that the relative is fiscally irresponsible. But legislative provision for "protective payments" should continue to include the careful safeguards now in Sections 405 and 406 of the Social Security Act.

Limitation on AFDC Caseload, Section 208, H.R. 12080

The League is opposed to any ceiling on the numbers of children who may be eligible for federal financing under the AFDC program.

Medical Assistance Amendments, Part 2, Title II, H.R. 12080

We wish to point out the vital importance to children and expectant mothers of the programs under Title XIX of the Social Security Act. Infant mortality rates reflect the socio-economic status of their mothers, as do the figures on the use of health and dental services. The lack of health care is most acute among persons of low income groups. For these reasons, we believe the states should be permitted to continue to develop programs under the terms of this new legislation without any modification at the present time. It is premature to modify Title XIX in any basic respect until the states have had further experience with these programs. We would urge particularly that there be nothing in any provision which would restrict the eligibility for Title XIX benefits for children in low income families who could not otherwise afford health care. Children should continue to receive the same care as the other groups now covered under Title XIX. We oppose the change in Section 220(a) of H.R. 12080 which would limit the eligibility for Title XIX benefits to an income standard no higher than one and one-third times that for money payments under AFDC because it would cut so drastically the number of eligible children in low income families who need this vital health care.

Social Work Manpower and Training, Section 401, Title IV, H.R. 12080

We endorse the social work manpower and training provision contained in Section 401. If the institutions of higher learning are to be able to provide the social work manpower and training necessary to implement the Social Security Amendments of 1967, it is essential that they have financial help to do so.

CONCLUSIONS

The League has always urged the availability of comprehensive child welfare services to provide care and protection for children both in their own homes and in foster care, as well as other services to strengthen family life and to prepare individuals for employment and self-support. The League believes that the whole range of family and child welfare services should be widely available to all families and children who need them and should not be confined to any one socio-economic group. Under H.R. 12080, however, services would be limited mainly to AFDC families, omitting the many other poor families not within the AFDC program, as well as other children who are also in need of care and protection. Moreover, the assistance and services for AFDC families would be given under coercive and discriminatory conditions which might well preclude their usefulness.

For these reasons, we wish to recommend that the Senate substitute the Public Assistance Amendments of Title II of H.R. 5710 for the Public Assistance Amendments of Title II of H.R. 12080 and substitute the provisions of S. 1116, introduced by Senator Pell, for the Child Welfare Services Amendments of H.R. 12080. If the substitution of S. 1116 is not possible, however, we would suggest as an alternative, the substitution of the Child Welfare Services Amendments of H.R. 5710. This would provide matching funds for additional child welfare personnel in addition to increased authorizations for child welfare services under Part 3 of Title V of the Social Security Act. Increased day care and foster care

services, as well as services to children in their own homes would then be possible and available for all children in need of such care and protection.

We wish to thank the Chairman and the Committee for their courtesy in permitting us to testify on behalf of the Child Welfare League of America.

SUMMARY AND RECOMMENDATIONS OF THE CHILD WELFARE LEAGUE OF AMERICA

The Child Welfare and Public Assistance Amendments of Title II, H.R. 12080 are potentially harmful to the health and welfare of the nation's children and not in the best tradition of the United States Congress which has heretofore concerned itself with promoting the health and welfare of all children and held that child welfare services should be available for all children in need of such care and protection, regardless of their finanical status. Although the goal of the Public Assistance Amendments (Part 1, Title II) namely, to help as many families as possible to achieve independence and self-support, is praiseworthy, the use of compulsive and coercive means to achieve that end is self-defeating and would ultimately harm the lives of millions of children. Limitations of AFDC caseloads, and threats to discontinue assistance ultimately deprive and harm children. Although the number of AFDC families receiving assistance may be cut by such means, the problems of dependency are not solved.

Families in all walks of life may at some time have problems resulting in a child's need for care and protection. Illness, death, dependency, illegitimacy, delinquency, mental instability, neglect and abuse are not limited to public assistance families. Title II is likely to result, however, in limiting programs to AFDC families instead of continuing to make services available for all children who need them.

The Child Welfare Services Amendments (Part 3, Title II) would greatly weaken and might destroy existing child welfare programs, despite the illusion of gain in increased child welfare authorizations, particularly when viewed in the light of the public assistance provisions of the bill. Merging the AFDC and child welfare programs will not provide the solution to the problem of insufficient services for the AFDC child. The basic problem is lack of sufficient welfare services for *all* children in this country, and this can only be solved by proper federal financing of child welfare programs. H.R. 12080 would create dual systems of financing for child welfare services, one for AFDC related children, and another for non-AFDC children, which might ultimately result in the loss of services for children requiring protection and care but not on AFDC. The Child Welfare League believes that a single system of financing for unified child welfare programs in the states is necessary.

Specifically, the League recommends that:

1) legislative provisions for child welfare services be kept as part of Title V of the Social Security Act;

2) there be no mandatory merger of AFDC and child welfare service programs into one unit at the local level, unless eligibility determination and income maintenance are completely removed from the service programs;

3) child welfare services be financed, preferably on a matching basis, through Title V and not through Title IV.

These recommendations could be achieved by substituting the Public Assistance Amendments of Title II of H.R. 5710 for the Public Assistance Amendments of Title II of H.R. 12080 and substituting the provisions of S. 1116, introduced by Senator Pell, for the Child Welfare Services Amendments of H.R. 12080. If this substitution of S. 1116 is not possible, alternatively, the Child Welfare Services Amendments of H.R. 5710 could be substituted. This would at least provide matching funds for additional child welfare personnel, the basic essential for sound child welfare programs, in addition to providing increased authorizations for child welfare services under Part 3, Title V of the Social Security Act. In either case, increased day care and foster care services, as well as services to children in their own homes would then be possible and available for all children in need of such care and protection.

In addition, the Child Welfare League:

1) opposes mandatory work and training for AFDC mothers as a "condition for receiving assistance." Work and training opportunities should be offered on a voluntary basis with assurance that suitable child care arrangements will be made so that the mother's absence and work will not be inimical to the welfare of the child;

2) recommends single programs for day care for both AFDC and non-AFDC children in the states, administered under the state child welfare program and with the standards and protection for day care established by Section 523 of the Social Security act;

3) recommends a single program for foster care in the states for both AFDC and non-AFDC children in need of such care, financed through the child welfare program. If the separate AFDC foster care program is continued, however, the requirement for court approval of AFDC foster care placements should be retained;

4) recommends that states be required to meet the full minimum financial need of AFDC families as determined by the states' own budgetary standards of such need;

5) recommends that the AFDC–U program be mandatory upon the states and opposes the narrow definition of "unemployment" contained in H.R. 12080;

6) opposes the use of vendor payments and the elimination of present safeguards for the use of "protective payments;"

7) opposes any ceiling on the numbers of children who may be eligible for federal financing of AFDC programs;

8) opposes changes in the medical assistance programs which would limit eligibility for Title XIX benefits for children in low income families;

9) endorses the Social Work Manpower and Training program of H.R. 12080.

Senator HARRIS. Mr. Michals, will you come forward.

The next witness is Mr. Eugene Michals, president of the American Physical Therapy Association.

Will you please introduce for the record those who accompany you here today, those you have with you?

STATEMENT OF EUGENE MICHALS, PRESIDENT, AMERICAN PHYSICAL THERAPY ASSOCIATION, ACCOMPANIED BY LUCY BLAIR, EXECUTIVE DIRECTOR; ROYCE P. NOLAND, EXECUTIVE DIRECTOR, CALIFORNIA CHAPTERS; AND JOHN PELLOW, MEMBER, OKLAHOMA CHAPTER

Mr. MICHALS. Thank you very much.

To my left is Miss Lucy Blair, executive director of the American Physical Therapy Association; to my far left Mr. Royce Noland, executive director of the California chapters of the American Physical Therapy Association; and to my right is Mr. John Pellow, member of the Oklahoma chapter of the American Physical Therapy Association.

Senator HARRIS. I want to say on behalf of the chairman and the committee that we apologize to you and your association for not having been able to hear all of the many witnesses who desired to appear at this hearing on this particular aspect of the bill we are now considering.

I am hopeful that the points you cover in your statement will involve the points which the various witnesses and the various State groups wanted covered. Further, I want to point out again to you that we have extended to each of these people who have wanted to appear an invitation to submit written statements in lieu of a personal appearance, and without objection any such statements submitted will be printed in the record following your testimony.

Mr. MICHALS. Thank you, Mr. Chairman.

We appreciate the opportunity to appear before the Senate Committee on Finance on matters regarding the Social Security Amendments of 1967, especially section 1861(5) of title XVIII.

In compliance with the request of your committee, our association has previously filed a copy of the statement relative to our appearance here today, and I should like this to be part of the record of this hearing.

Senator HARRIS. Without objection, that will be done.

Mr. MICHALS. In the interest of brevity and clarity, I should like to read selected portions of the statement along with certain additional comments and editorial changes.

The American Physical Therapy Association represents over 12,000 qualified physical therapists in the United States and has component chapters in all of the 50 States, the District of Columbia, and the Commonwealth of Puerto Rico. Embodied on page 1 of our statement are brief comments concerning the educational programs for physical therapists and the types of patients seen by physical therapists.

Physical therapy is one of the allied health professions concerned with the effective implementation of patient care services under the sections of the Social Security Act known as medicare and physical therapists are identified in the services for our senior citizens which are rendered in hospitals, extended-care services, and home health agencies and as a part of services provided by a physician. Physical therapy is excluded, however, when given by a physical therapist not identified with a provider of services.

Approximately 60 percent of our members are located in all types of hospitals. These are both public and private; 7 percent are in nursing homes on a full-time basis, 15 percent in nursing homes on a part-time basis, and 15 percent are affiliated with public health or home health agencies, and many physical therapists provide physical therapy on a part-time or a full-time basis in patient's rooms as a necessary service to both physicians and patients.

The majority of the physicians do not employ physical therapists in their offices and prefer to refer their patients in need of physical therapy—with appropriate prescription—to qualified physical therapists with whom they have developed interprofessional relationships in the local area.

During the past year, our experience in the implementation of medicare indicates that there has been inconsistent and ineffective utilization of qualified physical therapists because of restrictions in the law and because of some confusion and inequities in carrying out the regulations in local areas.

Although physical therapists have made themselves available for patient care services on a full-time or part-time basis, they have frequently not been utilized because of the lack of a certified home health agency or other providers of services in the area.

As an example, a community of 100,000 persons, approximately one-fourth of whom are over age 65, there is no hospital outpatient department or home health agency providing physical therapy services. In the same community, there are three physical therapy offices, well equipped and manned by five qualified and experienced physical therapists providing physical therapy as medically prescribed on an

outpatient or home-care basis. Because of the provisions in the present law, the eligible beneficiaries are denied reimbursement for the services that they receive from these physical therapists. The singular disqualifying factor is that these physical therapists are not connected with a hospital department or home health agency.

Another example which exists in many communities is one in which a physical therapist serves a small hospital in one area and maintains an office elsewhere. He divides his time assisting the in- and outpatients of the hospital in the morning, and providing treatment for patients in his office in the afternoon. As a result, the eligible beneficiaries can have their services reimbursed in the morning in one area but not in the afternoon in the other area.

In areas where there is no certified home health agency or where the agency may arbitrarily choose not to negotiate contracts with several qualified physical therapists, there has been a loss in the utilization of available qualified physical therapists.

The physical therapist who is available after the normal workday or on weekends is providing a needed service to a limited number of patients in his home area, upon referral of the patient's physician. This is no longer possible in many instances. Hence, the patient may need to be returned to the hospital or nursing home a distance away, at greater expense. Also, the available personnel are not being used to their optimal capacity. Reported costs on delivering physical therapy services through institutions and agencies in some parts of the country have been 14 to 20 percent higher than those delivered by a physical therapist not connected with an agency.

The amendments to the Social Security Act proposed in H.R. 12080 section 133(a) in relation to the hospital extending physical therapy services to outpatients will assist in some areas but the question has been raised as to whether this change will eliminate the present plans for services in extended-care facilities.

This will not provide the mechanism for an individual physical therapist to accept the prescription of the patient's physician in carrying out his directions in the patient's home or in the physical therapist's office and submitting acceptable charges to the designated carrier. Therefore, the beneficiary patient is denied the services which he needs.

It should be recognized that, properly utilized, physical therapy can increase mobility and restorate functional ability with the ultimate goal being one of maximum independence for the patient. The result can be less dependence on institutional care. A close correlation can be expected between effective utilization of physical therapy and decreased costs for other health personnel and for patient confinement. Voluminous documentation of this statement is to be found in appropriate technical journals of the last three decades. If there is an immediate slight increase in costs it would only occur in those areas where this service is now being denied the eligible beneficiaries. To purport to offer certain benefits and then to deny these benefits to some beneficiaries because of certain administrative arrangements does not seem congruent with the fundamental purpose of such a program as medicare or with good business practices of any health insurance carriers.

The association appreciates that the implementation of medicare has unearthed a variety of variables which will need to be explored, with eventual changes to assure the intent of the original legislation. We are not proposing additional coverage but a realinement of provision mechanisms for more effective utilization of facilities and manpower within the scope of the program.

We urge your consideration in supporting the amendment to section 1861(S) of the Social Security Act, title XVIII, as cited on page 4 of our statement. Such an amendment, we believe, would rectify the problems which were highlighted in this statement in an equitable and economical manner. We thank the committee for the privilege for appearing before you and we are prepared to answer any questions that you may wish to ask.

Senator HARRIS. Are there any affirmative statements on the part of any of your associates? If not, how are physical therapists licensed?

Mr. MICHALS. Physical therapists are licensed within individual States and territories, and presently we are licensed in all but two States, Missouri and Texas.

Miss BLAIR. They are the only ones who do not have regulatory acts.

Senator HARRIS. Do all of them require a certain amount of educational attainment?

Miss BLAIR. Yes.

Mr. MICHALS. If I may speak to that, yes, all of them require graduation from a school approved by the Council on Medical Education of the American Medical Association, in collaboration with the American Physical Therapy Association.

Such licensure is by examination, and this examination is written and in some instances also oral.

Senator HARRIS. All right.

Now, not considering the House bill, 12080, but only the present law, the provisions of the present law, under what situations is the service of the physical therapist provided for now?

Mr. MICHALS. These services are presently provided in hospitals to in-patients as well as out-patients. They are provided in home health care agencies or through home health care agencies.

They are also provided in extended care facilities. As such they are recognized as part of the medical care of the individuals who come under our treatment.

Senator HARRIS. How is that changed by 12080?

Mr. MICHALS. 12080 does not necessarily change this except for section 133(a) which would permit a hospital to contract with others to provide services within the home. Presently this is only provided through home health care agencies.

But, as cited in our statement, there is a dearth of such agencies, No. 1.

No. 2, they have apparently to quite some extent failed to negotiate such contracts and to provide such services where they would be available.

So that section 133(a) would presetntly extend this responsibility to hospitals to negotiate contracts with physical therapists to provide services in the homes of patients.

Now, this is some help over what it had been, but we also recognize that this does not completely and will not completely take care of the present problem, and that is providing physical therapy services to persons who have literally paid for this under present insurance coverage.

Senator HARRIS. The present situation is that physical therapy services may be recognized in the present law where it is in a hospital; outpatient service outside a hospital——

Mr. MICHALS. Within the hospital.

Senator HARRIS. Yes.

Then you have the home health agency in the home or an extended care facility.

Mr. MICHALS. That is right, sir.

Senator HARRIS. The hospital then adds home services under hospital——

Mr. MICHALS. That is right; under section 133(a).

Senator HARRIS. And you want to add to that what?

Mr. MICHALS. Our move and intent is to add to that the ability of the physical therapists upon prescription by a physician to render those services directly to a patient in his or her home without the need for negotiating a contract with some home health care agency which may not exist, and in many areas which do not exist, or with some hospital who may or may not be present in any geographical area. In other words, what we are concerned with is making our services available to all persons covered by insurance under medical care.

Senator HARRIS. So far as where a hospital is present in the geographical area, do you think the House provisions, the present House provisions, would take care of the situation in the home?

Mr. MICHALS. Well, it may, and some of my associates, some of the persons who accompanied me, may wish to speak to this.

Mr. NOLAND. It could, but it would not necessarily. The hospital, even though it may physically be there, is under no obligation to provide the service, and the illustration, as given in the statement, where there are, in fact, hospitals in that particular community but they do not provide either in- or out-patient physical therapy services; yet, in the same community, there are physical therapists who are noninstitutional based, yet qualified like any other physical therapists by education and all.

So our colleagues could render the service if the mechanism of having to be institutionally based were not an administrative requirement of the law and the regulations.

Senator HARRIS. Do any of you have any estimates as to the costs involved?

Mr. MICHALS. I would say, no, we do not. We discussed this thoroughly.

We estimate that approximately one-half of our membership, one-half of the 12,000 membership, would be available and probably participate in medicare.

Now, these persons are presently available but presently are not utilized. We hesitate, and we are very reluctant, to estimate what costs this might run to, but we can envision that this would be a very minor portion of the total medicare program costs because of our small numbers. In other words, there are few of us available.

Senator CURTIS. Would you yield at that point?
Senator HARRIS. Yes, Senator Curtis.
Senator CURTIS. Do I understand that you make the point that if the patient's physician prescribes the use of a physical therapist that you may be saving the administrative expense of handling that under a hospital or home care agency; would that be correct?
Mr. MICHALS. Yes, sir. In some instances this would be true.
Senator CURTIS. Is it also your contention that a physician can prescribe the use of a physical therapist and occasionally it might happen that it might make hospitalization unnecessary?
Mr. MICHALS. Yes, sir; this can be true.
Senator CURTIS. And these 46 approved schools, do you happen to have a breakdown to know what schools are, in my State of Nebraska included?
Miss BLAIR. There are none in Nebraska, but there are several approved schools in neighboring territory, two in Minnesota, and one at the University of Colorado, and one at the University of Iowa. Many of the physical therapists in your State——
Senator CURTIS. What are the two in Minnesota?
Miss BLAIR. Pardon me?
Senator CURTIS. What are the two in Minnesota?
Miss BLAIR. The University of Minnesota and the Mayo Clinic in Rochester.
Senator CURTIS. I think you will find there are some colleges that have an arrangement that is approved that provide for the pretherapy course.
Miss BLAIR. Right.
Senator CURTIS. I know that is strictly true of Mayo Bros.
Miss BLAIR. Right.
They may take their prephysical therapy preparation in a college in your State or other surrounding States, but they complete their professional preparation at Mayo Clinic, and that is——
Senator CURTIS. I believe in the case of Mayo that they indicate and designate the school——
Miss BLAIR. Right.
Senator CURTIS (continuing). That is acceptable.
Miss BLAIR. Right.
Senator CURTIS. But those schools are not included in your 46.
Miss BLAIR. No, because——
Senator CURTIS. These 46 are those that complete?
Miss BLAIR. That is right. That is the professional phase.
Senator CURTIS. What types of physical therapy treatment are most commonly used by people over 65? What do you do for them?
Mr. PELLOW. The poor grandmother who comes out on the front porch and falls and breaks her leg, she, in turn, needs physical therapy; and the arthritic needs physical therapy.
For instance, I can cite you an example——
Senator CURTIS. You mentioned one, the post treatment of a broken hip.
Mr. PELLOW. Yes. Later this morning, Dr. Adams is going to speak. He is an orthopedic surgeon. Let us say you stepped off the porch and broke your hip. You will later on be taught how to walk and how to exercise on the way to complete rehabilitation.

Arthritis is another area, a large area.

I think when this whole area of medicaid was conceived, that everybody really did not know how important or did not know exactly how physical therapy fit into almost all of the patients that could have Medicare benefits, not only because of the example we cited here of a broken hip, but with other conditions such as muscular schlerosis or arthritis.

Does that answer your question, sir?

Senator CURTIS. Yes, sir.

Senator HARRIS. Anybody else? Do you have anything further to add?

Mr. MICHALS. One other comment. The range of the type of treatment given to these individuals, Senator Curtis, runs to all age groups.

Senator CURTIS. I am trying to follow what they are. The breaking of a bone and arthritis. What are some of the others?

Mr. MICHALS. What are some of the types of patients?

Senator CURTIS. No; the treatment that is apt to be given to a person over 65.

Mr. MICHALS. There is therapeutic exercise which is scientifically designed exercise, exercise designed purposely for increasing muscle strength, endurance, increasing joint range or mobility, let us say, various exercises to improve a person's ability to use crutches and walk on crutches.

Senator CURTIS. How about following a stroke?

Mr. MICHALS. Recovery from a stroke. I am just smiling because this happens to have been one of my principal areas of interest. It involves usually fairly extensive types of exercise designed to retrain and thus restore functions in the involved extremity.

Senator CURTIS. I think you have given adequate discussion.

Senator HARRIS. Aside from the social security laws and Medicare, are you permitted in States to render services or give treatment without a prescription?

Mr. MICHALS. No, sir. It is strictly under referral and prescription by a physician.

Senator HARRIS. It has been educational for me. I appreciate your being here.

Mr. MICHALS. Thank you, Senator, for the time.

(The prepared statement of the American Physical Therapy Association follows:)

PREPARED STATEMENT OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION

The American Physical Therapy Association represents over 12,000 qualified physical therapists in the United States and has component chapters in all of the 50 states, the District of Columbia and the Commonwealth of Puerto Rico. There are 46 schools of physical therapy accredited by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association and, in addition, there are six new schools in their developmental stage.

Distribution of qualified personnel and costs of delivering effective patient care services have been of concern to us for years. The ratio of qualified physical therapists to general population varies from one per 11,000 population in some states to one per 89,000 population in others, with a concentration in the metropolitan areas. A recent study representing over 6,000 physical therapists indicates that the greatest number of patients receiving their services are recovering from a stroke, a fracture or a bout of arthritis.

Physical therapy is one of the allied health professions concerned with the effective implementation of patient care services under the sections of the Social Security Act known as Medicare and physical therapists are identified in the services for our senior citizens which are rendered in hospitals, extended care services and home health agencies and as a part of services provided by a physician. It excludes this service, however, when given by a physical therapist not identified with a provider of services.

Approximately 60 per cent of our members are located in all types of hospitals, 7 per cent in nursing homes on a full time basis, 15 per cent in nursing homes on a part time basis and 15 per cent are affiliated with public health or home health agencies for full time or part time services. Some of these physical therapists have established offices to provide physical therapy as medically prescribed on an out-patient or home care basis.

The majority of physicians do not employ physical therapists in their offices and prefer to refer their patients in need of physical therapy (with appropriate prescription) to qualified physical therapists with whom they have developed interprofessional relationships in the local area.

During the past year, our experience in the implementation of Medicare indicates that there has been incongruities in the effective utilization of qualified physical therapists because of restrictions in the law and some confusion in carrying out the regulations in local areas.

Although physical therapists have made themselves available for patient care services on a full time or part time basis, they have not been utilized because of the lack of a certified home health agency or other providers of services in the area.

As an example, a community of 100,000 persons, 26,000 of whom are over age sixty-five, there is no hospital out-patient department or home health agency providing physical therapy services. In the same community, there are three physical therapy offices, well equipped and manned by five qualified and experienced physical therapists providing physical therapy as medically prescribed on an out-patient or home care basis. Because of the provisions in the present law, the eligible beneficiaries are denied reimbursement for their services. The singular disqualifying factor is because the physical therapists are not connected with a hospital department.

Another example which exists in many communities, a physical therapist serves a small hospital in one area and maintains an office elsewhere. He divides his time assisting the in- and out-patients of the hospital in the morning and provides treatment for patients in his office in the afternoon. As a result, the eligible beneficiaries can have their services reimbursed in the morning but not in the afternoon.

Formerly, physical therapists were used on a part time or full time basis in carrying out the physician's prescription for physical therapy in the patient's home or at a suitable location in the patient's home area with the payment of services made by the responsible carrier. With the advent of Medicare, such service has changed and can only be provided through a contract with a home health agency or in the physician's office.

In areas where there is no certified home health agency or the agency is reluctant to negotiate contracts with several physical therapists, there has been a loss in the utilization of available qualified physical therapists.

The physical therapist who is available after the normal work day or on weekends is providing a needed serivce to a limited number of patients in his home area, upon referral of the patient's physician. This is no longer possible in many instances. Hence the patient may need to be returned to the hospital or nursing home a distance away, at greater expense. Also, the available personnel are not being used to their optimal capacity. Reported costs on delivering physical therapy services through institutions and agencies in some parts of the country have been 14 to 20 per cent higher than those delivered by a physical therapist not connected with an agency.

The amendments to the Social Security Act proposed in H.R. 12080 Sec. 133(a) in relation to the hospital extending physical therapy services to out-patients will assist in some areas but the question has been raised as to whether this change will eliminate the present plans for services in extended care facilities.

This will not provide the mechanism for an individual physical therapist to accept the prescription of the patient's physician in carrying out his directions in the patient's home or the physical therapist's office and submitting acceptable

charges to the designated carrier. Therefore, the beneficiary patient is denied the services which he needs.

We should all recognize that property utilized physical therapy should have a goal of increased mobility and restoration of functional ability with an alternate objective of maximum independence. The result should be less dependence on institutional care. There should be a close correlation between effective utilization of physical therapy and a decrease in the cost of other health personnel and patient confinement. Voluminous documentation of this statement can be found in the technical journals over the last three decades. If there is an immediate slight increase in costs it would only occur in those areas where this service is otherwise being denied the eligible beneficiaries. To purport to offer certain benefits and then to deny these benefits because of administrative expediencies hardly seems consistent with a humane program.

The Association appreciates that the implementation of Medicare has unearthed a variety of variables which will need to be explored with eventual changes to assure the intent of the original legislation. We are not proposing additional coverage but a more effective utilization of facilities and manpower within the scope of the program. Therefore, we support the proposal in H.R. 12080 for a study to determine the feasibility of the inclusion of certain services under Part B of Title XVIII of the Social Security Act.

Also, we urge your consideration in supporting another amendment to the Social Security Act, Title XVIII as follows:

Section 1861 (S) to insert another paragraph before "No diagnostic tests":

"(10) Physical therapy services performed by a qualified physical therapist as defined in regulations provided said services are performed in accordance with the prescription of a physican who certifies (or recertifies, where such services are furnished over a period of time) that such services are or were medically required but only with respect to the functions which a physical therapist is legally authorized to perform (as such) by the state in which he performs them:"

This would require that the present 1861 (S) (10) would become (11), the present (11), as amended by Sec. 129(b) of H.R. 12080, will become (12) and (12) would become (13) and (13) would become (14) respectively.

(A statement and letters from various registered physical therapists follow:)

STATEMENT OF PATRICK TROTTA, R.P.T., PRESIDENT, NEW JERSEY STATE PHYSICAL THERAPY SOCIETY

On April 12, 1966, Arthur E. Hess, director of the Bureau of Health Insurance, issued a letter, State Agency No. 21, wherein the qualifications required of physical therapists were set forth (see item A attached). Failure to meet the qualifications enumerated results in the inability of the physical therapist to practice his skills upon patients covered by medicare, because such a patient would have to pay for this therapy if he chose such a therapist.

The qualifications necessary are to be a graduate of a school approved by the American Medical Association and/or American Physical Therapy Association or to be a member of the American Physical Therapy Association.

Many of our membership have been practicing physical therapy for 30 years or more. Physical therapists are, and have been, licensed, or registered, by many of the States, of which New Jersey is one. Our members are all licensed or registered, and they have, over the years, relied upon the requirements for licensing or registration to guide them in satisfying such requirements and to be qualified physical therapists. Further, our organization has conducted an educational program to enhance the quality of our membership.

Under Public Law 89-97, medicare for the aged, Congress did not distinguish between a graduate from an American Medical Association/American Physical Therapy Association approved school or an AMA/APTA unapproved school of physical therapy, but merely states within this law qualified physical therapist.

Schools approved by the AMA/APTA did not exist at the time many of our membership became licensed or registered and became qualified to practice.

The alternative set forth to being a graduate of an AMA/APTA approved school is to be a member of the American Physical Therapists Association (APTA).

We consider this discriminatory.

Our organization has functioned through the years on the same plane but without as vast a coverage throughout the States. Many of our members would have been accepted to membership in the APTA when they commenced the practice of physical therapy had they applied.

But to say that our people are not qualified after this many years of practice under the direction and supervision of medical doctors (as required), and licensing or registration by the State, impairs their right to earn their livelihood and practice their professions.

A number of our members have since been dismissed from their positions with hospitals because of the refusal of medicare to recognize their professional standing and to pay for the services rendered.

A letter from Commissioner Ball, item B to me, Patrick Trotta, medicare chairman, paragraph two, clearly establishes that only the American Medical Association and the American Physical Therapy Association were consulted in the formation of the proposed regulation for qualifications for physical therapists under medicare. My letter of reply to Commissioner Ball, item C, points out the inequity of only hearing one group on the proposed regulation.

We wholeheartedly agree with the principle of the grandfather clause, but by what measure does the membership to a private organization make a person more qualified to practice his profession than State licensing or registration?

Let me bring to the attention of this honorable committee that the background of the aforementioned APTA is no more astonishing than any other professional group. Miss Catherine A. Worthinham, a woman holding high position within the APTA, states in an article of their journal, Physical Therapy, October 1965, volume 45, No. 10, page 937, under paragraph "Growth of Physical Therapy," "We must not forget that physical therapy has come rapidly through a sequence of patterns of education. There are still some of our members who traveled the apprentice path. Your speaker is one of them. There are many who entered the field through hospital courses."

How then can an APTA membership be declared the only measure of qualification when State license or registration of physical therapists not only meet this camouflaged grandfather clause, but actually surpass it? It becomes clear that the APTA has become, and unfairly so, the sole spokesman for State licensed or registered physical therapists in the United States. This point is presently being contested in the courts of New York State by a fellow physical therapist. I have at-

tached a copy of this action as reported in the AMA News, February 20, 1967, and listed herein as item D.

From the beginning when Director Hess issued his proposed regulation (item A), I endeavored to present the views of my State physical therapy society and of my national association. Since I could not obtain a hearing, I asked if we could meet with Commissioner Robert M. Ball. This meeting was granted with members of his staff on October 3, 1966, and a copy of the letter to the Commissioner, thanking him for granting this meeting, is herewith attached as item E. At this meeting, I and the members of my committee, plus the New York State and Pennsylvania representatives, presented our views and facts. We were convinced, after this meeting, that the members of Commissioner Ball's staff were impressed by our logic and plea to be included in the final regulations.

Additional meetings followed with other branches of Social Security and on May 25, 1967, in the office of Mr. Erwin Hytner, Chief Representative and Service Policy, Department of Health, Education, and Welfare, a grandfather clause was offered by our society as a compromise solution to our problem. We of State societies and our national, had reached the conclusion that although the Department of Health, Education, and Welfare appeared genuinely interested in making the proposed regulation equitable to all licensed or registered physical therapists, that the only guidance they would receive would be through us alone. We, therefore, concluded that to resolve the problem placed before us on the old worn out argument against us that "not every State meets the same standards as you" or "not every State presents the same highly qualified person like yourself," we would have to take the initiative with compromise. I therefore proposed with the able assistance of those appearing with me, a grandfather clause that was a credit to our profession and high in standards. I outlined this clause in my letter to Mr. Hytner, dated June 5, 1967.

In the latter part of July 1967, I was elated to learn that the Insurance Branch of Social Security had drawn up a grandfather clause for physical therapists and had submitted it to Secretary Gardner and Commissioner Ball for their approval and signature. This definitely indicated sympathy and respect for our position and a sincere desire to bring equity to the arbitrary and capricious proposed regulation that we were fighting. With hope and expectation we await Secretary Gardner's announcement that this grandfather clause proposed by the Insurance Branch of Social Security is accepted.

Unfortunately, we have learned that it is being opposed maliciously by special interest. Such a clear indication of monopolistic action should not be permitted to take place. To deny State licensed or registered physical therapists the right to practice their professions as they have been legally deemed to do so by their State governments, and having met the qualifications as set down by State legislators, is a complete injustice and an infringement on duly legislated rights.

Through our State and National associations, we have shown good faith in compromise. Is this not the true democratic spirit? Are our livelihoods to be taken from us by a subterfuge that Congress never intended? We treat only under the supervision of duly licensed physicians who are most capable of judging competence.

Based on the number of persons over age 65 in our State of New Jersey alone, there would be only one so-called qualified physical therapist for every 6,000 senior citzens. This is a fantastic shortage, for the senior citizen is not the only patient seeking physical therapy services. In addition, it has been reported that at the rate of population growth in the United States, by the year of 1975, 20,000 new physical therapists will be required. At present, in the entire United States, less than 1,000 physical therapists are being graduated annually. Thus, in the next 8 years, there will be added an additional 12,000 physical therapists to the critical shortage list that now exists. (Reference: 1. Lillian E. Chabala, Division of Professional Services, American Physical Therapy Association; 2. Association of Rehabilitation Centers, Title No. 1, 1966.

To further deplete the qualified physical therapists by setting up discriminatory qualifications as in the proposed regulation becomes

asinine in view of the aforementioned shortage, especially when the so-called unqualified physical therapist is very much qualified to serve other Government agencies such as the Veterans' Administration. The proposed regulation is completely biased in that where on one hand it claims higher standards must be set to cover States whose standards are not acceptable, it (the proposed regulation) then very capriciously as a grandfather clause to qualify all APTA members. Since we are their peers, why not us?

In conclusion, my request of the honorable Senate Finance Committee, in behalf of State societies and our national association, is twofold: One, that the committee send to Secretary Gardner a strong recommendation that he accept the grandfather clause as suggested by the Insurance Branch of Social Security and two, if Secretary Gardner does not accept the recommendation of the committee, then we humbly request that the honorable committee propose an amendment to Public Law 87-97 (medicare) qualifying all State licensed or registered physical therapists to participate under medicare.

(Attachments to Mr. Trotta's statement follow:)

[Item A]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., April 22, 1966.

BUREAU OF HEALTH INSURANCE LETTER, STATE AGENCY NO. 21

Subject: Qualifications for Physical Therapists.

The conditions of Participation for Home Health Agencies (Condition I) and for Extended Care Facilities (Condition VII) define a qualified physical therapist as follows:

"A physical therapist is a graduate of a program in physical therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association, or its equivalent, and when applicable, is licensed or registered by the State."

The Conditions of Participation for Hospitals (Condition XII) specify that a qualified physical therapist is a "graduate of a program in physical therapy approved by the American Medical Association or its equivalent."

In order to provide a standard definition and to interpret the term "or its equivalent," the following have now been determined to be the acceptable criteria for a "qualified physical therapist."

1. Graduation from a physical therapy curriculum approved by the American Physical Therapy Association from 1928 to 1936, or by the Council on Medical Education and Hospitals of the American Medical Association from 1936 to 1960, or by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association since 1960; or

2. Membership in the American Physical Therapy Association or registration by the American Registry of Physical Therapists; or

3. For physical therapists trained outside the United States;

a. Graduation since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located. The curriculum must have been in a country in which there is a member organization of the World Confederation for Physical Therapy; and

b. Membership in a member organization of the World Confederation for Physical Therapy; and

c. Completion of 1 year's experience under the supervision of an active member of the American Physical Therapy Association; and

d. Successful completion of a qualifying examination as prescribed by the American Physical Therapy Association.

It is expected that the majority of physical therapists who have been trained in the United States will be able to qualify under these criteria. However, in-

dividuals who graduated from a physical therapy program in the United States before 1928 or from a physical therapy program before it was approved by the appropriate accreditation body, are not qualified unless they are either (1) members of the American Physical Therapy Association; or (2) registered by the American Registry of Physical Therapy.

ARTHUR E. HESS, *Director, Bureau of Health Insurance.*

[Item B]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., July 1, 1966.

MR. PATRICK TROTTA,
Chairman, Medicare Committee, New Jersey State Physical Therapy Society, Teaneck, N.J.

DEAR MR. TROTTA: Secretary Gardner has asked me to thank you for and reply to your letter of June 8.

As I am sure you know, the advice and suggestions of interested professional groups, such as the American Medical Association and the American Physical Therapy Association, were taken into account in the formulation of the qualifications that physical therapists must meet to have their services covered under the health insurance program for the aged.

It is true that when a home health agency offers (either directly or through arrangements with others) physical therapy services as one of the therapeutic services available to patients under a home health care plan, the services must be provided by one or more physical therapists who meet the requirements outlined in the Bureau of Health Insurance issuance to which you referred. However, the home health agency (or the agency or organization with which arrangements have been made to provide the services) may also employ other personnel who do not meet these qualifications if they are under the direction or supervision of a qualified physical therapist.

The proposed regulations incorporating the Conditions of Participation for Home Health Agencies were published in the Federal Register on May 14. Following that date, there was a 30-day period during which interested parties could send comments and suggestions concerning any of the proposed regulations. Since your letter was received during that period, I want to assure you that your comments, as well as all other comments received (including those of Mr. Walter Carlson, President of the New Jersey State Physical Therapy Society), will be considered before final publication in the Federal Register of the regulations relating to the health insurance program.

Sincerely yours,

ROBERT M. BALL,
Commissioner of Social Security.

[ITEM C]

NEW JERSEY STATE PHYSICAL THERAPY SOCIETY,
Teaneck, N.J., July 12, 1966.

ROBERT M. BALL,
Commissioner of Social Security,
Department of Health, Education, and Welfare,
Social Security Administration,
Baltimore, Md.

DEAR COMMISSIONER BALL: Thank you for your reply to my letter of June 3rd, 1966, to the Honorable Secretary Gardner.

It is heartening to know you will give my comments consideration in regard to the inequities affecting New Jersey State registered physical therapists in the regulations relating to the health insurance program.

Your letter clearly establishes that only one group of physical therapists was specifically consulted when the regulations in question were formulated. A bill, S–178, which our Governor Hughes signed, regulating the standards and qualifications for registering physical therapists in New Jersey was accomplished on a mutual basis.

Our Society, of the above name, and the American Physical Therapy Society met on numerous occasions to draw up a mutually acceptable bill. This bill S–173 was then passed through the Legislature and signed by the Governor after an active campaign by our Society. This is the Democratic fashion.

My letter to Secretary Gardner requested an opportunity for a hearing so that I might present briefly our Society's views concerning the services of physical therapists under the health insurance program for the aged. In no way does your letter refer to this request. I sincerely believe this was an oversight for I cannot see how final publication in the Federal Register of the regulations relating to the health insurance program can be made without your department's listening to other organized physical therapists as represented by our State Society.

Congress did not pass a bill benefiting one group over another no more than our State Legislators when they passed our registration bill referred to earlier in this letter.

Quality care has been granted to all the people of our state by competent state registered physical therapists. The health insurance program for the aged as your letter indicates will utilize personnel other than state registered physical therapists which signifies that on a national level the aged *cannot expect quality care.* The intent of Congress will be destroyed if the regulations written in their present form are permitted to stand.

Once again, I request to appear before you so that I may present our Society's view; views that will strengthen the Medicare Act and *grant quality care* to the aged.

Sincerely yours,

PATRICK TROTTA, R.P.T.,
Chairman Medicare Committee.

[Item D]

[From AMA News, Feb. 20, 1967]

REVIEW ORDERED ON PHYSIOTHERAPY RULE

A requirement that non-members of the American Physical Therapy Assn., Inc., be excluded from the practice of physiotherapy under the medicare program, has resulted in a New York court order that a judicial review be made of the association's refusal to admit one physiotherapist.

The New York Supreme Court in the case of *Mable v. American Physical Therapy Assn., Inc.*, directed the hearing of the physiotherapist who is duly licensed under state law.

At Graduation: It was pointed out that at the time of the physiotherapist's graduation, his school was accredited and approved neither by the Association nor by the Council on Medical Education of the American Medical Association.

Therefore, the evidence showed, he did not meet the membership requirements prescribed by the association's board of directors and was refused membership.

The ruling said although it is not required by law, "admission to membership in a voluntary medical society, which has virtually a monopolistic control of the practice of medicine, will be compelled by mandamus where the applicant meets all the written requirements prescribed by the society."

The text pointed out the basis for this is that membership in the medical society is a "matter of economic necessity; (and) exclusion therefrom on the basis of an unwritten rule or regulation does not promote medical science or professional standards and is contrary to public policy."

Medicare Requirements: The court continued:

". . . It appears that under the recently enacted 'medicare' program, a physiotherapist, even though he is duly licensed but who is not a member of respondent (association) or who does not meet respondent's membership requirements, will not be able to qualify and therefore will not be eligible for employment by a hospital, institution, or physician who wishes to participate in the medicare program.

"Virtually every hospital and institution in New York State is or will be a participant in the 'medicare' program; and petitioner is therefore presently faced with a substantial inability to pursue his profession."

[Item E]

OCTOBER 10, 1966.

Mr. ROBERT M. BALL,
Commissioner of Social Security, Department of Health, Education, and Welfare, Social Security Administration, Baltimore, Md.

DEAR COMMISSIONER BALL: Thank you for permitting our group to meet with the members of your excellent staff on October 3rd, 1966, so that we could present our objections to the proposed regulation on qualifications for physical therapists under Medicare.

Your staff expressed keen interest in our problem, and this was most gratifying. They were a most commendable group and their questions were always fair. In reply we presented our facts with complete honesty. Your selection of Mr. Erwin Hytner as chairman of the meeting was an excellent choice, for we felt he dealt with our problem with interest and understanding. Your entire staff should be commended for the highly professional manner in which this meeting was held.

It is our hope justice will prevail and continue to permit *we* licensed or state registered physical therapists to serve our patient (under medical direction) of all ages and our government with the high professional standards we have maintained for decades.

Sincerely,

PATRICK TROTTA, R.P.T.,
Chairman, Medicare Committee.

SEPTEMBER 16, 1967.

Hon. RUSSELL B. LONG,
Senate Office Building,
Washington, D.C.

DEAR SIR: In reference to the newspaper article in the New York Times on August twentieth—Therapist Denied a Role in Medicare—I would like to urge you to give positive consideration to the Amendment by the American Physical Therapy Association to the present Medicare Law. The intent of the existing law PL 89-97 has certainly been misinterpreted. Although I am a practicing licensed physical therapist, I can no longer treat patients over the age of sixty-five on a private basis. I must refuse to do so when asked by a physician. Not only are many qualified physical therapists being denied the right to practice their chosen profession but the doctor is now unable to choose the physical therapist he wants.

Many people over sixty-five are being treated by unqualified "physical therapists". Because the Home Health Agencies do not have ample qualified physical therapists, they are training non-professional people to do the job of a professionally trained-licensed physical therapist. The standards of my profession are greatly reduced through this unfortunate necessity.

Thank you for your consideration and I trust you will support the Amendment so that more qualified licensed physical therapists may participate in the Medicare program.

Respectfully,

ANN BALLANTYNE, R.P.T.

CLIFFORD F. HEIDINGER, R.P.T.,
Stamford, Conn., August 24, 1967.

Hon. Senator RUSSELL B. LONG,
Senate Finance Committee,
Senate Office Building,
Washington, D.C.

DEAR SENATOR LONG: On August 9, 1967, I was personally interviewed by The New York Times. The enclosed article appeared in the Times on August 20, 1967.

This is a documented incident of the arbitrary discriminatory interpretation of the existing Medicare Law (PL 89-97) by the local Home Health agencies to control the para-medical services to be rendered, and the financial reimbursement for these services, which is certainly contrary to what was the original intent of the legislators. It excludes qualified physical therapists from rendering their

services throughout the country. It is an injustice to the physician, patient, therapist relationship.

The present bill, HR 12080, which is now in the Senate Finance Committee, of which you are a distinguished member, does provide for some additions that might have corrected some of these injustices. But, I still agree that there should be more attention given for defining Physical Therapy services under 1861–S. entitled, "Medical and other Health Services."

I am requesting your attention in the Senate Finance Committee hearings, which are now in session to the obvious injustice existing under the present Medicare Law.

Thanking you and requesting again your fair consideration in regards to this national problem.

Sincerely yours,

CLIFFORD F. HEIDINGER, RPT.

PROPOSED AMENDMENT TO TITLE XVIII OF THE SOCIAL SECURITY ACT, DRAFT—NOT FINAL

IN REFERENCE TO H.R. 12080—SEC. 129

Section 1861(s) to insert a new paragraph (10) before "tests performed in any laboratory. . . ." as follows:

"(10) physical therapy services performed by a qualified physical therapist as defined in regulations, provided said services are performed in accordance with the prescription of a physician who certifies (or recertifies, where such services are furnished over a period of time) that such services are or were medically required but only with respect to functions which a physical therapist is legally authorized to perform by the State in which he performs them;"

This would require that the present 1861(s) (10) become (11) and the proposed (11), (12) & (13) of HR 12080 Sec. 129(b) become (12), (13) & (14) respectively.

[From the New York Times, Aug. 20, 1967]

THERAPIST DENIED A ROLE IN MEDICARE

(By Jane Brody)

STAMFORD, CONN., August 19.—A physical therapist who has been in private practice here for 14 years says he is being denied the right to treat Medicare patients in their homes because of the way the Medicare law is being interpreted in his community.

Under Medicare, physical therapy may be provided through a hospital, an extended care facility (nursing home) or a home health agency selected by Medicare officials. The therapist must be on the staff of the institution providing the service, or he must have a formal arrangement or contract with the institution making it responsible for handling the therapist's bills.

CONTRACT REFUSED

The Stamford therapist, Clifford Heidinger, says the designated local home health agency, the Visiting Nurse Association of Stamford, Inc., has refused to grant him a contract that would enable the Medicare patients he treats outside a nursing home to be reimbursed by the Federal Government for his services.

The Visiting Nurse Association maintains that it is in no position at this time to give Mr. Heidinger such a contract, Miss Helen Meekin, executive director of the association, declined to discuss the matter further.

Following the refusal of the association in Stamford, Mr. Heidinger said he asked the Visiting Nurse Associations in New Canaan and Darien for contracts, but in both cases the response was the ame. All three associations have signed contracts with the Rehabilitation Center of Southern Fairfield County, Inc., as the local provider of physical therapy services for Medicare patients at home.

In an interview in his five-room office here, Mr. Heidinger charged that the local home health agencies "have chosen to interpret the provision of the law granting them discretion as to the number of contracts they may award in such a way as to grant a monopoly to the local rehabilitation center."

He added that "in refusing to sign contracts with eminently qualified physical therapists who practice privately, the agencies have disregarded the expressed

desires of both patients and physicians and have restricted the physician in his choice of therapists to whom he may recommend his patients."

The Medicare provision that prohibits a therapist in private practice from billing a Medicare patient directly was enacted largely to assure that only necessary treatment would be given by qualified therapists who would not charge excessively.

QUALIFICATIONS ARE MET

A physical therapist uses exercise, massage, heat, hydrobaths and other means to develop or restore movement to crippled limbs. Physical therapists are particularly important in the care of patients who have suffered strokes or fractures.

To be qualified to treat Medicare patients, a physical therapist must be licensed by the state in which he practices and must be a graduate of a program in physical therapy approved by the American Medical Association. According to the Connecticut Department of Health, Mr. Heidinger meets these requirements.

There is nothing in the law that prohibits physical therapists in private practice from obtaining contracts to treat Medicare patients. In other Connecticut communities—among them Meriden, Wallingford and Southington—the Visiting Nurse Associations have signed contracts with therapists in private practice.

OTHERS HAVE DIFFICULTY

Mr. Heidinger, however, apparently is not alone in his complaint. According to Miss Lucy Blair, executive director of the American Physical Therapy Association, qualified therapists in many communities throughout the country have been unable to obtain contracts with local home health agencies. In many communities, she added, there is no local home health agency with which to contract.

As a result, the association maintains, "There has not been an effective utilization of qualified physical therapists," which, the association says, are in short supply.

The number of therapists adversely affected by the interpretation of the present law is not known. But the association has gained the introduction in Congress of an amendment to the Medicare law that would eliminate home health agencies as the required organizations in providing physical therapy services for Medicare patients.

The bill is now pending in the House Ways and Means Committee.

(The following letter, with attachments, was submitted to the committee by Hon. Alan Bible, a U.S. Senator from the State of Nevada:)

AMERICAN PHYSICAL THERAPY ASSOCIATION,
NEVADA CHAPTER,
STATELINE, NEV., *August 15, 1967.*

HON. ALAN BIBLE,
Senate Office Building,
Washington, D.C.

DEAR SENATOR BIBLE: The following is a composite feeling of the Nevada Chapter of Physical Therapists, as well as our National Association.

In the State of Nevada, only three (3) Home Health Agencys are in existence, and consequently, many elderly people are unable to take full advantage of Medicare.

We would appreciate your consideration of the amendments, as suggested, and your affirmative vote.

Sincerely,

MARGARET CHRISTIANSEN R.P.T.,
Secretary.

STATEMENT REGARDING AMENDMENTS TO THE SOCIAL SECURITY ACT

The American Physical Therapy Association representing approximately 12,000 qualified physical therapists has supported in principle the Social Security Amendments of 1965, known as Medicare. As the law went into effect, its implementation has unearthed barriers which have prevented the full development of quality service which could be provided by the existing complement of qualified physical therapists. We believe that you and those concerned with our senior citizens who are struggling with the aftermath of a stroke or a fractured hip or are having a painful bout with arthritis will wish to do something to improve

or correct the delivery of the kind of service which was understood to have been the intent of the law.

Physical therapy is one of the allied health professions which has had identity in the United States since World War I. The American Physical Therapy Association, the professional organization of physical therapists in this country is a member organization of the World Confederation for Physical Therapy which has consultant status with the World Health Organization.

Since the founding of the American Physical Therapy Association in 1921, there have been over 18,000 qualified physical therapists identified with the Association, who have graduated from courses in physical therapy approved by the recognized approving agency. There are currently forty-three accredited curriculums in the country. Enrollment in approved programs has steadily increased particularly in recent years, and nearly 1,000 students are graduated each year.

We recognive that the ratio of qualified physical therapists to general population varies conspicuously from one region of the country to another with concentration around metropolitan areas. Our figures for this decade indicate a ratio of one physical therapist per 11,000 population for the States of California, Colorado, Connecticut and Massachusetts as compared with one per 89,000 population in Arkansas and one per 84,000 population in Mississippi.

The question of distribution of qualified personnel has been a major problem to the profession of physical therapy for years as it has been to the other health professions. When the Social Security Act was being implemented in 1935 and 1936, during World War II and the period of the serious poliomyelitis epidemic years the distribution of qualified physical therapists was a major factor in providing the needed services. Attempts have been made to improve the disparity through the establishment of new schools of physical therapy or expanding facilities of existing schools and at times a crash program was instigated to meet poliomyelitis emergencies by moving qualified physical therapists into epidemic areas to assist in patient care services. During the past two decades, the situation has improved markedly but there continues to be pockets of lack in certain areas of the country. Therefore, it becomes imperative that there is full and optimal utilization of qualified physical therapists on either a full time or part time basis.

During the past year and a half this Association through the work of its chapters in all of the states has promoted surveys and programs to identify qualified personnel and to participate in community planning and interrelationships with agencies in order to carry out effective patient care services made possible by Medicare. Workshops, refresher courses and continuing educational programs have been given as the means of encouraging the inactive qualified physical therapist to return to the work force to supplement services in hospitals, nursing homes and the patient's own home.

It is apparent that federal agencies have been broad in their interpretation of certain portions of PL 89-97 almost to the point of jeopardizing quality service for patients under the guise of expediency. We have identified problems in Title XVIII Part A, and particularly in Part B, which we believe should have serious consideration for correction. They fall into two major areas:

1. There has not been an effective utilization of qualified physical therapists because of restrictions in the interpretation of the law.

2. There has been a disturbance in the physician-physical therapist-patient relationship.

Physical therapy is an important adjunct in patient care for the prevention of disability as well as the restoration of functional ability. If effectively utilized it can have an impact on reducing the amount of hospitalization and other services required by patients.

Qualified physical therapists historically have made their services available to the home-bound patient. With the advent of Medicare, the patients had to be transferred to a certified home health agency in the community if reimbursement was to be made under the program.

Although qualified physical therapists have expressed their availability to the home health agencies, experience has demonstrated that the agencies have used instead other less qualified personnel to perform "physical therapy" which has not been satisfactory to the referring physician or the patient. Also, many communities do not have a certified home health agency. Thus the referring physicians and the beneficiary patients are not able to utilize physical therapy services even though qualified physical therapists are available.

The program provides for reimbursement of physical therapy services in the physician's office but not at the office of a qualified physical therapist. For good

sound medical and economic reasons the majority of physicians do not want to employ physical therapists in their office. They prefer to refer their patients in need of physical therapy (with appropriate prescription) to qualified physical therapists with whom they have developed inter-professional relationships for interchange of directions and progress reports. This may involve requesting an individual physical therapist to carry out the necessary physical therapy program in the patient's home or when the patient's condition permits, to come to the physical therapist's centrally located office as an out-patient. Very often these offices of physical therapists are in the same office building as the referring physician. In many communities over the country, this is the only economically practical means of delivering physical therapy services and in a large number of communities is the only physical therapy service available. Reports and comparative figures indicate that this method of service has been more satisfactory to patient and physician and costs have been less than some of the abridged services which have been instigated under the Medicare provisos.

It is not the intent or desire of the American Physical Therapy Association to extend the benefits or to increase the costs. The amendments we are proposing deal only with more effective manpower utilization within the intended scope of the program.

We are confident that the supporters of providing services for our senior citizens intended to promote quality service, and the utilization of personnel who are prepared by virtue of quality education to perform needed services.

PROPOSALS TO AMEND THE SOCIAL SECURITY ACT TITLE XVIII

Section 1832(a)(2)(B) by adding within the parenthesis "and physical therapy".

Therefore, Section 1832(a)(2)(B) would read:

"Medical and other health services (other than physicians' services unless furnished by a resident or intern of a hospital *and physical therapy*) furnished by a provider of services or by others under arrangements with them made by a provider of services."

Section 1861(m)(7) by deleting "or" before "at a rehabilitation center" and inserting after the phrase "at a rehabilitation center" "or at an office of a physical therapist".

Therefore, Section 1861(m)(7) would read:

"Any of the foregoing items and services which are provided on an out patient basis under arrangements made by the home health agency, at a hospital or extended care facility, at a rehabilitation center *or at an office of a physical therapist* which meets such standards as may be prescribed in regulations, and . . ."

Section 1861(s) to insert a new paragraph (10) before "No diagnostic tests performed in any laboratory . . ." as follows:

"(10) Physical therapy performed by a physical therapist who is legally authorized to practice physical therapy in the State in which he performs such function and who meets such standards as may be prescribed in regulations, provided said therapy is performed in accordance with the prescription of a physician who certifies (or recertifies, where such services are furnished over a period of time) that such services are or were medically required."

This would require that the present 1861(s)(10) would become (11) and present (11) would become (12).

Senator HARRIS. Our next witness is the Very Reverend Monsignor Lawrence J. Corcoran, who is secretary of the National Conference of Catholic Charities.

STATEMENT OF MSGR. LAWRENCE J. CORCORAN, SECRETARY, NATIONAL CONFERENCE OF CATHOLIC CHARITIES, ACCOMPANIED BY WILLIAM POLKING, LEGAL CONSULTANT

Monsignor CORCORAN. Thank you. I have with me this morning Mr. William Polking, who is legal consultant for the National Conference of Catholic Charities; and I speak also today for the Social

Action Department of the United States Catholic Conference and the Family Life Bureau of the United States Catholic Conference, all of whom have particular interest in particular parts of this bill.

I will summarize what we have submitted as a statement, and in the time limit that you have indicated.

Senator HARRIS. Without objection, the entire statement will be included in the record.

Would you state the name of your associate again?

Monsignor CORCORAN. Mr. Polking.

There are certain portions of this we would like to highlight.

First of all, with regard to the old-age survivors, disability and health insurance, we would like to indicate our belief that the provisions contained in the measure before you are inadequate because of the great need there is to assist elderly people today, retired people.

For instance, 10 percent of the population are persons over 65 years of age, about 20 percent of the people who are poor are over 65 years of age.

Senator HARRIS. What percentage?

Monsignor CORCORAN. Twenty percent.

Ten percent of the total population but 20 percent of the poor population.

Likewise, therefore, the increase in social security benefits should be more than 12 percent on the average, and especially for those who are in the bracket that receive the minimum or close to the minimum.

The exemption of earnings we think is very good. We think that the old-age and survivors insurance and the old-age assistance program should be considered together to assure that every elderly person has an income equal or even above that which is necessary for minimum subsistence.

There is a particular matter which I would like to be precise upon, and that has to do with the coverage of ministers which is contained in H.R. 12080. At present, clergymen are covered by the OASDI program who elect to be covered.

The change would effect an automatic coverage of all clergymen except those who apply for an exemption, basing their petition on conscientious objection to participate in the OASDI program.

This proposal might be acceptable for our diocesan clergy if the basis for a petition for exemption were broadened; namely, in addition to the wording that he is consicentiously opposed we would suggest also the wording "or opposed in principle," because we think there is a difference there.

Senator HARRIS. Would that apply to Catholic clergy?

Monsignor CORCORAN. Yes, for those who come under the category of diocesan clergy.

Now, for the religious orders who have the vow of poverty, however, there are special problems.

A great deal more study is going to be needed for them, which is being undertaken at this time. Our religious orders having a vow of poverty do not suggest such a change as is in the bill. Their present status, we hope, could remain unchanged until some recommendation could be forthcoming which we hope would be before too long; so that is the specific point on that matter.

Senator HARRIS. Wouldn't they be taken care of either by the present provision on conscience or the one that you have suggested on principle?

Monsignor CORCORAN. They might be. However, this automatic coverage, and it would be set aside only if they applied for an exemption——

Senator HARRIS. Yes, sir.

Monsignor CORCORAN (continuing). Is something that causes difficulties. In other words, in matters like this, there is a community approach usually——

Senator HARRIS. Yes, sir.

Monsignor CORCORAN (continuing). Rather than an individualized one.

The employer-employee concept does not apply. The whole question of their tax-exempt status, income tax, coverage by income tax and that type of thing, all the implications of this need to be studied very carefully before they would want to say whether they would be for or against this proposal. I am not saying they might or might not be for it, but it is a new concept.

Senator HARRIS. Yes, sir.

Monsignor CORCORAN. Great emphasis in the bill before you, under the public welfare aspects, is given to the program of aid for dependent children, families with dependent children, and I would like to comment on that briefly, also.

Certainly the program of aid to families with dependent children does need special attention. The figures about the numbers, the great increase over the last decade or decade and a half are well known.

Secondly, of the proposals that are in the bill, some are perhaps good, but some are indeed bad. Among the good features you might say that the objectives are good; namely, trying to get people to work who can do so, reducing illegitimacy and strengthening family life.

Also, it is good to have the assurance that there is a work and training program. It is also good to have work incentives such as permitting the recipients to keep a certain amount of the money which they earn before their grants are reduced.

However, there are many bad features in this particular measure, and the basic one, of course, is the whole coercive nature of it.

The whole idea of forcing people to work or go into work training is questionable, and it is questionable that a person will do a good job if you force him to work. It is questionable whether they will get anything out of the work training if you force them into it.

Relative to the question of school dropouts over 16 years of age, there is nothing in the bill which says the first effort should be made to try to get them back into school, which certainly should be the first effort. So these are some of the things that are particularly bad, among others, about the coercive nature of the bill.

But then, too, the whole matter of what it does to the mothers of the children, I think, is something that is likewise very, very questionable. Perhaps some can and should be urged to work or to take work training.

However, others should remain in the home because of the needs of their children. The determination of this demands a very careful and a very skillful social diagnosis. Yet the staff to perform this task is sim-

ply not available. Only 1 percent of the caseworkers, and 18 percent of the supervisors in public assistance programs have completed their graduate training in social work. This is the barometer of the readiness of the staff of the public assistance agencies to execute the tasks that are being assigned to it. Such a job assignment seems impossible of fulfillment under the present circumstances and, therefore, you will have people who are incapable of accomplishing the task, trying to do it, and having almost the power of life and death over the people they are treating.

Likewise, we would not see as beneficial the placing of a ceiling on the proportion of dependent children who can receive assistance. This has been treated by some of the witnesses this morning.

In the whole area of coercion there falls the question of family planning. In the bill, this likewise is basically a coercive program in spite of protestations to the contrary, because its objectives are to reduce the AFDC rolls, and to reduce expenditures. States are required to have a family planning program, and these pressures, therefore, will very readily and very quickly be transferred to the client, even though it is said they are supposed to be free from coercion and have the freedom of conscience to choose in this matter.

Very important also, is the fact that this provision as written which will open the door to the use of Federal and State funds for abortions, because some people will say that abortion is a method, a type, of family planning, a type of birth control, and will want Federal support. Therefore, we strongly oppose this.

We strongly oppose writing into law these programs of family planning because there is no need for it. There are interpretations made in the Department of Health, Education, and Welfare. That Department has decided it possesses extensive authority for family planning programs, and has allocated substantial sums of money for them. Therefore, this is a program that certainly does not need to be written into law.

Very briefly, under the broad concept public assistance we would support the provision that the States actually should be required to provide assistance grants which equal the amounts which they themselves have established as necessary for a minimum subsistence standard of living. This was something that was in the original bill considered by the House but was kept out of H.R. 12080. We think it is something that should be retained.

In the whole area of provision of social services, there are some very good features concerning the partnership that should exist between the public and the private programs, incorporating an encouragement of this. There should be such a partnership. In the bill, or in existing law, there is such wording as, "maximum utilization of other agencies providing similar or related services," speaking of services for strengthening family life; and then, referring to child welfare services, it is said that the facilities and experience of voluntary agencies should be utilized. We think there should be added to these two things, "facilities" and "experience," also the "services" of voluntary agencies. The majority of the trained workers are in voluntary agencies and to do an adequate job in this whole area of social services there should be a very close partnership.

To that end where child welfare services are defined as "public" social services, it would be much better to have "State licensed and approved" social services rather than implying that the Government is only interested in the welfare of the children under public care.

This might lead to a narrow and restrictive interpretation of the manner in which services can be assured.

We likewise would have some question about the way that the "single organizational unit" on a local level is given the responsibility of so many services. These should be separated and very clearly kept apart.

There are three things given to the single unit: The social services, the assistance payments, and the work and manpower. Those should be separated very clearly, especially so that the income maintenance program is separated from the social service programs.

Then, finally, there is a very important concept which comes into this whole idea of the relationship between the public and private programs and also comes in with the whole idea of the dignity of the individual and the responsibility of the individual in the programs. That concept is the freedom of choice in social services.

The bill provides for free choice by individuals eligible for medical assistance, providing that any eligible individual is free to choose to obtain the services he requires from any institution, agency, or person qualified to perform the service and which undertakes to do so. The same provision should be expanded.

Thus, an individual eligible for social services, including child welfare services, should himself or his parent or guardian be free to choose any agency, institution or person qualified to perform the services or give the care required, and who undertakes to provide the services or care.

This concept should be contained in legislation providing for social services and child welfare services. The clients should have the right to freely choose the social service or the child welfare services they desire, and freely choose where he will receive them.

Today there is freedom of choice in health services federally financed, freedom of choice in educational services, federally financed, and in any federally financed social service or child welfare service program this same principle of freedom of choice should prevail. The option should not merely lie with the public agency to choose whether or not to use the private nonprofit agency for the client. This choice should lie with the client.

Then we likewise would support the social work manpower provisions of H.R. 12080 which will help in providing more workers for these very necessary programs.

That then would complete my summary with gratitude to you, Mr. Chairman, and to the committee for the permission to appear before you.

Senator HARRIS. I want to say, in my former capacity as a State Senator and now in this body, and on this committee, I am very pleased that you are here, and pleased to express through you my appreciation to the National Conference of Catholic Charities for the great contribution that it continues to make in the broad field of social concerns.

I think, implied in the House bill, H.R. 12080 is the conclusion heard so much these days that the present welfare laws provide an

incentive for illegitimacy in two ways: One, the thought which some people have that people will have additional children in order to increase their welfare payments under AFDC; and, second, the effect of the present law is to cut off assistance if there is a person such as a husband or a father in the home.

Do you think that either of these two conclusions is valid?

Monsignor CORCORAN. Taking the first one first, we have discussed this in our conferences, I have discussed it with individual directors of charities, individual workers, and I can say that I have not found one who would be of this opinion, nor has had contact with anyone whom they could say had additional illegitimate children in order to get additional welfare. I would make that as a categorical statement.

Senator HARRIS. There is a kind of a point of diminishing returns in there somewhere.

I know in my own State that the amount of money involved for additional chi'dren is extremely low.

Monsignor CORCORAN. That is right.

Senator HARRIS. There is one other aspect on that while we are on the first part of the question I asked you, and that is the fear of a mother that there will be a point after which her children will be of the age to no longer entitle her to AFDC payments, and before she later will be eligible herself for old-age assistance and, therefore, this is some incentive for additional children in order to lengthen that period during which she receives AFDC.

Do you feel that is a valid conclusion?

Monsignor CORCORAN. I would not think so. I have not heard that proposed by any of our people who are close to the situation, nor when I, myself, was at the local level, that this prevailed—I would not think so.

Senator HARRIS. I think it is good to talk about that directly, and I think a lot of people do not realize what a small amount of money we are talking about here.

Monsignor CORCORAN. That is right.

Senator HARRIS. The second part of that question, could you respond to that?

Monsignor CORCORAN. Would you repeat it, please?

Senator HARRIS. The second part was that unless we provide for unemployed fathers as the House bill attempts to do more of, as I understand it, there is an incentive for the father to be away from home.

I was in Cincinnati just lately, and I talked to a group of young fellows on the street, about a dozen of them, ranging in age from 18 to 25 and, of course, you know of numerous examples of this same kind of situation, and I talked to them.

They were all unemployed and very interested in jobs. Each of the men had families, and I talked to a young fellow who was there in the area, and he told me that these men did not live in this section of this city but lived in another section and were not able to stay around in their own section during the day because it would make their families ineligible for AFDC.

What about that part of the question?

Monsignor CORCORAN. Yes, sir.

First of all, it does happen. The first thing, it would seem to me, would be to try to provide employment for those fathers. It certainly is not good enough to have them leave home. In effect, it forces them to leave home in order to, in that way, assure that their children will have food. This is a pretty hard choice to force a parent to make, and, therefore, the preferable thing would be to enable the parent to support his children, and it is necessary to provide some program to help the unemployed fathers.

Now, as sort of an addendum to that, not precisely to your question, but I for a long time have felt that the solution to unemployment is not through the children. In other words, aid to dependent children of unemployed parents is helping the unemployed parents through the children. It is making the father, so to speak, dependent upon the children, the child or children, and it sometimes forces him to leave in order to enable his child to have something to eat, if he simply cannot find work.

Therefore, there ought to be some program for the unemployed over and above unemployment insurance, some additional category if we are going to stick to the categories, or otherwise if we are going to one category based on need, something that will directed to the recognized person who is unemployed.

Now, the whole idea of a work program, if properly administered, work training, has great benefits, so I would not say we would be against that, but the coercive aspect of it we have some question about it. But there should be an unemployed program, help for the unemployed, both through unemployment insurance and otherwise, enabling the parents to stay with their children, because many children are growing up without the parental influence that they specifically should have.

Senator HARRIS. Do you have anything further? If not, thank you very much.

Monsignor CORCORAN. Nothing more. Thank you.

(The prepared statement of Monsignor Corcoran follows:)

STATEMENT PRESENTED BY MONSIGNOR LAWRENCE J. CORCORAN, SECRETARY, NATIONAL CONFERENCE OF CATHOLIC CHARITIES

I am Monsignor Lawrence J. Corcoran, Secretarcy of the National Conference of Catholic Charities. I appear here today also in behalf of the Social Action Department of the United States Catholic Conference and the Family Life Bureau, United States Catholic Conference. Each of us has an interest in one facet or another of the Social Security proposals before this Committee, and welcome the opportunity to provide our views on this very extensive piece of legislation.

I. OLD-AGE, SURVIVORS, DISABILITY AND HEALTH INSURANCE

We were pleased with the prospect of changes in the Old-Age, Survivors, Disability and Health Insurance Law which would provide greater benefits for those older persons who rely upon OASDI for all or part of their livelihood. We thought, and still do, that the present benefits are inadequate. We thought, and still do, that the Administration's proposals were inadequate. We, therefore, think that the bill passed by the House of Representatives, and which forms part of the deliberations of this Senate Committee on Finance, is inadequate.

The Report of the House Committee on Ways and Means on H.R. 12080 states: "According to Social Security Administration studies, social security benefits are

virtually the sole reliance of about half the beneficiaries and the major reliance of most beneficiaries. Thus, the level at which social security benefits are set determines in large measure the basic economic well-being of the majority of the Nation's older people." In February, 1966, 1,014,000 persons were receiving both OASDI benefits and Old Age Assistance, indicating that the former were insufficient to provide these beneficiaries with a minimum subsistence. With the increases proposed in the present bill, some of these persons will no longer be eligible for Old Age Assistance, but doubt still remains about the adequacy of benefits. The minimum grant is raised from $44.00 per month for an individual ($66.00 for husband and wife) to $50.00 and $75.00. This amounts to $600.00 per year ($900.00 for husband and wife). Obviously this is insufficient to assure the well being of these beneficiaries.

The OASDI benefits should be increased to enable recipients to live in decency in accord with their dignity as human beings. This will require a greater increase than the 12½ per cent average contained in H.R. 12080. Special consideration, by way of a larger percentage increase, should be provided for those presently receiving the minimum benefit.

We also strongly support the increase in the amount of money which a beneficiary can earn before suffering a reduction of Social Security benefits, namely, from $1,500.00 to $1,800.00. Many of our senior citizens would like to continue to work, not only for the additional income, but especially in order to be busy and helpful and to have the realization of still being useful. This increase would be an encouragement towards such a goal.

To accomplish these benefit increases, an increase in contributions will be necessary. This might be accomplished by broadening the wage base and/or increasing the amount of the social security tax beginning with the years 1969–1970.

Theoretically, when OASDI benefits are insufficient to provide a minimum subsistence level for a person who has no other earned income, the added amount needed to live decently should come from an Old Age Assistance grant. In practice, this does not happen, since the average OAA grant is $67.85 (February, 1967). Such an amount includes a computation of the OASDI benefit rather than adding to it. General assistance payments do not provide any help, since the payment level is still lower, an average of $36.25 per person in February, 1967.

The reciprocal reinforcement between these programs has never reached the necessary level of effectiveness. No doubt this is primarily due to the inadequacies of the Assistance category. At the same time, some of the blame falls upon the OASDI program, which also has been insufficient. The total situation, including program reciprocity, should be a matter of major concern to the responsible committees of the Senate and the House of Representatives. These programs, in concert, should respond adequately to the needs of our senior citizens.

H.R. 12080 changes the method of determining the coverage of ministers. At present those clergymen are covered by the OASDI program who elect to be covered. The change would effect an automatic coverage of all clergymen except those who apply for an exemption, basing their petition on conscientious objection to participation in the OASDI program.

This proposal would be acceptable for our *diocesan clergy*, if the basis for a petition for exemption were broadened. In addition to the wording that "he is conscientiously opposed," we would suggest also the wording, "or opposed in principle." There may be some clergymen for whom participation would not violate their conscience, but for whom it would be contrary to principles to which they adhere.

For members of *religious orders* having the vow of poverty, however, this change may cause many problems. It needs detailed study for determining its full import and implications. Our religious orders do not suggest such a change as proposed in H.R. 12080. Their present status should remain unchanged. Recommendations for or against charge will be forthcoming when studies now underway are completed.

II. PUBLIC WELFARE AMENDMENTS

1. Families with dependent children

In the Social Security Amendments being discussed by the 90th Congress, great emphasis has been placed on the program known as Aid to Families with Dependent Children. Such emphasis is warranted. Yet it should not completely overshadow an adequate consideration of the needs of other Public Assistance programs. Reference has already been made, for instance, to the Old Age Assistance program.

While the number of persons receiving aid from the other original categorical assistance programs (Old Age Assistance and Aid to the Blind) has decreased, the reverse is true for Aid to Families with Dependent Children. In the past decade, the number of recipients has doubled (from 2,408,000 to 4,946,000 persons). The amount of money allocated to this program has shown even more startling increases. Obviously it needs special attention.

The objectives of the changes proposed by H.R. 12080 are commendable: assuring that recipients who are able enter the labor force, reducing illegitimacy and strengthening family life. The emphasis on work and training programs may well augment the present program of the Welfare Administration, funded by the Office of Economic Opportunity. It responds to the desire of many AFDC recipients to obtain employment and not receive the assistance grants. This Committee already has been furnished the information that 34% of the closing of AFDC cases resulted from employment or increased earning of family members.

Granting all this, however, one still must question the basic method proposed in H.R. 12080 to accomplish its objectives, namely, coercion. It is highly doubtful that any person forced to work or take work training will perform an adequate job or develop work skills. This Committee would be well advised to remove the coercive aspects of the work and training program.

Children 16 years of age and older, who have dropped out of school, also are to be forced to work or to take work training. The first effort should aim to return these children to school, yet no mention is made of this in the House bill. Only after these efforts have failed should the youth be pressed into the labor force.

Perhaps the most unfortunate focus of the coercion in H.R. 12080 is upon mothers of children. Perhaps some can and should be urged to work, or take work training. Others, however, should remain in the home because of the needs of their children. The determination of this demands a careful and skillfull social diagnosis. Yet the staff to perform this skillful task is not available. Only one per cent of the caseworkers and 13 per cent of the supervisors in Public Assistance programs have completed their graduate training in social work. This is a barometer of the readiness of the staff of public assistance agencies to execute the task being assigned to it. Such a job assignment seems impossible of fulfillment under present circumstances.

We are pleased to note that incentives to work are provided for AFDC recipients whereby they can earn a certain amount of money which is not deducted from their assistance grant.

2. Family Planning

A particular provision of H.R. 12080 which contains the element of coercion is that dealing with family planning. It is injected in the context of the pressures built into the bill. As a part of the program which must be developed for each client for the purpose, among others, of reducing illegitimate births, family planning services must be "offered." Related to this is the limitation on the proportion of children in a State for whom the Federal government will provide funds. Thus, family planning services are to be a mechanism for the reduction of AFDC rolls and the reduction of the amount of money expended. In this context, the so-called "offering" of family planning services becomes a coercive operation.

The Report of the House Ways and Means Committee on H.R. 12080, and the testimony of the Under Secretary of the Department of Health, Education, and Welfare indicate that family planning services are to be offered in accordance with the policy outlined by the Secretary of the Department. Already, however, that statement is countermanded. It declares that "The Department will make known to the State and local agencies that funds are available for programs of the sort described above (family planning programs), but it will bring no pressure upon them to participate in such a program." Such programs are made mandatory upon States and local agencies in the House bill. It will be very easy for the agency to transfer the pressure to the client, in spite of policy statements to the contrary.

The program for providing family planning services also opens the door for the use of Federal and State funds for obtaining an abortion. Some will claim that abortion is just another method of birth control or family planning, and that it should be one of the family planning services offered to the client.

We therefore strongly oppose the inclusion of family planning services or grants in any part of this bill. There is no valid reason for making a statutory provision for such services. The Department of Health, Education, and Welfare has decided that it possesses extensive authority for family planning programs and has allocated substantial sums of money for them. We oppose writing such programs into the law.

3. Public Assistance

We strongly urge enactment of a requirement for States to provide grants which fully meet their own standards of what is needed to support a person eligible for Public Assistance. This is one of the most important steps which can be taken to correct the terrible inadequacies of the Public Assistance system. Accompanying this step should be the requirement that a State's established standards are current—that they be based on current prices and updated annually.

The proposal for Federal participation in emergency assistance is a valuable contribution to local programs to assist the needy. It is frequently difficult to obtain emergency help for a family suddenly deprived of resources or, more often, suddenly made known to a social agency. Help for such families has usually been provided from local public general assistance funds or from private resources. In many localities, both have been inadequate to meet the need.

4. Social Services

A broad range of social services, work-related services, and other services are provided in H.R. 12080, some of which are already in existence. Most, although not all, of these are commendable. The major question, however, arises in the implementation of these provisions, namely, how and by whom are these services to be delivered.

Responsibility on the local level is vested in "a single organizational unit." No doubt the objective in doing this is to achieve close coordination of activities for the development of a programmatic whole. Such an objective is desirable. Yet too many and too diversified services are to be furnished by this unit. It will be extremely difficult to administer. Some services will, of necessity, be provided by persons not attached to the unit (e.g., dental care, day care). Desirably, other services should be provided outside the unit (e.g., basic education, remedial care).

Basically, three operations can be identified which should be clearly separated: Delivery of Financial Assistance, Work and Training Programs, and Social Services. Certainly, the program of Assistance payments, with its complex determination of eligibility, should be a separate function. The other two, while related to it, demand a different skill and a different approach, and therefore should not be intermingled with the function of granting financial assistance. The Department of Health, Education, and Welfare has recognized this in its recent reorganization plan. This pattern should be imitated on both the State and local level.

It seems to be the intent of H.R. 12080 that many services may be provided by other than public agencies. This is always sound policy, and becomes very practical in consideration of the many and varied responsibilities assigned to the local public agency. It is also in keeping with the provision of the present law that, in relation to services for strengthening family life for children, "maximum utilization of other agencies providing similar or related services" must be assured [Sec. 402(a)(12)]. For this same purpose, H.R. 12080, Sec. 235(c) should be changed. This Section transfers Title V, Part 3, of the present law to Title IV. In the new Sec. 422(a)(2), referring to child-welfare services, there is the requirement that "the facilities and experience of voluntary agencies shall be utilized." To this should be added the "services" of voluntary agencies.

Such provisions as these will help maintain the pluralistic nature of welfare services, and advance the desirable partnership which should prevail between public and private agencies. Another important step in this direction would be the elimination of the restrictive definition of child welfare services contained in the present law and made part of the suggested new Sec. 425 by H.R. 12080. Child Welfare Services are defined as "public" social services. This implies that the government is only interested in the welfare of children under public care, and may lead to a narrow and restrictive interpretation of the manner in which services can be assured.

This is related to another important concept, namely, freedom of choice in social services. H.R. 12080 provides for free choice by individuals eligible for medical assistance, assuring that any eligible individual is free to choose to obtain the services he requires from any institution, agency or person qualified to perform the service and which undertakes to do so. This same provision should be expanded. Thus, an individual eligible for social services, including child welfare services, should (himself or his parent or guardian) be free to choose any agency, institution or person qualified to perform the services or give the care required and who undertakes to provides these services or care.

This same principle of freedom of choice of services by the client is embodied in other recent Federal legislation, e.g., the Elementary & Secondary Education Act, Office of Economic Opportunity legislation and Title XVIII of the Social Security Act. It should be contained in legislation providing for social services and child welfare services. The client should have the right to freely choose social services or child welfare services he desires and to freely choose where he will receive them. Today there is freedom of choice in health services, federally financed, and freedom of choice in educational services, federally financed. In any federally-financed social services or child welfare services, this same principle of freedom of choice should prevail. Thus, the client should be able to choose the social services or child welfare services he needs without the coercion implicit in the knowledge that Federal financial aid will be provided only if he chooses such services furnished under public auspices. The option should not merely lie with the public agency to choose whether or not to use the private, nonprofit agency for the client. This choice should lie with the client.

5. Social Work Manpower

We strongly urge the adoption of legislation to provide for an increase of social workers. The new services of H.R. 12080 will in themselves require an increase of trained personnel, at a time when there are already great shortages. We have referred to this in speaking of the very delicate job of social diagnosis which will be required of those providing service to mothers who must be urged either to work or stay home with their children. The Federal government should make grants for the expansion and development of social work educational programs. We are pleased to see that appropriate consideration is being given to both undergraduate and graduate programs in public or nonprofit private colleges and universities.

This concludes, Mr. Chairman, the presentation of the major changes which we propose in the legislation before your Committee, the Social Security Amendments of 1967. We appreciate the opportunity to express ourselves on such an important measure. It is not only an opportunity but a responsibility. This is especially true in these matters pertaining to Social Security and public welfare, since they directly and intimately affect the lives of millions of our citizens. We must all strive to develop the very best program, one which will be economically sound, reflecting compassion for our fellow man, designed to improve his functioning as an intelligent citizen, and adequately responding to the great human needs of our day.

Senator HARRIS. I am sorry that we are even more rushed now than we were because the Senate is now in session, so we will have to ask the next three witnesses if they can, to summarize their testimony even more than we have been doing.

Our next witness is Dr. Donald C. Smith. Dr. Smith is representing the American Academy of Pediatrics and the American Academy of Orthopedic Surgeons. He is accompanied by Dr. John P. Adams.

Dr. Smith, we appreciate these two groups you represent agreeing to make a joint appearance today in order to conserve the time of the committee. Other witnesses, too, have consolidated their testimony, and that has proved very helpful to us. We appreciate your willingness to do that and your presence here now.

STATEMENT OF DR. DONALD CAMERON SMITH, CHAIRMAN, COMMITTEE ON LEGISLATION, AMERICAN ACADEMY OF PEDIATRICS, ACCOMPANIED BY DR. JOHN P. ADAMS, CHAIRMAN, ADVISORY COMMITTEE ON NATIONAL HEALTH, AMERICAN ACADEMY OF ORTHOPEDIC SURGEONS

Dr. SMITH. Mr. Chairman, we have provided the chief counsel with copies of a statement and, with your permission, I would like to read an abbreviated and somewhat altered version of that statement.

Senator HARRIS. Without objection, that will be done.

Dr. SMITH. I would ask that this altered version be entered in the record.

Senator HARRIS. That will be done.

Dr. SMITH. I am Donald C. Smith, chairman of the Committee on Legislation of the American Academy of Pediatrics. I am also professor of maternal and child health at the University of Michigan in Ann Arbor.

With me is Dr. John P. Adams, the chairman of the Advisory Committee on National Health of the American Academy of Orthopedic Surgeons, and professor of orthopedic surgery at the George Washington University.

We are pleased to testify before this committee of the Senate on H.R. 12080 as passed by the House, and the testimony is being given on behalf of both the Academy of Pediatrics and the Academy of Orthopedic Surgeons.

Many of the provisions of this legislation are of interest and concern to our professional organizations, and we will limit our remarks to the proposals contained in title II which amends title V of the Social Security Act.

Our academies strongly endorse the need for additional funds which will permit each State to further extend and improve general health services for mothers and children.

In particular do we support the need for funds to strengthen services designed to reduce the infant mortality rate in this country, and to promote the early identification, prompt treatment, and aftercare for children who are crippled or who are suffering from conditions which may lead to chronic illness or disability.

It is only during infancy and early childhood that we can hope to significantly and favorably alter the child's growth and development.

It is during this same age period that preventive health measures are likely to be most effective.

What is sometimes overlooked is the fact that these preventive health measures applied so early in childhood provide the best possible conditions of significantly reducing the increasing burden of disability and chronic illness in the population at large.

We believe that it is highly desirable to consolidate into a single program for programs for maternal and child health services, part 1 of title V and for services to crippled children, part 2, and by 1972 incorporated into this program certain special projects, including those for maternity and infant care, for children and youth, and for dental care.

If these proposals are approved, and we very much hope that they will be approved, each State can, by 1975, develop a single comprehensive statewide plan of operation for all types of child and health services for children and adolescents.

A single State plan for maternal and child health and crippled children services developed under a common set of conditions, for approval of the plan, will permit States to eliminate unnecessary duplication of services and will greatly facilitate the more effective use of resources.

More cooperative arrangements can be developed by the agencies operating the combined maternal and child health and crippled children's programs, the State agencies providing for community mental health services, social services for children and young adults, employment services for youth, and care and treatment programs for youthful offenders. Comprehensive health services will thus be made available to a much wider group of children and youth, a goal entirely in accord with Public Law 89–749.

We believe that section 505 of this bill would be strengthened by the requirement that professional advisory committees representing the disciplines most concerned with the delivery of health services to children and youth be set up in each State to provide expert guidance in the development of these new comprehensive health programs.

The proposals contained in section 505 of this bill fail to emphasize the need for the integration of maternal and child health and crippled children's services.

Subsection 5 of section 505 is of particular importance in that it will require cooperation between State agencies providing child health care, and medical, nursing, educational and welfare groups and organizations.

Close cooperation between State health agencies administering maternal and child health and crippled children's programs, and State agencies responsible for the administration of title XIX services will be necessary if the goals of this latter program are to be realized.

We now know that children and adolescents represent a majority of individuals eligible for care under title XIX programs.

A significant percentage of these young people require specialized care of high quality, the kinds traditionally provided by our State crippled children's program.

It is essential that measures be developed whereby these children can be referred to the crippled children's program in their own State to receive such specialized care.

We would recommend that section 5 be extended or that an additional subsection be added to require cooperation between State agencies administering crippled children's programs and those administering title XIX programs, so the children and youth who need specialized medical care will receive such care.

These cooperative arrangements should also insure the referral of children receiving specialized medical care under the crippled children's program to title XIX programs for general medical care and for supporting social services.

Our academies are concerned, Mr. Chairman, about the apparent conflict between the language and intent of this bill and the recent reorganization of the Department of Health, Education, and Welfare which separated the administration of maternal and child health serv-

ices and crippled children's services. The latter were transferred to the Rehabilitation Services Administration, while the former were left in the Children's Bureau.

This reorganization will fragment rather than unify programs. It is difficult to understand how in this situation a State could develop a single plan and budget these health services for children and youth. It is almost inevitable that duplication of personnel at both Federal and State levels will result.

The operation of maternal and child health services, crippled children's services, and services for mentally retarded children is intimately related in prevention, in early casefinding, and in providing continuing medical supervision and care.

Separation of these programs will unnecessarily and seriously jeopardize the early detection and prompt medical treatment for the majority of children and adolescents with chronic illnesses and disabilities.

Immediate need of these two groups is for specialized medical diagnostic and therapeutic care of high quality. In a well-balanced rehabilitation program other modalities of service follow.

It appears to us that the recent reorganization of the Department of Health, Education, and Welfare emphasizes subordinate administrative considerations at the expense of basic medical principles.

We believe that it is in the best interests of the health and welfare of the children and youth in this country that overall responsibility for maternal and child health services and for crippled children's services be assigned to a single agency established within the Department of Health, Education, and Welfare.

This agency should be at a level to permit it to exercise leadership in the total field of maternal and child health and to provide effective coordination of all child health activities supported by this department.

This assignment of responsibility would clearly establish a national priority of concern for children, adolescents, and mothers, and would be consistent with our long-term national health goals.

If I could just add a brief summary statement there, Mr. Chairman, one, we are agreed on the additional need for funds aimed specifically at the reduction of infant mortality in this country.

Senator HARRIS. What is the rate as compared with other nations of the world?

Dr. SMITH. Well, we are in about 13th place.

Senator HARRIS. Why is that so; do you think?

Dr. SMITH. I think it is because we have not done enough to reduce infant mortality in certain sections of our country, especially in the large cities, and especially in our isolated areas.

Senator HARRIS. In some of our urban slums, I think, the infant mortality rate is twice as high as the national average.

Dr. SMITH. That is right, sir. Yes.

Second, we strongly support the proposal of combining maternal and child health and crippled children's services, and to incorporate into this single program all of the other special projects that have been developed over the last 5 years, aimed at particular aspects of the problem of child health.

And, third, we question the appropriateness of the recent reorganizational move whereby the crippled children's services were taken away

from maternal and child health services and placed in a different agency.

We hope that this reorganizational move will be reconsidered because we feel that, in the long run, the best solution would be the creation of and support for a single agency which would have the responsibility of administering all of the child health programs supported by the Department of Health, Education, and Welfare, and furthermore giving leadership to the entre field in this country.

Senator HARRIS. Dr. Adams, do you have anything to add?

Dr. ADAMS. No, sir.

Senator HARRIS. Thank you very much, Dr. Smith and Dr. Adams.

(The prepared statement of Dr. Smith and Dr. Adams follows:)

STATEMENT OF DONALD CAMERON SMITH, M.D., CHAIRMAN, COMMITTEE ON LEGISLATION, AMERICAN ACADEMY OF PEDIATRICS, AND BY JOHN P. ADAMS, M.D., CHAIRMAN, ADVISORY COMMITTEE ON NATIONAL HEALTH, THE AMERICAN ACADEMY OF ORTHOPEDIC SURGEONS

Mr. Chairman and Members of the Committee: I am Dr. Donald C. Smith, Chairman, Committee on Legislation, American Academy of Pediatrics. I am also Professor of Maternal and Child Health at the University of Michigan, Ann Arbor, Michigan. With me is Dr. John P. Adams, Chairman, Advisory Committee on National Health, the American Academy of Orthopedic Surgeons and a practicing orthopedic surgeon here in the District of Columbia. We are pleased to testify before this Committee of the Senate on H.R. 12080, as passed by the House. This testimony is being given on behalf of both the American Academy of Pediatrics and the American Academy of Orthopedic Surgeons.

Many provisions of the proposed legislation are of interest and concern to these professional organizations, but we will limit our remarks to the proposals contained in Title III, which amends Title V of the Social Security Act.

Our Academies strongly endorse the need for additional funds which will permit each state to further extend and improve general health services for mothers and children. Most especially, we endorse the need for funds to strengthen services designed to reduce the infant mortality rate in this country; to promote the early identification, prompt treatment and after cure for children who are crippled or who are suffering from conditions which may lead to chronic illness or prolonged disability. It is only during infancy and early childhood that we can hope to significantly and favorably influence the child's growth and development. It is during this same age period that preventive health measures are likely to be most effective. They provide the best possible chance of significantly reducing the increasing burden of disability and chronic illness in the population-at-large.

We believe that the proposal to consolidate into a single program the programs for Maternal and Child Health Service (part 1 of Title V) and for Services to Crippled Children (part 2), and, by 1972, to incorporate the special projects for Maternity and Infant Care, for Children and Youth, and for Dental Care in the same single program are highly desirable. If these proposals are approved—and we very much hope that they will be approved—each state can, by 1975, develop a single, comprehensive state-wide plan of operation for all types of child health services.

A single state plan for Maternal and Child Health and Crippled Children Services, developed under a common set of conditions for approval of the plan, will permit states to eliminate unnecessary duplication of services, and will greatly facilitate more effective use of resources. Similarly, more cooperative arrangements can be developed by the agencies operating the combined Maternal and Child Health and Crippled Children's Services with State agencies providing for community mental health services, social services to children and young adults, employment services for youth, and care and treatment programs for youthful offenders. Comprehensive health services will thus be made available to a much wider group of children and youth, a goal entirely in accord with Public Law 89-749.

The proposals contained in Section 505 of this Bill further emphasizes the need for the integration of Maternal and Child Health and Crippled Children Services. Subsection 5 of section 505 is of particular importance in that it will

require cooperation between the state agencies providing child health care and medical, nursing, educational and welfare groups and organizations. Close cooperation between state health agencies administering the Maternal and Child Health and Crippled Children programs and state agencies responsible for the administration of Title XIX services will be necessary if the goals of this latter program are to be realized. We now know that children and youth represent a majority of individuals eligible for care under Title XIX programs. A significant percentage of these young people require high-quality specialized care, the kind traditionally provided by our State Crippled Children Programs. It is essenital, therefore, that measures be developed whereby these children can be referred to the Crippled Children Program in their own states to receive care. We would recommend therefore, that Section 5 be extended, or an additional subsection be added, to require cooperation between state agencies administering Crippled Children Programs and those administering Title XIX programs so that children and youth who need specialized medical care will receive such care. These cooperative arrangements should also ensure the referral of children receiving specialized care under a Crippled Children Programs to Title XIX Programs for general medical care and for supporting social services.

We believe that Section 505 of this bill would be strengthened by the requirement that professional advisory committees, representing the disciplines most concerned with the delivery of child health services, be set up in each state to provide expert guidance in the development of these comprehensive child health programs.

Our Academies are concerned about the apparent conflict between the language and intent of this Bill and the recent reorganization of the Department of Health, Education and Welfare, which separated the administration of Maternal and Child Health Services and Crippled Children Services. The latter were transferred to the Rehabilitation Services Administration while the former were left in the Children's Bureau. This reorganization will fragment rather than unify programs. It is difficult to understand how in this situation a state could develop a single plan and budget for child health services. It is almost inevitable that duplication of personnel at both federal and state levels will result.

The operation of Maternal and Child Health Services, Crippled Children Services and services for mentally retarded children is intimately interrelated—in prevention, in early case finding, and in providing continuing medical supervision and care. Separation of these programs will unnecessarily and seriously jeopardize the early detection and prompt medical treatment of the majority of children with chronic illnesses and disabilities. The immediate need of these children is specialized medical diagnostic and therapeutic care of high quality. In a well-balanced rehabilitation program other modalities of service follow. It appears to us that the recent reorganization of the Department of Health, Education and Welfare emphasizes subordinate administrative considerations at the expense of basic medical principles.

We believe that it is in the best interest of the health and welfare of children in this country that overall responsibility for Maternal and Child Health Services and for Crippled Children Services be assigned to a single agency established within the Department of Health, Education and Welfare. This agency should be at a level to permit it to exercise leadership in the total field of Material and Child Health and to provide effective coordination of all child health activities supported by the Department. This assignment of responsibility would clearly establish a national priority of concern for children and mothers and would be consistent with our long-term national health goals.

Senator HARRIS. Our next witness is Mr. Leroy Clark. Mr. Clark is representing the NAACP Legal Defense and Educational Fund, Inc.

STATEMENT OF LEROY D. CLARK, ASSISTANT COUNSEL, NATIONAL OFFICE FOR THE RIGHTS OF THE INDIGENT AND NAACP LEGAL DEFENSE FUND, INC.

Mr. CLARK. Mr. Chairman, I appreciate the committee's willingness to hear me today. To expand on my oral comments I would like to introduce into the record this written testimony.

Senator HARRIS. Without objection, the entire statement will be included in the record.

Mr. CLARK. I will try to give a quick summary. I will not talk about the desirable or undesirable social policies embodied in any particular legislation but rather as a representative of an organization of lawyers interested in administration of the welfare in a lawful way, with particular emphasis on conformity to Federal statutes and regulations and, more importantly, the Federal Constitution.

We have recently spoken with lawyers representing welfare clients in 15 States, and have learned that protections of the Constitution and laws are being regularly denied to recipients of public assistance—especially clients receiving Aid to Dependent Children—in every section of the country. This lawless administration of the law is decumented in my written testimony.

A few of the provisions of the Social Security Act, such as those condoning residence requirements, are themselves unconstitutional, largely by reason of legal doctrines which have evolved since the law was enacted in 1935.

More numerous are the State-imposed regulations which are inconsistent with the Social Security Act and are also denials of equal protection of the law under the Federal Constitution. These include maximum limits on family grants, "substitute father" rules, which tend to do two things, one, to control the morality of the recipient mother or to impute income to that mother without any actual proof that there is sufficient income; also there are requirements of minimum periods of absence before desertion can be determined. Other States rules deny due process of law by creating irrebuttable presumptions—Georgia's employable mother rule and Pennsylvania's substitute father rule.

Some States enforce practices which may be constitutional but are inconsistent with Federal law, such as Connecticut's policy of forcing deserted wives to prosecute their husbands in order to be eligible for AFDC.

And a great many Staes have practices which are in direct violation of HEW regulations issued pursuant to the act. These States do not make prompt determinations of eligibility; they do not give adequate reasons for denials of assistance; they do not provide prompt review of decisions; they do not adequately inform clients of their right to review of these decisions; they do not permit clients to challenge the conditions of grants in fair hearing; they do not, in fact, have adequate hearing procedures; they have not ceased making abusive searches and investigations of the homes of recipients; they have not complied with Federal regulations governing the proper means of recovering agency overpayments; and they continue to impute outside income to clients where no such income is really available.

In addition, no State affords welfare clients their constitutional right to have a hearing before their grants are reduced or eliminated by agency officials.

It may at first seem surprising that so many abuses have been practiced for so long; after all, the courts are open to aggrieved welfare clients. But, Mr. Chairman, progress in vindicating the rights of large numbers of people by means of litigation has been very slow.

The neighborhood law offices for the poor founded by the Office of Economic Opportunity, a number of dedicated private attorneys, and the lawyers of the NAACP legal defense fund, NORI, and the Center for Social Welfare Law at Columbia University have been able to assist a few litigants challenging illegal or unconstitutional welfare practices. But the few legal services available to the poor cannot hope to meet the great need and demand of tens of thousands of welfare recipients.

In addition, welfare departments across the country have developed the practice of violating their rules and awarding the money asked for as soon as a lawyer enters the case. This solves the problem for the client who is represented, but it moots the case and thus can bring no relief to the thousands of similarly situated clients who have no lawyer and no way of knowing that the department practice is illegal.

Also, some lawyers have reported to us that welfare officials intimidate plaintiffs to withdraw their cases—they threaten them with sanctions such as neglect proceedings which may result in a mother's losing custody of her children.

Finally, progress is extremely slow because welfare departments obey only decrees entered against them. They have not been conforming their regulations and practices to Federal rules and to decisions rendered in other jurisdictions. Suits have to be brought over and over again.

For example, the welfare department in New Haven, Conn., has not even conformed its practices to a recent court decision in Hartford which prohibits the withholding of welfare from persons who are eligible in terms of need, but who have not resided in the State a year.

I submit, Mr. Chairman, that amendments such as those that have passed the House or those proposed by the administration should be second in the committee's list of priorities in the welfare field.

Primary attention should be given to a rigorous analysis of how to amend the Social Security Act so that adherence to existing Federal standards is mandated and invasions of fundamental constitutional rights are voided.

Congress should closely scrutinize the Social Security Act and eliminate any unconstitutional features of the act itself, for example, the sections sanctioning residence requirements. Similarly, Congress should supplement the implicit requirement of constitutional administration with specific and explicit provisions forbidding States to establish the unconstitutional conditions on eligibility which are analyzed in my written testimony.

Second, Congress should consider amending the act to require, rather than permit, the Department of Health, Education, and Welfare to hold hearings on the conformity of State plans alleged by aggrieved clients to be inconsistent with Federal statutes and regulations.

HEW has never acted on the petition filed 19 months ago by clients aggrieved by the substitute father rule in Arkansas and Georgia. Since it would be impractical for HEW to hold a hearing every time a complaint was received, some sort of triggering device would be needed, such as the submission of 200 signed complaints of aggrieved clients challenging a State plan, or 25 clients challenging a county rule.

Finally, Congress might provide recipients with procedural devices enabling them to get realistic relief from administrative or judicial authorities. Congress should require the States to grant clients the basic due process right to a hearing before a neutral examiner—who may nevertheless be a welfare official—before adverse action is taken against them, so that they will be able to maintain a subsistence income pending resolution of a disputed case, and so that individual workers and local offices will not be able to terrorize clients by threatening unilaterally to cut off their income if they do not cooperate.

In addition, Congress could authorize Federal district courts to award reasonable attorney's fees to successful clients, so that private attorneys will be able to accept their cases, thereby expanding the legal services available to the poor.

In these ways, Congress can do much to restore public confidence in the welfare system, and to convince indigents that they, too, have rights, and that their grievances will be dealt with in a fair and lawful manner.

I have not directed my comments to the present amendments before the committee, but I think that when the committee considers enacting measures which have coercive tones to them, it must be understood that you are enacting them against the backdrop of this kind of present administration of the welfare laws.

Senator HARRIS. Thank you very much, Mr. Clark. I think here in the District of Columbia we have recently had a case which vitiated the residence requirements and I think that that points up something we were talking about earlier with another witness, the migration of people in this country. I think this is very much bound up with the welfare system, what is available in one State or another, and also is very much involved with the residence requirement. Wouldn't you agree?

Mr. CLARK. I would say so.

We have just filed a case in St. Louis on behalf of an 11-year-old child who was denied assistance under these circumstances. The child was living in California with her mother. The mother died in February of this year.

A grandmother went to pick up the child and carried her back to St. Louis. The father is incarcerated in prison in another State.

When the grandmother applied for ADC aid, she is the recipient of only social security benefits, the State was required under its present law to refuse that aid.

Now, obviously this is not a child who is traveling from one State to another in order to take advantage of the welfare laws.

Senator HARRIS. Very good. Thank you very much, Mr. Clark.

(The prepared statement of Mr. Clark follows:)

TESTIMONY OF LEROY D. CLARK, ATTORNEY FOR THE NATIONAL OFFICE FOR THE RIGHTS OF THE INDIGENT, AND THE N.A.A.C.P. LEGAL DEFENSE FUND

INTRODUCTION

Mr. Chairman, my name is Leroy D. Clark. I have been a member of the New York State bar for six years, and am assistant counsel of the National Office for the Rights of the Indigent (NORI) and the NAACP Legal Defense Fund. NORI, established in 1967 with the help of a substantial grant from the Ford Foundation, has a staff of lawyers who assist in key cases involving the rights

of the poor: cases dealing with public housing, landlord-tenant law, debtor-creditor relations, consumer frauds, and the right to public assistance. NORI also develops strategy for the bringing of test cases likely to make legal precedents that will vindicate the rights of the indigent. The Legal Defense Fund is a much older institution. It was founded in 1939 as a separate organization by directors of the NAACP and since then has become the legal arm of the Civil Rights Movement. It is a completely independent organization under the supervision of its own board of directors, and raises its own budget in excess of two million dollars per year. Under the leadership of its first director-counsel, Thurgood Marshall, and its present director-counsel, Jack Greenberg, it has been involved in nearly all the major civil rights litigation of our generation—cases dealing with school integration such as *Brown* v. *Board of Education*, cases dealing with discrimination in employment, housing, the right to a fair jury and all the other basic liberties we all consider essential. In recent years, indigent Negroes and other indigents have become increasingly concerned about the right to welfare assistance, particularly Aid to Families of Dependent Children (AFDC), and cases dealing with the unjust and unlawful administration of welfare have been added to the dockets of both the Defense Fund and NORI.

I speak for the Defense Fund and NORI not as one opposed to or in favor of particular legislation, but as a representative of an organization concerned with the Constitution and laws of the United States as they impinge on questions of concern to this committee.

Dr. Winifred Bell, Demonstration Project Specialist for HEW's Bureau of Family Services, has observed that the states have attempted to use the welfare program to control morals as well as to relieve the sufferings of the poor: "the cost of providing public aid to needy families in their own homes has not been a cost that Americans welcomed with enthusiasm. The nation was well behind most other industrialized, urbanized nations in initiating efforts to place an income floor below families. When it did so, it was heavily influenced by the continuing belief that a substantial cause for family poverty was the irresponsibility immorality, or indolence of parents. The consequence of this conviction was that public aid programs were viewed not simply as income-maintenance measures but also as vehicles for applying social sanctions against offending or misbehaving adults." Bell, Aid to Dependent Children 174 (1965).

The use of AFDC to enforce standards of morality upon indigents has necessarily led to a program riddled with constitutional defects, which I shall enumerate shortly. For a long time, hardly anyone realized that many aspects of welfare administration were unlawful, because until very recently—the 1960's—welfare was thought of not at all as a right, but simply as charity. Even reformers who were concerned with what seemed to be abuses in AFDC administration concentrated only on what was wrong with the program, not on what was unlawful about it. No it is generally recognized that when the state and federal governments dispense cash benefits they must act lawfully, just as they must when they provide educational services, public contracts, or any other benefits, and just as when they impose sanctions. Public assistance deals with economic and social problems, but like any other government-administered program, it must be carried out in conformity with law.

Yet we know that in every state, public assistance, especially AFDC, is being administered in lawless fashion. In some respects, the Social Security Act is itself unconstitutional. In other instances, states have violated the mandate of the Act, the rulings, policies, and directives of the Department of Health, Education and Welfare, and their own state laws and rulings. In fact, in most states, public assistance is administered by the towns or counties rather than the state (the state maintaining only the loosest control), and individual counties or even district offices establish policies which bear no relation to the state or federal plans.

The amendments which have passed the House contain provisions which would take the program even further out of conformity with law. For example, the section which seems to repeat the "no imputation of income" regulation of HEW would destroy federal administrative attempts to avoid practices whose constitutionality is dubious. But the Senate has an outstanding opportunity to bring the public assistance programs into conformity with the Constitution and laws. This committee ought to recommend amendments which would render the Social Security Act free from constitutional doubt, and which would provide welfare clients a means of ensuring that they are assisted in a manner consistent with federal statutes and regulations.

THE SOURCES OF LAW

The United States Constitution is, of course, a primary source of the rights of welfare clients. The protections against unreasonable searches and seizures and against self-incrimination are relevant, but the constitutional provisions most important from our perspective are the equal protection clause of the 14th Amendment and the due process clauses of the 5th and 14th Amendments. The requirement, embodied in the equal protection clause, that legislative and administrative classifications be reasonable in relation to their purposes, casts doubt upon a number of eligibility criteria which various states have written into their public assistance laws. As will be noted, residence requirements, family maxima, substitute parent policies, and employable mother rules are among the state rules that fail to meet this basic constitutional test.

Under the rubric of due process, at least three distinct types of constitutional tests are applicable to the welfare laws. All states are required, by the terms of the Social Security Act, to provide recipients with an opportunity for a hearing in which they may contest adverse determinations. But in no states does the type of hearing that is actually afforded measure up to constitutional standards, and in many areas the hearing procedures are so lax that no reasonable man could find them to be fair. Second, due process requires that inferences and presumptions drawn from facts be reasonable, and that persons adversely affected be given an opportunity to rebut questionable or doubtful inferences. But a number of states have substantive rules, such as the employable mother rule in Georgia, which draw unreasonable inferences of fact and permit no rebuttal. Finally, due process prohibits regulations couched in language so vague that administrators have free rein to treat individuals arbitrarily, yet many states' public assistance regulations provide standards no more specific than "the best interests of the client and the state". See Sparer, Social Welfare Law Testing, 12 The Practical Lawyer 14, 28 (1966).

The second source of rights is the Social Security Act itself. Passage of the act in 1935 marked the transition from the age in which the poor were aided by towns and cities as a matter of charity to the age in which the Congress, recognizing that national economic factors beyond the control of individuals could lead to poverty, vested responsibility for public assistance largely in the federal government, and extended to the blind, the aged, the disabled and dependent children a right to minimal claims on the government for money needed to sustain life. Throughout the act can be found guarantees to recipients that their rights will not be affected by arbitrary administrative action; many of the Act's guarantees reinforce constitutional protections, such as the right to a prompt fair hearing, and the requirement that states restrict the disclosure of information which agencies learn about the client. Notwithstanding the language of the statute, practice in many states effectively denies protection to clients.

A third source of rights is Condition X—a hybrid between a constitutional and a statutory requirement. "When a state exercises its statutory option to prescribe stricter eligibility criteria than the ones outlined in the federal act, HEW approves the plan only if the classification effecting such [additional] limitation is a rational one in the light of the purposes of public assistance programs". Note, Welfare's "Condition X", 76 Yale L.J. 1222 (1967), citing A. Willcox, Memorandum Concerning Authority of the Secretary, Under Title IV of the Social Security Act, to Disapprove Michigan House bill 145 on the Ground of its Limitations on Eligibility, March 25, 1903. Condition X reads the requirements of equal protection into the Secretary's duty under the Act to approve only legal state plans. It has been invoked by the Secretary of HEW only in rare, dramatic instances in which states flagrantly denied would-be recipients their rights, e.g., an early Georgia plan with built-in racial limitations on assistance, and plans denying assistance to illegitimate children.

One of the most important modern applications of Condition X was the Flemming Ruling of January 17, 1961, which forbade states to deny assistance on the ground that a child was living in an "unsuitable home". As the Yale Law Journal note points out, a wide variety of state practices might be ruled illegal if the Secretary applied Condition X uniformly rather than sporadically. Among them must be included the practice of "removing" undesirable clients to other states, by conditioning temporary welfare on an agreement to emigrate; the minor unmarried mother rule (Louisiana requires a minor unmarried mother to live with her own mother to receive AFDC, unless her mother's community would experience

"moral outrage" at her presence); the substitute father rule; the employable mother rule; and the maximum family grant. See 76 Yale L.J. at 1229–33. Finally welfare recipients are entitled to the protections of HEW regulations which are regularly promulgated and distributed to welfare officials in the various states. Two recent transmittals, in particular, both of which reflect constitutional imperatives, guarantee clients that they will not be presumed to have outside income which they do not actually receive, and protect them against intrusions into their private lives. As will be shown, even the protections of specific federal regulations have not been afforded by all states to families receiving AFDC.

UNLAWFUL ADMINISTRATION OF THE LAW

Normally, statutes of doubtful constitutionality are soon tested in court, and abuses in administration come quickly to light through suits to enjoin their continuation. But in the field of public assistance, few of the statutory provisions have been tested in court, and no one knows in a detailed way how the law is actually administered in all of the states. What makes welfare different is the enormous power that caseworkers have over the lives of their clients, power which discourages clients from complaining of abusive practices or availing themselves of the statutory right to a fair hearing. In many states, only four or five hearings are held per year. Prof. Handler explains the position of an AFDC client whose worker has told her that to continue to receive any welfare she must leave her children during the day and take a job—the employable mother rule. Let us say that the client wishes to dispute the case worker's decision, either because she disagrees with the worker that it would be in the family's "best interests" for her to work, or because work is unavailable in her community, or because she claims that the rule is inconsistent with the Social Security Act as presently written. The client is very likely to be deterred by the awesome power of her worker:

"One of the critical facts to realize is that at the point where the caseworker tells the mother that she must take a job, the mother is still in the program. She and her family are currently receiving assistance and she will probably not be able to support her family with her earnings; besides, she does not want to leave her children. She knows that tomorrow and the next day the same caseworker will be making other decisions that affect vitally her level of living and style of life. She may want extra money to give herself or her children special vocational training; she may want a referral for herself or one of her children for mental health services or counseling; she may want the earnings of her children set aside for future higher education; or she may want to move to a better apartment in a better neighborhood. There are literally countless decisions that the caseworker may be called upon to make that can help this family: Boy Scout fees, a graduation dress or money for the graduation dance, money for a band instrument, money for tools to learn a trade, and so on. These can be matters of great importance to any of us; and they are decided by the county caseworker." Handler, Controlling Official Behavior in Welfare Administration, 54 Calif. L. Rev. 479, 494 (1966).

Despite these incentives to conform to caseworkers' decisions rather than contest them, clients have begun to assert their rights and to seek legal assistance from private attorneys, from OEO-funded neighborhood legal offices, and from the Legal Defense Fund and NORI. Welfare rights organizations of clients have sprung up, some of which have testified to this Committee. And an increasing number of lawsuits have been brought to contest the administration of the welfare laws.

In some states, therefore, but far from all, a handful of attorneys are aware of the grievances of clients and of the ways in which their rights are being denied. We have recently contacted such attorneys in fifteen states,[1] and we also have incomplete information about the administration of the laws in other states. This is what we have learned about the unlawful administration of the law.

A. Prompt determinations of eligibility

The 1950 amendments to the Social Security Act provided that eligibility for assistance be determined with "reasonable promptness". The federal regulations specify that in aid to the blind, old-age assistance, and AFDC, determinations

[1] We chose fifteen states in which attorneys are active in representing welfare clients. The states are Arizona, Arkansas, California, Connecticut, the District of Columbia, Georgia, Illinois, Iowa, Mississippi, New Jersey, North Carolina, Ohio, Oregon, Pennsylvania and Texas.

must be made in 30 days (or else the state must justify a longer delay to HEW and propose steps to correct the situation). Federal Handbook of Public Assistance § IV–A–2331. Nearly every state has written the 30-day rule into its own regulations. Yet we discovered that only eight of the fifteen states contacted conformed to the federal and state rules. Sixty days is the normal waiting period in Blackhawk County, Iowa; sixty to ninety days in D.C.; ninety days in Atlanta, Georgia, Dallas, Texas, and Phoenix, Arizona. In Georgia, outside of Atlanta, clients wait, without income, for four or five months for a determination of eligibility. Still, Georgia is in relative conformity compared to some states; clients have to wait six months for a decision in Jefferson County (Louisville), Kentucky, and six months in some counties (such as Phillips County) of Arkansas. And while four months is an average wait in Mississippi, clients have had to wait up to 11 months for a decision in recent years. The Mississippi manual sets 60 days as the period for decision; Mississippi has never conformed even on paper to the 1950 amendments.

As a protection to clients, the federal regulations prescribe that state plans must provide for informing a claimant "of his right to request a hearing on the basis of the promptness requirement if action is not taken within the specified period to furnish assistance to notify him of his ineligibility". But this rule is nearly meaningless, since almost universally the state moves less rapidly on hearing requests than it does on applications for assistance grants.

B. Provision of hearings

In furtherance of the constitutional right to a hearing when government acts so as to affect particular individuals, Congress required that a "state plan . . . must . . . provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for [assistance] is denied or is not acted upon with reasonable promptness." Social Security Act §§ 2(a)(4), 402(a)(4), 1002(a)(4), 1402(a)(4), 1602(a)(4), § 6200 of the Federal Manual sets out administrative requirements of such hearings. But hearing practice in many states meets the standards of neither the federal government nor the Constitution.

i) *Notice.*—The Federal Manual requires that every claimant be "informed in writing at the time of application and at the time of any agency action affecting his claim, of his right to a fair hearing and of the method by which he may obtain a hearing.". Many states which we investigated did provide adequate notice of the right to a hearing. But others failed to conform even in this simple regard. In some states with many Spanish-speaking clients, including California, the notice is given in English only. In Mississippi, only written notice is given to clients known to be illiterate. Ohio prints information about the opportunity for a hearing in a pamphlet that is distributed to caseworkers, but this is never distributed to clients. In New York City, a welfare client whose grant has been reduced or eliminated is given a paper which says:

"You may wish to review the pamphlet which was given to you at the time of your application. It explains the provisions under which this type of public assistance is granted and your rights with respect to review of this decision."

This obviously does not inform the client of "the method by which he may obtain a hearing, and it is of little help to the majority of clients who have lost the pamphlet given them when they applied. Yet in Newark, New Jersey, not even this much notice is given clients when they are adversely affected; the only notice is printed on the back of their application forms. A recent study by the Pennsylvania Welfare Department revealed that Philadelphia caseworkers informed less than 20% of rejected applicants of their right to a hearing.

ii) *Time for decision.*—Obviously the right to a hearing is an empty right unless it implies the right to a decision within a reasonable time. The federal regulations recognise this in requiring a "prompt' determination and a state-set overall time limit on decisions. But in many states decisions are far from prompt; three months typically elapse in Illinois between the time of a hearing request and the rendering of a decision, three months in Connecticut, four months in Ohio, and five months in Mississippi. And states violate their own rules on overall time; on the books, Ohio grants a hearing within 15 days of a request and renders a decision thirty days after that.

iii) *The right to a prior hearing.*—Denial of the right to a prompt hearing would not be so disastrous if states did not also deny clients their constitutional right to have a hearing *before* adverse agency action took effect. In every state, agency officials determine to their own satisfaction that the client deserves less money than he is getting, and unilaterally reduce the grant. Then, if he wishes,

the client may request a hearing. If he is successful in the hearing, the client's grant is reinstated, but in the intervening two or three or more months, his family will have received less than their entitlement and may have been subjected to great hardship. This injustice could be partially, though not completely, compensated for by an award of retroactive back payments where clients are successful at the hearing.

Some States do provide full back payments. See Calif. Welfare and Inst. Code § 103.3. But many other states empower hearing officers only to reinstate the client, not to award back payments wrongfully withheld, and others provide for only partial payments. New York, for instance, pays only verified debts incurred during the month of the hearing decision (not request) and the prior two months.

But no award of back payments can make up for the harm that is done clients whose grants are erroneously cut off. Due process requires that a hearing be held in an administrative proceeding "before the final order becomes effective". *Opp Cotton Mills, Inc. v. Administrator*, 312 U.S. 126, 152–53 (1941). The antiquated "right-privilege" distinction can no longer prevent this basic tenet of constitutional law from being applied to the Social Security Act. See Note, Withdrawal of Public Welfare: The Right to a Prior Hearing, 76 Yale L.J. 1234, 1237–39 (1967); Comment, Do the Present Regulations Governing the Time for Holding Fair Hearings in Public Assistance Violate Constitutional Due Process and the Social Security Act?, Welfare Law Bull., Dec., 1966, pp. 8–10. Clients injured by the denial of their right to a prior hearing, assisted by the Defense Fund, have recently brought suit against Mississippi officials. *Williams v. Gandy*, Civ. # —— (N.D. Miss.).

iv) *Reasons for denial.*—Whether the hearing is held before or after adverse agency action, it is of little value to the client who does not know why he has been cut off or denied assistance. The federal regulations (Handbook, § IV—2220(3)(d)) and perhaps also the Constitution (Cf. 1 Davis, Admin. Law Treatise, § 8.05 at 530) require that notice of adverse action 'must contain the reason why" and must provide a basis for the individual to express dissatisfaction with the agency action". Only then can he know whether he has a legitimate grievance, and only then can he prepare his case for a hearing.

But although many states' welfare manuals comply on their face with the federal rule (Cf. N.Y. Regs. § 355.3(a)(2)(i)), the reasons given in fact are often not adequate and do not conform to the federal law. In New York, clients are frequently told the reason is "failure to comply with department policies"; no specific rule or policy is quoted, nor are facts justifying the action alleged. In California, some clients have been told "your check has been withheld on the grounds that you *might* be ineligible for aid" (emphasis added). Ohio clients are told "you have been removed from the list of those receiving assistance because you are no longer eligible". Dallas applicants denied assistance receive an IBM card saying "unable to determine eligibility". In Philadelphia, many clients are told simply that "you have failed to provide adequate information".

v) *Hearing procedures.*—Obviously the requirements of due process and of the federal regulations govern fair hearings. But hearing procedures in some states meet neither standard. For example, § 6200 of the Federal Handbook specifies that "the verbatim transcript of testimony and exhibits, or an official report containing the substance of what transpired at the hearing, together with all papers and requests filed in the proceeding, and the hearing officer's or panel's recommendation, constitute the exclusive record for decision and are available to the claimant at any reasonable time." Also, the claimant must have the opportunity "to question or refute any testimony or evidence". But in Texas, the appeal board which renders the decision never sees the transcript; it receives only a summary of argument prepared by a clerk, and the client has no opportunity to examine the summary for accuracy or completeness.

And in North Carolina, the client and agency representative are simply seated in front of the microphone of a tape recorder and instructed to tell their stories; no hearing officer is present at all to resolve disputes that arise in the course of the hearing (e.g. disputes about the federally-guaranteed right to examine agency documents), and the client has no effective right to cross-examination.

vi) *The scope of the hearing.*—The federal regulations are clear that "the claimant may question the agency's interpretation of the law, and the reasonableness and equitableness of the policies promulgated under the law, if he is aggrieved by their application to his situation." Federal Handbook § IV-6331. But many hearing officers, such as those in Connecticut, construe their authority

narrowly, and contend in particular that they do not have the power, much less the duty, to render constitutional decisions. Yet federal regulations make some of the Constitutional guarantees (such as freedom from unreasonable searches, see Handbook Transmittal #77) specifically binding on state welfare agencies, and provide that conditions of payment are reviewable at hearings. Federal Handbook § IV-6331. Even aside from constitutional questions, many states do not permit clients to challenge the legality of agency policy, despite the clear language of the federal regulation.

C. Searches and Investigations

The Fourth Amendment's guarantee of protection against unreasonable searches and seizures by government officials obviously regulates the behavior of welfare investigators. Yet unlawful searches have been a notorious problem in the administration of public assistance. During the nineteen fifties, it was not uncommon to read news accounts of "midnight raids" by law enforcement officers and welfare officials, in which the officials forced their way into AFDC clients' homes in the middle of the night to see if any eligibility conditions were being violated, and to check, in particular, whether a man was living in the house. See Reich, Midnight Welfare Searches and the Social Security Act, 72 Yale L.J. 1347 (1963). These raids used to be justified on the theory that they were "consented" to by the clients, despite the fact that the client who refused to admit the investigators was threatened with being cut off for non-cooperation. The consent theory was demolished last March by the California Supreme Court, which reinstated a caseworker who had been fired for refusing to take part in a mass morning raid which he alleged was unconstitutional. To the welfare department's contention that they had consent to the raids, the court replied that no meaningful consent could be procured by the implicit threat of removal from welfare.

New Federal Regulations, effective July 1, 1967, should, if complied with, go a long way towards eliminating unlawful searches. State procedures for determining eligibility must now be "consistent with the objectives of the program, and . . . respect the rights of individuals under the United States Constitution, the Social Security Act, Title VI of the Civil Rights Act of 1964, and all other relevant provisions of Federal and State laws, and [must] not result in practices that violate the individual's privacy or personal dignity, or harass him, or violate his constitutional rights." Handbook Transmittal #77. Specifically, "States must especially guard against violations in such areas as entering a home by force, or without permission, or under false pretenses, making home visits outside of working house, and particularly making such visits during sleeping hours; and searching in the home, for example, in rooms, closets, drawers, or papers, to seek clues to possible deception." *Ibid.* But again, a number of states, especially those in the South, have not conformed either to the federal rule or the constitutional imperatives. We have not heard of any true "midnight raids" this summer, but in the District of Columbia, investigators still do their work outside of normal working hours; home visits are made until 10:00 p.m., and between 8:00 and 12:00 Sunday morning; and parked car surveillances of clients' homes are common. In Arizona, welfare officials still demand investigation of drawers and closets. Arkansas investigators hide under open windows to hear conversations in recipients' homes; they claim that this eavesdropping is no "search", but it cannot be described as a practice consistent with "privacy" and "personal dignity". Nor can California, the birthplace of the midnight raid be said to have conformed with the federal rule.

Attorneys on our staff have learned of instances, occuring since July 1, in which social worker-police teams have knocked on clients' doors, falsely stated they had brought checks for the clients, and, upon being given entry, taken the AFDC mothers downtown to the district attorney's office to interrogate them about their sexual relations. And night stakeouts of clients' homes have continued to occur in Alameda County.

Handbook Transmittal #77 says that "applicants and recipients will be relied upon as the primary source of information about their eligibility . . ." and that "reliance on the applicant (and public records) as the primary source of information will ordinarily make it unnecessary to consult other sources of information. The agency should take no steps in the exploration of eligibility to which the applicant does not agree, including contact with collateral sources. When information is sought from collateral sources, there should be clear interpreta-

tion of what information is desired, why it is needed, and how it will be used. Agencies should not rely on a "blanket" consent for each contact, whether with social agencies, doctors, hospitals, and similar resources, or with relatives or other individuals."

"The consent should cover the purpose of the contact as well as the individual or agency to be consulted."

Yet many states have not conformed to this rule, and most caseworkers are probably unaware of its existence. In states that are fastidious about consent, a blanket consent form is printed in small print on the application for assistance; this is true, for example, of Iowa and of Mississippi. Attorneys in other states, such as Georgia, Arkansas, Arizona, and Ohio reported to us that constent is not sought at all; welfare officials are known to have made inquiries of neighbors and relatives freely, and while it is nearly impossible to determine whether inquiries without consent are made of other public and private agencies, clients have not been requested to give such consent in the states reporting.

D. Family maximum grants

Twenty-two states have imposed maximum limits on the amount of AFDC assistance that any one family may receive. A certain amount of aid is given to each child in the household, but if the number of children exceeds five, or six, no more aid may be given the family. Thus each child in a Florida recipient family receives $23 per month, but in no event may the family receive more than $85 per month (1,030 per year). This law deprives children in large families of equal protection; it denies them benefits (or reduces the benefits due them) simply because they have a certain number of siblings. And the discrimination against such children is in no way related to the purposes of the Social Security Act (in fact, the Act seeks to enable impoverished children to grow up in their own homes, and the family maximum encourages farming out children to relatives so that they may receive their full grant). In fact, in the only court test to date of the family maximum, the Iowa Supreme Court found the maximum to be unconstitutional; it was held to have violated the State Constitution's equivalent of the equal protection clause. The court said the rule established a "subclassification of the original classification, i.e., dependent children based solely upon the number of children in the home, with no consideration as to need, a circumstance completely disconnected with the basic classification and the purpose and reason therefor." *Collins* v. *State Board of Social Welfare*, 248 Iowa 369, 81 N.W. 2d 4, (1957). While the Iowa decree is not binding in the twenty-two states which still have the family maximum, the equal protection clause of the federal constitution is, yet the rule is still enforced in every region of the country.

E. Recovery of agency overpayments

From time to time, a state welfare office gives a client a check for more money than his entitlement, either because the agency is not aware that the client's status has changed in a way that should reduce his grant, or, quite commonly, through a mistake in the agency's bookkeeping. Overpayment errors are often discovered months after the checks are distributed, and typically the client will have long since spent the extra money. It is not surprising that the uneducated client does not usually catch the error, since he can hardly be expected to perform each month the complex calculations used to determine the size of the monthly grant. Agencies have adopted the practice, however, of attempting to recover the overpayment, usually by deducting the sum from one or two of the client's current checks. This theoretically equitable solution has led to disastrous consequences for families which are barely able to subsist on the ordinary monthly grant, which is set in many states at a fixed percentage (27% in Mississippi) of the state's own computation of the family's minimum basic needs. (Recall that the average welfare grant in the United States is but $46 per month per person, and many states fall far below this average). To prevent the hardship brought on by reducing grants already at a sub-minimum level, the federal government issued a directive (Handbook Transmittal #120), effective July 1, 1967, which prohibits recovery of most overpayments:

"Assistance payments must be based on need in the light of currently available income and resources. Current payments cannot be reduced because of prior overpayments, if the recipient no longer has the income available, which occasioned the overpayment. Examples. Unreported income several months ago which is no longer available as well as agency overpayments."

Like so many other federal regulations, this ruling has been evaded in many areas. In Portland, Oregon, the welfare agency is deducting 10% per month from the clients' grants until the overpayments are recovered. In California, officials have interpreted the ruling to mean that any overpayment made within the last sixty days is "currently available" and therefore recoverable. Arizona changed its rules to conform with the federal regulation, but the Phoenix agency is still sending out dunning letters. And in Newark, New Jersey, the welfare agency attempts to recover overpayments from clients who are unaware of their rights, but complies with the federal regulation as to clients who seek help from an attorney of the Newark Legal Services Project. In Baltimore, when HEW instructed the local agency not to use civil suits to recover overpayments, officials brought 200 criminal prosecutions for alleged welfare fraud, in an effort to circumvent the federal regulations.

F. Unconstitutional Conditions of Eligibility

A major category of lawlessness in the administration of public assistance is the imposition of unconstitutional conditions on the receipt of welfare, particulary AFDC. In part, this is the fault of the Congress, although the Congress that passed the Social Security Act can be largely forgiven because the doctrines which render sections of the Act unconstitutional were, for the most part, evolved by the Supreme Court since 1935. The larger responsibility rests with the states. The Act sets broad categories of eligibility and permits the states to superimpose narrower classifications. Some of the states have employed this device to make the Act perform functions for which it was never intended, such as regulating the morality of welfare recipients. Many of the state-imposed conditions of eligibility violate the Fourteenth Amendment of the United States Constitution.

Residence requirements.—Most titles of the Social Security Act permit states to restrict assistance to applicants who have resided in the state for a specified period of time before seeking aid. For AFDC, the maximum period of required residence is one year; for the other programs, such as aid to the blind, the permitted maximum is still longer. (In enacting Title XIX—medicaid—in 1965, Congress demonstrated that it is attuned to the needs of a mobile society and to the constitutional rights of applicants; it forbade residence requirements for this program altogether. 42 U.S.C. § 139a(b)(3)). Most states have enacted the maximum permissible residence requirements—41 states have a one-year requirement for AFDC.

Every year five and a half million Americans move to a new state. A substantial number of these migrants are workers who become disabled and impoverished, or children in families who are adversely affected by regional unemployment. Serious hardship is inflicted on such people when they are not eligible for assistance either in the state of their residence or the state from which they came. Deputy Commissioner Antonio Sorleri of the New York State Department of Welfare, among other welfare officials, has severely condemned these laws: "Residence requirements cannot be reconciled with either our modern industrial civilization or with the objectives of our social security programs. The hardships imposed upon people are cruel indeed, as many of us can attest; the only saving grace is that no one in public welfare sincerely defends such restrictions." Quoted in National Travelers' Aid Assoc., Sessions on Residence Requirements for Health and Welfare Services 5-6 (1959).

The residence requirements condoned by the Social Security Act are not only cruel and anachronistic; they violate several provisions of the United States Constitution, including, perhaps, the prohibition of Article IV, § 2, of discrimination against citizens of other states; the privileges and immunities clause of the Fourteenth Amendment; the due process clause, the equal protection clause; and the implied ban on restriction of interstate travel derived in *Crandall* v. *Nevada*, 73 U.S. 35 (1867). See Harvith, The Constitutionality of Residence Tests for General and Categorical Programs, 54 Calif. L. Rev. 567 (1966). Whether or not residence requirements violate all these provisions, they are certainly unconstitutional denials of equal protection. As a three-judge federal court said in declaring Delaware's one-year AFDC requirement unconstitutional, residence laws are precisely at odds with the purposes of Social Security: "the purpose of the [Welfare] Code is, inter alia, 'to promote the welfare and happiness of all people of the State, by providing public assistance to all of its needy and distressed; that assistance shall be administered promptly and humanely with due regard for the preservation of family life'. . . . It is evident to us that as to these fam-

lies living in Delaware for less than one year the denial of public assistance fails to carry out the stated purposes for the Public Assistance Code. It in fact tends to frustrate them. The residency requirement prevents prompt assistance to some of the State's needy and distressed and to that exent is the antithesis of 'humane'. It also necessarily results in pressure on the solidarity of the family unit. Nor given these circumstances is it an acceptable answer to say that until they are here one year such persons are not a part of the state's needy and distressed. The discrimination based on length of residency thus finds no constitutional justification in the purpose declared in the statute itself."

The court considered other possible justifications for the requirement, including protection of the public purse from persons who might enter the state to get welfare assistance (a "constitutionally impermissible basis for separate state treatment"), and found none of them to be a valid state purpose reasonably related to the statutory residence discrimination. *Green* v. *Department of Public Welfare*, Civ. Action No. 3349 (D. Del. June 28, 1967). An identical result was reached by a three-judge federal court in Connecticut, which also held the residence requirement to be an unconstitutional infringement upon the freedom of interstate travel. *Thompson* v. *Shapiro*, Civ. No. 11,821 (D. Conn. June 19, 1967). In Pennsylvania a preliminary injunction has been entered against enforcement of the residence law (*Smith* v. *Reynolds*, Civ. No. 42,419, E.D. Pa., June 1, 1967), and in the District of Columbia, a three-judge court, including Chief Circuit Judge Bazelon and Senior Judge Fahy, has entered relief *pendent lite* for plaintiffs challenging the requirement, citing the opinions in the other three cases. *Harrell* v. *Board of Commissioners*, Civ. No. 1497-67 (D.C. D.C., 1967). Yet despite these rulings, residence requirements continue to be enforced in the states where suits have not yet been brought, and even in Connecticut, where the statute was declared unlawful, many local welfare offices are still denying aid to applicants on the basis of lack of a year's residence.

ii) *The substitute father rule.*—Nineteen states restrict AFDC support to children who are deprived of parental support by reason of the death, continued absence from the home or physical or mental incapacity of their fathers, and deny assistance to children who are deprived of parental support because their fathers cannot find a job.

These states have failed to take advantage of the AFDC-UP program (42 U.S.C. §607), and have therefore encouraged countless numbers of well-intentioned fathers to desert their families so that their children can have a little income. Arguably, this discrimination violates equal protection by discriminating against needy children by reason of the cause of their parent's inabality to provide—a cause that bears no rational relation to the purpose of the AFDC program or to the need of the children. But some of these nineteen states make an even more invidious discrimination which denies assistance even to needy children whose fathers *have* left home. Alabama, Arizona, Georgia, Louisiana, Utah and other states withhold aid where the child's mother, having been deserted, has sexual relations with another man—a so-called "man-in-the-house." The term is a misnomer, for in a number of states, the man need not live in the house at all. In Georgia, a child is disqualified if a man "visits frequently for the purpose of living with or cohabitating with the applicant." Ga. Manual Part III §V (3)(5). And a child is cut off in Arkansas if the mother maintains a "stable nonlegal union" with a man, which is "presumed, even though no father is living continuously in the home, where the mother affords the privileges of a husband to a man and there is a continuing relationship." Ark. Manual of Public Assistance § 2813. Such rules cannot be justified on the theory that they are mandated by the Social Security Act's restriction of AFDC benefits to children "deprived of parental support." The Act was intended to assist children deprived of financial support, not only children deprived of the psychological gratification provided by adult male company. The rules which deny assistance to children who have a "substitute father" violate the equal protection clause, the Act, and Condition X.

In fact, many of the "substitute father" rules represent successful attempts to circumvent a prior specific application of Condition X by the Department of Health, Education, and Welfare—the Flemming Ruling which prohibited states from denying assistance to children just because they lived in "unsuitable homes." The "suitable home" rule (which is still on the books in nineteen states (including Connecticut, Maine and Michigan, and is vigorously enforced in Mississippi [and in Texas when a caseworker takes it upon herself to

punish a recipient] was used by Louisiana in 1960 to drop from welfare children whose mothers had at some time misbehaved; i.e., who had had an illegitimate child, or who were living in stable relationships with a man they had never ceremonially married. After Secretary Flemming disapproved the use of this device to punish immoral mothers by depriving their children (95% of whom were Negro) of minimal assistance, the states affected simply turned to alternative devices, such as the "substitute parent" policy, to accomplish the same results. Bell, Aid to Dependent Children 149 (1965). "On the whole the plight of needy Negro and illegitimate children remains substantially unchanged by the Flemming Ruling." *Ibid.*

State plans containing "substitute father" rules are obviously out of conformity with federal policies as well as with the Constitution. In February, 1966, compainants in Arkansas and Georgia, represented by the Legal Defense Fund, filed with the Department of Health, Education and Welfare a petition for a hearing to determine whether the states were in conformity with federal law. HEW at that time began a departmental investigation of the state plans, but to this date has not scheduled a conformity hearing.

Another variation of the "substitute father" rule exists in certain Northern states. If a man (a stepfather or an unrelated man) is living in the house of a child receiving AFDC, it is irrebuttably presumed that he is contributing to the child's financial support. Section 3234.6 of the Pennsylvania Department of Public Assistance Manual, for example, says that:

"Because of wide variations in ways of sharing, it is usually impractical to determine the exact actual monetary benefit of such shared living arrangements to the client. The Department, therefore, has devised a set of formulae, based on normal living customs, to be used to establish the income from shared living arrangements . . ."

These formulae consider income of a spouse living in the home to be available to the dependents and the term "spouse" includes a "man and woman maintaining a home together as a husband and wife usually do." Compare Calif. W & I Code § 11-351. Similar rules exist in New Jersey, Iowa, New York City, and Virginia, and such a rule is enforced as to stepparents in Portland, Oregon, despite contrary state regulations. These rules raise Constitutional problems, since due process requires that one be allowed to rebut presumptions of fact. See Heiner v. Donnan, 285 U.S. 312 (1932). But more simply, they contravene another federal regulation which became effective last July:

"Reduced assistance payments based on assumed receipt of support payments or any other income that is not, in fact, available, are inconsistent with the welfare agency's responsibility for meeting need and strengthening family life. They result in inequity in meeting the continuing needs of the families affected . . ." Handbook Transmittal 86.

As far as we have been able to determine, the federal regulation has resulted in a number of changes on paper of some state rules, but has not had a dramatic effect on the actual appliction of the inferred-support rules.

iii) *Desertion.*—Children are eligible under the Social Security Act for AFDC assistance if they are deprived of parental support by reason of "continued absence from the home" of a parent, and are in need. In most states, if a father is imprisoned or drafted, he is immediately considered "continuously absent," even if it is known that he will return shortly (e.g. he has been sentenced to thirty days in jail). But a number of states presume that until a father has been absent for a specified minimum period of time, he has not deserted, and the mother may not rebut this presumption by showing that an overwhelming preponderance of the evidence establishes that he has left her forever. The required minimum period is a month in Kentucky, two months in Alabama and Illinois, three in California, Louisiana, New Hampshire, Ohio and Wisconsin, and six months in Maine, Michigan, Mississippi, Texas and Vermont. In a recent case in Texas, the husband had gone to Denver and informed his wife that he was never coming back, but the Welfare Department denied his children assistance on the grounds that since he hadn't been gone six months, he couldn't have deserted them. When the children, represented by Dallas Neighborhood Legal Services, sued the Welfare Department, the Department gave them assistance in violation of its own rules, thus preventing a court challenge to the rules, which have not been changed and are applied to clients who do not have legal representation. The presumption denies due process of law by permitting no opportunity to rebut it, and denies equal protection to the children affected;

unlike children whose fathers have been continuously absent because of imprisonment, children of deserting fathers may not receive assistance for a specified period of time.

(iv) *Prosecution of husbands.*—State AFDC plans must "provide for prompt notice to appropriate law enforcement officials of the furnishing of aid to families with dependent children in respect of a child who has been deserted or abandoned by a parent." 42 U.S.C. § 602 (a)(10). Congress intended that welfare officials give the required notice to law enforcement officers, and that assistance be given to the family whether or not the mother cooperates in prosecuting the father who has not fulfilled his responsibilities under state law.

"Congressional action was clear with regard to the difference between public assistance administration and law enforcement, and did not place upon the public assistance agencies responsibility for enforcing support. The public assistance job is seen as that of providing eligible children with the assistance they need and it is not the intent of the legislation to deprive needy children of assistance in order to punish their parents for neglect of their duties. Although accepting assistance involves notice to the law-enforcement officials if a parent has deserted or abandoned his child, the amendment does not impose an additional eligibility requirement." Federal Handbook § 8120.

Despite this clear language, nearly every state has perverted the meaning of § 602 (a)(10), and requires, as a condition of eligibility, that mothers prosecute their deserting husbands, either civilly, or, as in Connecticut and California, or criminally. Spouse-initiated prosecution frequently precludes, forever, reconciliation of a family whose father had fled with regrets and hesitations.

(v) *The employable mother rule.*—Some states already provide that children may not receive AFDC benefits if their mothers decline available work. It is doubtful whether this eligibility condition, which presses mothers to leave their children during working hours, is consistent with existing federal law. The Federal Handbook casts grave doubt on attempts to reconcile the rule with the purpose of the Social Security Act:

"It was clearly indicated by statements made in the reports of the Committee on Economic Security that the intent of the aid to dependent children program was to enable mothers to remain in their homes, so that their children would have the opportunity for parental care and the benefits of growing up in a family setting.

"The enactment of laws for aid to dependent children was evidence of the fact that long-time care must be provided for those children whose fathers are dead, are incapacitated, or have deserted their families; that security at home is an essential part of a program for such care; and that this security can be provided for this whole group of children only by public provision for care in their own homes.

". . . Before the adoption of these laws it frequently . . . happened . . . that she [the mother] . . . was encouraged to make the attempt to be both homemaker and wage earner, with the result in such cases that the home was broken up after she had failed in her dual capacity and the children had become delinquent or seriously neglected.

"In cases of families receiving aid to dependent children, children are already, in most instances, deprived of the care of one parent, and, therefore, need the protection and personal supervision of the available parent." Federal Handbook § IV–3401.1.

Rigid "employable mother" rules therefore frustrate the very purpose of the AFDC program. Although HEW has not yet ruled state programs containing employable mother rules out of conformity with federal law, and has merely "recommended" against state adoption of the policy, the rules seem to violate the purposes of the Act; they are also, ipso facto, violations of the equal protection clause.

In addition (just as in the case of the substitute father rules), some states have more radical employable mother rules, which by no stretch of the imagination could be thought to be constitutional. The Legal Defense Fund is currently representing plaintiffs who have brought a federal suit to enjoin the operation of the Georgia rule, one of the most outrageous limitations on public assistance in the country. See *Anderson* v. *Schaefer*, Civ. No. 10443 (N.D., Ga.). In Georgia, children of mothers who will not take jobs when jobs are available, may not receive AFDC, but if the mother can find only a job which pays less than what her family would receive in AFDC benefits, and takes that job, Georgia will not

supplement her income to bring it up to the level of those receiving assistance payments. Mrs. Anderson does work full-time, but she receives only twenty-four dollars a week for forty-eight hours of work, and the state will not give her additional funds to support her seven minor children. If she left her job, she would also be ineligible under the employable mother rule. The Georgia rules discriminates against needy children who are otherwise eligible for aid, on the basis of the *source* of their monther's income, for if Mrs. Anderson earned twenty-four dollars a week for part-time employment, interest on securities, support payments, rent from lodgers, or any of a number of other sources, she would be eligible for AFDC income supplementation. This distinction deprives Mrs. Anderson and her children of equal protection, for it can represent no conceivable rational policy and is but an arbitrary discrimination. Georgia may not defend the rule against supplementation of full-time wages by relying on the federal eligibility criterion of "deprivation of parental support"; clearly this refers to amount of support, not the source of the income.

Georgia's employable mother rule has yet another twist. The Georgia Manual § III–V–C–3–b(2), allows County Boards to terminate all AFDC to employable mothers when a picking season opens:

"In communities where seasonal employment exists, the County Board is held responsible for determining when such employment is available and will designate periods as full-time employment periods. During such periods all applications for AFDC are denied and cases closed wherein the mother meets the conditions of emloyment outlined in this Section."

Thus, when a County Board announces that the okra season has begun, all employable mothers are cut off from AFDC, *even those who try to find employment and fail because the Board's determination was erroneous or because no employer chooses to hire them.* These mothers are deprived of the elementary due process requirement of an opportunity to rebut a presumption of fact which operates adversely to their interests. See *Carrington* v. *Rash*, 380 U.S. 89, 96 (1964); *Heiner* v. *Donnan*, 285 U.S. 312 (1961); *Mobile, J. & K.C. R.R.* v. *Turnipseed*, 219 U.S. 35 (1910).

THE DUTY OF CONGRESS

Aggrieved clients in many states have recently brought suit challenging a number of the unconstitutional and non-conforming practices which I have described. They are assisted by lawyers in neighborhood law offices sponsored by the Office of Economic Opportunity, by the Legal Defense Fund, NORI, and the Center on Social Welfare Law and Policy of the Columbia University School of Social Work, and by a handful of private attorneys. Litigation in this field, we believe, has some value, in that it promotes judicial analysis of the rights of welfare clients. But, unfortunately, litigation is of very limited value in actually affording large numbers of people the rights to which they are entitled. Perhaps the history of school desegregation since *Brown* v. *Board of Education* in 1954 is the most dramatic illustration of this fact; real desegregation did not begin until Congress set up administrative machinery—the Civil Rights Act of 1964—to enforce the constitutional requirements. There are a number of reasons for this. First, welfare clients are not usually aware that they have any rights other than those which their caseworker tells them of. If they do learn that they have additional rights which the agency is unwilling to afford them, they are often intimidated by the enormous power which their caseworker has over their lives, which Prof. Handler has described. Few clients will become plaintiffs in a suit against the welfare department. Second, no client without legal assistance can hope to succeed in court, and the poor suffer from a fantastic shortage of legal services. Private attorneys cannot afford to accept without fee vast numbers of welfare clients' cases, and many are too busy to accept any such clients at all.

The Office of Economic Opportunity, when presented with a request from a local community, will fund a legal service program. Over a hundred neighborhood law office programs have been established by O.E.O. in the last two years, but even these programs cannot meet the need of indigents. (Their aggregate fiscal 1967 budget of thirty million dollars enabled them to serve approximately half a million clients. The chairman of the American Bar Association's committee on legal aid estimated recently that there are potentially fourteen million indigent cases annually. New York Times, August 7, 1967, p. 11, col. 1). Some areas have no legal aid societies, and only a handful of communities in the 11

Southern states have sought and set up legal aid offices under the O.E.O. program. Third, welfare departments across the country have developed the practice of violating their rules and awarding the money asked for as soon as a lawyer enters the case; this solves the problem for the client who is represented, but it moots the case and thus can bring no relief to the thousands of similarly situated clients who have no lawyer. A class action, as a practical matter, may not provide a solution to this problem since the individual plaintiff whose particular difficulty has been resolved has little incentive to proceed with the case. And some lawyers have reported to us that welfare officials intimidate plaintiffs to withdraw their cases—they threaten them with sanctions such as neglect proceedings which may result in a mother's losing custody of her children. Finally, as in the case of school desegregation cases, progress is extremely slow because welfare departments obey only decrees entered against them; they have not been conforming their regulations and practices to federal rules and to decisions rendered in other jurisdictions. Suits have to be brought over and over again. As I mentioned earlier, the welfare department in New Haven, Connecticut, has not conformed its practices to the decision, resulting from a case brought in Hartford, which declared the state's residences requirement unconstitutional.

Congress, I suggest, has a clear duty to guarantee the lawful administration of the law. The 1967 amendments to the Social Security Act present it with an appropriate opportunity to do so. The following legislation might have the desired effect:

I. Congress should examine closely any aspects of the amendments which have passed the House which set back efforts of the Department of Health, Education and Welfare to require constitutional administration of the Act. Section 202(b) of H.R. 12080 seems to repeal parts of Handbook Transmittal 86, which forbids states from imputing income from relatives to recipients, where no income is actually received. Since such imputation denies recipients of their due process right to rebut a presumption, it is unconstitutional.

II. Congress should scrutinize the Social Security Act and consider taking advantage of the present occasion to eliminate any unconstitutional features of the Act itself, notably the sections sanctioning residence requirements. Similarly, Congress might supplement the implicit requirement of constitutional administration with specific and explicit provisions forbidding states to establish the unconstitutional conditions on eligibility which I have listed above.
the unconstitutional conditions on eligibility which have listed above.

III. Congress could amend the Act to *require* rather than *permit* the Department of Health, Education and Welfare to hold hearings on the conformity of state plans alleged by aggrieved clients to be inconsistent with federal statutes and regulations. As mentioned earlier, HEW has not granted a hearing on the petition filed nineteen months ago by clients aggrieved by the substitute father rule in Arkansas and Georgia. Since it would be impractical for HEW to hold a hearing every time a complaint is received, some sort of triggering device would be needed, such as the submission of two hundred signed complaints of aggrieved clients challenging a state plan, or twenty-five clients challenging a county rule.

IV. Congress could provide recipients with procedural devices enabling them to get realistic relief from administrative or judicial authorities. States might be required to grant clients the basic due process right to a hearing before a neutral examiner (who may nevertheless be welfare official) *before* adverse action is taken against them, so that they will be able to maintain a subsistence income pending resolution of a disputed case, and so that individual workers and local offices will not be able to terrorize clients by threatening unilaterally to cut off their income if they do not cooperate. In addition, Congress could authorize federal district courts to award reasonable attorneys' fees to successful clients, so that private attorneys will be able to accept their cases, thereby relieving the already over-burdened neighborhood law offices and involving a larger segment of the Bar in servicing the poor.

In these ways Congress might do much to restore public confidence in the welfare system, and to convince indigents that they, too, have rights, and that their grievances will be dealt with in a fair and lawful manner.

Senator HARRIS. Our last witness for this morning is Dr. Luis A. Izquierdo, who is representing the Puerto Rico Medical Association.

STATEMENT OF DR. LUIS A. IZQUIERDO, PRESIDENT, PUERTO RICO MEDICAL ASSOCIATION, ACCOMPANIED BY DR. JOSE ALVAREZ, PRESIDENT-ELECT

Dr. IZQUIERDO. Mr. Chairman, my name is Luis Izquierdo, president of the Puerto Rico Medical Association. With me is Dr. Jose Alvarez, our president-elect.

Because of the time limitations we would like to submit our formal statement for the record, and summarize our views.

Senator HARRIS. Very good. Without objection, the entire statement will be placed in the record and the attachment of the Puerto Rico Medical Association Bulletin will be received for the committee files.

Dr. IZQUIERDO. Thank you, Senator.

We have come a long way and have 10 minutes which we will use to make one basic point. We ask that the medically indigent American citizens of Puerto Rico be treated exactly the same as the rest of the medically indigent American citizens.

Under the present Social Security Act there are three areas in which Puerto Rico is not treated equally and H.R. 12080 adds a fourth one.

First, section 227 of the Social Security Act grants persons who attain age 72 the sum of $35 per month, even though they have not obtained covereage under the retirement program. This provision has never been applicable to our senior citizens.

Recommendation: This provision of the law should be changed so that 19,000 Puerto Ricans can receive the same benefits provided to other American citizens of the same age.

Second, in all the categorical public assistance programs our indigents do not receive treatment equal to that received by other indigent American citizens because they are limited in two ways:

A. Puerto Rico is at present limited to a total Federal contribution of $9.8 million annually for welfare under all welfare titles whereas no State has such limitation. As a result of this limitation the average monthly welfare payment in Puerto Rico in 1966 amounted to only $8.50. In the case of a family of four, a mother and three children receiving aid to families with dependent children, AFDC, the limitation restricts the family to $5 per person each month. This low payment represents only one-third of the minimum basic needs of such a family.

B. The Federal matching formula is limited to 50 percent for Puerto Rico whereas the States receive Federal matching ranging between 50 and 65 percent depending on their per capita income. H.R. 12080 recognizes the results of the limitation but fails to fully correct the inequity. That bill raises the ceiling in steps but does not provide equality since it retains a limitation.

Recommendation: That the ceiling be removed and matching formula made the same.

Third, section 1905(b) of the Social Security Act limits Federal participation in the Puerto Rico medicaid program to 55 percent; on the other hand, Federal matching to the States ranges between 50 and 83 percent based upon per capita income. As a result of this inequitable treatment medicaid expenditures in Puerto Rico are limited.

In addition to the limitation on Federal matching contained in the present law, section 248 of H.R. 12080 would place a further limitation

on Puerto Rico's medicaid program. This section would limit Federal payments to Puerto Rico to $20 million for any given year.

This limitation will force Puerto Rico to further limit its program already declared deficient by the Department of HEW in a study that it conducted in January 1967. Under the existing law Puerto Rico will receive $22 million for medicaid for the present fiscal year. Obviously, the $20 million limitation contained in H.R. 12080 will result in a reduction of $2 million in Federal matching funds for medicaid.

Section 222 of the bill, which calls for coordination between title XIX and the supplemental medical insurance program, will require Puerto Rico to use at least $3 million for "buying in" for the medicare program, thus further reducing to $17 million the Federal funds available for medicaid.

Recommendation: That no ceiling be placed on our medicaid program and that the matching formula be made the same.

Fourth, and finally, section 227 of H.R. 12080 would require that State medicaid programs provide free choice of physician and facility for any individual eligible for medical assistance. This provision would become effective on July 1, 1969, for all the States; however, Puerto Rico is again set apart from the States under this proposal. The indigent of Puerto Rico, the medically indigent of Puerto Rico must wait until July 1, 1972, to have this right guaranteed to all other Americans.

While the Puerto Rico Medical Association feels very strongly about the desirability of freedom of choice for the medically indigent, it realizes that if Congress retains the limitation on Federal payments contained in H.R. 12080 the enactment of section 227 will be academic. Limitation of funds will effectively deny our medically indigent patients this basic right: Freedom of choice.

Recommendation: The Puerto Rico Medical Association on behalf of 1 million citizens, 2,200 physicians, and numerous organizations who have endorsed our position, respectfully requests the adoption of these recommendations which will result in providing the people of Puerto Rico better welfare and better health services.

On behalf of the Puerto Rico Medical Association, the citizens and organizations who backed us we wish to thank you for allowing us to present our views on this important social legislation.

Thank you.

Senator HARRIS. Thank you. Do you have anything to add, Dr. Alvarez?

Dr. ALVAREZ. No, sir. We were hoping you might have some questions to ask that we would answer.

Senator HARRIS. I understand that today you are going to meet with some of our people on the committee.

Dr. ALVAREZ. Yes, sir.

Senator HARRIS. Right. Well, I think that is what needs to be done. I think your statement is a very effective and influential one for equality for the citizens of Puerto Rico and, of course, we will be following very carefully the conference which you have arranged today with our committee people.

We appreciate your presence here.

Dr. ALVAREZ. Thank you, sir.

Dr. IZQUIERDO. Thank you, sir.

Senator HARRIS. Thank you very much.

(The prepared statement of the Puerto Rico Medical Association follows:)

TESTIMONY OF THE PUERTO RICO MEDICAL ASSOCIATION

Mr. Chairman, Distinguished Members of Finance Committee of the U.S. Senate, the Puerto Rico Medical Association comes before this Committee with gratitude, with pride and with hope in behalf of 2,200 physicians, of 1,000,000 citizens and numerous civic organizations which support our position, to testify on hearings on H.R. 12080, the Social Security Amendments of 1967.

We come before you with gratitude because we very sincerely appreciate the honor afforded us in being allowed to appear before you and be given the opportunity to state our case on behalf of our medically indigent patients.

We come before you with the pride of achievement as proved by our record. In February, 1966, the House of Delegates of the Puerto Rico Medical Association approved a resolution and we subsequently successfully implemented it, endorsing, without reservation, the provision of Title 18B of Public Law 89-97. Thus the Puerto Rico Medical Association became *the only* state medical Association *under the American flag* to do so.

With this gesture we helped at least 4% of the population of Puerto Rico to pass from medical indigence to solvency in accordance with the spirit and letter of the Medicare Law.

We come to you with just pride because in addition to our backing of Title 18B we have a unique record of community, social and medical service. In order to bring to the economically hampered citizen in Puerto Rico the highest quality of medical care, our medical association set up a voluntary pre-paid medical and hospital insurance plan. Special characteristics of this plan were that it rated fees to fit the financial resources of the economically impaired, and that it offered broad coverage of out-patient physician and laboratory services. The physicians of the Puerto Rico Medical Association went as far as accepting in times a drastic pro-rating of the already reduced fees. Today well over 125,000 Puerto Ricans have the benefits of this plan.

Living as we do in an ambient where almost 50% of the population is medically indigent, we have been most interested in socially oriented legislation. We have been trying for decades to eliminate the two-level quality in medical care. Position papers by the Puerto Rico Medical Association time and again give testimony to this fact.

On April 6, 1967, at the hearings on the "Social Security Amendments of 1967" before the Ways and Means Committee of the House, we submitted the following statement unanimously approved by the House of Delegates of the Puerto Rico Medical Association:

"The Puerto Rico Medical Association strongly believes that every citizen should receive the best quality of medical care through a system of free choice of physician and of facilities; we consider freedom of choice a cornerstone of high quality medical and health care.

"We believe that the effective date of the free choice provision should be the same for our residents of Puerto Rico as for those of any State of the Union. The physicians of Puerto Rico, represented by the Puerto Rico Medical Association, stand ready to grant reductions on their usual and customary fees for services to the medically indigent of Puerto Rico as long as we consider this necessary. Customarily, Puerto Rican physicians have granted such reductions from their usual and customary fees in the past and are even now granting such reductions in order to help other low income groups in their pursuit of quality medical care."

The Puerto Rico Medical Association recognizes one kind of patient: the sick one, one kind of physician: the one that is willing to serve mankind, one brand of medical care; first class of medical care to *all* citizens independently of their socio-economic status, race, religious or political beliefs. Our State Medical Association goal is *Operation Equality*, one and only one brand of medical care for everyone in the land, an ideal that will be of immeasurable benefit to all our countrymen.

We shall limit our presentation to those areas which in a special way affect the development of Health and Welfare services and Programs in Puerto Rico.

TITLE I—PART I

Section 101—Old Age, Survivors and Disability Insurance

The Puerto Rico Medical Association *recommends* that the increase in Old Age Survivors and Disability Insurance payments be of *15%* as recommended by the Administration, rather 12½% as specified in H.R. 12080.

Section 102—Increase in Benefits for Certain Individuals Age 72

Under this section there would be an increase from $35 a month to $40 a month the special amount that is paid to certain people age 72 and over who have not worked in covered employment sufficiently long enough to meet the regular insured status requirements, or who had no work covered under social security. This special payment to couples would be increased from 52.50 to $60 a month.

Under section 102 residents of Puerto Rico age 72 and over *continue to be excluded* from benefits under these programs, thus denying these very important benefits to several thousands of our Senior citizens. *We recommend* that our over 72 citizens be given the same benefits received by other American citizens.

TITLE I—PART 3

HEALTH INSURANCE BENEFITS

Section 125—Method of payment to physicians under supplementary medical insurance program.
Section 126—Elimination of requirement of physician certification in case of certain hospital services.
Section 127—Inclusion of podiatrists' services under supplementary medical insurance program.
Section 128—Exclusion of certain services.
Section 129—Transfer of all outpatient hospital services to supplementary medical insurance program.
Section 130—Billing by hospital for services furnished to outpatients.
Section 131—Payment of reasonable charges for radiological or pathological services furnished by certain physicians to hospital inpatients.
Section 132—Payment for purchase of durable medical equipment.
Section 133—Payment for physical therapy services furnished by hospitals to outpatients.
Section 134—Payment for certain portable X-ray services.
Section 135—Blood deductibles.
Section 136—Enrollment under supplementary medical insurance program based on alleged date attaining age 65.
Section 137—Extension of maximum duration of benefits for inpatient hospital services to 120 days.
Section 138—Limitation on special reduction in allowable days of inpatient hospital services.
Section 139—Transitional provision on eligibility of presently uninsured individuals for hospital insurance benefits.
Section 140—Advisory Council to study coverage of the disabled under Title XVIII of the Social Security Act.
Section 141—Study to determine feasibility of inclusion of certain additional services under Part B of Title XVIII of the Social Security Act.

Recommendation: The Puerto Rico Medical Association recommends the approval of the above-mentioned sections of Title I—Part 3.

TITLE II—PART 1

PUBLIC ASSISTANCE AMENDMENTS

Section 201—Programs of services furnished to families with dependent children.
Section 202—Earning exemptions for recipients of aid to families with dependent children.
Section 203—Dependent children of unemployed fathers.
Section 204—Community work and training programs.
Section 205—Federal participation in payments for foster care of certain dependent children.

Section 206—Emergency assistance for certain needy families with dependent children.
Section 207—Protective payments and under payments with respect to dependent children.
Section 208—Limitation on number of children with respect to whom federal payments may be made.
Section 209—Federal payments for repairs to home owned by recipient of aid or assistance.

Recommendation: The Puetro Rico Medical Association recommends the approval of the above-mentioned sections of Title II—Part 1.

The present formula for the allocation of Federal Funds to match States expenditures for welfare programs under Titles I, IV, X, XIV, and XVI of the Social Security Act *does not apply to Puerto Rico.* Under section 1108 of the Social Security Act the allocation of federal funds for this purpose to Puerto Rico is now limited to *9.8 million* dollars.

Under Section 248 of H.R. 12080, Section 1108 of the Social Security Act is amended to raise the limit of Federal participation in the public assistance programs of Puerto Rico to $12.5 million for fiscal year 1968, and allows increases in said limit or ceiling during each succeeding year to a maximum of $24 millions for fiscal year 1972 and each year thereafter.

Under Sections 1403 and 1603 of the Social Security Act the formula for Federal sharing in the public assistance programs of Puerto Rico is 50% while the Federal share in the programs of the poorer States goes as high as 83%. This discriminatory formula is left unchanged in H.R. 12080.

RECOMMENDATION

In regards to other State Programs assisted by Federal Funds, Puerto Rico is given the same opportunity to participate in such assistance as fully as any other States, but this has not been the case of Public Welfare Programs, and now by H.R. 12080 to the Medical Assistance Program.

We believe that the indigents of Puerto Rico *need and deserve* the same treatment as the poor of any other area. Puerto Rico is at present spending $10.5 millions of its own funds in public assistance. If Puerto Rico were to be treated on the same sharing basis as the States, it could receive $50 millions of Federal Funds in 1969 and it could do a real job of upgrading its public assistance programs. We are convinced that the Commonwealth government would continue its present policy of appropriating additional amounts which when matched with Federal Funds would result in great advances in our "*War Against Poverty*".

TITLE II—PART 2

MEDICAL ASSISTANCE AMENDMENTS

Section 220—Limitation on Federal participation in medical assistance.
Section 221—Maintenance of State effort.
Section 222—Coordination of Title XIX and the supplementary medical insurance program.
Section 223—Modification of comparability provisions.
Section 224—Required services under State medical assistance plan.
Section 225—Extent of Federal financial participation in certain administrative expenses.
Section 226—Advisory Council on medical assistance.
Section 227—Free choice by individuals eligible for medical assistance.
Section 228—Utilization of state facilities to provide consultative services to institutions furnishing medical care.
Section 229—Payment for services and care by a third party.
Section 230—Direct payments to certain recipients of medical assistance.
Section 231—Date on which State plans under Title XIX must meet certain financial participation requirements.

We believe that the preceeding Sections would result in definite improvement in the development of Title XIX programs throughout the Nation. (We take exception to the disposition that Section 227, the free choice provision, shall apply in Puerto Rico in 1972 rather than in 1969 as in the States).

However, the disposition in Section 248 (c), (1), that payments to Puerto Rico under Title XIX with respect to any fiscal year shall not exceed $20,00,000 and that of Section 248 (e) changing the Federal share for the Puerto Rico Title XIX program from 55% to 50%, make in effect all of these amendments academic for our Island.

On the mainland Federal reimbursement varies from 50 to 83% depending on the per capita income of the State in such a way that the poorer States get the higher Federal matching. In Puerto Rico (and in Guam and the Virgin Islands) there is under present law a fixed ceiling of 55% on Federal reimbursement. Since the per capita income of Puerto Rico is at present lower ($1,000 per annum) than that of the poorest State, this limitation makes it very difficult for our Island to be able to finance a program which requires the furnishing by July 1, 1975 of "comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources including services to enable such individuals to attain or retain independence or self care".

The population of Puerto Rico which on 1 January 1966 met "the plan's eligibility standards with respect to income and resources" was calculated by our State Title XIX agency (The Department of Health) as 1,700,000 persons of which 1.2 million were considered eligible for medical assistance with Federal reimbursement.

The Government of Puerto Rico is spending 16% of its budget in the provision of health services to the medically needy. Since the total budget amounts to much less than one billion dollars for the fiscal year 1967–68, it becomes evident that the purpose of Title XIX legislation may be defeated by the limitation of Federal matching to 55%.

The Puerto Rico Medical Association recommends that the law be amended so that matching funds be granted to all needy citizens on the basis of need as related to per capita income.

The local funds spent for our Title XIX program in 1966 amounted to $40 millions and the Federal share was $18 millions. For 1967 the Federal share is expected to be $22 millions. Section 222, the Buy-In Amendment, would use $3 millions of the proposed fixed ceiling of $20 millions, leaving only $17 millions for Title XIX purposes. This would require a cut-back in the program for 1968 making impossible the implementation of the "free choice" amendment in the foreseeable future. It would make it impossible to correct the deficiencies reported as existing in our Title XIX plan by the HEW task force which reviewed it in January, 1967. The recommendations of the HEW task force were the following:

1. Your agency should develop cooperative arrangements as rapidly as possible with representatives of private groups to achieve maximum utilization of all health resources—both public and private.

2. The Department of Health should try to achieve legislative change so as to permit the treatment of private patients in public hospitals and private physicians should be encouraged to join the staffs of such institutions. This would result in greater professional exchange among the physicians, a better utilization of scarce specialties, and greater continuity of care for the patients. There should be some mechanism in the medical assistance program to get the services of private practitioners into the system where needed. In some communities, there may be specialists in private practice and no one with that particular specialty may be on the staff of the local public facility. It might be better to use a local specialist as a consultant rather than to transport the patient.

3. Effective July 1, 1967, the Title XIX programs will be required to furnish home visits by physicians. Specific plans for meeting this requirement should be developed immediately and serious consideration should be given to using private physicians on a fee-for-service basis.

4. At present a beneficiary under Part B of Title XVIII received his medical care from a government physician in a government facility in exactly the same way as if he were not enrolled under Title XVIII. Thus, he is receiving nothing in return for his $3.00 monthly premium and neither is the Commonwealth making use of an available resource. There should be some mechanism to salvage this loss. Your agency should seek the necessary legislation permitting you to charge for professional services produced through the public sector. This would permit Social Security to reimburse your agency for the cost of providing physician services to their beneficiaries. Free choice of physicians (and facilities) should be

offered to all aged persons (or to those aged persons voluntarily enrolled in SMI) with payment from Title XIX of the deductible and coinsurance liabilities incurred; or both.

5. Governmental hospitals should bill Social Security Administration (or the intermediary) for hospital care provided to patients eligible under Title XVIII. This is a resource which could be used to spread the use of Title XIX funds.

6. There is a depersonalization of health services, long waiting periods, and little continuity of care by the physician. These problems should be given recognition and positive steps taken to eliminate them. Much can be done to decrease the impersonalization and the overcrowding and to improve the efficiency of patient care. Appointments could be structured for patients to see the same physician on repeated visits and at staggered times. An attempt should be made to develop comprehensive family care programs rather than fragmentation of services.

7. The lack of adequate medical records in some of the local health centers is a major deterrent to providing good medical care. There needs to be a well established system of records that will identify the patient's care over a period of repeated visits.

8. There seem to be inadequate drugs for patient care; drugs are not available around the clock in most of the smaller communities. These weaknesses should be corrected and in addition, system should be introduced to derive drug utilization data, prescribing habits, etc. Some of the pharmacies need physical improvement and better qualified personnel.

9. Every effort should be made for health centers to have the health and welfare units not only operating at the same location but also completely integrated and coordinated in function.

10. It is all but impossible to maintain high quality and efficiency in very small hospital units. Studies should be made into the feasibility of using the facilities of nearby institutions. If good private hospitals are available, the possibility of contractual arrangements should be explored. In some instances the outpatient clinics operated in local health centers might better be located at nearby general hospitals if they are convenient to the patients.

11. There is a most urgent need to simplify the registration and certification process for patients attending the health facilities. Better forms design would help to correct this weakness. Also, the certification process is so poorly organized at present that recertification is done quite frequently on repeated visits due to inability to locate the patient's previous certification.

12. The agency should reorganize and staff the medical assistance unit with appropriate personnel, including professional medical care administrators, in order to plan more effectively, manage and evaluate the Title XIX program. Emphasis of the staff development program should be shifted from the training of clinicians to that of administrative personnel. Matching funds are now being used chiefly to train interns, nurses, and pharmacists. The agency should institute a plan for continuous evaluation of the utilization and quality of medical services provided recipients of Title XIX.

13. Family planning has not been made available universally and greater efforts should be made in this direction.

14. The Children's Bureau should be consulted concerning the problem of the high infant mortality rate in Puerto Rico with a view toward financing projects which might improve the situation.

15. The agency should include representatives of medical care consumers on the Advisory Committee.

16. Medical care is more adequate than subsistence grants and the provision of social services. There should be improvement in these areas to the same level as that provided for health services.

In respect to the medical assistance program, we again *respectfully request* that Puerto Rico be given the same treatment as the States in regards to the Federal matching and wish to make it clear that the imposition of the proposed ceiling would make all Title XIX legislation *meaningless* to Puerto Rico.

The Puerto Rico Medical Association expresses its deepest gratitudes for this opportunity to appear before the members of the Finance Committee to express its position and ideas in regards as to H.R. 12080.

We will continue to look for our goal: *Operation Equality* until every single citizen received the best quality of medical care through free choice of physician

and other health services regardless of his socio-economic status, race, religious or political beliefs.

Thank you.

LUIS A. IZQUIERDO-MORA, M.D.,
President.
J. A. ALVAREZ-DE CHOUDENS, M.D.,
President Elect.

Senator HARRIS. That concludes our hearings for today. The committee will stand in recess until 10 a.m. tomorrow.

(Thereupon, at 1:05 p.m., the committee was recessed, to reconvene at 10 a.m. on Tuesday, September 19, 1967.)

SOCIAL SECURITY AMENDMENTS OF 1967

TUESDAY, SEPTEMBER 19, 1967

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, Hartke, Metcalf, Harris, Carlson, and Bennett.

The CHAIRMAN. The hearing will come to order.

The committee has a long list of witnesses to hear today. The public witnesses are under a time limitation on their oral statements. We have allotted 15 minutes for the first two public witnesses and after that 10 minutes for each witness. Out of respect to those who appear later on the list and to the committee, I hope that those who are testifying today will carefully confine their statements to the time allotted.

Our first witness this morning is the Senator from New York. Senator Javits, we are glad to have you with us to hear your views on this important matter. Tell us what you have to say. We will recognize your statement.

STATEMENT OF HON. JACOB K. JAVITS, U.S. SENATOR FROM THE STATE OF NEW YORK

Senator JAVITS. Thank you very much, Mr. Chairman. I will do my utmost to watch the time, and I hope not to be more lengthy than the other witnesses.

Mr. Chairman, I welcome this opportunity to appear before you to testify on H.R. 12080, which comes to us from the House of Representatives. This bill is one of the most important to reach the Congress this year.

As the Chair knows, this bill deals with matters which are of grave concern in my State. Hence, I wished to testify in greater detail and depth before this committee rather than to await the debate on the floor.

To a large extent concerned congressional reaction can be traced to the staggering increase in cost of the four federally assisted welfare programs in recent years. The combined Federal-State-local price tag has risen from $4.2 billion in 1962 to $6.1 billion in fiscal year 1966. And though over 7 million people are now receiving public assistance, this reflects only one-third to one-half of those who are eligible for payments. The growth of the welfare rolls has been particularly dramatic in the big cities. In New York City, for example, the monthly

average of recipients has risen from 531,000 in 1965 to 670,000 at present, and it continues to rise at over 12,000 per month.

In view of such staggering costs—costs which are increasing despite the emergence of new antipoverty programs—I can understand that Congress might be impatient even in its compassion. Massive changes in the welfare system are urgently needed. But what strikes one immediately about H.R. 12080 is the philosophy upon which those changes have been based. In its effect, it becomes a punitive and coercive approach which seems founded upon the belief that welfare recipients are universally shiftless and satisfied with being dependent upon a dole. It proceeds from the assumption that the recipient's status is self-imposed and that it is up to the Government to condition its assistance in such a way as to transform the attitude and motivation of welfare recipients into something comparable with those of middle-class America. In my view, it represents a great leap backward in terms of social legislation and congressional understanding of the problem.

Since I know that this committee has already received a great volume of testimony which dissects and analyzes that bill, I will deal only briefly with the specific provisions of H.R. 12080. But three of the most troublesome points deserve mention.

First, I must strongly oppose the compulsory work and training aspects of the bill. We have the virtually unanimous testimony of the experts that such coercion has not worked in the past. We have our own commonsense to tell us that forced work cannot instill motivation, but instead is likely to increase hostility and resentment. People will learn and earn successfully only if they have some desire to do so, and where they do not have that desire the result will be sporadic attendance and poor performance. Moreover, this coercive work and training approach is based on a false assumption about the characteristics of those who are receiving welfare. In fact, only 1 percent of those on the welfare rolls are potentially employable men, although in some places that figure is slightly higher; for example, in New York City it is 4 percent.

It is true that the public assistance rolls also include many potentially employable mothers who are now engaged in taking care of their children. I am not one of those who thinks that these mothers must invariably be left at home with the family; rather, these mothers on welfare should be given the same opportunity enjoyed by middle- and upper-income mothers to accept employments. But the choice should be voluntary—it should be theirs to make and should not be vested in some supposedly omniscient state or local bureaucracy. I have introduced legislation which seeks to give these welfare mothers such a free choice by providing Federal assistance for day-care facilities, and I hope that the committee will take the structure and philosophy of my bill (S. 1948) into consideration in designing any day-care program under this act.

I fear that the compulsory work and training provisions also dangerously misread the climate in the ghettos and the depressed rural areas of this country. We are in the midst of a "revolution" in which the poor of the Nation, so long denied equal opportunity, are awakening to their rights and powers and are gaining in new self-

confidence of self-assertion. The philosophy of the House bill runs exactly counter to that development and can only serve to exacerbate tensions and to further convince slumdwellers that the "power structure" will never respond to their legitimate needs.

And certainly this bill does not recognize the simple fact that many of the poor do wish to work and need no external coercion: a Department of Labor survey taken in the slums of New York shows that over 75 percent of the unemployed would be willing to take training to get a job, that over 55 percent would return to school if necessary, and that 25 percent would be willing to move to another area to get work. Rather than compelling welfare recipients to enter work or training, the better course would seem to be to greatly expand the opportunities for work and training and the knowledge about such opportunities. We can hardly be justified in moving toward a compulsory system when we have not given voluntarism a chance.

In this connection I would like to commend to the attention of the members of the committee the Emergency Employment Act of 1967, which has been approved by the Committee on Labor and Public Welfare and which will be called up on the Senate floor within a very few days. This bill would make some 200,000 job opportunities available for the poor. Job creation activities such as these must be at the heart of any effort to cut down on the size of the welfare rolls.

Second, I would urge the members of the committee to vest the authority for the establishment and operation of any community work and training program which is enacted in the Department of Labor. Surely it makes no sense to create a separate set of work and training programs for some of the poor under the aegis of the Department of Health, Education, and Welfare, when the Department of Labor has mounted a great variety of manpower training efforts for persons of exactly the same characteristics. The Committee on Labor and Public Welfare, of which I am the ranking minority member, has received persuasive testimony on the need to consolidate the many Federal manpower programs under the direction of the Secretary of Labor. I would like to submit for the record a report by Sar A. Levitan and Garth L. Mangum, the George Washington University, entitled "Making Sense of Federal Manpower Policy," a joint publication of the Institute of Labor and Industrial Relations, of the University of Michigan, and Wayne State University, and the National Manpower Policy Task Force, Washington, D.C., March 1967, which persuasively makes this case. Moreover, not only does the logic of coordination demand this consolidation of manpower programs, but there is every reason to believe that State and local departments of welfare often lack the capacity and expertise to conduct successful training programs.

(The report referred to above was made a part of the official files of the committee.)

Senator JAVITS Another report prepared by Sar A. Levitan (the George Washington University), an independent consultant to the Subcommittee on Employment, Manpower, and Poverty on the operation by the Welfare Administration of the work experience and training program under title V of the Economic Opportunity Act makes that lack of expertise clear, and I would like to submit that report

for the hearing record. I would urge the members of this committee to give this matter of administrative coordination and consolidation its urgent attention, taking into consideration the reports and conclusions which have come to us on the Labor and Public Welfare Committee, which has the primary jurisdiction in these matters.

(The report referred to above may be found in the staff and consultant report on Examination of the War on Poverty (vol. I) made for the Subcommittee on Employment, Manpower, and Poverty of the Senate Committee on Labor and Public Welfare, and was made a part of the official files of the committee.)

Senator JAVITS. Third, I would urge——

The CHAIRMAN. Senator Javits, if I might just suggest this—we ought to have a middle ground between those on public welfare and those who are totally self-supporting. We might do well to see if we cannot establish a wider middle ground where we simply pay whatever the welfare payments would be to someone who would give the person a job. That could be the city, the State government, or a private employer. It would be better if you are going to have to pay $75 to support someone anyway, to simply pay it to someone who will give him a job, at perhaps $150, so that the person makes more and at the same time the employers would get some benefit, too. We will try to explore some of those ideas.

Senator JAVITS. Mr. Chairman, may I say the Chair and I are thinking along exactly the same line and again, I would like to call two matters to the attention of the committee. One is this Emergency Employment Act which I mentioned a minute ago, which is now in the antipoverty bill before the Senate, and which due to my own intermediation, now carries precisely that concept. That is, contracting with private profitmaking enterprises to employ these people on public service jobs.

Also in the antipoverty program itself, there is a new provision for paying the difference between economic earnings and actual earnings and reimbursing employers for the added costs of hiring these people which carries out the concept the chairman has just referred to. This could also cover the payment of transportation costs so the person could be brought out of the ghetto to work in a plant which may be rather remote from the ghetto area, something which we ran into, for example, in the Watts situation in California. So I would hope very much, Mr. Chairman, that the staff and members will study very carefully what we have done. There is very great room for creativity in a coordination of the program which is before this committee and in the antipoverty program which is before us, and I think, too, Mr. Chairman, that if the Chair should feel that there is something that we need to do, even thought we have already reported the bill out, I know it would have, I would certainly see that it did have, and I know Senator Hill would, the most prayerful consideration of our committee and I am sure Senator Clark, chairman of the subcommittee, would feel the same way.

I just wanted to leave that thought with you, Mr. Chairman.

Third, I would urge the committee to reject the freeze on Federal AFDC payments which is contained in the House bill. As has been pointed out to you, the effect of such a freeze will either be a passing

on to the States and localities of all the costs of additional enrollments, or a lessening of the amount of assistance available to each child in the family. This provision constitutes an outrageous discrimination against States and cities, such as my own, which, by virtue of their relatively high employment opportunities and welfare benefits, are attracting large numbers of migrants. H.R. 12080 would penalize such States and cities by throwing the entire burden of additional welfare costs caused by migration upon their already overburdened fiscal shoulders. This action, in assigning the responsibility for dealing with a national problem to a small number of State and local governments, should be decisively rejected by this committee.

NEW PROPOSALS

But instead of simply reviewing the pernicious provisions of H.R. 12080, I can spend our time together this morning more profitably by offering for the committee's consideration several proposals which appear in neither the House bill nor the administration bill. I will be offering these proposals as amendments in the days ahead, and I hope that at least some will commend themselves to the committee for inclusion in a progressive reform of the public assistance law.

First, we must move to eliminate the so-called man-in-the-house rule. In 1962 the Congress gave the States the option of ignoring the presence of a man in the house in determining eligibility under the AFDC program, but 28 States and the District of Columbia have still not taken advantage of this option. In those jurisdictions, the father who cannot support his family is given a choice between leaving his wife and children or seeing the family go hungry—it's as simple as that. The disruptive effect on family stability of this characteristic of the law has been pointed out by every possible variety of expert, and still the Congress has not moved to correct the situation.

A mandatory extension to all States of the 1962 program—the so-called AFDC-UP program—would cost the Federal Government only about $60 million per year and would be well worth it.

Second, the law should be amended to allow for a simple affidavit or declaration of income by the recipient to replace the elaborate system of forms and investigations now used to determine eligibility. A random sample of the affidavits could be investigated, as in the Internal Revenue System's handling of income tax returns, to provide a check. Such a System is now being tried on an experimental basis in New York City and the first results indicate that there has been no significant falsification by recipients. Through such a simple administrative change, millions of dollars could be saved in reduced paperwork, and hard-pressed caseworkers would be enabled to apply their professional talents to people instead of to forms and figures.

Third, we should increase the participation of welfare recipients themselves in the conduct of the public assistance program by requiring that State and local departments of welfare create advisory councils of welfare recipients. Opening up channels of communication between program administrators and program clients should go a long way toward alleviating some of the onerous defects in the mechanics of the program.

Fourth, I support the position of the National Association of Social Workers that the earnings exemption for AFDC families be raised to $85 a month, plus one-half of the remainder.

Fifth, in order to provide a constructive incentive to men and women to undertake or remain in employment rather than to take up life on welfare, the Federal Government should provide assistance to help make up the difference between a person's earnings and what he would receive on welfare if that amount is higher. Such a program is now in effect in New York State and in a few other jurisdictions, but its costs are entirely borne by State and local contributions. Such a supplemental assistance program should be federally supported and extended on a nationwide basis, and should be coupled with enactment of the provision in the administration's bill which requires the States to pay benefits at least equal to their own determinations of minimum need.

Sixth, we should inaugurate a pilot project to begin to collect hard evidence on the desirability of moving toward some kind of automatic, guaranteed income program as a partial replacement for our present panoply of welfare and rehabilitation aids. In my view, the most attractive of the suggested guaranteed income models is the children's allowance, now being used in over 40 countries. Under such a scheme, the provision of services is fully separated from income payments—a cherished goal of social welfare professionals—and the stigma of welfare is substantially if not completely eliminated because payments are automatic and because others than those in the low-income category receive the allowances. I will propose that $10 million be allocated for a comprehensive pilot project to test the efficacy of the children's allowance scheme, experimenting with different approaches by varying the size of the payments, the eligibility levels in terms of number of children and family income, and the impact on motivation—including the willingness of the parents to undertake needed education, training, or employment.

This seven-point package contains hard proposals which I hope can be acted upon this year. I believe that they, more than the provisions of H.R. 12080, will assist in the reduction of the welfare rolls. In any case, Congress must not let its impatience with the cost of the public assistance effort prompt it into harsh and irrational reaction. The need for reforms of the welfare system has been with us for a long time; as Demosthenes put it over 2,000 years ago, "Like the diet prescribed by doctors, which neither restores the strength of the patient nor allows him to succumb, so these doles that you are now distributing neither suffice to insure your safety nor allow you to renounce them and try something else." Let us then react with intelligence and wisdom to the need for reform, and in a manner which will bring credit to this Congress.

The Congress and the people have already made clear that the riots will not be tolerated, but resentment leading to punitive action, against whole communities where the great majority did not riot, will not be tolerated either. We must stick to the merits and redress basic grievances in the slums and that is the true heart of government.

SOCIAL SECURITY

For many elderly and disabled people, social security benefits are the sole means of support. Thus, social security is a prime—perhaps the major—weapon in our "war against poverty." It is, of course, essential that we regularly raise benefits to the extent necessary to keep pace with increases in the cost of living.

However, I believe that this bill offers us a unique opportunity to go beyond merely "keeping pace." I believe that it is time we begin moving toward the full promise made to the American people when the social security law was first enacted: that is, that every American could live out his life in dignity and economic security rather than hopelessness and poverty. We should now move toward a social security system in which every older person is provided with a basic level of benefits which will lift them above the poverty level. I look forward to the day when public assistance for older and disabled persons will not be necessary, when every person in these categories will automatically receive an adequate level of minimum social security benefits and will not have to endure the humiliating—and economically wasteful—process of establishing "financial need" in order to qualify for public assistance.

If this is our goal then we must recognize that the social security bill approved by the House does not do what it should, even now. The "across-the-board" increase in benefits should be greater than the 12½ percent which is provided. Perhaps of even greater importance, the benefits at the lower end of the scale—the minimum benefits provisions—should be substantially increased. The $70 minimum benefit called for in the original bill, H.R. 5710, would seem the least we could do. Certainly, the $50-a-month minimum now in the present bill is not adequate.

Within the present system, it would appear that the most equitable manner of financing these needed increases would be to increase the maximum earnings base subject to contributions and creditable benefits. This would recognize the substantial increase in average total earnings over the past several years—as well as the likelihood of further increases.

The House bill does provide for an increase in the contribution and benefit base from $6,600 a year to $7,600. I believe the increase in the base can and should be greater.

The original goal of the social security program was that the contribution and benefit base was to be roughly equivalent to the full earnings of the individuals covered. We have drifted far from that. Information from the Social Security Administration indicates that the present base of $6,600 is equal to the total earnings of something less than 50 percent of the people covered. The $7,600 base provided for in H.R. 12080 would cover the full earnings of no more than 64 percent of the participants in the social security system. It is estimated that a base of $15,000 in 1968 would be necessary to cover the full earnings of most (95 percent) social security participants. Between the $7,600 base provided for in the bill before you and $15,000, there is ample room for increase if we are to approach the original intent of the con-

tribution and benefit base—and if we are to acquire the means to finance the necessary increases in benefits.

I would urge that this committee consider two other changes in this portion of the bill:

First, we should provide for automatic cost-of-living increases in social security benefits. This is really the only effective way that people living on social security benefits can adjust to losses in purchasing power due to rising prices.

Second, the earnings limitation should be, at minimum, increased to an extent greater than provided in the bill now before this committee. H.R. 12080 increases the amount a person may earn and still get all his benefits from $1,500 to $1,680 a year. The amount to which the $1 for $2 reduction would apply would range from $1,680 to $2,880 a year, rather than from $1,500 to $2,700 as current law provides. I doubt the propriety of any ceiling on the earnings of people over 65. They should be allowed full freedom to help themselves.

To make these changes in OASDI will not destroy the essential wage-related, contributory nature of the social security system. Indeed, it will strengthen the concept, while recognizing, at the same time, that social security's goals and effects are greater than this. Social security has—and must—respond to social needs. There is basis—for example, in the coverage of disabled persons—for giving adequate benefits to the lowest income participants in the social security system and to those who were never able to contribute in full.

I believe that these minimum changes must be made in the social security system if we are to keep fully the promises we first made 30 years ago.

MEDICARE

The medicare program is a relatively new program—and I am proud of the role I played in the long battle to establish it. Unquestionably, as with any program so large and so revolutionary, 2 years is not sufficient time to judge its effectiveness or full impact.

I would, however, suggest two changes in the program at this time:

First, the disabled should be extended coverage under the health insurance program in this bill. I am not convinced of the necessity of further study of the feasibility of including the disabled. The factors which motivated the creation of the medicare program in the first place apply with equally compelling force—if not greater—to the situation of disabled persons.

Second, in 1965 I urged this committee to include out-of-hospital drug costs under the supplementary medical insurance program. As has been pointed out frequently, the cost of prescription drugs is a significant one for older Americans. This cost can be a fearful—and continuing—drain on the fixed income of retired persons.

I would like to add that I am a member of the subcommittee, headed by Senator Nelson of Wisconsin, which is considering drug costs. I believe that we would be very measurably assisted in attempting to bring down some of the excessive cost of out-of-hospital prescription drugs if such cost were included in medicare. The resulting public interest and large-scale public participation would be the most effec-

tive tools in reducing the cost of the medicines about which so many complain.

MEDICAID

The provision in H.R. 12080 which would limit participation of the Federal Government in States' medical assistance programs is grossly unfair and would defeat the very purposes for which this program was enacted.

Under the bill, States would be limited in setting income levels for eligibility to medicaid, for which Federal matching funds would be available. The applicable income limitation is the amount equivalent to 133⅓ percent of the highest amount ordinarily paid to a family of the same size under the AFDC program. Such limitation deprives the States of their initiative in determining the applicable income level. States should be permitted to set their own limits.

Under the applicable provision of this bill, some 14 States would have to cut back the medical assistance programs they established under title XIX. In particular, I think it fair to say that this limitation would have a particularly adverse effect on my own State of New York, which is now to be punished for the breadth and comprehensiveness of its program.

I strongly urge this committee to alter substantially this provision limiting Federal participation in State medicaid programs. It is a regressive step—a step which, I do not believe, should be accepted by this committee.

New York is one of the States which already has established a medicaid program. Accordingly, under this bill, the limitation would be 150 percent of the amount ordinarily paid to a comparably sized family under AFDC in 1968—dropping to 133⅓ percent by 1970. While it is difficult to determine exactly the full effect of this limitation upon New York State, it is estimated that 10 percent of those now participating in the program would be ineligible next year.

The reasoning which applied to the original program is just as persuasive now as it was then: to protect a large proportion of the population from financial ruin and poverty by guaranteeing medical care. I argued in 1965 that the States be given maximum flexibility to experiment with different eligibility formulas. I still believe that to be necessary, and I do not believe it is necessary that the States be inhibited from experimenting with different income levels in order to limit Federal participation.

One must realistically accept the likelihood of some ceiling on Federal participation. It would appear to me that the Congress of the United States owes a special obligation to New York and other States, which, in good faith, have enacted broad medicaid programs in complying with the original Federal legislation. These States encouraged, enrolled, and offered medical care to their citizens. Now they must ask a large proportion of them to give up the protection just recently extended to them.

As a minimum, I would urge this committee to amend the limitation on Federal participation in State medical assistance programs so that the ceiling shall be 150 percent of the eligibility level for cash

assistance. Such a ceiling would at least recognize the promise made in the original bill and would avoid the danger of a definition of medical indigency too low and overly strict.

In addition, in the last Congress, I offered three amendments to title 19 designed specifically to reduce the cost of the New York program by removing certain Federal requirements which were not only costly but, in my judgment, unnecessary. I am pleased that the bill, as passed by the House, reflects at least one of these suggestions, by removing the requirement that all medicaid recipients receive identical benefits. It is my understanding that section 223 makes it possible to provide certain benefits to the elderly indigent without making them available to all age groups.

My remaining suggestions are still valid, and would allow States like New York—with broad eligibility—to reduce the cost of providing essential services. First, we should allow for some flexibility in establishing income eligibility standards. The Federal law now requires that these standards be the same throughout the State. This does not take into account differing average income and health costs in geographic regions of the same State, and I believe the State should be allowed to make such distinctions where necessary and practical.

Second, the Federal law now provides that a deductible feature in any State plan would be acceptable so far as medical bills are concerned., but it could not be required with regard to hospital bills. My proposal would have eliminated this prohibition with reference to hospital bills and would have allowed New York State to revise its plan, for example, to provide that 20 percent of income over the present eligibility levels ($5,300 for hospital bills and $4,700 for medical and hospital bills) be used for health expenses before the State would provide supplements.

And finally, I hope you will allow a State to determine levels of care in different parts of the State. In some parts of our State it is impossible to provide the care one could get, for example, at the Harkness Medical Center in New York City or some similar medical facility of extraordinary competence in our State.

I hope that the committee will reexamine the basic philosophy implicit in the medicaid program. And I hope you will draw upon the experience of New York State. In New York, we now have about 1,600,000 people on medicaid. Let the Congress take no action which would inhibit a State from doing what it wants to do, in a creative way, with its own citizens. Such a step would be unnecessary and inimical to the federal system.

The States should have flexibility, so that they can develop and operate medical assistance programs relevant to the unique needs of their own citizens.

Thank you.

Senator GORE (now presiding). Senator Harris?

Senator HARRIS. What would happen in your own State if we set that limit on AFDC with the population increase and with the migration that continues in this country?

Senator JAVITS. You would just take a city like New York City whose back is being broken and will be even more broken by the settlement of the teacher's strike—it has got to take more money—and

break its back more, just make it that much toughter. It has got to come out of something. It will come out of welfare, if it comes out as this is, comes out of welfare because the heart must be answered first. It is going to come out of education or it is going to come out of law enforcement. Something has got to give.

Senator HARRIS. In other words, you would not be able to just cut it off.

Senator JAVITS. We cannot. This is not a—the essence, the justice of it is that it is not a New York City problem. We are not advertising in areas of the country and saying come to New York. We are trying to get tourists to spend money there. We are certainly not trying to get migrants who are going to go on welfare, but they come. What do you want us to do, erect a fence and keep them out? This would cease to be America. It is a national problem. It will straighten itself out. In a decade these people will be good earners and good taxpayers and good citizens of New York, but in the meantime, it is very rough.

Senator HARRIS. That is all I have, Mr. Chairman.

Senator GORE. Mr. Bennett?

Senator BENNETT. No.

Senator GORE. Thank you, Senator, for a very helpful, constructive statement.

Senator JAVITS. Thank you.

Senator GORE. Thank you, Senator Javits.

The committee will next hear the Honorable Hugh Scott, U.S. Senator from Pennsylvania.

STATEMENT OF HON. HUGH SCOTT, U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Senator SCOTT. Mr. Chairman, members of the committee, I want to thank you very much for hearing me and I appreciate the opportunity to appear in support of S. 1954, my bill to provide for the expedited payment of social security monthly insurance benefits in cases of prolonged delay. I am hopeful that your committee will agree to incorporate this proposal by amendment into H.R. 12080, the 1967 Social Security Amendments bill now before you. My bill is cosponsored and supported by two distinguished members of your committee—by Senator Bennett of Utah, who is here, and by Senator Dirksen—as well as by Senators Brooke, Cooper, Cotton, Fong, Griffin, Hansen, Hruska, Jordan of Idaho, Miller, Pearson, Percy, Thurmond, and Tower.

We are concerned by the many reports reaching us of unnecessary delays in the payment of social security benefits; of older persons, often with no other source of income, who have been forced, for reasons of clerical error or other administrative mistake, to wait for periods of as long as 6 months to 1 year for social security payments to which they are rightfully entitled. All too often elderly citizens—those who have the greatest need—are forced to turn to congressional offices for a voice in what would otherwise be a losing battle with an impersonal Federal Government.

You may remember, Mr. Chairman, that I first called attention to this situation in a Senate speech last May. Among other things, I sug-

gested that the Social Security Administration establish some procedure at the local level for the immediate payment, or resumption, of all reasonable claims. The response I received to this speech—not only from constituents, but from virtually every State in the Union—convinced me that I was on the right track.

My bill seeks to implement my suggestion by law. It would direct the secretary and managing trustee of social security to establish procedures under which the person in charge in each local social security office—normally, the supervisor—would be authorized to approve the immediate, temporary payment of social security monthly insurance benefits to claimants establishing eligibility on the basis of information supplied through a special form that would be provided for this purpose. No regional or other authorization for payment would be required.

Claims for the immediate payment of temporary benefits could be filed in the local office if interrupted, and established benefits were more than 30 days late. New claimants, failing to receive their checks within 90 days, also could apply. For persons who have previously received benefits, the amount of payment would be equal to the last monthly benefit received. For new applicants, the existing provisions of section 228 or 215(a) of the Social Security Act, with regard to minimum benefits, would apply.

I think it is important to note that the standard utilized by S. 1954 is that of "compelling evidence to the contrary." In other words, supervisors would be authorized, by law, to make decisions in which the burden of proof would rest essentially with the claimant "in the absence of compelling evidence to the contrary." In essence, my bill would establish a standard which is lower than that currently available to any social security supervisor as a matter of administrative decision. It would establish an alternative which, I am informed, can be opened only by legislative direction.

It would not do so, however, without adequate safeguards. In no event would the payment of temporary benefits under my bill be authorized for a period exceeding 2 months—during which the delayed processing of the regular claim could be resolved. This 2-month provision will be found in my bill on page 3, subsection 3, lines 6–11. Furthermore, the bill specifies that temporary payments will be made "under the same conditions" as regular monthly payments so that existing provisions of the Social Security Act related to overpayments and fraudulent claims clearly will be applicable in all cases.

I would add here that it is definitely my intention that any liability for fraudulent claims shall rest with the claimant, and not with the supervisor acting in good faith under the direction of law.

S. 1954 was introduced for the first time on June 15 of this year. Subsequently, Members of Congress were informed of automation, hours worked overtime, the creation of special expediter groups in payment centers, and other steps being taken by the Social Security Administration to speed up the processing of delayed claims. We were also informed that district offices had now been given temporary authority for the final approval of certain classes of claims, skipping a stage of the process within the payment center—a step not unlike that which my bill advocates.

Nevertheless, I was interested to note that during an earlier part of your current hearings, on August 23 last, this very question of delays was raised with Commissioner Ball, whose response indicated that problems still exist. I am personally convinced that this is so. In just this last week alone, two cases have come to my personal attention; one involving a Pennsylvanian who has waited for more than 8 weeks for some response to his initial application for benefits, and the other involving a constituent who applied last November, and still has received no word.

Please let me emphasize, Mr. Chairman, that I have no quarrel with the steps that social security has taken to date. To the contrary, I believe these efforts to recognize and to meet a problem are commendable. My bill does not say to social security that all work done to date must be discarded for new and costly programs. Improvement is what we seek. In fact, it is my hope that the processing of claims, through regular channels within the time limits allowed, will be encouraged, and that no payments will ever have to be made through the special procedures of S. 1954. But what my bill does say is that if all else fails, then you have something to fall back on. In this sense, it is a kind of a "fail safe" approach.

I understand that your committee has received no official agency report on S. 1954 from the Social Security Administration. Apparently, here, too, there has been a delay in reacting to the speedup bill. I want to point out, however, that I am not wedded to every word and every comma of this legislation, as drafted. It may be, for example, that the provisions for the 30- and 90-day time limits should be rewritten so as to make clear that they would not preclude an earlier payment, if circumstances warrant it, and to avoid bureaucratic overinterpretation. It may also be that a period of 90 days is not sufficient where initial claims for disability are involved, requiring a greater degree of expert determination. These are matters which I would leave to your committee to decide, drawing on your greater fund of expertise.

I believe it is essential, however, that Congress itself not delay by failing to act now, by law, to meet this problem. Therefore, I urge that your committee give every possible consideration to the adoption of my bill as an amendment to the legislation now before you.

Thank you.

My purpose, I may add, is to see that the dealings of a government with its citizens be conducted with a maximum of cooperation and with a minimum of frustration.

Senator GORE. Thank you, Senator Scott.

Senator Anderson?

Senator ANDERSON. No.

Senator GORE. Senator Carlson?

Senator CARLSON. On this, your bill S. 1954, as introduced should be made a part of the record at this point, if you have no objection.

Senator SCOTT. I will be very appreciative if the bill can be introduced at this time and I so request.

(The bill, S. 1954, follows:)

90TH CONGRESS
1ST SESSION

S. 1954

IN THE SENATE OF THE UNITED STATES

JUNE 15 (legislative day, JUNE 12), 1967

Mr. SCOTT (for himself, Mr. BENNETT, Mr. BROOKE, Mr. COTTON, Mr. DIRKSEN, Mr. FONG, Mr. GRIFFIN, Mr. HRUSKA, Mr. JORDAN of Idaho, Mr. MILLER, Mr. PEARSON, Mr. PERCY, Mr. THURMOND, and Mr. TOWER) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend title II of the Social Security Act to provide for the establishment of special procedures designed to avoid undue delay in the payment of monthly insurance benefits to which individuals are entitled thereunder.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 205 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"Special Procedures to Avoid Undue Delay in Payment of Monthly Benefits

"(q) (1) The Secretary and the Managing Trustee shall establish and put into effect, not later than 60 days after the

date of enactment of this subsection, procedures under which expedited payment of monthly insurance benefits under this title will be made to any individual who files an application for such expedited payment at the local social security office serving the area in which such individual resides, and who is found, by the person in charge of such office, to be eligible for such expedited payment.

"(2) An application for expedited payment of monthly insurance benefits under this subsection shall be accepted only—

"(A) if, in the case of an application filed by an individual who has previously received a monthly payment of the particular insurance benefit for which expedited payment is requested, a period of at least 30 days has elapsed between the date the last monthly payment of such benefit was received and the date such application is filed, and

"(B) if, in the case of an application filed by an individual who has not previously received a monthly payment of the particular insurance benefit for which expedited payment is requested, a period of at least 90 days has elapsed between the date such individual completed application for such benefit and the date such application is filed.

For purposes of clause (B) of the preceding sentence, a

person shall be deemed to have completed application for a monthly insurance benefit on the date of filing of the basic application for such benefit and any and all other information and data which have been requested by the Secretary in connection with such application.

"(3) An expedited payment to an individual shall be made, on the basis of any particular application for such payment, with respect to the month in which application therefor is filed and with respect to the succeeding month, but in no event for any month with respect to which the regular payment of such benefit has been made.

"(4) An application for expedited payment under this subsection of a monthly insurance benefit shall be designed by the Secretary so as to reveal (to the maximum extent practicable) all pertinent information necessary to enable the person in charge of the local social security office receiving such application to determine whether the individual submitting such application is entitled to receive the monthly insurance benefit with respect to which expedited payment is requested and whether, if such individual is entitled to such benefit, such benefit is subject to suspension, deductions, or reductions under this title and the amount of any deductions or reductions to which such benefit is so subject.

"(5) The procedures devised by the Secretary and the

Managing Trustee for expedited payment under this subsection shall be designed to insure that—

"(A) any application under this subsection for expedited payment of a monthly insurance benefit will be acted upon within 5 days after such application is filed in the local office serving the area in which the applicant resides, and

"(B) any individual who is eligible for expedited payment of a monthly insurance benefit will be paid such benefit not later than 10 days after he files application therefor.

"(6) In determining the amount of any monthly benefit for which expedited payment is requested under this subsection, such expedited payment shall—

"(A) in case the applicant has, for any month in the 6-month period immediately preceding the month in which application is filed, received regular payment of such benefit, be equal to the amount of the last regular payment of such benefit, or

"(B) in case the applicant has not, within such 6-month period received regular payment of the monthly benefit for which expedited payment is requested, be in an amount equal to the amount provided under section 228, or if such section is not applicable, equal to the amount to which the applicant would have been

entitled if the primary insurance amount of the insured individual on the basis of whose wages and self-employment income claim for benefits is based were equal to the first figure appearing in column IV of the table set forth in section 215(a).

"(7) In the absence of compelling evidence to the contrary, the person determining the eligibility of an individual for expedited payment of a monthly insurance benefit under this subsection shall regard as true and accurate the data and information supplied by the applicant for such benefit.

"(8) For purposes of this subsection, benefits payable under section 228 shall be treated as monthly insurance benefits payable under this title.

"(9) Expedited payment of monthly insurance benefits under this subsection shall, except as is otherwise provided in this subsection, be made under the same conditions and from the same Trust Fund as are regular payments of such monthly insurance benefit."

Senator GORE. Senator Metcalf?
Senator METCALF. No questions.
Senator GORE. Senator Bennett?
Senator BENNETT. Mr. Chairman, as the author of the bill has indicated, I am one of the cosponsors of this proposal. I did it because I, too, have been requested to handle many of these problems on a personal private basis. When you get down to the social security offices, they move quickly to try and handle it, but I do not think people who are suffering from these breakdowns in the system should be subordinated to those who have the knowhow or the willingness to come to Congress to get their problem settled. Every man or woman who face these problems should have it handled promptly. The social security system has seen its burden greatly increased because of the problems of fitting into the new medicare and medicaid programs, and this has helped create the situation in which delays have occurred. I can see no possible objection to this program which just simply says you can handle a problem at the local level instead of having further delays created which are involved when you have to go through all kinds of channels, and the present situation which rewards only those who know how to get their congressional representatives to ask for help.

I would think this is an amendment that would be more or less automatically approved by the committee when we come to write up the bill. And I am glad Senator Scott brought it to our attention.
Senator SCOTT. I am most appreciative.
Senator GORE. Senator Harris?
Senator HARRIS. No questions, Mr. Chairman.
Senator GORE. Thank you, Senator Scott. Your statement has been very helpful.

The committee will next hear Mr. George Meany, president of the AFL-CIO.

STATEMENT OF GEORGE MEANY, PRESIDENT OF THE AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS; ACCOMPANIED BY ANDREW BIEMILLER, DIRECTOR, DEPARTMENT OF LEGISLATION, AFL-CIO; AND BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AFL-CIO

Senator GORE. You may proceed, Mr. Meany.
Off the record.
(Discussion off the record.)
Senator GORE. The entire statement will be included in the record.

Mr. MEANY. Mr. Chairman, I greatly appreciate this opportunity to present the views of the AFL-CIO on H.R. 12080, the amendments to the Social Security Act passed by the House of Representatives, which your committee is now considering. I will briefly summarize our position on the major features of the bill. You will find our detailed comments in my longer statement which I respectfully request be included in the record of these hearings. I have also attached the statement on the social security bill the executive council of the AFL-CIO unanimously adopted just last week.

The AFL-CIO has been frankly disappointed in the social security bill passed by the House. We welcomed the proposals the President announced earlier this year as a sincere, if somewhat modest, effort to improve the Nation's social security and public welfare programs. In my statement to the House Ways and Means Committee I said that we regarded the President's proposals as a significant downpayment toward the kind of social security system this country can and should have.

We were shocked, therefore, when the House sharply reduced the overall benefit increase the President recommended, especially for some of the most poverty-stricken social security beneficiaries who are receiving the lowest benefits. We also regard as indefensible such other features of the House bill as its failure to include the disabled under medicare, its drastic cutback in coverage and services under medicaid—a program which I remind you is just now getting underway—and its harsh and punitive restrictions aimed at destitute mothers and children receiving public assistance.

Let me turn first to needed improvements in social security benefit levels. I am sure that the members of the committee are well aware of how inadequate and out-of-date social security payments are today. Social security benefits have lagged far behind the rise in living costs, to say nothing of the better living standards most Americans enjoy. Since 1940 social security beneficiaries have been fighting a losing battle with the cost of living. Although social security benefits have been increased five times during that period, those increases have failed to keep pace with the rise in living costs.

If you look at the more recent situation, we had social security benefit increases in 1959 and 1965. Neither matched the increase in living costs since the previous benefit increase.

Let me cite an example of what I have in mind. The average monthly benefit today for a worker who retired in 1954 is $76, but it would have to be $82 to purchase the same goods and services that worker could buy with the $76 benefit he got when he retired 13 years ago. And to keep pace with wages of employed workers, he would have to get $104, 37 percent more than his actual benefit of today.

The fact is that the average individual or couple on social security can barely eke out a subpoverty level of living. The poverty standard is $1,470 for a single aged individual and $1,850 for an elderly couple. Frankly, Mr. Chairman, I would call it a standard far below the poverty level. But the average social security beneficiary is below even that subsistence level. On an annual basis, a single aged person now averages only $1,008 and a couple $1,716.

Yet, when we talk about social security we are talking about what is still the main retirement income protection for most elderly Americans. Less than 15 percent of those 65 and over receive private pension payments; even 15 years from now social security will be the only pension system for 70 percent of the people.

Clearly, therefore, the 12½ percent across-the-board increase in the House bill is inadequate. It will leave far too many social security beneficiaries, and not just those receiving minimum benefits either, in the mire of poverty at incomes far below their own earnings when they were working or those of most Americans still on the job.

We urge your committee to raise benefits generally by at least the 15 percent the President recommended. Indeed, even an increase of 20 percent would be fully justified, since it still would not permit most social security beneficiaries to escape from their dreary lives of want and deprivation. In fact, a fully adequate level of payments would require a boost of at least 50 percent. We would regard the increase of 20 percent or more we hope this committee will recommend as a down-payment toward that goal.

The House was even less generous in its increase for those at the very bottom than for average beneficiaries. The President recommended an increase in the minimum benefit from today's pitiful $44 to $70 (from $66 to $105 for a couple). Instead, the House raised the minimum to only $50, in percentage terms just a shade over the 12½ percent increase for all other beneficiaries. The House completely ignored the President's proposal for a $100 minimum benefit for long-service workers with 25 or more years of coverage.

Mr. Chairman, in a social insurance system, and I stress that word "social," it is entirely right and proper that those most in need of improvement in benefit payments should obtain the largest proportionate increase. If a social security system does not help those at the bottom the most, it is not advancing what should be one of its major goals. There, we ask the committee to recommend enactment of at least the $70 minimum the President proposed, indeed a substantially higher amount if possible, as well as the special minimum benefit for long-service workers.

We have other recommendations you will find in my detailed statement, but I should like to briefly mention only one. The House decided to cover disabled widows, a particularly deserving group largely without any source of income. However, they would be eligible only at age 50 and on a sliding scale of benefits beginning at only 50 percent of the regular amount. We urge full coverage for this group and at unreduced widows' benefits. Moreover, we understand the cost of our recommendation would be minimal, amounting to only 0.06 percent of payroll

Now, a word on how the benefit improvements should be financed. As we see it, the reason the House cut back so severely on the benefit improvements the President recommended, was that it failed to recognize the necessity for the earnings base to keep pace with the level of workers' incomes. This, we simply do not understand.

When the social security system got underway in 1936, the full incomes of about 95 percent of all workers were subject to the social security tax. At $7,600, the earnings base in the House bill, only two-thirds would be covered to this extent, declining to about one-half by 1974, approximately the proportion today.

We think this is wrong. It is wrong because it puts a disproportionate burden on low-wage workers. It is wrong because as the House bill so clearly demonstrates, it fails to provide the funds required for needed benefit improvements. And it is wrong because it puts an unduly low ceiling on the benefits paid to moderate- or high-wage workers, thus forcing them to suffer drastic reductions in their living standards when they retire.

The President proposed raising the earnings base from the present $6,600 in three steps to $10,800 by 1974. We think it could go even

higher to $15,000 which would cover about the same proportion of taxable payroll as did the $3,000 base in 1936.

We have no particular quarrel with the moderate rise in the contributions rate called for, with minor differences, in both the President's proposals and the House bill. We do wish to point out, however, that these increases in the rates are probably the maximum workers should be expected to pay. Therefore, you can expect us to urge the next time we come before you gradual introduction of a contribution from general revenues to the social security trust fund. Indeed, you may want to consider a beginning step in that direction even now to finance this year's social security improvements.

Now, as to medicare. We disgree 100 percent with the decision of the House not to include the disabled under medicare. Instead, the House has proposed that an advisory council be set up to study the question and make recommendations.

Well, Mr. Chairman, there was an advisory council, the Advisory Council ond Social Security, which did study this question as recently as 1964 and recommended that the disabled be covered. It made this recommendation for the very good reason that the disabled are a high-cost, high-risk group, living on drastically reduced incomes who are faced with far greater than average medical and hospital expenditures.

The House report on the bill argues that because the disabled are a high-cost group they should not be covered. I think that is putting things upside down. It is precisely because of the high costs the disabled have to bear to obtain needed medical care out of their very meager incomes that they should be covered under medicare. We sincerely hope the Senate will correct this omission in the House bill.

I want to register our enthusiastic support for S. 2299 (amendment 266), introduced by Senator Long, the distinguished chairman of this committee, which would encourage prescribing of drugs for medicare patients by their generic names, as well as S. 17 (amendment 265), introduced by Senator Montoya, which provides for coverage of drug costs of medicare patients at home or in nursing homes. These bills represent a sound approach to control of unduly high drug prices. We also request the committee to give serious consideration to the urgent need to control rapidly escalating physicians' fees and hospital charges under medicare, whose repercussions are having a tremendous impact on the entire health economy of the Nation.

One of the oustanding features of the amendments to the Social Security Act of 1965 was the launching of the so-called title XIX program, or medicaid. The aim was to make available to low-income families comprehensive quality medical care that they cannot afford to pay for themselves.

Medicaid was never thought to be confined to just the poorest families or families receiving public assistance. It was intended to meet the medical needs of not just the needy but the medically needy, those people who can afford to meet everyday living costs, but not the added costs of proper medical care.

The House bill completely departs from this fundamental principle. It makes medicaid just another charity medical program by cutting back eligibility so drastically that only the poorest families will have access to it.

No less than 14 States in various parts of the country would be immediately affected. A lot of publicity has been given to the New York eligibility standards which some people consider too high. But, not many people know that the formula in the House bill would have a drastic impact in other States, not just New York. For a four-person family, the eligibility requirement would be cut by $1,000 in Nebraska, $1,200 in Iowa, and $1,400 in Rhode Island.

These States established their medicaid eligibility standards in good faith on the basis of the 1965 law. There is no reason why the should be forced to deprive low-income people from needed medical care even before the program has gotten off the ground.

We also think the House made a serious mistake in eliminating the present requirement that the State must provide to medicaid patients the five fundamental health care services: namely, inpatient hospital services, outpatient hospital services, other laboratory and X-ray services, skilled nursing home services and physicians' services. It makes no sense whatsoever to permit the States to establish medicaid programs without physician and hospital services but including other less essential services. Congress was right the first time. We urge retention of the requirement for the five basic services.

Just a few words about child health. We endorse 100 percent the child health provisions in H.R. 12080 which would be still further strengthened by adoption of the very worthwhile program for medical screening of preschool children Senator Ribicoff has proposed in S. 590.

Finally, Mr. Chairman, we come to the provisions of this bill, which deal with our public welfare program.

This issue has generated a lot of heat. Frankly, Mr. Chairman, I think it is time for us to look at it both objectively and humanely.

Let us look at the facts. Let us remember also that we are not just talking about social theories or elaborate statistics. We are talking principally about mothers and their children for they are the overwhelming majority of those receiving aid to families with dependent children. And we are talking about the most deprived, the most disadvantaged, the most poorly housed and generally the most discriminated against group of people in the United States. In fact, the only group which is even more deprived is the 25 million poor people who get no assistance whatsoever.

Now, we know the public welfare program is a long way from being perfect. Furthermore, the few recommendations the President made for improvements in the public welfare program—the principal one being to require the States to meet their own minimum needs standards in their welfare payments—would permit only a slight improvement in the abysmally low level of welfare payments. The President's recommendations were in H.R. 5710 and we urge that they be reinstated in the bill this committee will report.

But the shocking fact is that the House did not even consider these minimum improvements. Instead, it put its full energies behind what we regard as a seriously misguided effort to pare the welfare rolls by forcing mothers and older children not in school into what I can only describe as a very badly conceived work and training program. And for those who do not conform to the requirements, the penalty is deprivation of assistance for themselves, and in practice also, for the com-

pletely innocent and still just as needy small children in their families. All of this is capped by a rigid formula which would hold the proportion of children in broken homes receiving public assistance at the level of January 1, 1967.

I do not have time to comment at length on all these changes. But, let me offer just a few ideas:

1. For some welfare recipients, training for adequately paying jobs for which they might qualify and which they might obtain could be the road out of poverty. But, clearly, this approach is not indicated for all welfare recipients. Some mothers can and should be trained for work. Others, because of either family conditions or personal limitations, would do much better to stay home and take care of their children. This is particularly true if adequate day care facilities are not available, and they are not in most communities. Neither can you set up adequate day care facilities with properly trained staff overnight. Having said this, I want to make it clear that we would support the provisions in H.R. 12080 for long-needed expansion of child welfare and day care facilities if they are not tied to the punitive measures in the bill.

2. For those who are to be trained, the worst thing that could happen is to provide inadequate training for poor or nonexistent jobs. This means that the work and training program must be entrusted to a qualified agency thta knows training and knows how to place trainees in jobs. Mr. Chairman, that agency, in my opinion, is the Labor Department. It is not the Department of Health, Education, and Welfare and the State welfare departments which are the administrative agencies for work and training under the House bill. We strongly urge that the work and training program for welfare recipients be placed under the administration of the Labor Department which has the skill, knowledge, and machinery for effectively training and placing welfare recipients in decent jobs.

3. The House report indicates that welfare recipients could be assigned for work and training to private employers and it asks the Secretary of Labor to permit this to be done at subminimum wages. Mr. Chairman, this would open the door to industrial exploitation of a defenseless group, the kind of exploitation organized labor has long opposed. We strongly urge this committee to require payment of the prevailing wage to participants in the work and training program and specifically not to permit employment at less than the regular minimum wage.

4. In order to keep families together rather than encourage their dissolution, we have recommended making the program of assistance to families with unemployed fathers mandatory upon the States instead of voluntary. Instead, the House bill ignores this proposal and narrows the possibilities to obtain needed help by making ineligible families where the father has not had a recent attachment to the labor force or is receiving unemployment insurance, no matter how inadequate these payments may be to meet family needs. We urge deletion of these restrictive provisions.

5. The administration proposed a new provision for grants to the States for temporary assistance up to 60 days for migrant workers and their families. The House bill provides emergency asistance for only 30 days and with only 50 percent Federal matching. We strongly

support the original provision which will more realistically meet the needs of migrant workers.

6. I understand that one of the main aims of the punitive provisions against welfare recipients in the House bill is to cut down on welfare expenditures. But the House report reveals quite clearly that the very questionable measures it would institute would result in increased, not decreased, costs. This is because the estimated cost of the work and training and day care programs would be five times the savings in welfare payments of those who would be removed from the rolls. We are for sound programs of work and training and day care for those welfare recipients who can benefit from them, but we are against expensive compulsory punitive approaches which will harshly penalize mothers and children while entailing huge additional costs.

Let me reiterate that we are concerned that the public welfare system is not meeting minimum subsistence needs for most welfare recipients. We are concerned that many of those receiving assistance are forced to comply with complex and often degrading procedures. We are concerned because welfare rules tend to disqualify and discourage people in need from seeking assistance and especially because they often force fathers to desert so that their families can obtain assistance.

It is these glaring deficiencies in our present welfare system which we respectfully suggest deserve the sympathetic consideration of the Congress. The punitive measures that the House bill provides contain the seeds for continued deprivation, misery, and unrest for decades into the future. Let us not take this backward step.

Mr. Chairman, I will not presume much longer on your patience. It would be presumptuous of me to emphasize the great responsibility which is yours in the actions you will take on this bill.

Through what I have been trying to say runs what I think is a common threat—that is, we should do the most we can do for those, who for various reasons beyond their control cannot, unaided, meet even their minimum needs. But the rest of us can meet their needs and together as a nation we can help the least fortunate amongst us.

Some of them, as for example, those receiving social security benefits, are fully entitled to decent payments now because of what they contributed while they worked. Others, usually even less fortunate, simply deserve our help—the most, not the least we can afford—because they are fellow human beings in distress.

This committee has not forsaken the neediest Americans in the past. I know you will not forsake them now.

The CHAIRMAN (now presiding). Thank you very much, Mr. Meany. Any questions?

Mr. Anderson?

Senator ANDERSON. On page 2, at one place you recommend the President's 15 percent, then you say 20 percent is not too much. Do you say 15 percent is all right?

Mr. MEANY. I am referring to the fact that less than 15 percent of those over 65 receive private pension payments. Is that the reference?

Senator ANDERSON. No.

Mr. MEANY. Oh, I see. Well, we recommend the 15 percent as a minimum, Senator. We mention later that we think that even increases up to 20 percent would be fully justified at this time.

Senator ANDERSON. You refer back to 1936, where the taxable wage base was $3,000. Is it not true that it should go higher than $10,000 to put it on the same parity with 1936?

Mr. MEANY. If you put it at the same ratio as it was in 1936, it would go even higher than $10,000. It would go to $15,000.

Senator ANDERSON. When the Senate committee has approved a raise from $3,000 to $6,600, you supported that.

Mr. MEANY. Yes.

Senator ANDERSON. You referred on page 4 to an advisory council and said the Advisory Council on Social Security studied the question and recommended the disabled to be covered. Was not it true that after they made the recommendation HEW produced some new figures, showing four times perhaps as much cost as outlined before?

Mr. MEANY. I was referring to the study they made in 1964.

Senator ANDERSON. They made the study, Mr. Meany, and then found out the figures were not right.

Mr. MEANY. I did not know that. I was not aware of that.

Senator ANDERSON. I think that is correct.

Mr. MEANY. I can check that.

Senator ANDERSON. February, $225 million, and then when they found out some important information, the estimate shot up to $695 million. Would you not think they could be justified in making the study again if the figures were that far apart? The cost was very, very much higher than what they originally estimated.

Mr. MEANY. Mr. Seidman would like to comment on that.

Mr. SEIDMAN. If I am not mistaken, Senator, I believe that the recommendation was contained in their final report. Now, I do understand——

Senator ANDERSON. Was what?

Mr. SEIDMAN (continuing). Was contained in the final report of the Advisory Council in 1964. Now, I do understand that the Social Security Administration has since then made studies which indicate that the cost of covering the disabled under medicare would be considerably greater than the cost of covering the aged under medicare and as President Meany indicated in his statement a few moments ago, we feel that that is not a reason for not covering the disabled under medicare, although we recognize that for this relatively small group, the cost per patient or per person covered, would be greater than for the disabled. I do not know if that responds to your question.

Senator ANDERSON. I merely say that a recommendation was made by your group and others, and made by the Advisory Council, that we pick up this group and they thought the estimate would be $225 million, Administration estimate. Subsequently, HEW found it to be $695 million. Do you not think that ought to——

Mr. MEANY. I think they ought to try to straighten it out and see what it actually costs.

Senator ANDERSON. Yes.

Mr. MEANY. But, I think these people should be covered and we had a study in 1964, have one in 1967. Maybe we can go on studying the question, but I think at the same time, I think these people should be covered.

Senator ANDERSON. I am not arguing that, Mr. Meany, just so when you recommend figures as being $225 million and finally it costs almost $700 million, it makes quite a little difference in your calculations.

Mr. MEANY. Yes.

Senator ANDERSON. I have nothing further.

The CHAIRMAN. Senator Carlson?

I would like to notify members that that buzz was for a vote. Senators can be making their way over there and we will come back as soon as the vote has been concluded.

Senator CARLSON. Mr. Chairman, all I wish to do is commend Mr. Meany and his staff for appearing before our committee and giving us this information which I think will be very helpful when we consider this legislation.

The CHAIRMAN. Senator Metcalf?

Senator Harris?

Senator HARRIS. I am going to vote.

Senator METCALF. Mr. Chairman, I want to commend Mr. Meany, too, for a very provocative and helpful statement, a statement that I am sure the committee will take into consideration in amendments proposed for this bill.

Now, Mr. Meany, you suggested, what, 15 percent of the people of America, the workers of America, are those who have additional pension programs.

Mr. MEANY. That is right. At this time. Less than 15.

Senator METCALF. Less than 15. Now, most of those people are members of the union you represent; is that correct?

Mr. MEANY. I would say a good many of them; yes. I would say, yes, most of the 15 percent.

Senator METCALF. So by and large, we are speaking on behalf of the welfare recipients and unemployed, and those who have no additional pension programs other than social security. You are largely speaking for the humanitarian, rather than as a spokesman for your union itself.

Mr. MEANY. Well, we are speaking for the people generally and you are right in indicating that our people are less affected because there is hardly a union we have in the country now that does not have some kind of a private welfare plan of its own in conjunction with its employers. So, they are certainly a great proportion of the 15 percent, which I mentioned, and even—and we say that even 15 years from now there will only be—there will be 70 percent that will be dependent on social security. So, that means we will be up to 30 percent who perhaps will be on private pensions of some kind.

Senator METCALF. Then, if this committee should adopt one of the philosophies of this bill, that is, less than standard, substandard salaries, we would return to an exploitation provision that would not only destroy benefits that you have given as a result of your activities and the organization you represent, but we would also destroy the very people we are trying to benefit.

Mr. MEANY. You see, there is always a hope that you can get to the point where you do not have to put anybody on welfare.

Senator METCALF. We all hope that.

Mr. MEANY. That is, of course—that is not attainable but that is the idea. Now, if you are just going to put them on welfare and work-

train them and then give them inadequate salaries, you are just taking hope away from them. You are just keeping them where they are. We do not think that makes any sense.

Senator METCALF. Not only that, but you are putting other people——

Mr. MEANY. Bringing other people down to that level. That is what would happen.

Senator METCALF. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Mr. Meany: I am pleased to see that in addition to your other recommendations, with which I find myself in considerable agreement, you favor the measure that I and some other Senators have introduced to try to keep the price of drugs at a reasonable level. I am pleased to see that your organization supports that.

Mr. MEANY. Mr. Chairman, I can say personally every time I walk into a drugstore these days to buy something I have not bought in a few years, I come out in a state of extreme shock. [Laughter.]

The CHAIRMAN. Well, I was pleased to notice that the former executive of Squibb corporation, I believe his name is George S. Squibb, stated just the other day——

Mr. MEANY. Yes, I read his testimony.

The CHAIRMAN. Mind you, that is a man who is a second generation drug producer. He said there is no other industry that engages in such double pricing methods.

Now, the Squibb company produces drugs that they sell generically at a reasonable price, but they also may put a fancy name on it and sell it for a much bigger price. I am pleased to see here is one man who has the honesty to come out and tell the public that you are not getting anything better just because you pay the big price—that the product sold by the so-called generic name or official name is just as good as the product produced on the same production line, by the same labor, using the same materials, but put in a different package and sold under a fancy name. So, there is just a great amount of money that could be saved here by buying the drugs for what they are really worth. I think I will ask that this statement by Mr. Squibb be put in the record at this point.

(The statement referred to and a telegram from Mr. George Squibb follow:)

Senator RUSSELL B. LONG,
Old Senate Office Building,
Washington, D.C.:

I am very disturbed to hear of your interpretation as expressed in your Finance Committee hearings yesterday of a Washington Post article discussing an interview with me on the subject of my paper on pricing problems of the pharmaceutical industry which I been discussing with Senator Nelson staff. I could find no resemblance to my thinking as expressed in that 38-page paper, or for that matter in the interview itself, and the comments you made. So that you may be accurately informed I am sending you at once a copy of my complete statement as the Nelson committee has it, and I would greatly appreciate your putting it into the record. I also wish to state that neither in my paper nor outside it am I in favor of S. 2299 as it is now proposed. I am taking the liberty of sending copies of this telegram to members of the Finance Committee.

Kindest personal regards.

GEORGE SQUIBB.

Drug Prices: The Achilles Heel of the Pharmaceutical Industry

(By George Squibb)

Drug prices have been under attack from many directions ever since the Kefauver investigations. Particularly sharp have been the criticisms by politicians and economists and there is no sign of abatement. Indeed there is renewed vigor in the attacks from political sources as the government turns its attention more and more to enacting and implementing new social legislation providing all kinds of medical benefits to the aged and needy. The potential effect of the attacks on the pharmaceutical industry in the light of current trends towards government-supported medicine indicates the urgent need for a careful reexamination and reconsideration of all aspects of pharmaceutical company operations, short- and long-term, as well as the more specific question of pricing philosophy. There is no doubt that there are developing new forces and new pressures that must be carefully studied and understood if the industry is to continue—progressive and productive—making major contributions to the medical knowledge of our times.

It has been pointed out in recent weeks that since the first attacks launched against the industry and its prices in 1959–1961 by Senator Kefauver there has been no essential change in either the price structure or the profits of the leading pharmaceutical companies. Apparently the Kefauver investigation failed in its avowed purpose to lower the cost of medicine in the United States. As Senator Nelson pointed out in the Senate on June 13, 1966, "Even though inquiry into drug prices by the late Senator Kefauver had the result of strengthening the regulatory powers of the Food and Drug Administration it seems to have had little effect upon the shocking profiteering that goes on in the drug industry."

There are those in the pharmaceutical industry who draw confidence from the fact that prices and profits have held firm in spite of the various attacks and highly unfavorable public attention absorbed by the industry, and who feel therefore that these latest blasts need not cause major concern, particularly because they are based essentially on the same data and the same product and company examples which Kefauver used originally six or seven years ago. It would seem that this opinion may lead into serious difficulties if it is followed by the majority of pharmaceutical houses because it fails to take into consideration a whole set of new circumstances which have only come into existence the last eighteen months or so. The basic new fact is, of course, that now the government itself under its Medicare programs must pay a large drug bill. It now has a direct interest in the prices charged for drugs, and any proper economies that can be made are suitable matters for attention.

It will be our purpose here to examine in detail and objectively the situation in which the pharmaceutical industry finds itself as it faces the next two years in which more legislation affecting it will be introduced at federal and state levels than has been done in all history, and in which more words, mostly unfavorable to the industry, will be spoken than ever before, and in which a whole new set of operating and regulatory conditions will apply for the first time to complicate an already difficult situation.

I

The basis of all attacks on the pharmaceutical industry is "high" price, and from this starting point many other sorties are made—against drug patents, price rigidity, advertising, nomenclature of drug products, substitution laws, detail men, and many other operational procedures of the industry, and, of special recent note, of the entire drug distribution system including the functions of the retail pharmacist. However, the starting point for every unfavorable criticism is "high" prices. It is essential that the strong light of analysis be thrown on this area before we can move attention to problems in other narrower applications.

It should be understood that there are two separate and distinct approaches to the attack on "high" prices—first, against those products which are marketed as "brands" of chemical compounds which are available non-branded from many different sources without restriction as to patent or license or new drug status; and second, against those which are covered by a patent and generally available only from one manufacturer or his licensees. Pricing for these two types of products must be distinguished because they are subject to completely different rationales, and need not rise and fall together. Indeed there seems to be no connection when all the facts are understood.

Drug prices for products in the first category chiefly are "high" in relation to prices of chemically comparable non-branded drugs on the market. When the charge of "high" or "exhorbitant," or "fabulous," or "unconscionable" or "shocking" is made against the price of the product it is always made with the simultaneous quotation of another much lower price for a purportedly similar or even identical compound with no brand name. Those who are critical of drug prices rarely analyse absolute price in terms of per diem cost to the patient, value in relation to alternate procedures without drugs, or in terms of comparative expenditures in other areas. It is simply pointed out that the "same thing" can be obtained at greatly less cost per tablet, per ounce, or per dose.

There is no question at all that the savings are very great as stated in the tables and arguments offered along these lines. Whether or not the "same thing" is involved is of course quite another matter which will be discussed in detail later. An analysis of the pricing alone is called for at this point.

Every brand-name pharmaceutical product bears on its label in prominent display the common or chemical name of its active ingredient or ingredients. This is by regulation both as to prominence of the words themselves and their location on the package. These words are the same as appear on non-branded products for the particular compound. There can be no doubt that the difference in price is related to the brand name and what that brand contributes to its prod-

uct in consumer acceptance. It must be recognized that all brand-name products not covered by patent or marketed under an approved New Drug Application are sold in the market against many non-branded products. These brand-name products have achieved a high degree of consumer or professional acceptance at the prices established for them. Whether these are real or unreal values, and whether this acceptance comes from ignorance or from sales pressure will be discussed later, but there can be no question that there are many who are willing to pay a premium for brand-name products. Both brand-name products and non-branded products exist in the same market. The extraordinary thing is that they do exist with so great a disparity in price.

This paradox seems to be the thing that catches the attention of all students and critics of the drug industry. In all fields price differentials exist among generally similar products. Top quality, de luxe, or specially packaged products of all kinds are marketed at higher prices than their plain or standard counterparts, but the difference in price is seldom more than double if the more expensive item is to exist for long, and never six- to ten- to twenty-times more as is often the case among the cited products in the drug industry. These unparalleled differences in price for commonly labeled drug products are the chief targets for attack; not the mere fact that there are differences. It has been stated many times by critics of the drug industry that they would expect brand-name prices to be higher than those of non-branded products because of the added expenses assumed by suppliers of the former in research and product promotion, quality control and distribution. It is the size of this differential that seems to be inexplicable by any normal standards of accounting or competitive operation as seen in other industries.

It is clear that brand-name products of generally available chemical compounds are often priced much higher than non-branded competitive products. Why this is so is worth examining because it is the basis of the charge that somehow the drug industry operates without the beneficial competitive forces of the free enterprise system.

What keeps sales volumes of these higher priced products at a satisfactory level in spite of apparent extensive competition? Is it the nature of the market for which these products are produced, or is it the result of unusually successful promotional procedures? Or is it some other forces, hinted at frequently in legislative circles, which might arise out of conspiracy or false advertising or coercion somewhere along the line?

An examination of the leading products on which a large price differential exists in the market place shows a number of significant points. Taking the latest list as published in the Congressional Record of July 20, 1966 by Representative O'Neill and comparing it with those products covered in various parts of the Kefauver report it is notable that except for some items coming on the market recently all of the Kefauver-cited items are present in the new list. A close study reveals little price change. Sales volumes, however, are greater since 1961 in many cases. Competition, at least in terms of the number of products bearing same chemical names as the branded items, is very substantial. Checking Red Book pages shows that there are about 69 suppliers of Rauwolfia Serpentina tablets competing with Squibb's *Raudixin*, 76 suppliers of Dextroamphetamine Sulfate versus SKF's *Dexedrine*, 85 suppliers of Secobarbital Sodium versus Lilly's *Seconal* Sodium, and so forth. How many of these unbranded products are available at a given moment at a specific place has never been determined, but it is certain that any continuity of use of a particular manufacturer's product would be impossible with many of them without advance inventory buildup. However, it is certain that the existence of a brand-name product does not deter the introduction of a non-branded competitor.

It is clear that the market price level as established by the brand name leader holds a fine umbrella over those who wish to make a product entry. It is clearly profitable for many manufacturers to supply products at a considerably lesser price than the leader in many drug markets. Nevertheless, while their research, production, and particularly selling and distribution costs are not as large as the brand-name producer's, the ratio of such costs to the price received for their products is in most cases much the same as for the brand name manufacturer's products. This fact must be borne in mind when the question is asked why the non-branded product has made so little progress in spite of the large price advantage it often has.

Several reasons are suggested for this lack of progress: *First*, the physician can't remember generic names as they are too long and complex; *second*, the physician does not know that the cheaper products exist because of lack of advertising; *third*, he knows they exist but is convinced that they may leave something to be desired in quality; *fourth*, he knows the cheaper product exists but is not persuaded that the price differential is worth any risk of low quality because such price differential, after it is priced out on prescription and then on a per diem dosage basis, is small; *fifth*, general availability at all points of the brand-name products and the certainty of continuity and identity of the prescription when refilled.

Whichever reasons are accepted for the dominance of a particular brand-name product, it must be basically because either the price difference for the patient is not great, or the physician doesn't think it is great enough to be of significance.

Another alternative, that of lack of availability to the physician of complete, or even proper information on drugs, is getting more attention in recent months by some government authorities who look at it as the most logical explanation for the fact that the more expensive brand-name products not only exist, but actually are used much more often than not. While this point of view seems to be unrealistic—in terms of a physician's professional and technical training and his continuing need to prescribe and use drugs in his practice about which he must

have basic knowledge—in the light of several recent developments it must be given careful thought.

To examine the possibilities in order—a study of prescription prices of brand-name products and their comparative non-branded competition shows that there are often substantial differences as the table shows:

BRANDED VERSUS GENERIC PRODUCTS

Product	Average Rx size	Consumer pays	Estimated price per tablet or capsule (cents)
Serpasil, 0.25 mg	60.6	$4.76	7.8
Reserpine, 0.25 mg	66.1	2.61	3.9
Mocinc, 7.5 gr	31.0	2.94	9.5
Chloral hydrate, 7.5 gr	31.8	2.77	8.7
Achromycin, 250 mg	19.1	6.02	31.5
Tetracycline, 250 mg	20.5	3.95	19.3
Feosol tablets	84.6	1.87	2.2
Ferrous sulfate tablets	102.5	1.71	1.7
Miltown, 400 mg	44.9	4.81	10.7
Meprobamate, 400 mg	51.1	4.23	8.3
Meticorlen, 5 mg	36.5	9.50	26.0
Prednisone, 5 mg	45.6	3.07	6.7
Penids, 400,000 units	16.6	3.85	23.2
Penicillin G, 400,000 units	23.4	2.70	11.5

At various times industry representatives have stated that "only pennies" per day is the measure of the differences, or have tried to minimize the effect of these figures with arguments that compared with other medical costs prescription prices are small, and a minor percentage of the whole. This is not a satisfactory approach and does not in truth answer the point raised that brand-named products frequently cost much more than comparative non-branded items.

Assuming that he is aware of these higher costs for brand-name prescriptions, does the doctor continue to prescribe them because he believes that price is of no concern compared to getting the exact medicine he wants for his patient, or does he believe the differences are not great enough to be of significance? It would appear that he is generally aware, without knowing exact figures, that brand-name products frequently are more expensive for his patient, but this does not deter him from using them. While this may be due on occasion to lack of ready familiarity with chemical or non-proprietary names, it is probably much more often due to a feeling that it simply is better practice to prescribe a known quality product. "Quality" must be taken to include not only standards of purity, uniformity and safety, but also a consistent level of therapeutic efficacy which can be relied on over the full extent of the product utilization.

While it can not be denied that there are quality drugs sold under the chemical name, it is also well established that there are poor ones. The physician has no knowledge, more often than not, of where the prescription will be filled. It is natural for him to try to be as precise as possible in his drug usage. Experience has taught him the acceptability and effectiveness of certain shapes, tastes, and formulations of particular pharmaceutical products. Why gamble with the possibility of something different? Even price advantage does not offset therapeutic assurance insofar as it can be obtained.

It would appear that basically the medical profession has not been convinced that all drug products bearing the same chemical name are alike. Indeed it is doubtful that even the harshest and most vociferous critic of "high" drug prices would be willing to have his family swallow the lowest priced medication he can find on the market, and by this attitude he admits that there at least *could* be a difference. Therefore it seems that in spite of competition on a price basis, where drugs are not covered by a patent or license or a New Drug Application the medical profession is not persuaded that it is to the patient's advantage to use non-branded medicine, all things taken into consideration, and therefore a specific selection for the patient is made in most instances from among the products available.

There is now underway at several levels of government an effort to organize material to persuade or inform the physician to the contrary—that (a) there is a cost advantage in using non-branded drugs, and (b) there are no other offsetting disadvantages. Many words have been and will be spoken to this end, most of them by sincerely motivated men speaking from lack of knowledge and appreciation of all the factors involved in the manufacture, distribution, dispensing and use of medicine. Also some words have been and will be spoken to this end by insincere men and demagogues who use the emotional content of illness and its cost to further their own purposes, mostly political. Ignoring for the moment these last, and assuming the sincerity of those who believe that all drugs are alike either because of natural causes, or because of government regulation and supervision, or because of the essential goodness of mankind, and that physicians just don't know it, it is not too difficult to establish the *possibility* of real differences from which it would follow that the risk of such possible differences existing in practice would have to be discussed. In the context of medicine and the conditions under which it is prescribed, which seem to be fundamentally requisite of the avoidance of any unnecessary risk no matter how small, we begin to shape up an approach which establishes a risk vs. cost basis which applied in the direct, personal terms of medicinal usage can be the basis for the final judgment of "high" costs.

What actual costs are we talking about on the pharmacist's dispending counter? What risks are we talking about in terms of existing counterfeiting, diversion of merchandise, lack of uniformity, process and production control, poor work, unskilled labor, unsanitary or ill-equipped production facilities, lack of product responsibility and liability, etc., etc? Who are we talking about—the well or the sick? The strong or the weak?

In the practical reality of the drug distribution procedures in the United States there are many factors possible, and definitely known to have existed on occasion, that can affect the drug before it reaches its ultimate consumer—the patient—in relation to its cost, identity, quality, and effectiveness. In the market place at any given

moment there are outright counterfeit drugs made under appalling conditions, fire- or flood-damaged drugs, drugs damaged by faulty storage, outdated drugs, contaminated drugs that have been exposed to improper handling, and last, but not necessarily by any means least, there are drugs so cheaply and poorly made that they can not in fact meet any standard. Just how much of this material is on hand in a given city at a given moment can never be proven, but study after study shows the reality of all such conditions prevailing to some extent. All manufacturers and wholesalers handling drug products in their distribution systems have run into practices over the years involving the counterfeiting, theft, improper handling and deterioration of drug products. All have seen inferior, dirty and certainly questionable merchandise offered for sale by irresponsible and unethical distributors. All of this in spite of local, state and federal regulations and policing efforts.

The degree to which these conditions exist can be minimized, and indeed in the overall volume of drugs dispensed annually they represent certainly a tiny fraction, but why take any more chance than is necessary to expose a sick or weak or infirm patient to this sort of danger. Specification of a brand-name product does not eliminate all possible hazard, but it does help to control some, and this appears to be important to the physician. Of course, added to the reduction of the danger of obtaining impotent or even deleterious drugs, the physician by brand-name selection does assure himself and his patient continuity of product and regularity of therapeutic effect.

It is therefore clear that there can be real differences in drugs and that this has been established without doubt. The question of whether these differences in the context of the products used are worth extra cost to the patient, and if so, how much extra cost, is the central point. Clearly they are worth something. It is growing increasingly doubtful if they are worth the large differences in price that now exist compared with the prices of other chemically similar products, and if such be the case, sales of brand-name products will suffer accordingly. The fact that these lower prices may not be consistently passed along to the consumer by the pharmacist is beside the point when debating the issue in legislative chambers. If necessary, and it seems increasingly certain that it will happen, corrective steps can be taken to be sure these prices are in fact reflected in the cost of the prescription itself.

One of the difficulties in establishing the proper cost for medicine has been the nature of the arguments advanced for justifying it. Most of them have not been sound and have essentially stayed away from the real economic facts available to all.

The pharmaceutical industry marketing brand-name products can not lay *all* of its higher prices to research expense. The figures for research as a percentage of sales dollars, or on profits before taxes, or by any other measure do not justify a claim that the price differential between branded and non-branded products is due to research on the former. Some of it is, no doubt, but care must be taken to be realistic and factual in assessing the effect of research expenditures. The Kefauver report states, and it has not been successfully refuted, that "Even under the liberal interpretation of 'research' allowed by the Internal Revenue Service, research costs of the twenty major drug companies represent only 6.4 percent of the total sales dollar."

The industry can not cite its risk from the uncertainty of research results or from product obsolescence as the reason for the price differential. For some of it, no doubt, but not much, because year after year the profits of the industry are far above the average for other major industries and currently appear to be improving rather than worsening. The "risks" of the pharmaceutical business seem to those outside it to be pretty ephemeral in view of the impressive profit performances of the last two decades. Indeed it is the consensus of the industry's critics that more risk is needed to make it more sensitive to the normal influences of competition.

The industry can not use nearly as forcefully as it once could the argument that the price differential is due to better manufacturing procedures, quality control, and generally more careful and therefore more expensive production all the way from the conception of its formulas to their final distribution. Some of the differential is due to this but how much? The cost of goods for the leading pharmaceutical firms is a well known fact, and its relation to the sales dollar and to other operating expenses is too well established to use it as an argument for any extraordinary pricing levels. And then too, the best pharmaceutical firms have been having widely publicised product troubles in spite of all of these extra quality and production safeguards that have cost so much money.

On the other hand, those engaged in trying to establish in the minds of physicians the equivalency of all similarly labeled drug products have a steadily improving ground for argument. FDA inspection has been increased, good manufacturing practice regulations have been developed, new standards have been set in assays and new higher frequencies of inventory inspections are utilizing these assays. More drugs are batch released after advance FDA examination and approval. Negative controls are no doubt better than they were five years ago. In theory at least all manufacturers of drugs are approaching a standard for product quality under government regulation and supervision. However, because of the inevitable gap between the theory and the practice of such controls and the need for extra care, higher standards, and therefore higher prices than required by government standards is not widely understood, and certainly not accepted by the critics of the industry. The pharmaceutical trade associations will be giving more attention to explaining the significance and necessity for better products than the government requires under its minimums. The public should know that there is no such thing as the "perfect" drug product. Improvement is always desirable and important in many ways, and essentially it is

only the brand-name manufacturers who are working along these lines.

Generally speaking, industry's arguments for the price differential fail not because a need for differential is not explained, but because the size of the actual differential can not be justified satisfactorily. Up to this point in time, however, physicians have not been persuaded that the differences in price warrant any less utilization to a significant degree, of brand-name products, or the substitution of non-branded items. How long this will continue is of course uncertain. In view of the public attacks currently being made on this concept, and the attention that it is receiving in legislative, regulatory and medical circles, it would appear that major changes in this attitude are likely relatively soon.

II

The second area for the "high price" attack on the drug industry is against those items marketed under a patent or license arrangement, and for which there is no non-branded competition on the market.

Any criticism of "high" prices on such items has quite different reference points than those discussed previously for products which are widely available non-branded.

In this instance, the "high" price charge is based on one or more of several points—a comparison with prices charged for the same product in foreign markets outside the patent or license; a comparison with allegedly similar and comparable (but not the same) items sold in the United States; a knowledge of actual product manufacturing cost; a knowledge of promotion costs; knowledge of industry profits; and last but by no means least, the general feeling that any costs for illness that include a profit for anybody are subject to sharp critical examination.

The volume of pharmaceutical products sold under patents or license arrangements is the major part of the prescription sales dollar in the United States, and therefore these prices have received a great deal of attention at the legislative level starting with Senator Kefauver and continuing down to Senators Long and Nelson currently. They have also received critical examination from many academic viewpoints, from economists and writers in the medical field, as well as others who have seen an opportunity to exploit them for their personal publicity or advantage on many political and socio-economic battlefields. The industry has not been successful in halting the attacks, but on the other hand the attacks to date have not had much effect on the industry in terms of lessened prices or profits, or changes in operational procedures. Whether this stand-off can continue under current conditions and for how long is of course the dominant issue at hand.

It would seem probable that attacks against prices on patented or licensed products would have little effect on pharmaceutical operations generally if it were not for the emergence of government spending as a major factor both in the support of medical research and in the direct purchase of medicines under the terms of Title XVIII of Medicare and the indirect support of state welfare plans under title XIX of that legislation.

Until the economic aspects of Medicare with its vague but surely enormous budgetary requirements began to come under legislative scrutiny (incidentally, only *after* the legislation itself was adopted) the government was devoting its attention chiefly to the issues of drug safety and efficacy without particular regard, it might be said, for the effect of such activity on the cost of drugs to the public. The overriding need in the minds of the FDA and associated government bureaus was for safe and effective drugs, and for proper procedures to develop them for, and maintain them in, the market place. While there are overtones of economic evaluation of drugs in many of the programs of the FDA, basically their approach to their regulatory functions has been through the scientific and medical route.

However, now that realization is growing every day of the actual and potential cost to the government of its commitments to health programs for the people in total, legislators have seized upon the "high" prices of drugs as an obvious and easy area for economy. The data for their efforts in this direction are already in the record for them to a large extent, and they are accumulating new material following closely the general guidelines laid down by the Kefauver investigation.

At the present time there seem to be three definite and separate methods to get at the "high" prices of patented or licensed drug products. First, to attack the patent system itself; second, to charge illegal acts under the antitrust laws to the industry; and third, direct attack on intra-industry procedures which can be claimed to contribute to "high" prices.

In the attack on the patent system itself numerous and varied arguments have been offered all the way from questioning the basic premise on which patents have been historically granted down to an exhaustive analysis and comparison of research results under governmental systems with and without patent protection for new discoveries. While there appears to be some substance in the debate on the rigidities of the United States Patent law, and whether or not it might be modified to good public advantage, the most telling argument of all to bring about new rules of the game is the ever-increasing and major role that government-financed research is playing in leading to the issuance of patents. If the taxpayer contributes to the creation of a new patentable drug or drug manufacturing process, why should an exclusive patent be granted one producer to exploit this knowledge for his own benefit? This question has been asked loudly in legislative halls and will continue to be pressed until a satisfactory answer is given. A satisfactory answer in this case clearly will involve government decision and control over what it pays for, and this is even clearer in the case of patents in the health field where the public welfare is involved, and where the personal and emotional involvement of individual people runs strong. It seems very possible that there will be one patent law (the present one) for many fields, and a new one involving compulsory licensing

at the least, and outright government ownership at the most, for those areas where government money has been used for research and development expenses.

It seems quite apparent that modification of the patent law to restrict, limit and even deny such rights in the pharmaceutical field, and thus create the opportunity for the marketing of competitive imitations much more widely than is now possible, is a really strong and potentially serious threat to the operational plans and programs of the industry. Realistic consideration must be given, point by point, to the documentation of patents in the industry as spelled out in Chapters 6, 7 and 8 of the Kefauver Report, with the new fact very much in mind at all times that *now* government is often paying for a large part of medical research. The industry can not have the cake of direct government financial support for its research achievements, and the enjoyments of eating that cake in the form of profit beyond average levels.

The government attack on "high" prices through charges of antitrust conspiracy in the pharmaceutical industry has been heavy, persistent, but generally inconclusive as well as obviously ineffective in the pricing area. A great deal of time and money have been spent by both sides in attempting to prove and to disprove antitrust charges that might much better have been utilized in other activities no matter which point of view is considered. It is worth noting that to date the government has generally been unable to show violations of the antitrust laws that go to the heart of the pricing problem, and it is quite unlikely that they will be able to in the future for the very simple reason that such violations do not exist. This approach to "high" prices is not and can not be effective from the government viewpoint, and only damaging from the industry viewpoint to the extent of adverse and unfair publicity given to unproved charges in the public press—publicity which later on when charges are thrown out of court is quite lacking.

Getting at "high" drug prices for products covered by patents or licenses by exposure to public view of the internal procedures of pharmaceutical firms in a variety of ways is perhaps the most significant approach to the situation at present.

This method probably results in more damage to the public image of the pharmaceutical industry than any other, although to date it seems to have had little effect on the actual operations of individual companies.

Almost every phase of the industry has received critical attention. Profits have been compared with those of other consumer goods industries as well as with those of heavy industry and a variety of non-related business activities. Pharmaceuticals profits are high by any standards. When such comparisons are made there is rarely anything more stated than the figures themselves which are offered as proof that prices could be cut and still permit a return considered normal in most other major industry areas. Sales costs have received especially close scrutiny and critical analysis. The detail man, although generally conceded an effective sales producer, has been attacked as to his cost, his objectivity in a field where the responsible imparting of accurate information is essential, and as to his method of doing the sales work itself with use of samples, "gimmicks," and personal pressures for his physician customer. There can be no argument that sales costs are high as percentage of sales dollar when compared with other industry. Advertising in medical journals and other publications, and through the mail, has been criticized both as to its content and its volume. The FDA has attacked sharply a few prescription product advertisements receiving considerable publicity through its methods of product seizure and press release without concurrent opportunity for the industry or the firm involved to explain its position. The FDA also has moved energetically in the publicizing of product recalls of impotent, contaminated or substandard products. There also have been speeches, surveys, and hypercritical analyses made by various authorities in and out of government which purport to show insufficiencies and failings in pharmaceutical industry claims for the quality, effectiveness, nad reliability of their products. Some of these debunking efforts have been, to say the least, inaccurate, unfair, and on occasion quite misleading, but on the other hand there have been a number of clear-cut failures within the industry upon which can properly be based substantial criticism. It does appear, however, that a few mistakes, a few shortcomings have been exaggerated beyond reasonable levels to smear an industry whose performance generally has been excellent.

The research efforts of the industry have been attacked on all fronts. Their basic research goals have been challenged as insignificant, duplicative, and wasteful of manpower and money. Their effectiveness as to the discovery of new products has been questioned, compared with that of institutional, government and foreign laboratories. Their relationships with government research have been seriously criticized in the areas of patent utilization and exploitation.

In short, the research, production, and sales activities of pharmaceutical companies, as well as their profits, all have been subject to the most vigorous public examination, usually in a sharply critical climate, of that given to any industry in recent years. Probably this scrutiny is the most detailed and at the same time far reaching that has ever been given to any industrial group by such a wide variety of examiners from the press, from academic life, and from the government.

The publicity given to industry procedures, profits, promotion costs, and comparative financial data of all kinds exposes no illegal or improper activities per se. The charges of too much advertising—too much sales pressure—too much profit—all seem to beg the real question—"should there be some limitation imposed from without to the operations of the pharmaceutical business?" Anyone can run his shoe business or his farm machinery business any way he wants to in terms of new product activities, production procedures, or sales costs, but can this be

permitted in the pharmaceutical business when products are involved upon which depend the nation's health? Anyone can make all the profit he is able to in the furniture business, the food business, the automobile business, but can this be permitted in the pharmaceutical business when that profit comes from prices on products used to treat illness? More than that, these products are *required* for illness, which can afflict everyone no matter of what economic status, but which more often than not is the particular burden of the poor and undernourished and aged segments of the population.

It is squarely on this point that the industry today must do its most serious thinking. Is there some kind of special responsibility inherent in the nature of the product and service it supplies that requires the limitation of price and profit by some artificial standard? And if so, by what standard, and who sets it? Would the industry be under attack today if its profits were on the average of all major industries or if its expenses for selling and distribution were more in common proportion to those found generally in other consumer goods industries? The answer is probably "Yes"—although in a different way, and with emphasis more clearly given to the social responsibility concept rather than to the out-of-the-ordinary procedures and results of pharmaceutical companies.

The industry has not accepted the role it has been assigned by those economists who are developing the theory of "welfare" capitalism as opposed to the older brand of "laissez-faire" capitalism. The industry does not look upon itself as a special contributor to the "welfare" state with social responsibilities of a nature different from that, let us say, of the food industry. Up to this point the industry consists of individual corporate entities trying to do the best they can for their own stockholders. Their efforts to discover and market new drugs, while holding on to sales volume on already existing products, follow the patterns set by all private enterprise. It is true their efforts duplicate each other's, their products often overlap, their sales pressures are strongly competitive, and their prices are related to what the market can bear, but this also can be said of every consumer product industry. Pharmaceuctical companies are subject to the same antitrust laws as all industry, they comply with regulations by local, state and federal governments, they contribute to educational, professional and trade activities within the scope of their interest, they buy, sell, and carry on manufacturing and research activities as do all industries, varying only in degree. Is there some reason for these practices to constitute "immorality" in the drug industry while being normal business practice everywhere else?

It is hardly to be expected that pharmaceutical industry leaders will espouse the cause of profit limitation on a voluntary basis and yet it is surely most important for them to understand the thinking of those who sincerely feel that such limitation must be imposed for the public good in the welfare state. To the extent that "high" prices continue to provide the basis, or excuse, for legislation and regulations which in the long term will have an adverse effect on his organization, a pharmaceutical manager today must clearly see the choice that lies before him. He must accept the fact that his industry indeed carries a high degree of social responsibility or he can see that social responsibility spelled out for him slowly but surely by legislation prescribing more and more of his operations, and taking over more and more of the functions he now guards so fiercely.

The CHAIRMAN. Mr. Meany, we would all like to ask you some additional questions and compliment you for your statement, but we are voting now and I am the last holdout. Thank you very much for your testimony here. We will be back in session at 15 minutes of 12.

Thank you very much.

(Mr. Meany's prepared statement, with attachment referred to previously, follows:)

STATEMENT OF GEORGE MEANY, PRESIDENT, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

My name is George Meany and I am President of the American Federation of Labor and Congress of Industrial Organizations.

We appreciate the opportunity to appear before this Committee to present our views on pending Social Security legislation. I have attached to my statement the statement on this bill the Executive Council of the AFL–CIO adopted just last week.

The long-standing and vigorous support of the AFL–CIO for Social Security improvements is well known to this Committee. As representatives of nearly 14½ million workers and their families, we recognize the enormous contribution this program has made to the improved welfare of all Americans. Today, we come before you to testify concerning basic changes that are the most important this Committee has considered in many years.

The AFL–CIO has advocated more far-reaching Social Security legislation than that proposed by the Administration. We were, therefore, dismayed by the severe cutbacks made even in those modest proposals by the House of Representatives. We hope your Committee will recommend enactment of at least the proposals contained in H.R. 5710 and that, if possible, you will go even further.

I think we can all agree that benefit increases are long overdue. The question is how much of a benefit increase is needed. We feel the facts show it should be considerably larger than the increase passed by the House.

As poverty has become an issue in our country there have been a number of attempts to define it. The poverty standard is about $1500 for a single person and $1900 a year for a couple. Even maximum Social Security benefits do not exceed these levels by much and an overwhelming majority of beneficiaries receive less than the maximum. On an annual basis, the average benefit for an individual is only about $1008 a year and about $1716 for a couple, well below the poverty line.

The Bureau of Labor Statistics made a more precise effort in 1959 to measure poverty based on a "modest but adequate" budget for retired couples living in twenty selected cities. The median budget was even at that time $3000 a year in a large city and $2500 in a smaller one. This budget is indeed a modest one—about one-half pound of meat and less than two eggs per day; three dresses a year (including house dresses) for the wife and a new topcoat for the husband every nine years; twenty percent of the couples were assumed to have a car which they could replace only every 7 or 8 years; four local bus rides a week for the couples that didn't have cars; and one movie every four weeks.

Even without adjusting for the cost of living increase since 1959, these budget figures are far in excess of benefits received by most Social Security beneficiaries and, in fact, exceed the total income from all sources of the large majority of aged couples.

The bleakest standard of poverty is the Department of Agriculture "economy food budget" based on minimum nutrition needs at a bare minimum cost. It is a bare bones budget—20-25% less than the Department's low cost plan which traditionally welfare agencies use as a basis for determining food allotments for needy families. For example, the budget allows roughly 22¢ per person per meal. Even using this minimum budget, an aged individual (non-farm) would require an income of $1470 per year and an aged couple (non-farm) about $1850.

I know of no reputable authority who has defined poverty in any lower minimum figures. Yet the average Social Security benefit does not equal this level for either non-farm couples or single persons. More important, the 1963 Survey of the Aged showed that the total income of a majority of single persons and close to 30% of all aged couples was below this bleak standard.

Social Security benefits have been increased five times since 1940 but these increases are less than the rise in the cost of living during that period of time. For more than 26 years, social security beneficiaries have been fighting a losing battle with the cost of living. The 3.3% increase in the Consumer Price Index in 1966 was the greatest in 15 years and the first 7 months of this year give every indication of a similar jump this year. Instead of reflecting our increasing standard of living, the real value of social security benefits has been eroded by the rising cost of living.

Neither of the two most recent increases in 1959 and 1965 compensated for increased living costs since the previous benefit increase. This is particularly significant since 90% of retired beneficiaries on the rolls retired since 1954, the year of the increase immediately preceding that in 1959. The average monthly benefit of a worker retired in 1954 was $66 and benefit improvements in 1959 and 1965, totalling aobut 15%, increased this to $76. It would require a benefit of about $82 to purchase the esame goods and services by the end of 1966. To keep pace with wages, the 1954 retiree would need about $104 or an increase of 37% over the present level.

What about other sources of income of the aged in addition to Social Security? The Social Security Administration has just published its final and complete report of its 1963 Survey of the Aged. The study clearly shows that generally our aged population has insufficient income from all sources to meet essential needs. Obviously, the only benefit increase since that time, the 7% increase in benefits in 1965 since it did not even restore lost purchasing power, did little to improve their economic situation.

Social security benefits accounted for nearly a third of the total income of the aged. Some beneficiaries did have income from other sources, i.e., wages, private pensions, help from relatives, public assistance, and dividends. Including all income sources, the median income was $1130 for single persons over 65 and $2875 for couples. About 30% of the elderly couples received less than $2000 a year.

The largest source of income for the aged, about 32%, was from employment earnings. But 75% of all persons over 65 did not work at all and only 20% of all men worked full time. Income from assets amounted to 15% of total income but over 70% of the aged received less than $150 per year from this source. Private pensions accounted for only 8% of total income and less than 15% of the aged 65 and over received income from this source.

The incomes of the aged have been rising slightly but primarily as a result of public and private pension plans. But as previously stated less than 15% of persons 65 and over received private pension payments and even 15 to 20 years from now, social security will be the only pension system for 70%.

In view of the inadequacy of social security benefits and the paucity of other income of the aged, this Committee should recommend a general benefit increase of at least 15% and substantially higher if possible.

MINIMUM BENEFIT INCREASES

Not only is the general increase of the House bill inadequate, but the general intent of the bill seems to be weighted against those who are the poorest. The Administration Bill, H.R. 5710, recommended raising the present social security minimum to a modest $70 from the present woefully inadequate $44. The House passed only a token increase to $50. This is only an increase of 13.6%, not much more than the general increase provided all beneficiaries and a far cry from the 59% increase proposed by the Administration. Unfortunately, the House also eliminated higher minimum benefits for those with long histories of contributions which would have permitted the 25 year worker to receive not less than $100 a month.

The poorest of the poor deserve greater consideration. A large proportion of those drawing the minimum benefit are among the lowest paid workers in the Nation—agricultural workers. About half the men had earned insured status at least in part from farm employment. Of all the men with earnings credits for farm work during the 7 years before entitlement, 25% received the minimum benefit—five times greater than for workers with non-farm earnings only. Those with a minimum benefit based on farm work are not those with a limited attachment to the labor force. Low wages result in low benefits.

Twenty-five percent were receiving public assistance. Less than one-sixth of the couples and less than 1 in 25 of the single workers had other retirement

benefits. Only 45% of the minimum benefit group had any reasonably permanent income other than their social security benefit—including income from property, veterans and other retirement and survivors programs. This compares with the figure of 80% for those whose benefits were near the maximum. The figures indicated that the higher the benefit the greater the likelihood of supplemental asset income and greater the additional protection by a private retirement system. This is clearly a good argument for a higher minimum benefit.

The plight of widows with minimum benefits is particularly bad. Two-thirds of the widows receiving minimum benefits had no other retirement income than Social Security and only 5% had other public or private pensions. Twenty percent had to rely on public assistance for support.

Amendments of 1965 and 1966 made people age 72 and over eligible for social security payments on the basis of less than normal work requirements. Presently, they receive benefits of $35 per month ($52.50 for a couple). The Administration's proposal to increase this to $50 was reduced by the House to $40 per month ($60 for a couple). Beneficiaries receiving these minimum special benefits, like those receiving the minimum social security benefits, are among the most deprived.

It is inevitable that many individuals, through no fault of their own, will not be able to earn enough during their working lives to permit even a minimum level of income during retirement. The causes are many, ranging from lack of education to death, disability and disease—causes largely beyond the control of individuals. It seems inhumane to deny to these individuals even the barest subsistence.

Public concern has increased concerning poverty in our affluent Nation. Over a third of the poverty group are over 65. The only feasible way of lifting this group as a whole above the poverty line is higher cash benefits. Because of the crucial role played by the social security benefit in the economic life of the aged, it must play the major role in lifting the burden of poverty from them. Increasing the minimum benefit to $70 per month or more and the special benefits to at least $50 per month would be a significant step forward in the war against poverty.

DEFINITION OF DISABILITY

The House included a more restrictive definition of disability than now in the law by providing that a disabled worker is not eligible for disability benefits if he can engage in any kind of substantial gainful work which exists anywhere in the national economy.

The large majority of the seriously disabled are over 50. We all know that once an older, disabled person loses his job, his chances of obtaining a similar position are about zero. It is unrealistic and unfair to say to this severely disabled worker that he is not disabled because there may be employment someplace in the national economy which he might be able to handle even though he has no way of reaching that place and it is very unlikely he would be hired if he did apply. A major complaint of disabled workers has been the stringent administration of the disability provisions. Greater liberalization, not restriction is needed.

The problems of disability, age and unemployment are all interrelated and what is needed is a comprehensive and broad program to deal with them as a group. Many people suffer chronic ill health during their later working life. Unless they are so totally disabled that they can meet the stringent definition of disability in the Social Security Act, they are in an economic no-man's-land. They are unable to work but are not yet eligible for their regular retirement benefits.

There are a number of changes that could be made in the Social Security Act that would help alleviate this problem.

First, we feel there should be an occupational definition of disability that would permit older workers after age 50 or 55 to receive disability benefits if their disability prevents them from doing their usual occupation.

Second, an increase in the number of drop-out years in the benefit formula would also help. At the present time, the social security law permits the dropping out of 5 years of low or no earnings in computing a worker's benefit which does provide some limited protection against unemployment, illness and low earnings. Because of the low wage bases in the earlier years of the system, which must be used in computing the average wage on which benefits are based,

the typical worker receives a low percentage of his wages earned shortly before retirement. The problem is compounded for older workers who are laid off by plant closings, technological changes, ill health, etc. who must include these years of low or zero earnings in determining their average wage. Additional drop out years would be of great help to them.

Third, the AFL–CIO also advocates a flexible zone of retirement between 60 and 65 that would permit retirement at age 60 with less than full actuarial reduction, In general, as workers grow older, they often find the pace of their work is beyond their physical ability. A flexible zone of retirement, if coupled with a substantial increase in benefits, would permit the individual to make a retirement decision during a period of years based on his financial resources, age, health and the nature of his occupation.

Though the social security program can be of considerable value to unemployed older workers, we know that it cannot solve what is essentially an unemployment problem. We are also advocating changes in other programs so that efforts in these various programs may dovetail to solve this social problem. It may not be possible to include all or most of our proposals for changing the Social Security law in this respect in the present legislation, but at the very least, Congress should refrain from making the problem of older workers more difficult by a more restrictive definition of disability.

DISABLED WIDOWS

The House bill restricted the Administration proposal to cover disabled widows without children by limiting it to those over age 50 and by reducing benefits to 50% of the deceased worker's primary benefit at that age and gradually increasing the amount, depending on the age at which benefits begin, to 82½% at age 62. The disabled widow would be condemned to a life of poverty on this amount. The reduced benefit will usually be less than public assistance disability benefits and these low social security benefits will do little except reduce the amount the widow receives from this source and leave her situation of dire poverty unchanged.

The theory in denying healthy widows without children a social security benefit is that she is capable of earning a living. This argument is hardly valid for disabled widows. In addition, surely the younger widow totally dependent on her deceased husband and incapacitated from work has as great a need as that of widows age 50 and over. The cost of full coverage is negligible and the difference in initial coverage of disabled widows of the two proposals is only 5000—65,000 vs. 70,000. Full coverage of disabled widows at unreduced widows' benefits would cost little, only .06% of payroll, but would be of immense benefit to the younger disabled widow in dire need of such protection.

RETIREMENT TEST

Both the Administration proposal and the House bill would liberalize the retirement test by raising the earnings exemption from $1500 to $1680 a year and by increasing from $2700 to $2880 the amount above $1680 a year for which a beneficiary can retain $1 in payments for each $2 in earnings.

Social Security (OASDHI) is a social insurance program that insures against the loss of income from work due to death, disability or retirement. The retirement test is a convenient means to determine if such a loss actually occurs. Only a small proportion, 9.4% or about 1.6 million people 65 or over, would benefit from the elimination of the retirement test. About half of these are receiving at least partial benefits because they are earning less than $2700 a year and probably would not be helped a great deal. Its elimination would benefit primarily those 800,000 persons who work full time and are not eligible for benefits because they earn more than $2700 a year.

The proposed liberalization is only adjusting for the increase in wages and prices since the $1500 limitation was adopted and, for that reason, we do not oppose it. However, we are concerned about the strong agitation for undue liberalization of the retirement test as a step toward its eventual elimination. The cost of its elimination would be equivalent to a 10% increase in benefits at the wage base proposed by the Administration and 8% at the present base. It is preferable to raise benefits which would help all beneficiaries including the majority who do not work after retirement and, therefore, would not be helped by elimination of the retirement test.

COVERAGE OF AGRICULTURAL WORKERS

The House eliminated the Administration proposal to lower the annual cash wage test for social security coverage for farm workers from the present $150 to $50 and to reduce the 20 day time test to 10 days. Many farm workers and their families do not have greater social security protection because they do not receive full credit for their work due to the short-term and seasonal nature of that work.

These workers are largely unorganized and only a minute number have any supplemental retirement income and badly need improved protection. The Administration proposal would improve social security protection for more than 500,000 farm workers by covering all or a larger part of their farm earnings. Of particular importance is the greater coverage of the earnings of more than 100,000 migratory farm workers.

This change would also enable farm workers to more quickly secure the required quarters of coverage to be insured in the event of early death or disability and provide protection for many farm families who do not have this protection under present law. We urge the inclusion of such a provision in any bill reported by this Committee.

WORKMEN'S COMPENSATION OFFSET

Under present law, a disabled worker receiving both workmen's compensation and social security benefits, has his social security benefit reduced by the amount combined benefits exceed 80% of his average earnings. The House made a minor improvement in this provision by providing, that in reducing benefits, earnings in excess of the taxable wage base can be included when computing the average wage. This avoids the situation, for example, where actual earnings are double the amount counted for social security purposes, and the disabled worker may receive combined benefits of only 40% of actual wages at the same time he is losing all or most of his social security benefits.

This is a step in the right direction, but we feel that any adjustment in overlapping benefits should not involve the social security benefit. A worker pays all his life into the social security program and it is unfair to take all or part of this benefit away from him. It should be his as a matter of earned right. In addition, the social security program is a universal program and it is impossible for this program to make special provision for all public and private plans.

FINANCING

The Administration would finance its social security proposals by an increase in the scheduled contribution rates on each party of 0.1% on January 1, 1969, and an additional .05% on January 1, 1973, for a total increase of .15% and by a three step increase in the taxable wage base to $7800 in 1968, $9000 in 1971, and $10,800 in 1974. The House would finance their much more modest improvements by raising the wage base to $7600 January 1, 1968, and increasing the eventual social security contribution rate .25% on each party. The less adequate House improvements require a higher tax rate because of the lower wage base.

The AFL-CIO has long felt that a substantial increase in benefits should be partially financed by increasing the earnings base on which both contributions and benefits are determined. In the early years of the Social Security program, contributions were paid on a very large proportion of most workers' earnings. The wage base would have to be increased to around $15,000 to cover the same proportion of payroll covered by the original $3000 wage base.

Because of the failure to raise the taxable wage base, there has been an erosion in the adequacy of benefits in relation to earnings since large numbers of workers are not receiving benefit protection related to their full earnings. It is imperative that the program cover the total earnings of the large majority of workers so that their benefits, which are based on covered earnings only, will be related to what they actually earned.

How adequate is the $7600 wage base in the House bill? The Social Security program began with about 95% of the persons in the program having their full earnings covered. A little over one-half of regularly employed men working in covered employment are covered at the present time. A $7600 base would increase this to about two-thirds and this proportion is projected to decline to about one-half again by 1974.

The higher wage base proposed by the Administration would not only improve the relation between a worker's actual earnings and his social security benefit

but would also provide additional income to further improve the program. Failure to raise the wage base puts an unfair burden on low-wage workers. In past years, increased coverage partially made up for the decreasing proportion of taxable payroll. But social security is now virtually a universal program and the possibilities of expanding coverage in the future are few.

If the wage base remains relatively static while earnings rise, social security contributions will be an ever decreasing proportion of the total national payroll. Higher benefits would require a higher tax on the decreasing proportion of income. Since the tax rate is uniform, low-wage workers bear a greater cost burden. One way to help relieve this problem would be the gradual introduction of general revenue contributions into the Social Security Trust Fund and we hope that your Committee will consider making a beginning step in that direction this year.

HEALTH INSURANCE FOR THE AGED

The AFL–CIO profoundly regrets that the House of Representatives did not include the disabled in the Medicare program. The definition of eligibility for disability benefits is a strict one—too strict. It requires that the disability be an extreme and chronic type involving incapacity for substantial gainful employment, of prolonged or indefinite duration, and frequently terminal in nature. In short, the definition of incapacity represents, in addition to ill health, loss of employment, earnings, and occupational activity.

Obviously, even more than the aged, the disabled are a high cost, high risk group and the cost of adequate private health insurance is beyond the means of most of them. According to the comprehensive survey of disabled workers in 1960, almost all required medical care during the year. Like the aged, they are hospitalized frequently and their hospital stays are long.

Health costs have increased at an accelerated rate and the disabled lack the income to pay for them. The 1960 study showed that 50% of the married disability beneficiary units had less than $170 per month in income exclusive of social security benefits. Most of the income for these family units came from the earnings of a working spouse. The income of non-married disability beneficiaries was less than $7 per month not counting social security benefits.

The House rejected coverage of the disabled on the grounds that the cost of providing health care for the disabled would be higher per capital than providing the same care for the aged. The fact that the cost of covering the disabled is greater per capita than for the aged is an argument for their coverage by Medicare. The higher cost indicates a greater incidence of illness and a greater social need. Though the per capita cost is higher, the total cost is much less and could be financed by only .05% of payroll on each party assuming the Administration's wage base.

The House recommended a study of the problem. The Advisory Council on Social Security has already studied the problem and recommended in its 1964 report that the disabled be covered. The failure to include coverage of the disabled by Medicare is one of the most glaring defects of H.R. 12080. We urge the Senate to correct this omission so that the disabled, like the aged, may have adequate health care with the dignity and self-respect that goes with the ability to pay.

CHANGE IN BILLING PROCEDURES

The House changed present billing procedures so that the patient can be reimbursed on the basis of an itemized bill rather than on the receipted bill basis as is now the case. In other words, if the doctor insists on direct billing, the elderly patient does not have to raise money to pay the bill so he can secure a receipted bill to send in for reimbursement. He simply submits an itemized bill. If the bill is within "the reasonable and customary fee," the doctor is reimbursed directly less deductibles and coinsurance. If higher, the patient receives the check and pays the doctor and any additional costs resulting from the higher than "reasonable and customary fee."

This does help eliminate the problem presently faced by many elderly—the difficult task of paying bills prior to reimbursement because the doctor refuses to accept assignment and insists on direct billing. On the other hand, since the elderly are overwhelmingly poor, there is a great pressure for the doctor to use the assignment method and accept reimbursement by the intermediary rather than force the elderly patient to raise the cash. We understand that some 57% of the doctors are using the assignment method, and what is of great importance, agree to accept the "reasonable and customary fee" in so doing.

The danger is that the proposed billing procedure will remove this pressure for the assignment method and greatly increase direct billing and the number of bills that excede the "reasonable and customary fee." Though the AFL-CIO does not oppose this change in billing procedure, we feel the best way to resolve the problem is to require that the assignment method be the only one for paying doctor bills.

We are greatly concerned about rising medical and hospital costs. The 7.8% increase in doctors' fees in 1966 was the largest in 44 years and we can expect a similar increase this year. Sooner or later the Congress is going to have to come to grips with the rising health costs facing the American people and the Medicare program is a good place to begin.

The "reasonable and customary fee" of the program is based on the "prevailing charge" for the service in question. This is the amount within a range which most doctors in an area charge for the service. This tends to build in automatic escalation for if some or most doctors raise their fees, the "prevailing charge" automatically increases. Prevailing fees, which were increasing about 3% in previous years, jumped 7.8% in 1966.

A recent HEW report to the President on the cost of medical care points to the increase in doctors' productivity as justification for recent fee increases. But something should be made clear here. When we talk about an increase in doctors' fees, we are not talking about an increase in income but what, in a rough sense, an economist calls unit labor costs. In other words, doctors' incomes will go up to a greater extent than the increase in fees because increases in productivity accrue to them as well.

It is interesting to note that we have not heard undue concern expressed by the Administration or the Council of Economic Advisors concerning these inflationary increases. What would be the reaction of the Administration and Congress, if a large international union in its negotiations with an employer, would achieve a wage agreement that absorbed the annual increase in productivity plus an additional wage increase that raised unit labor costs of that employer by about 8%?

Since organized labor is harassed for wage settlements far less than this, we find it hard to understand why the medical profession has been exempt from similar pressures.

A union must negotiate across the bargaining table. The medical profession is pretty much in a position to set its wages since it is in a sellers' market and, as far as the Medicare program is concerned, the method of determining the prevailing fee does little to retard fee increases. The rising cost situation clearly indicates a need for immediate action. We suggest for your consideration:

Doctors should be required to accept assignment and abide by the "reasonable and customary fee' and consideration should be given to holding that fee in line with increases in the Consumers Price Index.

If Congress does not eliminate direct billing, the intermediary should list the "reasonable and customary fee' range for each procedure and that list should be conspicuously posted in the doctor's office. Now the patient only finds out what he has to pay above that fee after he has already paid the bill. (The House bill does change the direct billing procedure so that the patient receives the check to pay the doctor if the bill is above the "reasonable and customary fee." The patient would know at that time how much his bill exceeds the prevailing fee.)

Each intermediary should have an advisory board, a majority of whom should be consumer representatives, including members of organized labor and the elderly. Consideration should be given to adoption of a fee schedule for doctors. Major changes in the fee schedule should require review by the advisory board and the Secretary of Health, Education, and Welfare.

MEDICAL FACILITY PLANNING

The rise in hospital costs has exceeded that of doctors fees—increasing by 16.5% during 1966. The cost situation is so serious that even the American Medical Association felt compelled to pass a resolution at its last convention stating in part:

"Historically, hospitals have been insulated from the discipline of the market place. The price of hospital care is a reflection of the hospital cost curve and now these costs appear to be out of control. The hospital's privilege of automatically translating all higher costs into higher prices must now be questioned. Incentives for increased efficiency and productivity are mandatory."

Yet, in spite of these serious-cost problems, the House eliminated an essential Administration proposal for holding down health costs by encouraging area-wide planning. This proposal provides that the depreciation of plant and equipment could be included in "reasonable cost" for hospital reimbursement only as such amounts are used for either capital or non-capital purposes under conditions approved by State planning agencies.

Conformity to health planning recommendations would minimize unnecessary duplication and inefficient use of facilities and would help save money, conserve personnel and reduce costs. Planning activities are already widespread. Twenty-three Blue Cross plans in 13 States include planning and/or depreciation funding provisions in contracts with member hospitals. The American Hospital Association in its "Principles of Payment for Hospital Care" makes similar recommendations and the Advisory Council on Social Security recommended a Commission on Planning for Medicare. We urge the inclusion of this Administration proposal in any Social Security bill reported out by this Committee.

OTHER PROVISIONS

There are several exclusions in the bill, though minor, which are unfortunate steps in the wrong direction. Currently, the patient must replace or pay for the first three pints of blood used. A House amendment provides that in order to get credit for replacement of that first pint, the beneficiary (or a person acting on his behalf) has to give two pints of blood. Those eligible for Medicare are past the age that they can give blood and so are most of their friends. Thus, it is not easy for them to find voluntary donors to avoid paying the blood deductible and they may be required to buy commercial blood to meet this burden. Union members make up a major donor group and based on our long-time experience, the AFL–CIO stands for one-for-one replacement for blood and urges that this continue to be the practice in the Medicare program.

The House bill also provides that "no payment may be made for expenses incurred for procedures performed (during the course of any eye examination) to determine the refractive state of the eye." This is only a tightening of an existing restriction but unfortunate since the emphasis should be on eliminating deductibles not expanding them. Failing eye sight is common among the elderly and frequent adjustment of eye glasses necessary. Not only refraction tests but eye glasses as well should be covered.

Similarly, prescription drugs are not covered. A large proportion of the aged have chronic ailments which do not require hospitalization but do require the continuous use of expensive drugs. During 1965, persons aged 65 and over spent more than $600 million for prescribed drugs and an additional several hundred million dollars for nonprescribed drugs. More than 3 million of them spent more than $100 a year for medicine including 600,000 who had drug expenses in excess of $250 per year.

Senator Joseph Montoya with 19 co-sponsors has introduced a bill (S. 17) which would extend present in-hospital drug coverage to elderly patients at home or in nursing homes after they pay the first $25 of drug expense. The new drug benefit would be financed by a 50¢ increase in the current $3 a month premium under Part B of Medicare. There would be an equal increase in the Federal contribution.

Another bill (S. 2299) introduced by the distinguished Chairman of the Senate Finance Committee, Russell Long, with two co-sponsors, would encourage prescribing of drugs for Medicare patients by their generic names, whenever these meet quality standards. This would reduce the price of drugs for the aged. The AFL–CIO supports both of these bills and urges their incorporation in any Social Security bill reported out by this Committee.

Many administrative problems have arisen in billing for outpatient services because of the difficulty in separating costs of these services between Part A (Hospital Services) and Part B (Physicians' Services). The House bill simplifies these billing procedures by including all outpatient services in the voluntary Part B program but subject to the higher deductibles and coinsurance features of that program. In return, inpatient hospital services such as pathology and diagnostic radiology would no longer be subject to any deductibles and coinsurance.

These changes help eliminate certain difficult administrative complexities and, for that reason, are not opposed by the AFL–CIO. However, a better ap-

proach would be the total elimination of the troublesome coinsurance and deductible provisions. The House proposal should also be modified so that in-hospital services of hospital-based physicians would be reimbursed under Part A. Experience shows that costs are less when such specialists as radiologists and pathologists are directly employed by the hospital. If hospitals are to be efficient and effective institutions and costs held down, there should be no intrusion into the pattern of employment relationships between a hospital and its medical staff by requiring reimbursement through Part B.

The House bill amends the definition of physician to include a doctor of podiatry with respect to the non-routine functions he is authorized to perform under the laws of the State in which he works. We have reservations about this change.

For example, what is considered routine foot care under the Medicare law is not routine for many of the elderly especially when coupled with a serious illness. The elderly for many reasons—arthritis, unsteady hands, and impaired vision are unable to reach their feet but routine care may be essential. For example, aged people frequently have diabetes and routine foot care is necessary to reduce the continuing danger of amputation. We see no reason why routine foot care should not be covered at least when certified as medically necessary by a qualified doctor.

In addition, we are always concerned about the quality of care in any medical program when certain specialities, with standards less than that required for fully qualified physicians, are included. We are concerned, for example, that high school graduates, with only 3 or 4 years of subsequent podiatry training, will be assuming responsibility for the care and diagnosis of some of the most difficult problems in medicine—conditions which are often attended by symptoms in the feet, but are systematic in origin. Podiatrists can play a useful and necessary role in health care for the aged but these services should not be provided except under the supervision of a qualified doctor.

The House would increase the number of days of hospitalization which can be covered in a spell of illness from 90 to 120 days but also would increase the coinsurance from $10 per day, now applying from the 61st to the 90th day, to $20 for the extended period. This is a slight step forward but the $20 coinsurance is too high. We urge the Senate to at least reduce the amount of the coinsurance to $10 per day which now applies after 60 days and, preferably, to eliminate it altogether.

Another change would abolish the National Medical Review Committee established by existing legislation but not yet formed. The Health Insurance Benefits Advisory Council (HIBAC) would assume the duties of that Committee and would have its membership increased from 16 to 19. We would not oppose this change if the additional members include consumer representatives. Providers of care already have a disproportionate representation on HIBAC. Those who have the greatest stake in health care, the consumers, are virtually ignored. We urge this Committee to specify congressional intent for greater consumer representation on HIBAC.

Eliminated was the Administration proposal to credit Federal service for social security purposes if a worker has no protection under either retirement system at the time of death, disablement or retirement. Federal employees and their organizations oppose this change at this time. Because of the complex issues involved, it is best that no action be taken now and that further study and exploration of the subject with employee organizations be made.

TITLE XIX—MEDICAL ASSISTANCE

The AFL–CIO deeply regrets the provisions of H.R. 12080 reducing both coverage and services under Title XIX or "Medicaid." While the changes in Title XIX are not all bad, most of the provisions of H.R. 12080 dealing with this title all but repeal, in our opinion, the basic goal of the program, namely, providing comprehensive health services to all individuals who cannot afford to pay for the medical care they need. Title XIX was a monumental achievement of the 89th Congress. Was the legislation, as passed in 1965, too statesmanlike? too far-sighted? too concerned with the public welfare? We think not, and to place the importance of "Medicaid" in proper perspective, we would like to cite a few facts.

As we stated before the House Ways and Means Committee last March in our testimony on H.R. 5710, the relative rank of the United States in regard to in-

fant mortality rates among the nations of the world has been falling. In 1950, the U.S. ranked sixth among the nations of the world. In 1960, we fell to eleventh place and in 1965, the United States ranked fifteenth. We have noted that the Report of the House Ways and Means Committee on H.R. 12080 cited a 5% reduction in infant mortality rates in the last year which in 1966 reached a new low of 23.4 per 1000 live births. There are no international comparisons after 1965, but rates in other countries are improving too, and our rate of 23.4 per 1000 live births compares with 12.4 for Sweden, 14.4 for the Netherlands and 16.8 for Norway.

We think it significant that the countries whose infant mortality rates are lower than ours have a system of providing or of financing health care for the great majority of their population, rich and poor alike. While we would favor a single financial mechanism, such as national health insurance, to provide protection against the cost of illness for the entire population, a combination of programs such as we now have in Titles XVII and XIX of the Social Security Act, the provisions in the Social Security Act regarding child health and voluntary health insurance, in combination, could come close to meeting the same objective.

However, this is not true if the Title XIX program is limited to the very, very poor. As originally intended it should continue to cover both the needy and the medically needy, that is, anyone whose income is so restricted that he cannot pay for the medical care required for himself and his family.

The American people now consider health services as a right which should not be denied to any citizen because of his inability to pay. Medical services should therefore be made available on the basis of the health needs of people rather than their ability to pay. The question arises, of course, what should a person, on the average, pay for the medical services he needs? Undoubtedly, there are difficulties associated with determining what people should spend to meet their health needs. One measure might be what people with moderate and higher incomes actually spend for medical care. People who can afford it can presumably meet their need.

According to the National Health Survey study, "Medical Care, Health Status and Family Income," families with income of over $7,000 per year spent $153 per person per year for their medical care. The survey was for the latter half of 1962 and since then medical costs have risen about 19 percent.

Let us, however, be conservative. In 1964, consumer expenditures for health services averaged $131.18 per person. Adjusting this to May 1967 for the rise in medical care prices, the average person, including the poor person who does not spend enough to meet his health needs, should be spending about $149 per person per year. On this basis an average family of four would be spending almost $600 per year for health services. At the poverty level of $3100, such a family could not afford to spend anything like this. Even for a family of four with a $6000 income, such expenditures would represent about 10 percent of their income. We believe the Title XIX program should have as its goal the paying of medical bills for all people who cannot afford the care they need. Unless this is done, we predict the relative health standing of the United States will continue to decline in the future.

Federal Matching Formula

It is on the basis of these facts that we oppose the limitations imposed on the States by H.R. 12080. The House bill provides two ceilings and each State would be required to apply the formula which would yield the lower result. One formula would limit Federal participation to 133⅓ percent of the AFDC cash assistance level which is much too low. This limitation would mean that the States of California, Connecticut, Delaware, Illinois, Iowa, Kentucky, Maryland, Michigan, Nebraska, New York, Oklahoma, Pennsylvania, Rhode Island and Wisconsin would be immediately affected and would either have to reduce their income levels for eligibility or increase State expenditures for medical assistance. These States acted in good faith on the basis of the Social Security Amendments of 1965, and we do not think it fair or equitable that they should be so penalized.

We most strenuously object to these provisions in that they appear to reflect a reversal in the philosophy of Federal-State relationships. In most Federal-State programs, the Federal government establishes minimum and not maximum standards and generally encourages the States to improve upon such

minimum standards. Based on this principle, we also oppose the ceiling on Federal matching of Title XIX of 150 percent of the highest income standard used by the State in determining eligibility for cash assistance as was provided by H.R. 5710 even though few States would have been affected by this more "liberal" ceiling. The stringent provisions of H.R. 12080 would not only affect 14 States, but would also mean that four States would have to lower their eligibility standards for medical assistance by more than $1000 for a family of four if they could not afford to offset Federal funds with State funds. For a family of four persons, Illinois would need to reduce its eligibility standard by $1,200, Nebraska by $1,100, New York by $2,100 and Rhode Island by $1,400.

The alternative limitation on Federal matching would limit Federal payments under Title XIX to 133⅓ percent of the State per capita income. While this alternative formula does not appear to affect any additional State at this time, the provision appears to be directed to prevent a State from raising both its eligibility standards and payments for cash assistance and thereby raising the income standard for medical assistance.

One of the major goals of the Title XIX program was to enable those persons whose incomes were above cash assistance levels, but whose incomes were insufficient to pay for needed medical care, to have their health needs met. Since one of the major causes of dependency, today, is the crushing burden of paying the cost of a serious illness, the concept of medical assistance for the medically needy was a sound one from both a health and economic standpoint. Yet, the provisions of H.R. 12080 would actually deny medical assistance not only to the medically needy but even to persons eligible for cash assistance. This paradox results from the fact that the House bill limits Federal participation in Title XIX to those families whose incomes are less than 133 percent of the highest amount ordinarily paid a family under the AFDC program.

Take, for example, the case cited by HEW Under-Secretary Wilbur J. Cohen in his testimony before this Committee on August 22, 1967. In Indiana, a family of 4 is eligible to receive cash assistance if their income is below $271.40 per month. Yet the highest cash payment is $103. For purposes of Federal matching, the family could receive medical assistance only if their income were below $137.00.

Other parts of H.R. 12080 relating to Title XIX that we find objectionable are:

1) *Maintenance of State effort.*—H.R. 12080 appears to completely repeal the present requirement that the various States must maintain their level of fiscal effort for medical care after new Federal funds become available to them. We strongly believe additional Federal funds should be utilized to expand medical assistance programs and not provide an offset for State expenditures.

2) *Co-ordination of Titles XVIII and XIX.*—Under H.R. 12080, the poorer States which receive more than 50 percent participation by the Federal government in their Title XIX programs would be required to increase their financial commitments for medically needy aged persons over age 65 who are enrolled under Part B of Title XVIII. This results because there is no Federal matching for the $3.00 Medicare premium which the States would have to pay for their medically needy senior citizens. While the $3.00 per month premium is matched on a 50–50 basis by the Federal government under Title XVIII, all those poorer States which receive more than 50 percent matching by the Federal government would lose in comparison with present law. This will certainly discourage the States with low per capita incomes from providing Medicare coverage for the medically needy. While the AFL–CIO favors coordination between Titles XVIII and XIX, provision should be made for Federal participation to the same extent as such participation is allowed for persons under age 65.

3) *Comparability Provision.*—Since the goal of the Title XIX program is to provide comprehensive health services to all eligibles based on an income resource level by 1975, the AFL–CIO regrets the provision in H.R. 12080 modifying the requirement in present law that various categories of needy and medically needy should receive benefits that are equal in amount, duration and scope. Discrimination as between those over 65 and those under 65 discriminates as between different categories of people and is repugnant to American principles of equal treatment of all citizens. We suggest that implicit in this provision is the possibility that the law will discriminate against children. We are confident that the Congress, upon examination of this provision, will not tolerate discrimination against needy children.

4) *Required Services.*—We can see no rationale whatever to justify the provision in H.R. 12080 that the States may have the option of providing 7 out of a total of 14 stipulated services in present law. The law now stipulates each state must provide, in order to receive Federal funds:

(a) In-patient hospital services.
(b) Out-patient hospital services.
(c) Other laboratory and X-ray services.
(d) Skilled nursing home services.
(e) Physician services.

Is it seriously suggested that other services can be substituted for (a) and (e) above? Without physician services what kind of unbalanced bob-tailed program do we have? I cannot believe the House of Representatives fully understood the implication of their action. Without physician services, how does a patient get referred to a hospital or to a nursing home? Who orders diagnostic tests, either on an in-patient or out-patient basis? What happens to a critically ill patient if hospital services are not provided?

The five services which Title XIX required by July 1 of this year are the basic core of a medical program and, in our opinion, substitution would inevitably be self-defeating. We urge elimination of this provision.

5) *Limitation on Matching for Puerto Rico.*—We also oppose the provision in H.R. 12080 which would limit the ratio of Federal matching for Puerto Rico to 50 percent instead of the present 55 percent. The overall dollar limit of $20 million should also be repealed.

6) *Direct Billing.*—Lastly, we believe the appropriate method of reimbursing physicians is through assignment of doctor bills to the State agency or fiscal intermediary. Because the aged and the poor often have no resources with which to pay their medical bills, both H.R. 5710 and H.R. 12080 provide payment under the direct billing procedure on the basis of an itemized rather than receipted bill. Because this provision does resolve the problem of people without cash resources paying their bills we have indicated we are willing, under Title XVIII, to give this procedure a try despite the fact that about half of all physicians are now accepting assignments. However, we find the direct billing procedure more objectionable under Title XIX than under Title XVIII. Under Title XIX we have not only the dependent aged but also the disabled, dependent children and the blind. Many of such people would not know what to do when presented with a doctor bill. We therefore belie evdirect billing should be eliminated for Title XIX.

Improvements

H.R. 12080 does include some improvements. We favor the same 75 percent Federal matching for physicians and other professional medical personnel working on the Title XIX program regardless of the agency for which they may be working. We support the Advisory Council on Medical Assistance. Lately, we are particularly pleased with the provision in H.R. 12080 that people covered by Medicaid should be allowed free choice, not only of physicians, but of systems of delivering health services.

CHILD HEALTH

In general, we believe the Child Health provisions of H.R. 12080 represent an improvement over those of H.R. 5710. The consolidation of three programs under a single authorization should afford greater flexibility in meeting child health needs based on priorities established by planning agencies. Our only reservation in regard to the Child Health Amendments is that 10 percent of the total authorization for research and training may be too small a percentage. We also question the wisdom of transferring authority to the States for project grants to help reduce the incidence of mental retardation, to promote the health of children and youth and to provide dental care to children. Finally, we strongly support S. 580, introduced by Senator Ribicoff providing health screening for pre-school age children.

TITLE IV—GENERAL PROVISIONS

We strongly approve of Section 402 in H.R. 12080 granting authority to the Secretary of Health, Education and Welfare to experiment in methods of reimbursement for hospitals and other institutions toward the goal of increasing the efficiency by which such services are delivered. The section applies only to

organizations and institutions entitled to reimbursement on the basis of reasonable cost and not to physicians reimbursed on the basis of reasonable charge.

The physician is the key to controlling costs, not the hospital. It is a physician who decides whether the patient should be hospitalized or not hospitalized and for how long. It is he who decides the course of treatment, what drugs are prescribed and what diagnostic procedures are required or appropriate to facilitate his diagnosis. The fact that physicians in group practice prepayment plans use about half as much non-maternity hospitalization as do physicians paid on a fee-for-service basis demonstrates the need for experimentation and innovation in methods of reimbursing physicians. We therefore urge your consideration to extending this experimental provision to reasonable charges of physicians as well as to reasonable costs.

PUBLIC WELFARE

The public assistance program was established to provide at least the basic necessities of life to those who because of age, illness, disability, unemployment or other reasons were unable to provide for their own needs. It was intended as the ultimate guarantee against destitution and social deprivation. Today, our public assistance programs fall far short of these goals. It has become increasingly obvious to everyone concerned with the problem that drastic steps must be taken to overhaul our welfare system.

We in organized labor have long been concerned with the problem of our welfare system. We are aware of its inadequacies and its shortcomings.

We are convinced that for some welfare recipients who are able to work, the way out of poverty and dependency is good jobs at decent wages. For many others, because of their social and physical handicaps, this route out of poverty may have little to offer. Therefore, it becomes the responsibility of government to provide maintenance income at levels that meet at least subsistence needs. But more, we are concerned with the fact that many family breadwinners, both men and women, are unable to find jobs so that they can become self-supporting. We are concerned that the public welfare system is not meeting minimum subsistence needs for most welfare recipients. We are concerned because for those receiving assistance, it is often a complex and degrading procedure. We are concerned because welfare rules serve to disqualify and discourage people in need and because they sometimes force fathers to desert so that their families can get assistance.

It is against these facts that we must look at H.R. 12080. The public assistance provisions of H.R. 12080 contain two major approaches to the problem of reducing the welfare rolls. One is to put as many as possible AFDC parents and children over 16 and out of school into work and training programs. The other is to simply keep as many needy people as possible off public assistance through restrictive clauses in the law.

The idea behind the first approach is that the work and training programs will curtail the welfare rolls by making those participating in these programs self-supporting. It assumes that in most cases mothers of young children should work rather than look after their children. The bill compels mothers and children over 16 and out of school to take training on the assumption that there will be jobs available of the kind that they are capable of filling.

Let us examine these assumptions. Some mothers obviously can and should be trained for work. Others would do much better by staying home and looking after their children. Whether a mother works or not should depend on a number of factors which this bill does not take into account. It gives the welfare departments almost complete control over the determination as to whether or not assignment to a work-training program is warranted. The bill provides them with punitive leverage which, in effect, would force an AFDC mother to go into a work-training program.

To enforce this approach the following punitive measures are included in the bill to cover those families who do not cooperate:

1. They could be cut off assistance.
2. The family could be placed under protective payments or voucher relief, with none of the restrictions of the present law on the application of these drastic steps.
3. The family could have their payments reduced by eliminating all adults.
4. The family could have their children removed by court order and placed in foster care.

It is unrealistic to assume that adults who have been on the welfare rolls for a long period of time can be placed in jobs within a relatively short time. The

job of individual and family rehabilitation is a long, slow process. Then, where are the jobs that the people on welfare are going to? There's a widely held belief that there's a job for every citizen—if he really looks hard enough and wants to work. Unfortunately, this just isn't true. There are not enough jobs to go around, especially for those with limited skills and education. Today, there are 3½ million Americans looking for work. There are another million, perhaps more (no one knows for sure) who have given up hope and are no longer actively looking for work and are no longer counted in the official unemployment figures. But in our ghettos unemployment runs between 30 and 50 percent.

The AFL–CIO is not opposed to community work and training programs as one way that public assistance recipients can prepare for jobs. We have repeatedly said that the way out of poverty is good jobs at decent wages for all who can work.

The AFL–CIO is opposed to the work and training provisions of H.R. 12080 that are based on programs that have in the past not been notably successful in giving welfare recipients effective training for jobs. These programs have an even worse record in job placement for those who have taken training programs.

The AFL–CIO is opposed to the authoritarian methods that are proposed in H.R. 12080. The entire work and training program bristles with coercive mandates that may be exercised against a welfare recipient. The major thrust of prior amendments to the public welfare law has been in the direction of humanising and dignifying the relationship between the recipient and the welfare system. This approach is completely absent from H.R. 12080.

The AFL–CIO is opposed to the restrictions and penalties proposed in H.R. 12080 when refusal to cooperate can only be for "good cause" and no guidelines are offered to determine what "good cause" is.

The AFL–CIO is opposed to the punitive measures that can be invoked under the provisions of H.R. 12080, that are directed at the children of AFDC parents and that only serve to accelerate family disintegration.

In addition, H.R. 12080 raises many other questions.

The Use of the Welfare Department for Work and Training Programs. Congress, over the past several years, has given the Labor Department the responsibility for manpower development and training programs. The Administration in H.R. 5710 included a provision which would, in effect, have made permanent and expanded the provisions for work and training which were included in Title V of the Economic Opportunity Act and placed them under Labor Department administration.

The AFL–CIO feels strongly that if a program of work and training is to be embarked on, it should be brought under an already existing manpower development system which is at present operating at a relatively high degree of efficiency. The AFL–CIO recommends that the community work and training program should utilize and expand existing structures within the Labor Department rather than have a new training structure established as proposed by H.R. 5710.

Secretary of Labor Willard Wirtz, in a recent letter, stated: "The Committee, in writing a mandatory community work and training provision, was obviously influenced by the projected increase in AFDC cases during the next several years. If this is to be a rehabilitation program, then its size and scope should clearly be geared to potential for rehabilitation which would lead to viable employment opportunities. The punitive approach would not be necessary in our judgment if meaningful training and job opportunities were developed for welfare clients who are able to participate. The Department of Labor is today involved with a number of manpower development programs which are proving this point and which could be expanded to meet the needs of this specific group." A copy of this letter is attached to this statement.

The present bill (H.R. 12080) provides that work or training of welfare recipients can be provided by private employers, among others. There are no provisions in the bill which would protect a welfare recipient from exploitation by an employer or from having an employer use the services of the welfare trainee to satisfy an immediate job need without providing any long-range benefit to the welfare trainee either in usable skills, meaningful work experience or adequate remuneration. This can indeed lead to a form of industrial exploitation which organised labor and forward-looking citizens have long opposed.

Care of Children of Mothers Absent From Home. Another related question raised by the proposed legislation is the problem of day-care for AFDC mothers participating in the work and training program. It is true that the present legis-

lation provides funds for greatly expanded day-care facilities. We in the AFL-CIO have long advocated the need for increased day-care services and facilities for those mothers with small children who choose to enter the work force. The massive program contemplated requires a vast increase in day-care facilities. Although no Federal standards are mandated for day-care, a weakness in itself, among the other barriers to providing adequate day-care are the lack of trained personnel as well as lack of adequate quarters and food handling facilities which many States do, and all States should, require before licensing such facilities. Nor can such resources of personnel and facilities become rapidly available.

Without adequate day-care, the daily departure of the mother from the home for her work or training program would create an untold hardship both for the mother and the children and the prospect of large numbers of children inadequately cared for carries the potential for impairment of the development of young children which may ultimately reflect itself in anti-social behavior patterns.

AFDC Ceiling. There are several provisions in the present House bill which are definitely restrictive in character. The bill places a limitation on the number of children eligible for assistance. Under H.R. 12080, the States would receive from the Federal government only an amount reflecting the number of children from broken homes receiving AFDC in ratio to the total number of children in each State under 21, as of January 1, 1967. It does not recognise the possibility of changing economic conditions or heavy in-migration into the various States. This would force the States which continued to take onto its rolls all those normally eligible for AFDC, to reduce the assistance payments for all families, or to assume the full cost of the additional applicants or to cut those who are eligible but who are in excess of the quota.

This provision would penalise the children in the harshest manner for what society happens to consider the shortcomings of the parents. This is indeed a reversion to something even beyond the Elizabethan poor laws and certainly cannot be tolerated by a society such as ours whose moral values are based on Judeo-Christian concepts. This could have an even more profound effect in the ghetto in that it would add another and a very real grievance to those which many ghetto residents already hold. To saddle added burdens onto those who already live with a daily overload of anger and frustration will only make for increased tensions in the slums.

Work Incentives. H.R. 12080 has allowed a work incentive which would permit a family receiving Aid to Families with Dependent Children (AFDC) to earn $30 monthly with no reduction in assistance, plus one-third of the remainder for each month.

Both H.R. 5710 and the somewhat different new Administration proposal presented to this Committee are rather more generous in that they allow welfare recipients to earn a larger amount with no reduction in assistance. This is an important way to develop motivation for those on relief to seek to become self-supporting. The incentive allowance should be made as generous as possible so as to serve as a motivating factor to welfare recipients to seek work in the job market.

States Should Meet Full Need. H.R. 5710 would require the States to meet full subsistence need as they themselves determine it to be with at least one repricing each year. This provision is eliminated from H.R. 12080.

In view of the extremely low subsistence payments being made by the States, it is clearly the intention of H.R. 12080 to continue those individuals and families that require public assistance in dire poverty.

The overwhelming number of individuals and families who receive public assistance do so usually because of circumstances beyond their control. They should be allowed money payments at least at the level determined by the States to meet their subsistence needs. The AFL-CIO recommends that this requirement now in H.R. 5710 be incorporated into the Senate bill.

Assistance to Migrants. In H.R. 5710, the Administration took cognisance of the fact that there are large numbers of migratory workers who for reasons beyond their control may not be able to find employment. A provision was written into the bill which would permit grants to the States for temporary assistance up to sixty days for migratory workers and their families. The House-passed bill (H.R. 12080) has revised his proposal to one which would offer emergency assistance up to thirty days to needy children and their families, with 50 percent Federal matching.

The Administration proposal meets the needs of migratory workers much more adequately than the existing proposal. Many States will not take advantage of the program because of the 50 percent matching requirement. For many migratory workers, even a sixty day emergency period would not carry them from one work season to another. We urge that the provision in H.R. 5710 for migratory workers be restored.

Assistance to Families with Unemployed Fathers. For the first time, H.R. 12080 requires that the parent must have had a substantial connection with the work force in order to qualify for assistance. This provision will eliminate many men who have never had an opportunity for regular employment. In addition, the provision in the legislation denying assistance to unemployed parents who have applied for or are receiving unemployment compensation will penalize those who need both kinds of help to survive. This provision is a clear example of short-sighted handling of a problem, since it will, in effect, only succeed in forcing families to break up, causing fathers to leave home so that the family can obtain assistance under AFDC.

The AFL-CIO is opposed to this punitive approach to the problem of unemployed fathers and urges the extension of the AFDC program to cover unemployed parents without the restrictions contained in H.R. 12080. In addition, we urge this program be made mandatory upon the States.

Costs of Proposed Program. The report of the House Ways and Means Committee estimates that H.R. 12080 would make possible savings in the year 1972, "for persons trained who become self-sufficient" of $130 million over what it would cost if none of these people were to be separated from the rolls. This is only 7 percent of the 1972 cost of the program, indicating a reduction in the rolls of only this number of welfare recipients. However, the report estimates that in 1972, the cost of day-care for children whose mothers are in the work and training programs at $470 million plus $225 million for the work and training program itself. This $695 million is more than five times the $130 million saved on welfare payments.

If the estimate of the 7 percent reduction in welfare recipients is too low, it is obvious that the anticipated cost of the work-training program and day-care would also rise. In this way, it can be expected that the five-to-one ratio between costs and savings will remain.

Therefore, by the Committee's own estimate the programs proposed under H.R. 12080 will not cut the cost of public assistance when the outlays for day-care and work-training programs are included.

Our welfare system deeply affects the mood and temper of the slums. We are not going to solve the crisis of our cities by cutting people off the welfare rolls. Nor are we going to solve this crisis by forcing welfare recipients to accept training for jobs when we have no idea whether jobs will be available when they have finished their training. Nor can we expect that the punitive aspects of the House bill will be accepted without bitterness and hostility.

It is our hope that this Committee will give serious consideration to accepting the provisions of H.R. 5710 relating to public welfare. They are not all we would like to see by way of revising and overhauling the public welfare system to make it adequate to today's needs, but at least this bill makes constructive proposals that are relevant to the problems before us.

STATEMENT BY THE AFL-CIO EXECUTIVE COUNCIL ON SOCIAL SECURITY BILL, NEW YORK, N.Y., SEPTEMBER 11, 1967

Substantial Social Security gains, as a down-payment on the fully up-to-date Social Security system the nation should have as soon as possible, are a major legislative objective of the AFL-CIO this year. The bill passed by the House of Representatives (H.R. 12080), while providing somewhat higher Social Security benefits and a few other changes, falls far short of the steps which can and should be taken now to improve the lives of 23 million elderly and others dependent on Social Security.

While the House did improve the Social Security system somewhat, though not nearly enough, it also has made drastic and punitive changes in our Public Welfare system which, if allowed to stand, could deprive hundreds of thousands of mothers and children of the pitifully meager payments they have been receiving.

The House bill provides for a 12½ percent increase in Social Security payments with only a minimally higher benefit rise for those receiving lowest benefits. By contrast, the President recommended and the AFL–CIO strongly supports a 15 percent across-the-board increase with substantially higher minimum benefits. This would mean not only retirement benefits more in line with pre-retirement incomes for all beneficiaries, but would have a significantly more effective impact on the living conditions of the 8 million Social Security beneficiaries now below the poverty line. Here the contrast is sharpest: The President's proposals would lift at least 2 million Social Security beneficiaries from the mire of poverty. The House bill would achieve this goal for only half that number.

The House refused to extend Medicare coverage to the disabled. This is a group with limited incomes and higher-than-average medical costs who particularly need and deserve the protection Medicare can offer. The House bill contains some minor Medicare improvements but does virtually nothing to put brakes on skyrocketing fees and charges paid under Medicare. These rapidly rising costs are not only holding back needed Medicare improvements but, by their impact on the general structure of medical charges, are forcing up, at an unprecedented rate the medical costs of all Americans.

By sharply restricting eligibility standards for participants in the Medicaid program, the House would bar hundreds of thousands of the needy and medically needy from medical care their limited incomes put beyond their reach. To make matters worse, the House has also made possible severe limitation of essential medical services for those who will still be eligible for Medicaid.

The worst features of the House-passed bill are those relating to public assistance. Since the days of Franklin D. Roosevelt, this country has adhered to the fundamental principle that people who are unable to work or cannot find jobs are entitled to assistance. That assistance is provided by the states and localities, largely under their own standards of eligibility, need, and level of payment, with some of the costs defrayed by the Federal government. Everywhere the assistance is extremely meager; in fact, in most states it is below the estimate of minimum needs set by the states themselves. In the majority of states, no assistance whatsoever is available when there is an able-bodied father in the home, regardless of how determined his efforts to secure work.

What American needs is a thoroughgoing overhaul of the public assistance system; which would include raising to at least minimum levels the below-subsistence payments prevailing today and greatly stepping up training and employment programs for welfare recipients. This would improve existing sub-poverty living conditions and give able-bodied public assistance recipients, who are not caring for small children, the opportunity to obtain jobs at decent wages and under good working conditions.

Instead, the House of Representatives has passed a punitive measure which does nothing to improve shockingly inadequate public assistance payments, but jeopardizes the chances of large numbers of the poor of continuing to obtain even these pittances. Under sanction of removal from assistance, the House bill would force mothers with children into locally-administered training programs with no assurance that the training would be adequate or that there would be employment after training is completed. Even worse, there would be no guarantee of adequate day-care for children in such families or of financial support for needy children whose parents would be removed from the rolls. To reinforce these harsh conditions, the House placed an absolute ceiling on the number of children in a state whose families could be given assistance because of the absence of a father. Thus, the full weight of these punitive provisions would fall most heavily on innocent children who could be deprived of either the bare necessities of life or of their mother's care.

We are deeply disturbed that the House has failed to transfer the community work and training program to the Department of Labor, as the President wisely recommended. The Labor Department has developed the skill, knowledge and machinery for effectively training those who have been marginally equipped to enter the labor market. Welfare recipients need the best possible training, under good working conditions and decent wages, to restore them to self-sufficiency. We also strongly object to the fact that under the House bill welfare recipients, assigned to community work and training, could be placed in private industry at subminimum wages and without other safeguards that would prevent their exploitation.

The Social Security bill is now under Senate consideration. The AFL–CIO urges the Senate to make the necessary changes in H.R. 12080 in order that it

more nearly meets the nation's Social Security and Welfare requirements. In particular, we ask the Senate to:

1. Raise the minimum Social Security benefit level to $70 for a single person and $105 for a couple, and increase all other benefits by at least 15 percent. This would make possible the over-all 20 percent increase in benefit payments the President has recommended.
2. Finance the benefit improvements by an increase in the earnings level on which both contributions and benefits are determined, by steps from the present $6,600 to $10,800.
3. Extend Medicare coverage to the disabled.
4. Establish reasonable controls on unduly high hospital charges and physician fees paid under Medicare.
5. Assure that Medicaid is available to the needy and the medically needy whose limited incomes cannot pay for adequate health care, and that it provides essential medical services to those covered.
6. Improve present appallingly inadequate public assistance payments and assure adequate day-care for children of families receiving assistance in which the mother is participating in work and training programs; eliminate provisions in the House bill which would force mothers with small children into work and training programs without assurance of decent jobs after training or adequate day-care for their children; and remove inflexible ceiling on assistance to families with dependent children eligible because of absence of a parent.
7. Strengthen rather than weaken the possibility of poor families remaining together by requiring States to make assistance available where the father is in the home until he can obtain work for which he is qualified.
8. Transfer administration of community work and training to the Department of Labor with provision of adequate safeguards for those assigned to this program, including requirement of payment of prevailing wages and in no case less than the applicable minimum wage.

U.S. DEPARTMENT OF LABOR,
OFFICE OF THE SECRETARY,
Washington, August 23, 1967.

Mr. BERT SEIDMAN,
Director, Department of Social Security,
AFL–CIO,
Washington, D.C.

DEAR MR. SEIDMAN: HR–12080 as reported out by the House Ways and Means Committee differs considerably from the provisions in HR–5710 which was the Administration Bill introduced in the House. In amending a comprehensive piece of legislation such as the Social Security Act, one of the real dangers is that significant amendments may be overlooked by interested groups and that the full impact of such amendments may not be thoroughly aired. This may be the case with the community work and training provisions in HR–12080.

The Committee, in writing a mandatory community work and training provision, was obviously influenced by the projected increase in AFDC cases during the next several years. If this is to be a rehabilitation program, then its size and scope should clearly be geared to potential for rehabilitation which would lead to viable employment opportunities. The punitive approach would not be necessary in our judgment if meaningful training and job opportunities were developed for welfare clients who are able to participate. The Department of Labor is today involved with a number of manpower development programs which are proving this point and which could be expanded to meet the needs of this specific group.

With regard to your specific questions relating to training programs and occupations which could be developed for this group, we are now in the process of analyzing our experiences with welfare clients in training programs. Within the next few days, we will furnish to you these data showing training characteristics of welfare clients as well as training results.

I appreciate your interest in this important area and trust that the information we will soon provide will be of value to you.

Sincerely,

W. WILLARD WIRTZ,
Secretary of Labor.

(A short recess was taken.)

The CHAIRMAN. Is Mr. Henry Chase of the Humble Oil & Refining Co., present? Mr. Chase, I am going to call the committee hearing back to order and we will be pleased to hear your statement, sir.

STATEMENT OF HENRY CHASE ON BEHALF OF THE CHAMBER OF COMMERCE OF THE UNITED STATES; ACCOMPANIED BY WILLIAM P. McHENRY, THE NATIONAL CHAMBER'S STAFF

Mr. CHASE. Thank you, Senator.

My name is Henry Chase and I am employed by the Humble Oil & Refining Co., Houston, Tex. With me is Mr. William McHenry of the national chamber's staff. Mr. Chairman, I am speaking on behalf of the Chamber of Commerce of the United States to express its views based on policies established by the majority of its members. We appreciate this opportunity to appear before your committee and express our views on H.R. 12080.

I would like to begin by reviewing briefly the purpose and principles of social security.

The purpose of social security is to protect workers and their dependents against presumed need arising from job-income loss on reaching old age, from permanent and total disability or early death of the wage earner. To achieve this purpose, certain principles were laid down by this committee and by the House Ways and Means Committee and approved by the Congress. I refer to the following concepts:

(*a*) Benefits are paid as a matter of right and without regard to individual "need."

(*b*) Benefits provide partial replacement of the job-income loss.

(*c*) Benefits are directly related to the job-income loss.

(*d*) Benefits are financed solely from payroll taxes levied on workers and employers.

(*e*) Benefits are intended to provide a "floor of protection" upon which the individual can build a higher standard of living through homeownership, savings, private pensions, and insurance.

The chamber has supported, and it continues to support, an effective social security program based on these fundamental concepts.

Let me now summarize the recommendations we will advance to strengthen and improve the present social security program.

The national chamber recommends:

(1) An across-the-board increase in benefits.

(2) An increase in the monthly benefits paid to the aged who are receiving special payments as a consequence of the Social Security Amendments of 1965 and the Tax Adjustment Act of 1966.

(3) That eligibility requirements for disability benefits be liberalized for young workers.

(4) That no arbitrary dollar limit be placed on the benefits payable to the spouse of a retired or disabled worker.

Now, I would like to turn to the provisions of the bill commencing with section 101.

The chamber recommends that Congress approve an across-the-board benefit increase that is commensurate with the rise in the cost of living. The chamber concludes that a benefit increase of between 9 per-

cent and 10 percent would be appropriate. Any increase appreciably greater than this would be excessive when gaged by appropriate criteria of benefit adequacy.

Because the purpose of social security is to prevent presumed dependency and need—chiefly for the aged—benefit adequacy usually has been appraised in terms of what proportion of elderly beneficiaries must seek old-age assistance to supplement their social security benefits. A guideline enunciated by the House Ways and Means Committee in 1954 states:

> The protection afforded by the program may be considered adequate only when benefits are high enough, when added to savings and assets normally accumulated, so most beneficiaries will not have to apply for public assistance for the ordinary expenses of living.

The first Commissioner of Social Security, Dr. Altmeyer, said the benefit structure would be satisfactory if the vast majority of beneficiaries, about 90 percent, did not have to seek public relief to supplement their social security benefits. By this test the existing benefit structure appears satisfactory.

Nevertheless, in order to assure that the burden of inflation does not fall with disproportionate weight on retired workers and other social security beneficiaries during this period of rising prices, we do recommend that benefits be increased by about 9 to 10 percent.

I think that the section of the bill governing the benefits to the special aged groups should be considered in conjunction with the mimimum primary insurance amount. In 1965 Congress provided a special old-age benefit of $35 a month for persons with little covered employment, who were 72 and over. In the Tax Adjustment Act of 1966, Congress added identical benefits for persons 72 and over who had never worked in covered employment.

H.R. 12080 would raise the special $35 benefit to $40, at the same time, the bill would raise the minimum primary insurance amount from $44 to $50.

Now, the Department of Health, Education, and Welfare notes that most individuals who qualify for the lowest benefits had only marginal attachment to the labor market. In our judgment, there is little reason to differentiate between one group of individuals who had only marginal covered employment and another group whose covered employment record was not significantly different. The chamber, therefore, recommends that the special $35 benefit be raised to the minimum primary insurance amount established for other individuals.

Section 103 would limit the benefits paid to the spouse of some retired and disabled workers. The bill provides that the benefits payable to a wife cannot exceed $105 a month even though that is less than half of her husband's benefits. The apparent effect of this proposed limit is slight, since under the bill the maximum benefit payable to a wife in the absence of this proposal would be only $106.

The recommendations made to the Committee on Ways and Means by the Department of Health, Education, and Welfare included a proposal to limit a wife's benefits to $90 a month. In commenting on that proposal, the chamber noted that it would introduce into the social security program for the first time the concept of "need" as a determinant for limiting monthly benefit amounts. Since the value placed

upon the benefit limitation by the Government's chief actuary, Mr. Meyers, was only one-hundredth of 1 percent of taxable payroll, it could not have been suggested for the purpose of limiting costs. Apparently the purpose was to prevent a segment of one type of beneficiary from getting "too much" in benefits.

The Department's proposal and the proposal incorporated in H.R. 12080 are identical conceptually.

We think this proposal should be rejected.

Existing law denies virtually all workers under the age of 31 the protection of the disability benefits program. This happens because the law contains a "prior work" requirement which few young workers can meet. We recommend that a worker who becomes disabled before age 31 be able to qualify for benefits if he has been in covered employment for a reasonable period of time.

The House bill follows the longstanding principle that the social security program should be maintained on a self-supporting basis from payroll taxes levied on workers and employers. We believe that Congress, but more especially this committee and the Ways and Means Committee, are to be commended for adhering to the self-support principle while making changes and improvements in the social security program over the years.

About 60 percent of the benefit costs added to the bill would be financed from the existing long-range "tax surplus." The remaining 40 percent would be financed by increasing the taxable wage base to $7,600 and by increasing the tax rates.

On page 9 of our statement is a table that compares the tax increases scheduled under present law with those proposed under H.R. 12080. The amount of tax shown in each instance is the maximum combined tax levied on an employer and his employee. Under present law the tax is scheduled to rise from $580 this year to $712 in 1963, a 23-percent increase.

Under the bill the maximum tax would rise to $858 in 1973, an increase of 48 percent.

With respect to financing the national chamber recommends: (1) that the taxable wage base be continued at $6,600 for the present, (2) that the added benefit costs which cannot be paid for from the existing tax surplus be financed by higher tax rates, and (3) that the special benefits for those age 72 and over be financed from the trust fund.

Mr. Chairman, I am now going to move to page 11 in our statement which deals with public welfare provisions of the bill.

The basic objective of the public welfare proposals in H.R. 12080 is to encourage and assist as many as possible of those receiving aid to families with dependent children to become self-supporting.

At present it is unrealistic in the case of many recipients to expect them to secure gainful employment and move off the welfare rolls. The plain fact is that all too often they lack the most rudimentary skills. Experience indicates, however, that many of these individuals are capable of attaining financial independence if they receive the proper encouragement and assistance. Heretofore, such assistance in the form of basic literacy training, job training, financial incentives and other encouragements has not been made available to them except to a very limited degree.

Providing an education and work training program, for each individual for whom that is appropriate, specifically designed to enhance the employment prospect of that particular individual is a basic need that has been too long ignored. Unless this fundamental need is met, many recipients may be barred forever from full participation in our society and relegated to the public welfare rolls, either indefinitely or repeatedly. No one can view that prospect without dismay and concern.

The national chamber endorses the fundamental objective of helping AFDC recipients enter the mainstream of American society through the gateway of basic literacy, job training, employment and self-support. Under H.R. 12080, this objective would be implemented by imposing new Federal requirements on the States. The chamber, however, urges Congress to accomplish this objective by encouraging rather than by requiring the desired State action.

Section 220 of the bill would limit the Federal financial participation in Federal-State medical assistance programs. A significant number of families who have moderate incomes are eligible, or may become eligible, to receive medical assistance under some of the State programs. As a consequence, the Federal financial commitment is far in excess of what was anticipated, when Congress initiated the Federal-State medical assistance program 2 years ago.

As this committee knows, the Federal Government has an open-ended financial obligation under the medical assistance program and under the categorical aid programs. In discussing the rising Federal cost of these programs, the chairman of the House Committee on Ways and Means said, and I quote—

> These are items over which no one, including the President, has any control—except the Congress. The states send in their bills and we give them a check, after the expenditures have been incurred. There is no way to reduce these in the Appropriations Committee.

The chamber believes it is desirable to limit Federal financial participation to assure that medical assistance is not extended to those in the working population who have adequate incomes. Most such persons now have voluntary health insurance protection, either on an individual basis or under collective bargaining arrangements, and are capable of paying for their own medical care.

Mr. Chairman, let me reiterate briefly the principal point in our testimony on H.R. 12080.

The national chamber endorses the more realistic eligibility requirement for disability benefits that would be applicable to workers under age 31. It also endorses the proposed Advisory Council study on providing medicare for disabled beneficiaries.

The chamber supports an increase in benefits for the special aged groups qualified under the Social Security Amendments of 1965 and the Tax Adjustment Act of 1966.

We favor a limitation on Federal financial participation in the medical assistance program. The chamber endorses the fundamental objective of helping AFDC recipients enter the mainstream of American society through the gateway of basic literacy, job training, employment, and self-support.

We believe an across-the-board increase in benefits of about 9 to 10 percent would be appropriate at this time. An increase of this magni-

tude could be and should be financed without any upward adjustment in the taxable wage base.

Finally, the national chamber is opposed to the imposition of an arbitrary dollar ceiling on benefits payable to a wife or retired worker.

Mr. Chairman, I thank you.

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

Any questions?

Senator HARRIS. I might just ask one. You said in the first paragraph on page 16, "it also believes that the basic objective of the public welfare proposals incorporated in H.R. 12080 is sound."

I was wondering about the provision in that bill which provides an upward limit on the number of AFDC cases a State can have, fixing the limit as of January 1, 1967. Do you have a position on that?

Mr. CHASE. Senator, I believe that this goes to the question of limiting the Federal financial participation in the program, in the State program. I would think that this is not in the category of a restrictive provision on the State that would compel them to move in a certain area, but rather a limitation on the amount of Federal financial participation in the State program.

Senator HARRIS. Do you think that is realistic in view of the population increase in the country and the migration, heavy rural to urban migration, we continue to have in this country?

Mr. CHASE. Senator, I think that this is perhaps an open question. This might cause difficulty in some States. As Senator Javits commented this morning, he anticipates this might cause some difficulty in New York. It would seem, however, that this is a provision which might well be tested and my recollection is that under the provisions of the bill, this would not become a mandatory provision until 1969. My recollection is that this would not be immediately applicable and that the States, therefore, would have an opportunity to test this to see how it worked out.

Moreover, I would assume that most of the States would have past experience on this and that they could examine their records and determine whether this would be a severe burden to them.

Senator HARRIS. The other question I have on the same basic objective of the welfare proposals that you mention: Do you think that it is right to do what the House bill proposes, punish the children by cutting them off AFDC in the event the mother would not go into a work training program for various reasons?

Mr. CHASE. Senator, my understanding of the bill is that the children's benefits would not be affected at all but only the benefits of the adult who refused without good cause to take the training.

Senator HARRIS. I understand that, but she would be eating somewhere and do you not think that would probably just dilute the payments for the child?

Mr. CHASE. It would certainly provide less of an income to the family if the amount that the mother was receiving were cut off because she refused to take training. However, the bill does provide that the individual can refuse if there is good cause and the Secretary of HEW is given authority to determine in broad outline, at least, what might be considered good cause.

Senator HARRIS. Do you not think that it might be better as we move into this concept of giving people enlarged opportunities for self-

sufficiency, a very good concept, I think, that we do it on a voluntary basis? Aren't we more likely to have success on a voluntary basis than if we make it on some kind of mandatory basis?

Mr. CHASE. Well, in essence, Senator, I think this is in basic agreement with the chamber's position, that this is something which has a desirable and a sound end but that the degree of compulsion which the House provisions contain ought to be reduced or eliminated.

Senator HARRIS. That is all I have, Mr. Chairman.

The CHAIRMAN. Mr. Chase, we appreciate your testimony here today. We will study your statement very carefully, along with your recommendations. Let we say that you not only speak for a great organization, but I notice that you come from a very fine company that is responsible for a great deal of jobs in the State I have the honor to represent, Louisiana. I regret you do not have as many people working at that Baton Rouge oil refinery as the old Standard Oil of New Jersey had down there, but automation, I suppose, has had something to do with it. You are paying more wages but there are not as many jobs. We would welcome you to take another look and see if you cannot justify finding something else to produce in that area.

Thank you very much, sir.

I appreciate your statement, also your assistant here who is with you.

Mr. CHASE. Mr. Chairman, since I did paraphrase the statement, would you please insert the full statement in the record?

The CHAIRMAN. Yes, we will print the entire statement, together with—I believe you have some—you have a chart or two here that should be printed in the record. We will include that. Thank you very much.

(The prepared statement of Mr. Chase follows:)

STATEMENT ON BEHALF OF THE CHAMBER OF COMMERCE OF THE UNITED STATES BY HENRY H. CHASE

My name is Henry H. Chase. I am employed by the Humble Oil & Refining Company, Houston, Texas. Today I am speaking on behalf of the Chamber of Commerce of the United States, to express its views based on policies established by a majority of its members. For several years, I have been a member of the National Chamber's Committee concerned with Social Security.

With me today is Mr. William P. McHenry, the National Chamber's staff specialist on Social Security.

The National Chamber appreciates this opportunity to express the views of business on H.R. 12080, a proposal that would make significant changes in various titles of the Social Security Act. This Act encompasses many important programs, including Old-Age, Survivors and Disability Insurance Benefits, Medicare and federal-state grant-in-aid Public Assistance programs. Since all of these programs are designed to deal with social problems, periodic re-examination and reappraisal are essential to determine whether they are achieving their objectives.

We have reviewed carefully the many provisions in this important Social Security proposal, H.R. 12080. In presenting the views of the National Chamber on some of those provisions, I will take up: first, the proposed revisions of Title II of the Social Security Act; second, certain proposed revisions affecting the Public Assistance and the Medical Assistance programs.

By way of background, I would like to review briefly the purpose of the OASDI program and certain basic principles, enunciated by Congress, which are important to an understanding of that program and its long run objective.

PURPOSE AND PRINCIPLES OF OASDI

The purpose of Social Security is to protect workers and their dependents against presumed need and want arising from job-income loss on reaching old-age, from permanent and total disability or early death of the wage earner. To

achieve this purpose, certain principles were laid down by this Committee and by the House Ways and Means Committee and approved. In expanding and improving Social Security Congress has continued to maintain these principles. I have reference to the following concepts:

a) Benefits are paid as a matter-of-right and without regard to individual "need."

b) Benefits provide partial replacement of the job-income loss.

c) Benefits are directly related to the job-income loss.

d) Benefits are financed from payroll taxes levied on workers and employers.

e) Benefits are intended to provide a "floor of protection" upon which the individual can build a higher standard of living through home ownership, savings, private pensions and insurance.

The Chamber has supported, and it continues to support, an effective Social Security program based on these fundamental concepts.

Before commenting directly on the provisions of H.R. 12080, I would like to summarize briefly certain specific recommendations we will advance to this Committee which are intended to strengthen and improve the present Social Security program. The National Chamber recommends:

1) an across-the-board increase in benefits.

2) an increase in the monthly benefits paid to the aged who are receiving special payments as a consequence of the Social Security Amendments of 1965 and the Tax Adjustment Act of 1966.

3) we recommend that eligibility requirements for disability benefits be liberalized for young workers.

4) we recommend that no arbitrary dollar limit be placed on the benefits payable to the spouse of a retired or disabled worker.

I would now like to comment on the principal provisions of H.R. 12080.

ACROSS-THE-BOARD BENEFIT INCREASE

The Chamber recommends that Congress approve an across-the-board benefit increase that is commensurate with the rise in the cost of living. The last benefit increase approved by the Congress fell slightly short of maintaining the purchasing power which benefits had in 1954; accordingly the increase should be measured from that year. In testimony presented to the House Ways and Means Committee last March, the Chamber pointed out that an increase of about 8 per cent would be sufficient to offset the rise in the cost-of-living. Taking into account the price changes that have occurred during the last six months, however, the Chamber concludes that a benefit increase of between 0 per cent and 10 per cent would be appropriate. Any increase appreciably greater than this would be excessive when gauged by appropriate criteria of benefit adequacy.

Because the purpose of Social Security is to prevent presumed dependency and need—chiefly for the aged—benefit adequacy usually has been appraised in terms of what proportion of elderly beneficiaries much seek Old-Age Assistance to supplement their Social Security benefits. A guideline, enunciated by the House Ways and Means Committee in 1954, states:

"The protection afforded by the program may be considered adequate only when benefits are high enough, when added to savings and assets normally accumulated, so most beneficiaries will not have to apply for public assistance for the ordinary expenses of living."[1]

The first Commissioner of Social Security, Dr. Arthur J. Altmeyer, contended that the benefit structure, on the whole, would be satisfactory if the vast majority of beneficiaries—at least 90 per cent—did not have to seek public relief to supplement their Social Security benefits.[2] In other words, if no more than 10 per cent of the old-age beneficiaries were receiving Old-Age Assistance, the benefit structure should be considered adequate to achieve the basic objective of this social program.

By this test, the benefit structure appears satisfactory today since the proportion of aged Social Security beneficiaries who also receive Old-Age Assistance to supplement their benefits has fallen from 12.6 per cent in September 1950 to 7.1 per cent in February 1966.[3] Nevertheless, in order to assure that the benefit

[1] See, *Social Security Amendments of 1954*, House Report #1698, 83rd Cong., 2nd, p. 2.
[2] See, Hearings, *Social Security Act Amendments of 1949*, House Ways and Means Committee, 81st Cong., 2nd, pp. 1089 and 1220.
[3] See, U.S. Department of Health, Education and Welfare, *Tabular Release on Concurrent Receipt of Public Assistance and Old-Age, Survivors and Disability Insurance by Persons Age 65 and Over, Early 1966*, Table I, p. 3, Sept. 1966.

structure continues to be properly maintained during this period of rising prices so that the burden of inflation will not fall with disproportionate weight on retired workers and other Social Security beneficiaries, we recommend that benefits be increased by about 9 to 10 per cent.

In determining the benefit increase required, Congress should take into consideration the effect of the new Medicare program. The sharp rise in medical care costs from 1954 to 1966 was an important factor in the rise in the cost-of-living during that period. Congress, of course, has to a very appreciable degree eliminated this cost item for the aged through enactment of the Medicare program. And it has done so in a manner that automatically protects the elderly against any major rise in the cost of medical care in the future. Accordingly it is appropriate that the value of this protection be taken into account when evaluating proposals to increase old-age cash benefits.

MINIMUM BENEFITS FOR SPECIAL AGED GROUPS AND MINIMUM PRIMARY INSURANCE AMOUNT

In the 1965 Social Security Amendments, Congress provided a special minimum old age benefit of $35 a month for persons, with little covered employment, who were 72 and over. A benefit equal to one-half of that amount was provided for a dependent spouse. In the Tax Adjustment Act of 1966, Congress added identical benefits for persons 72 and over (or those who would become 72 before 1966) who never worked in covered employment.

H.R. 12080 would raise the special minimum $35 benefit to $40, and provide a comparable increase in the spouse's benefit. In addition, the bill would raise the minimum primary insurance amount from $44 to $50 a month.

Most individuals who qualify for the lowest benefits have had only marginal attachment to the labor market.[4] There is little reason to differentiate between one group of individuals who had only marginal covered employment and another group whose covered employment record was not significantly different. When the two groups are compared, there is no appreciable difference in the amount of wages earned.

Accordingly, the Chamber again recommends, as it did in testimony presented to this Committee during previous Social Security hearings, that the benefits provided those aged individuals qualified for the special minimum benefit under the provisions of the 1965 Social Security Amendments and the Tax Adjustment Act of 1966 be raised to the minimum primary insurance amount established for other individuals.

LIMIT ON BENEFIT PAID TO SPOUSE OF RETIRED OR DISABLED WORKER

The dependent wife of a retired or disabled worker now receives a monthly benefit equal to half her husband's primary benefit. Thus, if the husband's benefit is $140 his wife's benefit is $70.

Section 103 of the bill provides that the benefit payable to a wife cannot exceed $105 a month even though that is less than half of her husband's benefit. The effect of the proposed $105 limit is slight, since under the bill the maximum benefit payable to a wife in the absence of that limit would be only $106. This means, however, that a worker could be taxed on earnings up to $7,600 a year, but his wife's benefit would be computed as if he earned only $7,500.

The recommendations made to the Committee on Ways and Means by the Department of Health, Education and Welfare proposed to limit a wife's benefit to $90 a month. Under the Department's proposals, a worker could be taxed on earnings up to $10,800 a year, but his wife's benefit would be computed as if he had earned only $6,000. Section 103 would introduce into the Social Security program, for the first time, the concept of "need" as a determinant for limiting the monthly benefit amount. Since the value placed upon the benefit limitation by the Government actuary was only .01% of taxable payroll, it could not have been suggested for the purpose of limiting program costs. Apparently the purpose was to prevent a selected segment of one group of beneficiaries from getting "too much" in benefits.

---

[4] For example, in 1964, 62 percent of those receiving the minimum primary Social Security benefit of $40 (currently $44), had no more than 5 years of covered employment. Moreover, in their peak earning year from 1951 to 1963, 71 percent earned under $1,200. See, Lenore A. Epstein, "Workers Entitled to Minimum Retirement Benefits Under OASDHI," *Social Security Bulletin*, March 1967, Tables 4 and 7.

The Department's proposal and the proposal incorporated in H.R. 12080 are identical conceptually.

The Chamber is opposed to the imposition of an arbitrary dollar ceiling on any benefit for the purpose of preventing some individuals from getting "too much" in benefits. The Chamber also believes that establishing such a ceiling would adversely affect the wage-benefit relationship.

Some may regard the limit on the wife's benefit proposed in H.R. 12080 of little importance, particularly since it would not adversely affect current beneficiaries, or those coming on the rolls in the near future. The Chamber is compelled, however, to urge that the proposed limitation on the wife's benefit be rejected because of the basic principles involved.

Furthermore, we cannot ignore the fact that the Social Security program is a dynamic program which is frequently changed by the Congress. While the effect of the limitation proposed in H.R. 12080 may appear slight, and not of immediate consequence, subsequent upward revision in the benefit and tax structure could produce a significant adverse effect on many aged couples sooner than now anticipated.

DISABILITY BENEFIT PROTECTION FOR YOUNG WORKERS

The existing Social Security law denies virtually all workers under the age of 31 the protection of the cash disability benefits program. This problem arises because the law contains a "prior work" requirement which few young workers can meet. In order to qualify for disability benefits, a worker must have at least 20 "quarters of coverage" out of the 40 calendar quarters preceding the onset of disability. This requirement has proven to be an insurmountable barrier for most young workers who become disabled.

Congress partially resolved this problem in 1965 when it provided an alternative "prior work" requirement for workers afflicted with blindness before age 31. We believe Congress should act now to resolve the problem completely.

Workers who become disabled before age 31 should not be excluded from the protection afforded by the disability benefits program. They should be able to qualify for benefits if they have coverage in at least one-half of the calendar quarters elapsing after age 21, and up to and including the quarter in which disability occurs, with a minimum of 6 quarters of coverage.

FINANCING THE PROPOSED CHANGES

The House bill, with one minor exception, follows the long standing principle that the Social Security program should be maintained on a self-supporting basis by the taxes on workers and employers and interest credited to the Trust Funds. (The minor exception, discussed later relates to the "special" benefits payable to those 72 and over under the Tax Adjustment Act of 1966.)

We believe that Congress—but more especially this Committee and the Ways and Means Committee—are to be commended for adhering to the self-support principle in developing changes and improvements to the Social Security program over the years.

This Committee is aware that the National Chamber has long endorsed this intent of Congress to maintain Social Security on a fully self-supporting basis. In our view, payroll tax financing has at least two advantages: first, it provides an assured method of financing; thus, benefits will be forthcoming as promised by Congress. Second, if Congress must raise payroll taxes enough to properly finance each benefit increase, future Congresses will be less likely to raise benefits above the level which workers and employers are then willing to support.

FINANCING H.R. 12080

About 60 percent of the cost of the proposed changes in the Social Security cash benefits program can be financed from the existing long-range "tax surplus." According to the Social Security Chief Actuary, Mr. Robert J. Myers, estimated "tax-take" under present law will exceed benefit payments (and administrative expenses) by about ¾ of one per cent of taxable payroll.[8] This margin is suffi-

[8] Under the present tax schedule—over a 75-year period—the Old-Age and Survivors Benefits program has a "positive actuarial balance" of 0.89 percent of taxable payroll. Conversely, the Disability Benefits program has a "negative actuarial balance" of 0.16 percent of taxable payroll. Thus, on a long-run basis, the system as a whole has a "favorable actuarial balance," of 0.74 percent of taxable payroll. See, Robert J. Myers, *New Actuarial Cost Estimates for OASDI*, a memorandum to Robert M. Ball, Commissioner of Social Security, October 11, 1966.

cient to pay for an across-the-board benefit increase of about 8 per cent without change in the existing tax structure.

The remaining 40 per cent of the benefit costs would be financed by an increase in the Social Security taxable wage base and tax rates. Section 106 would raise the taxable wage base from $6600 to $7600 in 1968. No further increase is called for.

Section 109 would raise Social Security tax rates for the cash benefits program on each employee and employer in 1973 from 4.85 per cent to 5.0 per cent. In addition, there would be a further increase in tax rates for the *existing* Medicare program because hospital costs have risen more than originally projected. Medicare tax rates scheduled for 1969–72 would be increased by 0.1 per cent (from 0.5 per cent to 0.6 per cent) on each employee and employer.

The table following compares Social Security and Medicare tax increases under present law and under H.R. 12080 for an employee, and his employer, paying the maximum tax. Under present law the combined employee-employer tax is scheduled to rise from $580.80 this year to $712.80 by 1973. This is a 23 per cent increase. By 1987, the maximum combined tax is scheduled to rise to $745.80. Under H.R. 12080, the combined employee-employer tax would rise from $580.80 this year to $858.80 by 1973. This is a 48 per cent increase. By 1987, the maximum tax would rise to $896.80.

RECOMMENDATIONS

The National Chamber recommends that the:

1. Social Security taxable wage base be continued at $6600 for the present. When Congress raised the taxable wage base to $6600 in 1965 (effective in 1966) it was $850 above the median earnings of the male four-quarter wage and salary worker. Today, it is estimated that the existing wage base is still $300–$400 above the median earnings of the regularly employed male worker. Any consideration of a further increase in the wage base should be deferred until median earnings reach $6600.

Median earnings of the regularly employed male worker is a reasonable yardstick to use when considering whether or not a wage base change is necessary. Using the median will assure that half of all regularly employed male workers have their total earnings protected against job income loss. At the same time, this would give to the other half of the workers, who have some earnings not taxed, an added opportunity to provide more old-age income protection on their own.

2. Social Security program be kept on a self-supporting basis by financing the cost-of-living adjustment, and any additional cost increase in excess of the existing "surplus" by higher Social Security tax rates. Because the benefit increases are broadly distributed, all covered workers and their employers should bear a share of the added benefit cost burden. This result can only be achieved through an increase in the tax rate.

SOCIAL SECURITY AND MEDICARE TAX INCREASES, PRESENT LAW COMPARED WITH H.R. 12080

[Employee-employer taxes combined]

Year	Taxable wage base		Social security tax rate		Medicare tax rate		Total tax rate		Maximum combined tax	
	Present	Proposed	Present (percent)	Proposed (percent)	Present (percent)	Proposed (percent)	Present (percent)	Proposed (percent)	Present	Proposed
1967	$6,600	$6,600	7.8	7.8	1.0	1.0	8.8	8.8	$580.80	$580.80
1968	6,600	7,600	7.8	7.8	1.0	1.0	8.8	8.8	580.80	668.80
1969 to 1970	6,600	7,600	8.8	8.4	1.0	1.2	9.8	9.6	646.80	729.60
1971 to 1972	6,600	7,600	8.8	9.2	1.0	1.2	9.8	10.4	646.80	790.40
1973 to 1975	6,600	7,600	9.7	10.0	1.1	1.3	10.8	11.3	712.80	858.80
1976 to 1979	6,600	7,600	9.7	10.0	1.2	1.4	10.9	11.4	719.40	866.40
1980 to 1986	6,600	7,600	9.7	10.0	1.4	1.6	11.1	11.6	732.60	881.60
1987 and after	6,600	7,600	9.7	10.0	1.6	1.8	11.3	11.8	745.80	896.80

3. Existing deficit in the disability benefits program be corrected. The Chamber supports the provision in Section 110 which allocates a larger share of Social Security tax revenues to the disability trust fund to correct the existing deficit.

This new allocation should be sufficient to finance completely the disability protection for workers under age 31 and the cost-of-living increase recommended by the Chamber.

4. Cost of the special benefits for those 72 and over, approved under the Tax Adjustment Act of 1966, should be financed from payroll taxes. We urge repeal of Section 228 (g) of the Social Security Act which authorizes General Fund financing of these special benefit payments. While it is true that these persons represent a "closed end" group, the National Chamber is most apprehensive about financing any Social Security benefits from the General Fund of the Treasury. "Needs test" money from the General Fund of the Treasury has no place in a sound Social Security program which is intended to pay benefits without a "needs test."

MEDICARE FOR THE DISABLED

Section 140 of the bill would create a 12 member Advisory Council for the purpose of studying "the need for coverage of the disabled" under Title 18 of the Social Security Act. This group would be appointed in 1968, and instructed to submit a report to the Secretary of HEW no later than January 1, 1969.

The House Ways and Means Committee gave extensive consideration to the question of providing Medicare protection for disabled beneficiaries. This matter was deferred pending completion of the proposed Advisory Council's study. A major factor in the Committee's decision involved the added costs of this proposal. During the House debates on the Social Security bill Chairman Mills pointed out that:

". . . data which first became available while the proposal was being considered indicated that the per capita cost of providing health insurance for the disabled under Medicare would be considerably higher than the cost of providing the same coverage for the aged. As a result of the new data, estimates of the cost of the proposal were increased significantly, and this increase in the cost estimates would raise serious problems with respect to the financing of the proposal." [6]

Moreover, at the present time, adequate data are not available to evaluate the extent of health insurance coverage among those now on the disability rolls, or whether the type of protection offered by the Medicare program is responsive to the needs of disabled beneficiaries. Therefore, any decision about extending Medicare to the disabled should be deferred until this Advisory Council completes its study and the Congress has had ample opportunity to evaluate the findings and recommendations.

PUBLIC WELFARE

Title II of the bill would make numerous changes in the federal-state grants-in-aid program of Aid to Families with Dependent Children. The most significant of these proposed changes, which states would be required to implement by July 1, 1969, involve family employment and services (Section 201), work incentives (Section 202) and community work and training programs (Section 204). Specifically, H.R. 12080 would authorize federal financial support for a state AFDC program after July 1, 1969, *only* if the state:

1. adopts a program to prepare family adults and older youths for productive, self-supporting employment. (Such a program must include testing, counseling, basic literacy and skill training, and job development services.)
2. establishes a program to combat illegitimacy among AFDC adults.
3. furnishes, or contracts for, day-care services for AFDC children so family adults can participate in the literacy and job training programs.
4. exempts some earnings of AFDC adults in order to provide an incentive to work.
5. establishes community work and training projects in every area of the state where a significant number of AFDC recipients reside.

Since its inception AFDC's primary objective has been to prevent destitution on the part of recipients. The public has always been given to understand that most families would need such assistance for a relatively short time until the head of the household could get a job and become self-supporting. However, this has proven not to be true for a great many families. It is now recognized that many family adults need positive, constructive help such as literacy and job-skill training—before they could possibly qualify for and hold a family-supporting job.

---

[6] *Congressional Record*, August 17, 1967, p. H10665.

The objective of these new proposals is to encourage and assist as many as possible of those on the AFDC rolls to become self-sustaining and self-reliant. Instead of attempting merely to sustain life, the intent is to provide recipient families with an opportunity to move up to a higher and more rewarding level of living.

Obviously, not all AFDC recipients will be able to reach that goal; and not all are expected to do so. Experience has shown, however, that many of them would much prefer to be economically productive members of society. At present, it is unrealistic in the case of many recipients to expect them to secure gainful employment and move off the AFDC rolls. The plain fact is that all too frequently these individuals lack even the most rudimentary skills. Such individuals now are barred from becoming self-sufficient by their lack of education, by their lack of training, by their lack of good work habits, by responsibilities in the home, et cetera. Experience also indicates that many of these individuals are capable of attaining financial independence and the dignity and self-respect that accompany it if they receive the proper encouragement and assistance. Heretofore, such assistance—in the form of basic education, job training, financial incentives, and other encouragement—has not been made available to them except to a very limited degree and in isolated instances. H.R. 12080 proposes to meet this situation by requiring the establishment of mechanisms aimed at making realization of the new objective a practical possibility for many AFDC recipients.

One of the main objectives of H.R. 12080 is to raise the work potential of AFDC recipients and, thereby, expand their employment horizons. Providing an education and work training program—for each individual for whom that is appropriate—specifically designed to enhance the employment prospects of the particular individuals is a basic feature that too long has been ignored. Unless this fundamental need is met, many recipients may be barred forever from full participation in our society and relegated to the public welfare rolls either indefinitely of repeatedly. No one can view the latter prospect without dismay and concern.

Another feature of H.R. 12080 involves work incentives. Numerous critics of the existing public welfare programs have complained that recipient who works—but who earns less than enough to sustain himself—is, in effect subject to a 100 percent income tax on those earnings since his welfare payment is reduced by the amount of his earnings. Few would argue that such a situation is conducive to the acceptance of a job which can produce only a limited inome. H.R. 12080 proposes to alleviate the problem by providing a financial incentive for a recipient to augment his welfare payment by permitting the individual to retain all or a part of the fruits of his employment.

This inducement is an essential concomitant of the requirement that all individuals for whom a work training program is deemed appropriate undertake such training. In the absence of such an incentive, it would be less than realistic to anticipate a real return on the educational and training investment made for those who endeavor to upgrade their work potential. Although some individuals undoubtedly will be able to move directly from a training program to complete financial self-support, it is unlikely that the majority will be able to do so. It is tion in several steps and those who may never fully succeed in making the transition be encouraged to continue to work toward the goal of complete self-support.

The National Chamber endorses the fundamental objectives of helping AFDC families enter the mainstream of American society through the door of basic literacy, job training, employment and self-support. However, under H.R. 12080 this objective would be implemented by imposing new federal requirements on the states. The National Chamber has indicated on many previous occasions its opposition to such mandatory federal requirements. Accordingly, the Chamber urges this Committee to accomplish the objective by positively encouraging, rather than by requiring, the desired state action.

FEDERAL GRANTS FOR MEDICAL ASSISTANCE (MEDICAID)

Section 220 of the bill would initiate a limitation on federal financial participation in the federal-state Medical Assistance programs. Federal funds would not be available for vendor medical payments made by the states to individuals or fam-

lies whose annual incomes exceed certain prescribed levels.[7] States could provide Medical Assistance to persons whose incomes exceed the prescribed levels, but there would be no federal sharing of such costs.

According to this Committee, the objective of Congress in initiating this federal-state program in 1965 was to: " . . . liberalize the federal law under which states operate their medical assistance programs so as to make medical services for the needy more generally available."[8] The program was intended to do two things: 1) consolidate into one system all vendor payment medical care provided those receiving cash assistance under the categorical aid programs; 2) provide payment for needed medical care for persons financially unable to pay their own health care expenses and unable to qualify under any of the categorical aid programs.

The National Chamber believes that it would be advisable to place a limitation on the extent of federal financial participation in Medical Assistance.

Some states have made large numbers of their adult working population with moderate incomes eligible to receive medical care under their tax-supported programs. Such action has imposed a heavy financial obligation on the federal government. The federal commitment is far in excess of what was anticipated when Congress initiated the federal-state Medical Assistance program under the 1965 Social Security Amendments.[9]

Today, it is estimated that if there is no change in the present Medicaid law the federal share of expenditures will increase from $1.4 billion to $3.1 billion between fiscal years 1968 and 1972.

As this Committee knows, the federal government has an open-ended financial obligation under the Medical Assistance program and under the categorical aid programs. In discussing the rising federal cost of these programs the Chairman of the House Committee on Ways and Means said: "These are items over which no one, including the President, has any control—except the Congress. The states send in their bills and we give them a check, after the expenditures have been incurred. There is no way to reduce these in the Appropriation Committee."[10]

The Chamber also believes it desirable to limit federal financial participation to assure that eligibility under Medical Assistance is not extended to large numbers of the working population who have adequate incomes, because many such persons now have voluntary health insurance protection—either on an individual basis or under collective bargaining arrangements—and are capable of buying insurance protection against the costs of medical care. Undue extension of medical assistance eligibility could encourage those with voluntary health insurance protection to abandon their coverage and obtain medical care under a tax supported program. It seems clear that Congress never intended that this should happen. The Ways and Means Committee said:

"Your Committee expected that the state plan submitted under Title 19 would afford better medical care services to persons unable to pay for adequate care. It neither expected or intended that such care would supplant health insurance presently carried or presently provided under collective bargaining arrangements for individuals and families in or close to an average income range."[11]

CONCLUSION

We want to reiterate briefly the principal points set forth in our testimony today on H.R. 12080.

The National Chamber fully endorses the more liberal eligibility requirement for disability benefits that would be applicable to workers under age 31. It also fully endorses the proposed Advisory Council study of the question of providing Medicare for disabled beneficiaries.

---

[7] The family income level could not be higher than either of the following: (1) 133⅓% of the highest amount ordinarily paid to a family of the same size without income or resources under the program of Aid to Families with Dependent Children; or (2) 133⅓% of the state per capita income for a family of four (with comparable amounts for families of different sizes). For states that initiate a Medical Assistance program after July 25, 1967, these ceilings would apply immediately. For states with plans already approved, the limit on federal sharing under both tests would be 150% effective July 1, 1968; 140% effective July 1, 1969; 133⅓% on July 1, 1970.

[8] Senate Finance Committee, *Social Security Amendments of 1965*, Report 404, 89th Cong., 1st, p. 74.

[9] See Robert J. Myers, "Cost Estimates for Vendor Medical Payments Under Public Assistance," *Limitations on Federal Participation Under Title 19 of the Social Security Act*, House Report 2224, 89th Cong., 2nd, pp. 7–8.

[10] *Congressional Record*, August 17, 1967, p. H 10668.

[11] House Ways and Means Committee, *Social Security Amendments of 1967*, Report 544, 90th Cong., 1st, p. 118.

The Chamber supports an increase in benefits for the special aged groups qualified under the Social Security Amendments of 1965 and the Tax Adjustment Act of 1966. It believes such benefits, however, should be raised to the level of the regular minimum Primary Insurance Amount.

The Chamber favors a limitation on the extent of federal financial participation in the Medical Assistance program. It also believes that the basic objective of the public welfare proposals incorporated in H.R. 12080 is sound.

The Chamber supports an across-the-board increase in benefits. An increase of about 9 to 10 per cent would be appropriate at this time. An increase of this magnitude could be and should be financed without any upward adjustment in the taxable wage base.

Finally, the National Chamber is opposed to the imposition of an arbitrary dollar ceiling on the benefit payable to the wife of a retired or disabled worker.

The CHAIRMAN. The next witness is Dr. George A. Wiley of the Poverty Rights Action Center.

STATEMENT OF DR. GEORGE A. WILEY OF THE POVERTY RIGHTS ACTION CENTER; ACCOMPANIED BY MRS. JOHNNIE TILLMAN, NATIONAL CHAIRMAN, NATIONAL WELFARE RIGHTS; MRS. ETTA HORN, VICE CHAIRMAN; MRS. BEULAH SANDERS, SECOND VICE CHAIRMAN; MRS. MARION KIDD, TREASURER; MRS. ALICE NIXON, SERGEANT AT ARMS; MRS. DOROTHY DI MASCIO, SECRETARY; AND MRS. HAZEL LESLIE

Dr. WILEY. Mr. Chairman, I have with me the officers or some of the officers of the newly formed National Welfare Rights organization. On my right, Mrs. Johnnie Tillman, who is the national chairman; next to her, Mrs. Etta Horn, who is the first vice chairman; on my left, Mrs. Beulah Sanders, who is the second vice chairman; Mrs. Marion Kidd, who is the treasurer of the organization; Mrs. Alice Nixon, who is the sargeant at arms; and on the far end, Mrs. Dorothy Di Mascio, who is one of the secretaries of the organization.

The CHAIRMAN. Where is your headquarters and how many members do you have?

Dr. WILEY. The headquarters of the organization is here in Washington, D.C. The Poverty Rights Action Center of which I am the director, is the headquarters. We have 4,000 dues-paying members who joined the organization since we started the formal organization in June. They represent directly about 15,000 welfare recipients in those households.

Indirectly, they represent more than 5 million ADC mothers and their children and they are here as they want to be heard on this vital issue of this terrible bill that directly affects their lives, their families, and their children, and they are here to testify.

As you know, we attempted to come on the 28th. We wanted to be heard by the committee, when all of the members of the—and all of the delegates from the 22 States would be in town. We regret that the committee did not hear us on that day because it would have been a significant step toward direct participation of the people directly affected, for the first time people directly affected.

I am going to turn all of the time over to Mrs. Tillman and the officers. I will submit technical testimony for the record. I have submitted some in the form of two statements. We will submit additional testi-

mony but I would like to have the recipient officers have all of the time with the committee.

Mrs. Tillman.

Mrs. TILLMAN. Thank you, Mr. Chairman. We certainly appreciate you allowing us to talk to you at this time. We are welfare recipients ourselves and I think this might be the first time that you ever had the opportunity to hear directly from the people who this AFDC program affects.

We want to talk about the bill itself, the 12080. There are portions in it that we are very concerned about, the illegitimate parts, the unemployed fathers, the work and training program they have outlined for us that we had no opportunity to talk to them about before this bill was drawn up.

Right now I will let Mrs. Etta Horn, who is a resident of Washington, an ADC mother, elaborate.

Mrs. HORN. As Chuck told you, I am a welfare recipient, mother of seven children. I have five at home now. And what I see of this bill is a disgrace. It is a terrible disgrace, what I see in this bill, when it says that you freeze Federal aid for children, children in America not to be fed, but yet if they live long enough to fight, fight for this country.

What this bill is telling us is that you refuse to feed babies but you are sitting in wall to wall land.

Also denying aid to unemployed parents. This is ridiculous. Where would they go? What would they do? It seems to me, you are saying we will put half of you in a stockade and feed the other half.

Also to go to this foster plan that is in that bill. When you say that you will take a child from his mother and pay his foster mother an enormous salary when you will not pay his mother to let him sleep in his own bed.

You also are saying in this bill that after you put him in a foster home, if he makes it through from being not a psychiatric patient, that you will make him fit for service to fight for this country. I say America must go to bat for its kids so its kids can go to bat for America.

[Applause.]

Mrs. TILLMAN. I now let Mrs. Beulah Sanders, our second vice chairman from New York City welfare——

The CHAIRMAN. Ladies, I think I ought to tell you the rules of the Senate just do not permit demonstrations in these committee rooms. You are perfectly privileged to say anything you want to say. That is your privilege and that is why we conduct hearings, but I think I should tell the audience here that you are guests of the Senate and our rules are we do not permit demonstrations. This is not a mass meeting, and you are certainly welcome to say anything you want to say, but we just do not permit demonstrations in a committee room. It is against our rules.

I am sorry. Go ahead.

Mrs. SANDERS. Thank you, Mr. Chairman.

My name is Beulah Sanders and I am an officer of this organization and I would like to say, speak directly with reference to the training program and forcing the parents out of the home. As a mother, I

would like to say this: I cannot see this bill telling us mothers that we must put our children in adequate day care centers, that we must leave our children regardless of what the circumstances are, that we must go to work because you say so. This I cannot see. I do not believe that we should be forced to work. I do not believe that we should be forced to take training if it is not meaningful. If you are going to give us something that we can hope for and advance in, possibilities to go on to higher salaries, then I would agree to it. But at this point, speaking for New York and across the Nation, I cannot agree to your plan.

Forcing parents out of the home will only cause more delinquency. When we are out of the home working, our children are picked up by the police. The first think they are going to say is, "Where are your parents?" When they say, "My mother is working," they are going to go before the judge and find out why these children were out in the street and why they were picked up. Yet still, we have to pay that penalty and you are sitting here in this bill stating parents must go to work, they must get off welfare.

I admit that the welfare system is rotten. It needs overhaul. Everyone must take a big part in changing the welfare system.

Today I would like to state one fact. We have quite a few children that are dropping out of school and if you will go back and look at your statistics, you can find out why. There is lack of money. There is lack of all sorts of support. There is lack of recreation. Our children do not get to do the things that the middle class do because there is not any money. Now, you are saying that we do not need welfare.

What do we need? This is what I am asking you. What can you give me to guarantee that my child and all the other children are going to grow up and be decent American citizens and they are not going to be convicts? Is there anything in this bill that can convince us if we are forced to go to work our children are going to be decent citizens, they are not going to be convicts? Is there anything in this bill that states if you go to work that you are going to be able to advance into a higher paid position? Is there anything in this bill that states are your children going to be cared for?

We know best what we want for our children because we had them. We want our children to have the same as any other equal citizen in this country. We want our children to grow up and be the kind of persons maybe that we would hope to see you be some day, because at this point I do not think that you are really a good guy for me because you set an example for all of us that we cannot live under.

There are two recommendations that I would like to give to you. Give us a training program, yes. Make sure at the end of the training program we have a job with a guaranteed wage, a minimum wage. If you cannot do that, give us guaranteed income on welfare above the Federal poverty level, or if you want to do something about day care, then exploit some of the money that you have into day-care centers. Do not force mothers to take care of other children. You do not know what kind of problem that parent might have. You do not know whether she gets tired of her own children or not but you are trying to force her to take care of other people's children and forcing the parents to go out in the field and work when you know there is no job.

This is why we have had the disturbance in New York City and across the country. We, the welfare recipients, have tried to keep down that disturbance among our people but the unrest is steadily growing. The welfare recipients are tired. They are tired of people dictating to them telling them how they must live.

It is time for you to change. Let us tell you how we want to live. We cannot live by your law. We are human beings. We want to be treated as such. Let us tell you what we would like to see in that bill which is nothing. I recommend that you get rid of the bill, throw it out completely, give us a guaranteed income, give us jobs that we can go into and we can look forward to a decent future.

At this point we cannot do that. And I strongly suggest and recommend that you get rid of that bill.

Thank you.

Mr. KIDD. I am Marion Kidd from Newark, N.J. I am here to give my testimony because this summer I lived through some of the things that have been going on. Why? Because people are restless, because they do not have jobs. It is not only poor people but people on welfare that are feeling the effect.

Now, when this H.R. 12080 bill appeared, all the welfare mothers in Newark and New Jersey and across the country were worried about it. We are worried because our sons, as my sister has said here this afternoon, have to live under these conditions, but still and all, when they are 18, they come off the welfare rolls, they go in the service. They are not asked, are you on welfare, but they are taken into the service to fight. Fight for what? They have nothing to really fight for.

I have a few things here I would like to bring to you. You say job training programs. What kind of jobs will there be after we finish training? Will there be domestic work? This has not been specified, what type of work we welfare mothers can get after coming off the welfare, I was told but in my own city by one of the welfare administrators, I mentioned to her that if the mothers want to work and—there is a program called SEP. Many of the mothers wanted to go on this job and training but they were afraid if they did, they would be cut off welfare and then they still would not have a job. We said that if we can get a job that is going to take us off the welfare, this would be good. But I was told by this head official that these training programs and the jobs afterward would not take you off welfare. So, I see no benefit in the training unless you have something that is going to be substantial, that is going to really help us, not survive, because that is all we are doing now.

I would like to go on to the 16-year-olds. You say you are taking them off the welfare if they are not in school. While they are talking about dropping the age for voting at 18, I think you had better drop it to 16 because if these children have to go out and work on 8-hour jobs, 40 hours a week, then I think they are going to be adult enough to vote.

And I would like to speak on our men. This FAC program has really disillusioned many men. Our men are just—they have nothing to do when they have no work. There is no work for men. The Labor Department has really degraded the men when they have to leave the homes because there are not enough jobs, enough money to support their families.

I am here today to testify that I hope you do not pass this bill because if you do, we will have the same thing we had back in July all over the Nation again.

Mrs. NIXON. I am Mrs. Alice Nixon, from the State of Pennsylvania. I would like to say to you, why do you not take your heads out of the sand? We back home are getting tired of all this nonsense. You sit there and you worry about the antiriot bills and here you are going to pass a riot or guaranteed riot bill.

The people are so sick and tired hearing about illegitimacy. The whole country was built on illegitimate children. We were brought here illegitimately, the country did not want—they brought us over here and you worry about the illegitimate children. These are Americans, they are your Americans of tomorrow. What are you going to do with them? You keep feeding our children about the American way of life. When are you going to stop feeding it to them and teach it to them and show them what the American life is? I have to sit down here and listen to people who say, why do you fight, Alice? It is not working. Congress does not care about it. They are getting it every day, day after day, and you know, we women sit here and spend over 10 hours a day trying to help somebody who is a sister who is supposed to help. We take tranquilizers. Why do you not take your heads out of the sand and why do you not bring your investigation teams into the neighborhoods and hear what they are saying? It will not be long before they are going to stop mumbling.

You think you had trouble this summer and the thing is this is not a black man's problem. We are tired being used, black and poor white, as economic footballs. You say we are not taxpayers. What do you mean we are not taxpayers? Every time we buy a can of beans we keep the bean farmer in business, or buy a can of tomatoes, we keep the steel people in business, the aluminum companies in business, and if we decide we would not buy a can tomorrow, how many steelworkers would be out of work? Our Government any time they want to can change the image of the welfare recipients and will you please stop using us as a political football.

Talk about jobs. We are tired of these vacuum jobs. You talk about training programs. Where are your guidelines? They will be same doggone thing, keep training, training, and training us in a vacuum. I have seen men walk around here almost crazy. I was surprised more of us do not commit suicide.

You are going to take, you going to spend $1,800 a year to put a child in a day-care center and half of us do not even live on that in a year. They do not even get that much.

You take—you have OEO programs, you caught those. How are we able to participate in OEO programs when we do not even have the money to eat. Take your heads out of the sand and come down and listen to what the people are saying. They are getting tired. You are too soft. Life is too easy upstairs. You forget about us downstairs. There is going to come a time when the fire starts burning and your children are going to suffer. Your seeds and my seeds, they are tired. So take your heads out of the sand.

You think I am bad. You ought to hear the people down here. You wonder why they are burning down the cities. Do not pay heed. I hope

you do pass your bill. Maybe you should pass it and then they will get rid of the system a little quicker. When I say the system I mean the welfare system as it is set up today. I do not say thank you. Half of us had to scrap money to get here. My God, we nearly went crazy to get money. No, no. I am not going to stop. Maybe I should. I said enough.

Mrs. DI MASCIO. I am Dorothy Di Mascio from New York State. After Mrs. Nixon there is not too much left for me to say, but I want to stress, give you my opinion about——

The CHAIRMAN. Pardon me just a moment. The Senate is voting at this very moment. I am going to have to vote and Senator Harris is going to have to vote and we will be back just as soon as we can. We will be back as soon as we get through with that vote. So, if you will just save your positions there, we will come back as soon as we can.

(A short recess was taken.)

Senator HARRIS (now presiding). The committee will be in order.

We will resume the testimony. I apologize again for our having to leave to go over for a vote. Our chairman asked me to express his apologies also. He asked me to continue the hearing until he could get here. He is tied up now on the floor with this bill on the independent offices appropriation.

You may continue.

Mrs. DI MASCIO. Thank you. I am Dorothy Di Mascio from Rochester, N.Y. We are a little concerned about the fact that many of us were here for our first national welfare rights convention August 28. At that time we asked to be heard and we were not given an opportunity. We would really like an answer to this, as to why we could not be heard at this time when we wanted to speak, when we wanted to be heard, and voice our opinions and our views. All of these changes that will affect us, changes that will affect our families, our way of life and everything else, we really feel that we have not been treated fairly. We felt that we deserved a chance to speak up and to express the way we feel and things that we feel we need and what our desires and really what our needs are.

I feel that this whole portion of the bill regarding welfare should be completely dropped and that special hearings should be held in the cities where the people are actually living that are affected by this. Here you should come to the cities where we live, where we have a chance to testify and express our feelings, give you our ideas and discuss it with us.

It just does not seem right, it seems like it is some kind of a dictatorship where the changes that are going to be made, and you will not be affected by it, we will. We are the ones that will be affected, us sitting here and thousands and thousands more across the Nation, and it seems so strange that everybody else is going to make these changes and they are going to tell us what they are going to do with us and with our children and with our husbands and with our life, and yet we have nothing to say about it. And nobody has even thought to ask us, any of us, how we feel or what we want or even how do you feel about the changes that are made for us. We have not even been asked about it, and we feel that hearings should be conducted throughout the United States in the areas where people are going to be affected so that they have a chance to speak up.

Also regarding the children 16 years and older being forced to go to work or be cut off, I wonder how we can expect a 16-year-old child

who for some reason or other—maybe there is no visible problem—for some reason or other a 16-year-old or 17-year-old who has dropped out of school or was not able to assume the respnsibility of continuing in school, how can we expect these teenagers to go to work and assume the responsibilities of a full-time job when they have no other rights. They have nothing coming to them.

The men who have been working, who have become unemployed, and are collecting unemployment insurance, they would not be eligible for any type supplemental assistance. I could very well understand and I have seen it becauss I live with it every day, why a man, and I am sure there is nct a man in this room, if he had six or seven children and become unemployed today and started collecting unemployment insurance next week, if the amount if his unemployment was only $56 a week and he had a wife and six or seven or more children to feed, and to pay rent for and to keep warm and to put clothes on them and send them to school and have them looking decent, the way they should, I do not believe there is a man in here that would feel much like a man if he had to live on that kind of money and I can well understand a man saying that he would leave his family and doing just that because the welfare will do better, $56 a week will do for them.

It is quite understandable. I am sure every man in this room would feel very small if he were not able to do more for his family.

I would like to just comment on the issue—I am not sure who it was that spoke about it a little earlier—but the issue in regards to allowing employed persons to keep the first $85 of their earnings, one-half of everything over that, until they reach the Federal poverty line, and were able to sustain themselves and really become fully independent.

I have seen a lot of the training programs, I have been involved in some of the training programs, specifically the OEO programs. They have some good training programs and some fine. You receive supplemental assistance until under the Economic Opportunity Act it changed. In certain areas, I am not sure—it was in Albany—we were allowed to keep the first $85 and half of everything over that. This changed, I believe it was in March, March 13 of this year, where it states that anyone employed for 12 months in a federally funded program is no longer eligible for this type grant. At the end of 12 months we forget about the first $85 and the one-half over that and they go down to $40 and you are allowed to keep the first $40.

People who have not for many years, and some of them never, had to face the responsibility of a family out on their own, who finally get to the point where they are involved in a training program, some of these people at the end of the year are able to take over and assume full responsibility. These are few and far between.

A person who has not had to assume responsibility or for some reason or another was not able to before, it is going to take him this whole year to really believe that this program is going to do something for them. that this training is really worthwhile, and that at the end of a year they are finally just starting to get their feet up where they belong, and then the minute they get on good ground, somebody just pulls the rug right out from under their feet because they are just

starting. They have faith. They are just starting to begin to believe somebody is going to give them a chance, that they might just be somebody worthwhile, and the minute they get thinking this, somebody proves that they are wrong.

I do not know what else to comment on except for the fact that like Mrs. Nixon said, the problems we have in our cities today, I do not think anyone realizes the situation is critical and it is not so much of a racial issue any more. It has become very quickly an economical issue, where black people, white people, poor people, are finally realizing that their problems are much the same and they are banding together all over the Nation. Welfare rights groups are working along with other groups and the Negroes and the whites, the poor whites, are getting together. They are establishing a better relationship and a better understanding and they are tired, and I am down here and it just so happens I am white but I am poor and I am down here with them and I know both sides of it and they are tired. All of them, and they are getting together and they are starting to talk about how tired they are and if this bill passes, you can believe that the situation then will not be critical. It will be beyond that point.

Thank you.

Mrs. LESLIE. Good evening, sir. I am Hazel Leslie of Philadelphia, Pa. There really is not too much that I can add to what these nice ladies have said but I would like to ask a question. I see so many names here and I know all those people, though they are not from New York or Pennsylvania or something—I just want to know how they feel about us. I get the impression sitting here that those people are listening to us and nodding their heads and smiling at each other and getting up and quietly moving out as if we do not even count. But, everybody sitting here is a voting agent. Everybody sitting at this table votes. Every time there is an election we run to the poll and cast our ballot for somebody. The same people have people just like us in their State, doing the same thing as we are doing, and living the same as we are doing. But yet, they do not even give us the courtesy to listen and they come in and nod at each other and laugh and walk out.

I do not want to add to anything the ladies said. I am just wondering just what sort of treatment we are getting. I think to the people who are sitting behind us, I think they can see. We are just completely ignored and we come here to testify. Dr. Wiley is here and he has given us his time, and they do not even want to hear what we have to say. And I do not understand it but perhaps somebody can give me an answer to it or write me a letter or something because as I said, I am with the Philadelphia Welfare Rights organization and if anybody lets me know, I would appreciate it and if they let me know, let everybody else know.

Thank you.

Senator HARRIS. May I just say there is another rollcall and they have sent for all Senators to go to the floor of the Senate. I sent word that I would not be able to come. But that is where the members of this committee are.

Mr. LESLIE. May I ask you a question please, Mr. Harris? I think we all appreciate the fact that you are listening to us, but now, I ask the question not to be smart because I do not know——

Senator HARRIS. Might I also say that everything being said is being taken down and tomorrow we will have it in writing and it will be studied by all the members of the committee. This is quite the usual procedure.

Mrs. LESLIE. So, they really do not know how we feel except what we are saying now. In other words, they are not even going to take time to—maybe there is something they might ask us or we can give them an answer that might help somebody, maybe us, maybe even help them think about something. But they are not here.

Since we have suffered so hard and begged and borrowed money and gas and drivers and whatnot to get here, I think everybody here would appreciate a little recess while the good Senators go about their buisness for a few minutes and then come back and listen to us. I mean they might not have done anything about what we have heard but it would make us feel as if we are part of something because it is a funny thing, we are all citizens. I do not understand how we have to be treated different.

Now, if there is an answer to that, I would appreciate it, please, sir.

Senator HARRIS. I will be glad to hear it. Dr. Wiley, do you have anything further that you wanted to present?

Dr. WILEY. Well, the ladies have indicated that they have been concerned about not having adequate opportunity to be heard when all of our people were here on the 28th. Mrs. Di Mascio raised the question. We do not have an answer. Mrs. Leslie asked a question where the members of the committee are. Will they hear them. We do not know that people read these testimonies. This thing came up in the House and was passed, this antiwelfare bill was passed in secret sessions. Nobody had a chance to testify in the House on 12080. For all they know, they are going to go back to their cities and you people will have your huddle and the next thing they know they will be saddled with this thing and they want some—first, they want some commitment from your people as to what your positions are and want to begin to get some response and find out what you are going to do on the bill, but then further, they want an opportunity for this welfare bill to be fully aired and all the issues of welfare taken to the people by hearings in the cities.

I mean, if we cannot open up the democratic process for the people in the ghettos and barrios who have been left out, and everybody knows it, and they shall carry this problem into the streets in violent revolt and everybody knows that, and if the Senate committee, the Senate of the United States, is not really prepared to take the issues that directly affect these people and listen to the leaders and have a dialog with them—this is the democratic process—then we are not going to have a democracy. We will all go home and just wait for the place to burn down, and I think we ought to get a response to these questions. [Applause.]

Mrs. HORN. Also I must add to that, the District of Columbia has always been a powder keg. They even hire kids to go to work but they would not listen to our problems, and when we go to the welfare departments—we know this is not only a city but the Nation's Capital and they are doing everything possible to keep from blowing up in this city. Well, I will tell you if that bill is passed it is going to be a holo-

caust in every city. Believe me, I do not feel like my children want to live or are going to die for a people and the people suffering in a country when the country do not want to hear us. Every man that is supposed to be representative in the city, you know, this is the capital of the United States, we do not vote. But remember, we are absolutely hot about it because we are tired. We are living in slavery and this is a part of it. They do not even care whether we got into—we got no talk on the 28th. We were banned. There again, members were from welfare groups right here in the city who asked to be heard. They were not heard. They were ignored. We were only given 10 minutes. This is a disgrace. It is a disgrace. This is a dictatorship.

I see the eagle sitting behind, up on that wall. But I am wondering, I am wondering, are you representing that eagle fully? No. Because in your hearts I see something that really reminds me of 20 some years ago when all of Germany was messing with its own people and then messing with other people.

I say we should start—charity begins at home and if you are going to start anywhere, start in the United States. And stop having a dictatorship and not listening when people are begging.

The only time you want to listen is when all over houses and stores are burned down or when over half the people are dead. I think it is a disgrace. The time is now.

Senator HARRIS. Let me just wind up by saying the bill on the floor of the Senate today involves appropriations for such matters as the demonstrations cities bill and the rent supplement bill, matters that are not totally foreign to what we are talking about here.

Furthermore, I would just say as Dr. Wiley knows, and I think many if not most of you know, that this is a bill which came to us from the House of Representatives. This is the first time, you see, that we have had an opportunity to look at this bill.

We have not written this bill, as I think some of you mistakenly feel. It is a bill which was written in the House and came to us. Now we have the opportunity to study this bill, taking into account what you have said, along with what others have said, and to rewrite it if we so desire, but up to this point, you see, it has been passed by the House of Representatives only, and the Senate has not acted on it.

So, I want to say on behalf of the committee, that I appreciate your being here, and I think you are certainly to be commended for the great trouble you have gone to to be here. I think your testimony has been eloquent and I assure you that it will be considered by this committee in its actions.

Thank you very much.

Dr. WILEY. Senator Harris?

Mrs. SANDERS. May I ask you a question? I understand there have been so many million dollars allocated for the babies overseas that our boys went over there and produced. I would like to know what is your position on the money that you cannot allocate for the babies here that some of us, all of us are producing?

Senator HARRIS. That is a fair question. I do not know the answer to it.

Mrs. SANDERS. Well, I cannot see you passing this bill. Not you personally. But they have—the Senate Finance Committee has not come up with a bill to stop that overseas. So, how can you stop it in this country? This is our country.

Senator HARRIS. You see, the Senate Finance Committee has not acted on this bill yet.

Mrs. SANDERS. Has not acted on it?

Senator HARRIS. No.

Mrs. HORN. Then, may I suggest if they have not acted on it, why do we not get together, your committee, our organization, and why do we not write up a bill that is going to fit our needs because that bill that you have not acted on might very well cause too much chaos and you still will not get any place, but if we get together we might get 3 or 4 feet ahead of each other.

Senator HARRIS. That is the purpose of this meeting exactly and of the other meetings that we have been holding.

Mrs. HORN. It does not seem that way because nobody is listening but you. I see all these empty seats here and they pick today to go and vote.

May I ask you something else? What are they voting on?

Senator HARRIS. I just said a moment ago—I thought I had made that clear—it is on the independent offices bill, which includes such matters as rent supplements and the demonstration cities funds; matters which you and I and everybody else are also interested in.

Mrs. HORN. I am familiar with the rent supplement. It will not work for welfare recipients. Are you familiar with that?

Senator HARRIS. There are several amendments to the bill for such purposes.

Mrs. HORN. Well, it has been tried in urban renewal areas. We are still waiting for housing for welfare recipients and it will not work.

But I still say if you sit down with us, let us go to another room, if necessary, and let us work on this bill because this is the only way you are going to get some satisfaction.

Senator HARRIS. What I am going to have to do now is recess the committee until 2 o'clock.

Mrs. HORN. We ain't finished yet. You are treating us wrong now.

Senator HARRIS. I am sorry.

Mrs. HORN. We have not finished. You see, this is what I am saying.

Mrs. TILLMAN. Before you recess, I would like to know, does it take all day for these gentlemen whose names, taken from their names, to vote on a bill?

Senator HARRIS. I am sorry. But that is another rollcall in the Senate, and so we will have to recess the committee at the call of the Chair, and I do appreciate your having been here.

(Whereupon, at 12:55 p.m., the committee adjourned to reconvene at 10 a.m., Wednesday, September 20, 1967.)

(By direction of the chairman, the following statements are made a part of the printed record:)

STATEMENT OF HERMAN ROSANETZ, NEW YORK, N.Y.

Mr. ROSANETZ. I appeal to you U.S. Senators who are on the Finance Committee of the 90th Congress for your support of H.R. 2015 which is a proposed social security amendment. This proposed social security amendment would extend benefit under section 228 of the Social Security Act to the aged citizens over 72 years of age who never worked to make contribution to the social security fund who live in Puerto Rico. As you are fully aware those aged citizens who

want to receive benefit under section 228 of the Social Security Act one must live within the 50 States and District of Columbia. I do not believe it is fair to deny those aged citizens who live under the American flag in the American possessions the same benefit that those aged citizens who are living and receiving benefit within the 50 States and District of Columbia. I ask you U.S. Senators who are members of the Senate Finance Committee of the 90th Congress please consider the plight which this group of senior citizens find themselves today since they are being denied the benefit under the 1966 Social Security Amendment while living under the American flag but outside of the 50 States and District of Columbia. I urge you U.S. Senators who are members of the Finance Committee of the 90th Congress please support a social security amendment to extend benefit under section 228 of the Social Security Act to persons over 72 who live outside of the 50 States and District of Columbia. I hope and trust that my appeal to you U.S. Senators will receive favorable consideration to such a worthy social security amendment which the Committee on Ways and Means of the 90th Congress gave this proposed H.R. 2015 social security amendment since I, Herman Rosanetz of 68 East Third St., New York City 10003, testified on behalf of such a needed social security amendment. If you wish to check my statement you will find my statement on page 1640 of the public hearings on social security legislation before the Committee on Ways and Means of the 90th Congress. Please don't let my appeal to you members of the U.S. Senate Finance Committee go unanswered since people who live under the American flag outside of the 50 States and District of Columbia are American citizens and are entitled as a matter of right to the same benefit as the people who live within the 50 States and District of Columbia.

(An attachment to Mr. Rosanetz' statement follows:)

STATEMENT OF HERMAN ROSANETZ, NEW YORK, N.Y., BEFORE THE WAYS AND MEANS COMMITTEE

Mr. Chairman, I appeal to you members of the Committee on Ways and Means of the 90th Congress, to consider the feasibility of having general revenues of the U.S. Government to finance the social security fund. I do not think it will serve the interest of the senior citizens by further increasing the social security tax since it will further increase inflation in America.

As the social security tax operates now, worker and employer pay equal share. If the social security tax is to be further increased such as H.R. 5710 proposes the employer will further increase the price of his product, such as when an industry gets an increase in salary by a labor organization.

I ask you, members of the Committee on Ways and Means of the 90th Congress, what benefits will the senior citizens receive by further increasing the social security tax since the increase will be eaten up by an increase in the cost of living?

I urge you to eliminate the tax deduction on charity as well as exempt foundations and use that money to support the social security increase.

I do not believe it is fair to permit anyone to claim any money they give to charity as tax deduction since I believe anyone who wants to give charity should give it because that person wants to give it.

I am also opposed to the idea of tax-exempt foundations which favors big corporations in order to beat their fair share of the tax.

I ask you, members of the Committee on Ways and Means of the 90th Congress, why permit those tax-exempt foundations to exist in order to beat their share of the tax? I say anyone who wants to do charity work should do it without having any tax-exemption break or deduction on their contribution to any do-gooder organization.

I can inform you that 95 percent of the charity organizations as well as those tax-exempt foundations use their money to pay for their staff operation and very little comes to the person in need. I am quite sure you members of this committee have received reports about those organizations who try to use any idea to beat the tax.

I therefore urge and appeal to the Committee on Ways and Means of the 90th Congress not to permit charity as tax deduction as well as tax exempt foundations and use that money to support the social security fund and its programs.

The idea of using general revenues through the U.S. Government is not a new idea since section 228 of the Social Security Act is supported by public funds. If general revenues can be used to support section 228 of the Social Security Act which is the 1966 Social Security Amendment, why cannot general revenues be used to support the entire social security program and give every retired person $200 per month and not on the basis of what he earned during his working years?

I do believe that America can afford to support such an idea so that no aged citizen be compelled to apply for public assistance or support from their children. Remember the American taxpayer is supporting every country throughout the world. Yet our aged parent is living in poverty.

I now appeal to you members of the Committee on Ways and Means of the 90th Congress for your support of H.R. 2015 as a social security amendment which the Resident Commissioner of Puerto Rico introduced through my suggestion. I am quite sure some of you members are fully aware of the fight I waged all alone on behalf of those unfortuned aged citizens who never worked to make contributions to the social security fund and are past 72 years of age.

I wish to express my thanks and appreciation to you members who were on the conference committee on the Tax Act of 1966 to support a social security amendment to give benefit to those aged citizens who never had the opportunity of working to make contributions to the social security fund.

The idea which U.S. Senator Winston L. Prouty, from Vermont, used as general revenues from the U.S. Treasury was from me, Herman Rosanets. I am fully aware U.S. Senator Robert F. Kennedy and Congressman Jacob Gilbert, a member of the Committee on Ways and Means of the 90th Congress have introduced social security proposals whereby the social security fund should be partly supported by general revenues and partly by a small increase in the social security tax.

Yet during the 89th Congress, U.S. Senator Robert F. Kennedy, from New York, and U.S. Senator Jacob Javits, from New York, did not cosponsor S. 350 as a social security amendment which was introduced through my suggestion by U.S. Senator Winston L. Prouty from Vermont, so that those unfortuned aged citizens can receive social security benefits financed through general revenues of the U.S. Government.

Now U.S. Senator Robert F. Kennedy is sponsoring a social security bill in the U.S. Senate to use general revenues and a small increase in the social security tax.

I am certain you members are fully aware that section 228 of the Social Security Act, which is the 1966 social security amendment permits those aged citizens over 72 years of age, who never made contributions to the social security fund to receive benefits at the rate of $35 per month and financed through general revenues of the U.S. Government.

I ask you members of the Committee on Ways and Means of the 90th Congress why should the senior citizen over 72 years of age who never worked to make contributions to social security fund and lives outside the 50 States and the District of Columbia be denied the same benefits which the same senior citizen would enjoy if he lived within the 50 States and the District of Columbia.

I urge you and appeal to you members to act favorably on H.R. 2015 which Resident Commissioner of Puerto Rico Santiago Polanco-Abreu introduced through my suggestion so that those aged citizens living in Puerto Rico, who are past 72 years of age and never worked to make contributions to the social security fund can receive the $35 per month.

I urge and make a special plea to Congressman Jacob Gilbert who represents a large population of Puerto Ricans within his congressional district in the Bronx, N.Y., to use his influence as a member of the Committee on Ways and Means of the 90th Congress for the passage as a social security amendment H.R. 2015, which means so much to those aged parents who live in Puerto Rico as well as other American territories.

Remember the American possessions outside of the 50 States and the District of Columbia is part of the United States of America and by denying benefits under section 228 of the Social Security Act is unfair and unjust to those aged citizens who live under the American flag.

I urge you and appeal to you Mr. Chairman and members of Committee on Ways and Means of the 90th Congress to support H.R. 2015 as a social security amendment so that those aged citizens living outside of the 50 States and the District of Columbia can receive benefits under section 228 of the Social Security Act.

In closing, I wish to express my thanks on behalf of myself as a son of a parent who is receiving benefits since she will receive an increase from $35 to $50 a month.

STATEMENT OF MRS. HENRY STEEGER, CHAIRMAN, NATIONAL COUNCIL ON ILLEGITIMACY

Mrs. STEEGER. The National Council on Illegitimacy is a national voluntary organization sponsored by the Child Welfare League of America and the Family Service Association of America. It has a membership of 18 major national and 281 State and local health, welfare, and religious organizations and 165 lay leaders and members of the different helping professions, such as attorneys, physicians, social workers, members of religious orders, and so forth. Membership represents all religious groups as well as non-sectarian public and voluntary agencies.

The National Council on Illegitimacy is the only agency in the United States with an exclusive and all-inclusive concern for the serious social problem of illegitimacy. It serves as a clearinghouse of information on all aspects of the problem of illegitimacy, fosters study of the type and pattern of services needed to help prevent illegitimacy and to provide required assistance to unmarried parents and their children; encourages research, and publishes current literature.

The National Council on Illegitimacy shares the concern of the Congress with respect to the seriousness of the problem of illegitimacy. We also agree that welfare programs should be designed to help people become self-supporting. We strongly object, however, to specific provisions in title II of H.R. 12080 which penalize children born out of wedlock. In our view, though designed to reduce illegitimacy, these measures actually are self-defeating. The amendments, whatever their intent, will serve to aggravate rather than alleviate the problem of illegitimacy. Punishment of helpless children and unmarried mothers through denial of public assistance benefits and through enforced separation of mothers from children can only lead to further social and psychological deterioration. It will not prevent dependency nor strengthen family life. It cannot rehabilitate the individual or the family. The threat of child removal in families with illegitimacy has been found to be a powerful deterrent to the mother's applying for assistance regardless of the child's need. Under such conditions, mother and child will be cut off not only from decent maintenance, but also from rehabilitative help.

The National Council on Illegitimacy, while committed to work toward prevention, is equally strongly committed to the principle of provision of full rights for illegitimate children on the same basis as rights enjoyed by legitimate children. Punishment for a social status

of birth over which the child has no control may well conflict with the 14th amendment to the U.S. Constitution. In any case, such stigma will breed social isolation and resentment against society. Powerful roadblocks against rehabilitation will have been created.

The report of the House Committee on Ways and Means stresses concern over the fact that the 1962 legislation has not had the results that those in the administration who sponsored the amendments predicted. It is true that a large number of families have not achieved independence and self-support. However, only a small minority of unmarried mothers receive the benefits of AFDC. An HEW survey conducted in late 1961 showed that four-fifths of all out-of-wedlock children were not receiving public assistance. Nor can it be said that the illegitimacy rate is going up to any significant degree. From 1957 to 1965 the rate increased by 3.5 percent, but during the same period the number of unmarried women of child-bearing age rose from 9.9 million to about 12 million. A 1964 investigation by the Community Council of Greater New York found that only 3 percent of unmarried mothers and their children were solely supported by AFDC during the first 18 months after the birth of their first child.

The stark fact remains that rehabilitative services are generally unavailable to that large majority of unmarried mothers who keep their children. Society puts many, often insuperable, roadblocks in the path of the unmarried mother who wishes to become a self-supporting and contributing member of society. Many public housing projects exclude this group as a class. Most public school systems prohibit pregnant girls and young mothers from continuing their education. Adequate day care facilities for infants are almost nonexistent. Counseling services do not reach the very poor and deprived.

It must be stressed above all that social welfare alone cannot combat the problem of illegitimacy. Public welfare services are desperately needed for alleviation of the results and can aid in prevention. However, society as a whole is responsible for the very existence of the problem and it is unrealistic and perhaps naive to lay the blame on the welfare system that only struggles with end results. Illegitimacy has many causes which demand fundamental action by all societal institutions. Among such root causes are, to name but a few:

1. The high unemployment rate for minority group males which precludes marriage.
2. Lack of adequate housing for the establishment of mature and responsible family life.
3. The country's deteriorating moral climate which in every way through industrial advertisements, provocative clothing, literature, and so forth, glorifies sex as an isolated entity without considering it in the framework of mature and responsible family relationship. There is a general confusion about moral values.

The restrictive provisions of H.R. 12080 penalize the victims of the climate prevalent in our whole body social. They do not attack the problem at the roots. A comprehensive plan for prevention of illegitimacy must go far beyond amendments to the Social Security Act.

Specifically the National Council on Illegitimacy objects to the following inhumane provisions of the bill which are giant steps backward in the interest of children:

1. The ceiling placed on Federal grants to States for AFDC which does not take into account the possibility of economic recession and the rising number of women of childbearing ages. This will reestablish a system of "less eligibility" and force the States to penalize all children in need.

2. Required cooperation with law enforcement agencies in determining paternity. We agree with the principle that the unmarried father should assume, when able, financial responsibility for his child. The provisions of the bill, however, are not designed to further the father's interest in his child. Rather, they will lead to time-consuming litigation during which children will suffer. Experience has shown also that such provisions will deter needy mothers from applying for public assistance, again depriving innocent children. Court systems in some local communities are reinvoking 18th century laws, trying on charges of fornication unmarried mothers who file paternity suits. Conviction may result in jail sentence, depriving the child of his mother's care at expense to the taxpayer.

3. Referral to the courts for possible removal to foster care of a child from a home with "multiple instances of illegitimacy." Multiple illegitimacy alone does not make a woman an inadequate mother and should not deprive the child of parental care. This provision, again, will deter a woman from applying for assistance, thus depriving her and her child of needed counseling and financial assistance.

4. The proposal to force mothers and out-of-school youngsters over 16 into the labor market as a condition of receiving assistance. This provision does not allow for individualization, and does not take into account the social value of a mother's work in the rearing of her children and caring for their home. Also youngsters, rather than be urged to enter the labor market prematurely, into possibly dead end jobs, should be urged to complete schooling so that their long-range earning power is enhanced. Continued schooling should be available for pregnant girls and young mothers.

5. The provision that illegitimate children who qualify for OASDI benefits only under the 1965 amendments—section 216 (h) (3) of present law—receive residual benefits only. This is a regressive step and clearly discriminatory. It penalizes illegitimate children, who cannot help their social status not only financially but also psychologically, placing them into the position of outcasts.

We earnestly urge redrafting of title II of H.R. 12080.

STATEMENT OF DR. HERMAN D. STEIN, DEAN, SCHOOL OF APPLIED SOCIAL SCIENCES, WESTERN RESERVE UNIVERSITY, ON BEHALF OF THE COUNCIL ON SOCIAL WORK EDUCATION

Dr. STEIN. My name is Herman D. Stein. I am the dean of the School of Applied Social Sciences of Western Reserve University in Cleveland, Ohio. I appear before you today in my capacity as president of the Council on Social Work Education.

The council is the one and only national agency exclusively concerned with social work education. The constituent members of the Council on Social Work Education include not only the 63 accredited graduate schools of social work in the United States and almost 200 colleges and universities with undergraduate programs in social welfare, but also over 40 major national health and welfare organizations, and the National Association of Social Workers with over 45,000 members who are concerned about social work education. In addition, thousands of State and local health and welfare agencies, libraries, individual educators, practitioners and interested citizens are also affiliated with the council.

The key purposes of the council are to set and maintain standards for graduate schools of social work and to give leadership to the enhancement and expansion of social work education at the undergraduate, master's degree, and doctoral level.

I speak in support of the Mills bill, H.R. 5710, and especially of title IV on "Social Work Manpower and Training."

ADEQUATE SUPPLY OF PROPERLY PREPARED MANPOWER IS CRITICAL

No service is better than the quality of personnel who direct it. This is as true in health and welfare as it is in business and industry.

There are today over 10,000 budgeted social work positions in health and welfare agencies that are unfilled. Many social work positions requiring the highest level of competence are filled by people who do not have adequate preparation. Billions of dollars are provided each year by private citizens, business and labor groups, foundations, and government—local, State, and Federal—to carry out the many programs and services with which the United States helps its needy, physically sick, mentally ill, young and aging, and its physically and emotionally handicapped. To utilize both the tax and contributors' dollars judiciously and effectively, an adequate number of appropriately educated social work personnel is essential. The need is critical both in positions requiring professional competence and to fill the rapidly growing number of positions not requiring graduate professional education, in order to achieve effective service at minimum cost.

CURRENT SOCIAL WORK MANPOWER NEEDS CANNOT BE MET WITHOUT FEDERAL AID

Schools of social work have increased their enrollments and their graduates more than 100 percent in the last decade. Yet, the existing programs of social work education are unable to graduate enough students to meet even the manpower needs of the past. Implementation of the provisions and intent of the many significant laws dealing with health, education, and welfare passed in the last session of Congress calls for a far larger number of social work personnel than ever before. Unless new and major Federal support becomes available to help social work education to expand substantially, schools of social work will not—cannot—produce enough social workers to meet current, much less future, demands.

MAJOR EXPANSION OF SOCIAL WORK EDUCATION IS NECESSARY AND URGENT

It has been estimated that in the next decade, because of the growing population alone, there will be a need for a 50-percent increase of social work personnel in the United States just to maintain the present level of service—inadequate as it is. In addition to the population explosion, the many problems resulting from Negro ghettos in our cities, from increasing automation, from the swelling migration to huge urban centers, demand highly trained professionals. More specifically, the 1962 Public Welfare Amendments, with their emphasis on rehabilitation, the new developments in comprehensive community planning in health and medical care, in prevention and treatmet of crime and juvenile delinquency, and new community mental health programs, all call for more social work personnel. The Task Force on Social Work Education and Manpower of the U.S. Department of Health, Education, and Welfare, in its report entitled "Closing the Gap in Social Work Manpower" published last year, documented the need by 1970 for 100,000 new social workers with graduate professional education and for many more thousands of college graduates to be employed in certain tasks in social welfare not requiring graduate professional education. Increased use of auxiliary personnel also increases the need for professionally educated personnel in planning, administration, and supervision. There has also been growing recognition that social workers can and should play a major role in the prevention as well as the alleviation of individual and social problems. This, again, calls for more personnel and more highly trained social workers.

It is not only Government services, the Protestant, Catholic, or Jewish agencies, or the voluntary nonsectarian agencies which require more social work personnel but also industry and the military services which in recent years have begun to seek social work staff in increasing numbers.

The supply-and-demand relationship of social work manpower is out of balance and growing worse. Operating at full capacity and at an alltime high, all the schools of social work now graduate fewer than 4,000 social workers each year. Similarly, it is estimated that fewer than 4,000 students complete undergraduate programs in social welfare annually. At the present rate, it would take the existing schools of social work over 20 years to train the 100,000 new professionally educated social workers needed for the public services by 1970. Obviously, major expansion of social work education is necessary and urgent.

THE "OUTPUT" OF SCHOOLS OF SOCIAL WORK HAS GROWN; BUT NOT NEARLY ENOUGH

The schools of social work have done everything possible within their resources to expand and increase the number of graduates. The "output" in recent years has grown substantially, but the increase has not been adequate to the need.

The number of schools has been growing consistently

As of January 1967, there are 63 accredited schools of social work in the United States. The number of accredited schools has grown in

recent years at an average rate of about one new school a year. In 1950 there were 48 schools. Between 1950 and 1960, nine new schools were accredited; since 1960, six more have become accredited schools. These are located in Arizona, California, Georgia, Maryland, Oregon, and Wisconsin.

Enrollment has been increasing each year in the past decade

There has been an annual increase of about 14 percent since 1954. In the academic year 1966–67, there were 9,335 full-time master's degree students enrolled in the 63 schools of social work. This represents an overall increase of 11 percent in enrollment in the master's degree programs over last year—from 8,380 to 9,335—and marks an alltime high.

The number of graduates from schools of social work has reached an alltime high

The increased enrollment in the master's programs of schools of social work in recent years, as would be expected, is reflected in the number of graduates. The year in which the fewest students were graduated in the last decade and a half was 1957, with less than 1,700. By 1960, the number had grown to about 2,000. At the end of the academic year 1965–66, 3,693 students were graduated from the 63 accredited schools. This number represents more than a 100-percent increase since 1957, from 1,612 to 3,693.

While no similar comprehensive and reliable data are available for undergraduate programs in social welfare, there is ample evidence of their growth and development in recent years. One example is the increase in the membership of undergraduate programs in the council from about 50 in 1957 to 198 in 1967.

FURTHER EXPANSION OF SOCIAL WORK EDUCATION IS NECESSARY AND POSSIBLE

The enrollment of schools of social work is at an alltime high. Most schools are filled to capacity and are forced to turn away qualified students.

In a survey conducted by the council in 1964, 48 out of the then existing 59 accredited schools of social work reported that they could not accept all the applicants who met their entrance requirements. The situation has grown worse since then. In the same 1964 survey, 57 out of the 59 schools indicated that, if funds were available, they could and would expand.

A special committee of deans, in the spring of 1966, made a study and prepared a detailed report on how much and how fast social work education could expand in the decade, 1966–76, if adequate funds became available. They concluded that social work education could produce 96,700 master's degree graduates from schools of social work; 100,000 college graduates from undergraduate programs in social welfare; and 1,200 doctoral degree graduates from social work programs.

The committee indicated in its report:

> We recognize that to achieve the projected quantitative growth, without a negative effect on quality, will require a supreme effort on the part of schools of social work and all others related to social work education. . . . The manpower

needs in social welfare make these projections for a major expansion of social work education imperative. We believe that they are attainable if substantial new support for faculty, facilities and student aid becomes available quickly.

The output of social work education can be increased through (*a*) the establishment of new schools and programs; (*b*) the expansion of existing schools and programs, and (*c*) the development of different patterns of education.

Six new schools of social work have opened in the past 2 years and are working toward accreditation. These are located in California, Florida, Illinois, and New York. As a rule, the interest and impetus for new schools has come from public or voluntary agencies in the area and/or the university officials. Usually it takes many years for the interest in establishing a school of social work to be translated into reality. Almost invariably, the lack of adequate funds is the cause of slow progress or no progress. The availability of Federal funds to help establish new schools of social work in both private and public institutions of higher learning could be a critical factor in the next few years.

At the present time, 18 States have no schools of social work. These States include two represented by members of this committee, Arkansas and Montana. Some believe that every State should have at least one school of social work. They argue that in addition to meeting staff needs, the State will derive other benefits from a school in the area, such as professional leadership, a center for research on the social problems of the State, and encouragement of continuing study by practitioners. The Council is currently working with universities in 31 States which are at various stages of planning for new programs of social work education. It is anticipated that, if adequate funds become available, schools of social work will produce additional social work personnel in the near future in Alabama, Arkansas, California, Florida, Illinois, Massachusetts, Michigan, New York, North or South Dakota, Ohio, Pennsylvania, Texas, Virginia, and Wisconsin.

Although existing schools of social work have increased their enrollments annually, the lack of funds for new faculty and enlarged facilities has been a limiting factor on growth. Schools have indicated that they cannot continue to increase enrollment and maintain high quality education without new and additional funds.

Colleges and universities have been slow or unable to initiate new undergraduate programs due to limited university funds. For the same reason, existing programs have been unable to add to their faculties in order to prepare more students. The availability of Federal funds would make a major difference.

LACK OF FACULTY IS A KEY OBSTACLE TO EXPANSION OF SOCIAL WORK EDUCATION

The deans' committee report mentioned earlier estimated that to achieve the projected expansion of existing graduate schools of social work, the creation of new schools of high quality, and the development of undergraduate programs in social welfare will require, between 1966 and 1976, approximately 1,600 new full-time faculty members for graduate schools and 300 new full-time social work faculty for undergraduate programs. This estimate took into consideration the current

and continuing use of part-time faculty, improved utilization of faculty in the years ahead through new teaching patterns and educational technology, and a probable 20-percent loss of existing faculty due to marriage, motherhood, retirement, and other causes. To this total of 1,900 new full-time faculty needed for the expansion of social work education in the next decade must be added at least another 100 for currently existing vacancies.

It will require a major effort to recruit, prepare, and pay for new faculty for social work education in the next decade. Many but not all of these new faculty members will need doctoral or other advanced preparation. The new schools as well as the existing programs will require financial aid in order to produce and employ faculty needed to produce more graduates.

Colleges and universities will need additional resources for field instruction and will need increased staff in the dean's office, the admissions office, and in various supporting services. They will also need to find, renovate, or construct facilities for increased student bodies, faculties, and research activities. We are disappointed that the bill does not provide funds for new construction which will be necessary for new schools and will also be needed by existing schools in order to continue to expand. We all hope that, in the future, Congress will provide funds to help meet the cost of new physical facilities for social work education, as has been done for various other professional schools.

FEDERAL AID CAN MAKE THE DIFFERENCE

Schools of social work in the years ahead can be the spur or the bottleneck in efforts to improve and increase needed health and welfare services by insuring adequate quantity and quality of social work personnel. Major expansion of existing schools of social work and undergraduate programs in social welfare, and the establishment of new schools and programs will require Federal aid. Until and unless there is expansion of social work education, the ever-growing shortage of social work personnel will be an insurmountable obstacle to the effectiveness of existing health and welfare programs, as well as to their further improvement and expansion.

As president of the Council on Social Work Education, I want to pledge to you, on behalf of all our member schools—whether State universities, those under religious auspices, or private nonsectarian institutions—that we will exert every effort to make every dollar of Federal support go as far as possible in turning out the maximum number of well prepared personnel so urgently needed in the various health and welfare services.

STATEMENT OF MARTIN C. SEHAM, GENERAL COUNSEL, ALLIED PILOTS ASSOCIATION

Mr. SEHAM. My name is Martin C. Seham, and I am general counsel to the Allied Pilots Association. The association wishes to thank the committee for the opportunity to present its views on the Social Security Amendments of 1967. Our association is an organization representing the 3,400 pilots in the employ of American airlines. We are

appearing before the committee because we believe that the pendency of the amendatory legislation offers Congress an opportunity to correct an inequity under the present law and an inequity which is likely to become more aggravated in future years.

As the committee undoubtedly knows, the professional life of airline pilots is cut off at age 60 by Federal regulation. This is a regulation which all airline pilots feel is wholly unwarranted and an arbitrary measure unrelated to the individual pilot's personal capability and physical condition. The organized pilots of this Nation vigorously, but unsuccessfully, opposed the issuance of these regulations, and pilots must now order their professional and personal lives on the basis of these regulations.

Testimony has already been offered by Capt. Nicholas J. O'Connell, Jr., president of the Allied Pilots Association, in connection with this pending legislation. That testimony begins at page 1499 of the transcript of hearings before the House Committee on Ways and Means, and we do not intend to repeat it here. However, we want to take special note of the action taken by this committee in submitting to the Secretary of Health, Education, and Welfare a question raising the issue of inequitable treatment to pilots, or others, who are forced to retire at an early age by Federal regulations but must, nonetheless, wait until the "normal" retirement date to be eligible for social security benefits. We want to specially thank the committee for its action in recognizing the issue we are raising.

The answer of the Secretary of Health, Education, and Welfare begins by stating: "It would be difficult to justify making full social security benefits available to airline pilots at age 60 while denying benefits to other workers age 60 whose need for the benefits might be just as great." The simple answer to the Secretary's statement here lies in the fact that other workers are not required by Federal law to terminate their employment at this early age. Presumably, the requirement for the retirement is for the public's protection, and as we have pointed out, it has been over the disagreement of the pilots affected. Certainly, if commercial airline pilots must abide by a federally imposed retirement regulation and be cut off from their normal gainful employment, there is no reason whay they should be prevented from receiving full social security benefits at that time. In a real sense, the Federal Government has already set the "normal" retirement age for pilots at age 60 and is discriminating against these men by not making payment at that time.

The next objection raised by the Secretary is based on his statement that "the cost of the program would be substantially increased." We presume that this comment is a standard one made by the Secretary on any occasion when benefits of any kind are opposed. Certainly, a vague, meaningless statement of this kind merits no consideration at all from the committee. The balance of the Secretary's reply is devoted to suggestions to remedy the pilots' inequitable situation. The first suggestion is that any inequity be remedied by the airlines. Of course, the same observation could be made with respect to the entire social security system, but we feel that the underlying principle of the legislation rejects such a thesis. If the committee will join with us in accepting the premise that pilots are entitled to full social security benefits at their federally imposed "normal" retirement age, then the Sec-

retary's argument that these men constitute a special group and that their special problems must be handled—if at all—by their own employers must be rejected.

The final suggestion by the Secretary is that special legislation be enacted to meet the situation we have described. Of course, this again misses the point that we have been trying to stress—that pilots are not asking for special treatment, but only for the same treatment on their normal retirement date as other workers receive. Moreover, the committee well knows the burden and delay which would be involved in the adoption of new legislation to remedy this problem. Congress is now considering comprehensive amendments to the social security law, and the present moment provides a rare opportunity for the correction of the type of inequity we are discussing. We want to emphasize again that airline pilots or others forced to curtail their careers by Federal regulation do not want special treatment, but only fair treatment.

I again want to thank the committee for the attention it has given to the problem we have raised and to these remarks.

STATEMENT OF HON. SEYMOUR HALPERN, A U.S. REPRESENTATIVE FROM THE STATE OF NEW YORK

Mr. HALPERN. Mr. Chairman, it is a privilege for me to present my views on H.R. 12080, the Social Security Amendments of 1967, which directly affect 15 million citizens of our country.

Many bills were submitted to the House before this measure was finally passed after long and detailed debate. Among them was an omnibus bill, H.R. 12327 I sponsored, which was broader in scope and, in my opinion, met the ever-growing problems and needs of social security more effectively and realistically than H.R. 12080.

Like many of my colleagues in the House, I was deeply disappointed that we were prevented from offereing amendments to improve the House bill by the closed rule that prevailed. We had no choice but to accept the bill as it was, or get nothing at all.

Our hope to improve it now lies in this body and I know I reflect the hopes of many Members of the House that in its wisdom, your committee will report a liberalized, more inclusive bill geared to today's social and economic conditions. Such a bill will meet more adequately our obligations to our senior citizens.

Social security benefits today are no longer adequate to aged people out of poverty, more than 5 million still remain impoverished and needy. The main reason for this shameful situation is that benefits are too low.

How can a person be expected to live on $44 a month, the present minimum allowance, or even $50 as the House bill proposes? In my opinion, a minimum benefit increase of at least 15 percent, and a $70 monthly minimum would remove 1.4 million aged from poverty.

Automatic adjustments of benefits should also go hand-in-hand with cost-of-living increases. This is vitally necessary if we are to assure ourselves that social security benefits will meet the future needs of our older citizens.

The 15-percent increase should be computed on a gradually increased ceiling on taxable wages, reaching $10,800 by 1974 and yielding maxi-

mum benefits of $288 per month by that time. This is one more way of providing equitable and adequate social security benefits in the years to come.

I feel strongly, too, that a special minimum benefit should be assured to those who have contributed to the social security fund for long terms. I urge a substantial increase of up to $50 in special monthly benefits for all those recipients who are 72 and older. The House bill limits the increase to $40.

The House bill takes a step in the right direction by increasing the amount an individual may earn without suffering benefit deductions from $1,500 to $1,680 a year. However, this is insufficient and still discriminates against those over 65 who choose to remain active in their careers. I propose a higher limit of $3,000. This is by no means an exorbitant figure, even when supplemented by maximum social security benefits.

The House bill ignores one of the President's original major proposals, to extend medicare benefits to 1.5 million disabled workers younger than 65. This would provide medicare for a large group of deserving people whose essential need for health insurance is similar to that of the aged.

I strongly urge consideration for a problem in medicare that has been unfairly neglected since the program's inception in 1965. Before medicare was enacted, all persons over 65 were allowed a special income tax deduction for all medical and drug expenses. Upon enactment of medicare, its recipients lost their special tax status. Thus, many of our aged are required to pay large sums of money every year, out of their own pockets, for much needed drugs and medical services.

This cost is an insufferable burden to anyone with a limited income, especially those receiving as little as $44 per month, the current monthly minimum. I urge you to include all approved drugs under medicare.

Probably one of the most necessary and most costly personal budget items for the elderly is medical expenses. It is unfair to increase this burden by taxing their medical costs. I urge you to provide 100 percent tax deduction for medical expenses incurred by social security recipients.

One area which has long concerned me is the penalty paid by the very citizens who have led the most productive lives, and have been most diligent in providing for their golden years by becoming eligible for retirement pensions. For years, I have advocated tax exemption for at least part of pension benefits. I suggest that the first $4,000 in pension and annuity returns each year be fully tax exempt.

I enthusiastically support the House bill's provisions to include podiatrists' services within the supplementary medical insurance program and to add outpatient hospital and diagnostic specialty benefits for the aged and disabled.

I cannot let this opportunity go by without speaking directly in behalf of my State, New York. H.R. 12080 includes a provision which severely limits the income level for participation in the medicaid program.

Section 220 provides that the income level for participation in the program cannot be higher than 133.5 percent of the income level for

eligibility for the aid to dependent children program, with the ceiling effective January 1, 1967.

New York State now bases its eligibility requirement on the 1965 medicaid provisions. As a result, New York has provided many people with aid whch they will not be qualified to receive under the new ceiling. This provision, if enacted, would have a direct and very adverse effect on the citizens of New York.

New York State has always manifested a great concern for assuring needed medical care to its residents. This program is in keeping with New York State's historical humanitarian social outlook.

The present estimates for the cost of medicaid in New York State for the current fiscal year are: Federal share, $120 million; State's share, $115 million; and local share, $155 million.

The cost projections for the next fiscal year are Federal share, $237 million; State share, $210 million; and local share, $210 million.

These funds would assure all families and individuals who cannot afford needed care of receiving necessary medical attention without fear of financial ruin and tragedy that often occurs with serious illness. The effect of a cut in funds cannot be measured in money alone, but must also be measured in increased human suffering.

New York State and its citizens have relied in good faith on the 1965 provisions. If H.R. 12080 is enacted in its present form it will be responsible for the dashed hopes of many indigent people. Six million New York State residents now benefit from medicaid. At least 10 percent of them—600,000 people—who are now receiving aid will be confronted with the loss of benefits, if the present bill prevails.

This provision would mean losses of Federal aid to New York State of at least $29 million the first year, $40 million the second year, and $50 million the third year. From the present estimates and cost projection figures I have cited, it becomes obvious that New York State would not only be prevented from expanding its program, but the current funds would be decreased. This situation would be intolerable.

When the mayor of the city of New York was interviewed after presenting his testimony before this committee last week, he was quoted as stating that the results of these changes would be "a flaming crisis" for New York City.

Mr. Chairman, I urge you and the distinguished members of this committee to keep in mind the fact that the basic purpose of our Nation's social security program is to prevent the kind of crisis which can descend upon so many of our citizens through no fault of theirs other than the fact that they have lived long, and passed their most productive years.

Again, I offer my thanks for this opportunity to express my views in connection with this important humanitarian legislation which is before this committee.

STATEMENT OF GLENN E. WATTS, PRESIDENT, HEALTH AND WELFARE COUNCIL OF THE NATIONAL CAPITAL AREA

Mr. WATTS. The Health and Welfare Council of the National Capital Area, through its citizen representatives and its member agencies, has had a continuing concern about the impact on people living in the

Washington area of Federal welfare programs. This area includes the District of Columbia; Montgomery and Prince Georges Counties in Maryland; and the city of Alexandria; Arlington, Fairfax, and Prince William Counties in Virginia. The effects on people of these programs and the changes enacted from time to time are witnessed by HWC member agencies as they serve families in need.

The Social Security Act has provided fundamental economic protections to thousands of families in the Washington metropolitan area. It also includes the basic provisions of the Federal-State-local public welfare programs which have served thousands of needy families. These national programs must be relied upon to provide an economic and social floor so that no family in genuine need will suffer economic deprivation or social inadequacy.

The Advisory Council on Public Welfare appointed in accordance with a recent amendment to the Social Security Act made a thorough study of the act and recommended many significant and valid improvements. The Johnson administration, after study of the Advisory Council's report, prepared its recommended changes in the act, incorporated in H.R. 5710. In general, the administration proposals fell considerably short of the Advisory Council recommendations.

The House of Representatives has adopted 1967 amendments to the Social Security Act in a completely new version contained in H.R. 12080. Many of the changes included in this bill would improve the programs. The Health and Welfare Council has very deep concern, however, about a number of the provisions of the House bill. We urge the Senate to change these provisions and the Congress to enact a bill which will improve existing programs. Some of the House-passed amendments would be major setbacks in services for people, would seek to save money in the short run at the expense of people's urgent needs, and in the long run would cost the Nation more. Money saved on public assistance would be spent on foster care which is more expensive, on medical care which is much more expensive, and on broken families which are beyond pricing.

I. OLD AGE, SURVIVORS AND DISABILITY INSURANCE

A. Minimum benefit

Some aged persons receive the minimum social security benefit of $44 per month, an amount which provides total income of $528 for a full year. For some of these persons, social security benefits are the only regular source of income. Clearly these persons will live in poverty unless their income is supplemented. Public assistance provides a supplement for some.

We believe it is a more humane approach and a more economical administrative arrangement to increase the minimum social security benefit to approach a level for adequate living for the individual.

The administration proposed that the minimum benefit be raised to $70 per month. Even this provides only $840 per year. The House bill raises the level to $50. A total of $600 per year. We believe this is an inadequate advance, and we urge at least the level recommended by the administration.

B. General benefit increase

The report of the House Ways and Means Committee accompanying the bill notes that "social security benefits are virtually the sole reliance of about half the beneficiaries and the major reliance for most beneficiaries." The report also notes that currently, the average benefit paid to a retired worker and his wife is $145 per month.

This provides an annual income of $1,740 for two persons, a level which places the couple below the poverty criterion. The House bill would increase the general benefits by 12½ percent. This would raise the average benefit for a couple to $164 monthly or $1,968 per year. This is still an inadequate level. The administration recommended a general increase of 15 percent, and we believe this is the smallest increase which can be supported. We urge at least this level of increase in general benefits.

II. MEDICAL ASSISTANCE

Under title XIX of the Social Security Amendments of 1965, provision was made for Federal financial assistance to States to organize medical care—medicaid—for low-income persons under 65 years old. Maryland has adopted legislation to participate in this program. The District of Columbia has sought congressional action to participate, and the House has passed a bill to acomplish this, but the Senate has not yet acted.

The Virginia Legislature has not yet acted to participate.

Under the provisions of H.R. 12080, Congress would establish a cutoff point for Federal financial assistance to the States. Federal funds would be provided only to assist families whose income is not higher than one-third more than the amount of the State grant under the program of aid to families with dependent children (AFDC). These maximum grants under AFDC are generally quite low and are inadequate for decent family living. As applied locally, the new bill would limit medicaid to families of four persons with incomes as shown, based on figures prepared by the Department of Health, Education, and Welfare:

District of Columbia	$2,600
Maryland	2,700
Virginia	2,500

We believe these limitations are much too stringent. They would reduce the benefits of this program substantially. They would force low-income families to continue to put off required medical attention. We urge the rejection of these severe limits on eligibility for medicaid.

There is no valid basis for tying eligibility for medical care to public assistance standards. Medicaid is, and should be, designed to serve a different group of persons than public assistance recipients. In part, it is needed by the working poor who can manage normal expenses but cannot pay for the high costs of hospital and medical care.

III. PUBLIC ASSISTANCE

A. Level of payments

Each State determines the amount of funds which families require for subsistence. Frequently, in making cash payments to families receiving public assistance, the State pays less than its own subsistence standards. In Virginia, for example, the State pays 90 percent of the standard. In Maryland the State pays less than the standard.

The administration recommended that all States be required to raise public assistance cash payments to the subsistence minimums, and to bring these standards up to date annually. This provision was dropped by the House in H.R. 12080.

We urge the Senate to include this provision. It is inhuman to set a minimum subsistence standard, and to give poor families less. This practice provides no basis for decency, dignity, and incentive to rehabilitation.

B. Family employment

Three negative and restrictive provisions of the House bill give us the deepest concern, and we urge most strenuously that the Senate reject these provisions.

We believe that there needs to be considerable strengthening of programs which can help to rehabilitate families, so that fewer persons need public assistance payments, and those who require aid will need it for a shorter time. More day care is needed, and the House bill would further such programs. We are in agreement with the goals of family independence and self-support expressed in the report of the Ways and Means Committee. We do not believe, however, that the goal of reduced public assistance payments can be achieved by restrictive programs without serious suffering inflicted on individuals, and ultimately the community will pay in some other form.

The House bill would require that each appropriate AFDC adult and older child not attending school be equipped for work and placed in jobs. We oppose this requirement because it is based upon an unsound philosophy. With respect to children, we believe that maximum effort should be made to assist older youths to complete their education. There are Federal programs which lead to this aim. The requirement that they work is contradictory to what we believe is sound public policy.

With respect to mothers of children on AFDC, some may wish to work, and can do so with no damage to the family when adequate child care plans can be made. It is not sound, however, to make work a requirement for mothers in order to receive assistance for their children.

C. Limitation on number of AFDC beneficiaries

The House bill would introduce an unprecedented limitation on the number of families eligible for Federal financial assistance under the AFDC program. It would freeze the level of participation. The proportion of all children under age 21 who were receiving aid to families with dependent children in each State in January 1967, on the basis that a parent was absent from the home, would not be exceeded for Federal participation after 1967.

This is an arbitrary restriction on aid to needy persons. It is unsound and inhumane. It would cause serious suffering among many persons. It would not rehabilitate any family, and it is no path to independence and self-support.

An example of the impact of this provision is the fact that, if this restriction had applied in August 1967, 3,000 families in Maryland who are clearly in need and clearly eligible today would have been denied public assistance. Under this provision, the children whose

father deserts too late, that is after the ceiling on eligibles has been reached, would be told that they must go hungry.

We urge the Senate to reject this provision.

D. Earnings exemption for recipients of public assistance

We are strongly in accord with the aim of encouraging and assisting persons to earn all or part of their needed income through work, often following training. An incentive toward this goal is to permit recipients of public assistance to retain the income from work without reduction of their assistance grant. Most often the combination of their full assistance grant and their earned income is barely adequate for sustenance and a growing sense of independence.

The administration proposed that public assistance recipients be permitted to retain without loss in their assistance grant the first $50 per month of earnings, plus one-half of the amount above. The House bill reduces this exemption to the first $30 per month of earnings plus one-third of the amount above.

We believe this reduction will also reduce incentive, and we urge adoption of the administration proposal.

E. Social work manpower

We commend the inclusion in the House bill of an authorization to help finance social work manpower training. The personnel shortages are severe. Although $5 million will not be enough for this program after the first year, it will provide a satisfactory base for the inception of the program.

STATEMENT OF JOSEPH D. CALHOUN, M.D., CHAIRMAN, BOARD OF CHANCELLORS, ON BEHALF OF THE AMERICAN COLLEGE OF RADIOLOGY

Dr. CALHOUN. Mr. Chairman and members of the committee, the members of the American College of Radiology appreciate the opportunity offered by the Senate Finance Committee to present a statement relative to H.R. 12080 and allied proposals which are being considered by the committee.

The members of the American College of Radiology are 6,500 physicians in the United States in active practice who specialize in the use of X-rays and radioactive substances in the diagnosis and treatment of disease and injury. The 1,500 physicians who are currently in residency training programs in radiology are also members of the college.

The American College of Radiology favors existing provisions affecting radiology in Public Law 89-97; if amendment is deemed essential, we support H.R. 12080; and we oppose any legislative proposal which would convert the medical specialty of radiology into a hospital service by placing radiology within part A of title XVIII.

Our principal concern is high-level medical practice and patient care. We are sympathetic with the fact that implementation of medicare has been a tremendous task. It involved and is still involving a massive educational effort directed at beneficiaries, hospitals, physicians, and those who administer the program. For this reason, we can support

proposed changes that will simplify administration of the law, but only if these proposals will not adversely affect present and future services that radiologists provide to patients. We do not agree that the interests of simplified administration should be allowed to take precedence over a high level of diagnostic and therapeutic services in radiology.

THE PRACTICE OF RADIOLOGY

To provide a context for our statement, radiologists perform a medical service for 100 million Americans annually. In each instance a radiologist provides an individual, personal service. In undertaking physical examinations of patients by using X-rays, we personally do all fluoroscopy, interpret every film, prepare a consultation report on every examination, consult with other physicians and many of us inject the drugs used in complex procedures and wait with patients to handle possible adverse reactions. In our practice we use trained assistants, radiologic technologists, in the same manner as other physicians use the services of nonphysicians throughout medical practice.

All treatments with radiation are individualized for the particular patient, and are performed personally, or directly supervised, by a radiologist. In treating with radiation, a radiologist must decide how and when to treat each individual patient. The patient's sex, physical condition, psychologic state, family situation, and the like, all have a bearing on medical decisions that must be made. This is the art of medicine and it has a tremendous influence on whether and how a patient responds to treatment.

PATIENT SERVICE AND RECRUITMENT

We oppose any proposal that segregates physicians' services in radiology from like patient services of other physicians by removing radiology services from part B of title XVIII. Such a treatment would be innately discriminatory and we know it would injure future patient service in our specialty. At this point in time, any action that would place our services under part A, or remove them from part B, would be a very pointed differentiation from the coverage of services in other branches of medicine.

To make a radiologist a second-class citizen of medicine in any fashion will injure his morale and performance. It is certain to promote administrative interference in—and hospital domination of—the practice of radiology. This, we believe, is contrary to the interests of individual patients, the persons who are the primary concern of all doctors, and also contrary to the public interest, which is the primary concern of the U.S. Senate.

We are the individuals who have the difficult task of recruiting bright young doctors into radiology. We talk to young physicians contemplating specialization in radiology. We know that many elect to enter other branches of medicine because of the threat that radiology may be segregated from medical practice by definition as a part of hospital service under a Federal law.

We have a critical manpower shortage in radiology. A report to the Surgeon General prepared by the National Advisory Committee

on Radiation, "Protecting and Improving Health Through the Radiological Sciences," submitted in April 1966 and published by the U.S. Department of Health, Education, and Welfare tells the story. Two brief quotes from page 13 sharply define the Nation's problem:

> Indeed, it appears that the number of radiologists needed in the United States is almost twice as great as the number actually available.
>
> If present growth rates and clinical demand continue, the need for physician manpower in the radiological sciences seems likely to rise to a level of three or more times current supply by 1975, i.e., to a level of from 20,000 to 25,000 radiologists in ten years. Such a need presents a disturbing picture to those responsible for the nation's health. It is clear that major attention must be given to the problems of radiological manpower as quickly as possible.

Removing the services of physicians in radiology from part B and placing them either in part A, or in any other special section, would represent a critical blow to recruitment in radiology. We contend that this blow is scarcely supported by a desire to eliminate one of many solvable administrative problems within medicare.

AMENDMENT NOW PREMATURE

We have noted our support of provisions affecting radiology in Public Law 89-97. Preliminary regulations covering our services were published only 2 days before the law went into effect. Final regulations were published 4 months later. These regulations introduced a concept alien to the law, "hospital-based physicians," and then proceeded unnecessarily to complicate administrative procedures for payment for the direct patient services rendered by radiologists.

Because medicare is such a tremendous undertaking, voluminous and sometimes conflicting explanations of regulations have been issued. We question whether the law as written has been given time to work and whether sufficient time has elapsed to eliminate problems in administration insofar as radiology is concerned. It may well be premature to amend the law on the basis of limited experience. Amendment at this time will introduce new and further problems, and very possibly further confusion. None of us concerned have had time as yet to completely absorb and digest current regulations, let alone the new regulations that amendment would necessitate.

Intermediaries and carriers in administering payment for radiology benefits under medicare are not faced with unique problems. Outside the scope of medicare, virtually all major commercial insurance companies in the United States have accommodated administrative procedures to independent billing for professional services by radiologists. Likewise, Blue Shield and Blue Cross plans in most—though not all—States have adapted procedures to the sort of billing established within medicare without penalizing those insured by these plans. Where insurers, physicians, and hospitals have worked in a cooperative way, problems have been minimal.

H.R. 12080

If, however, amendment is deemed essential, we can support sections 129, 131, and 134 of H.R. 12080.

Section 129

There is logic in subjecting all ambulatory services, whether received in offices, clinics, or as outpatients, and whether diagnostic or thera-

peutic, to the same conditions relating to coinsurance and deductibles as part B services. Elimination of the special $20 part A deductible imposed on diagnostic outpatient services received in the hospital should simplify administration. We therefore support section 129.

Section 131

We are further appreciative of the fact that in section 131 there is reaffirmation that radiology is a physician service and should be reimbursed from the part B trust funds. We are, however, disturbed that coinsurance and deductibles have been eliminated from the reimbursement formula for radiologic services provided to inpatient medicare beneficiaries. It is quite possible, as the House Ways and Means Committee has pointed out, that this might simplify billing for these services. The elimination of coinsurance and deductibles, however, will almost certainly lead to pressures for unnecessary utilization of hospital beds for patients admitted solely for the purposes of undergoing diagnostic radiologic studies. We believe that many of these studies could be performed with greater economy to the medicare program on an ambulatory basis, but that many patients will seek and obtain hospitalization in order to save money. The present proposal clearly discriminates against the patient who requires rather extensive diagnostic workup, but who neither needs nor desires hospitalization for this purpose.

This, of course, will place an unnecessary burden upon already overtaxed hospital facilities. With the emphasis on more efficient and economic utilization of hospital facilities promoted vigorously by the Federal Government, the medical profession, and hospital organizations, any legislation which would tend to increase unnecessary use of hospital beds should be open to serious question.

Section 134

Section 134 of H.R. 12080 refers to diagnostic X-ray examinations with portable equipment "including tests under the supervision of a physician, furnished in a place of residency used as the patient's home."

This has no economic impact on the practice of radiologists, but in the interests of quality medical care and the welfare and safety of the public, we can approve this section only so long as these services are provided under the supervision of a physician. The safeguards necessary are explained in the report of the Ways and Means Committee on H.R. 12080 at page 47. There are radiation dangers to patients and operators associated with the portable equipment used. Problems of proper radiation control are most difficult under conditions calling for use of portable equipment. Use by personnel not under the supervision of appropriately trained physicians should not be encouraged or permitted. Films obtained are usually of marginal quality and require evaluation and interpretation by a radiologist.

Without special comment, we would like to record our support of Section 125: Payment on Basis of Physician's Itemized Bill; Section 126: Physician Certification; and Section 132: Payment for Purchase of Durable Equipment.

In closing, we strongly support retention of the requirement that hospitals relate their charges to costs of services actually provided on a departmental basis. This will ultimately permit patients, insurers,

and medicare to pay only for the costs of services received without unknowingly paying the costs of services received by others; cause hospitals to cease subsidizing bed costs from other sources of income such as the pharmacy and department of radiology; and sufficiently illuminate hospital fiscal operation to facilitate efforts to reduce waste and unnecessary costs.

This concludes our statement. We again thank the committee for this opportunity to present our views. We will appreciate such consideration as the committee is able to give to them.

STATEMENT OF PAUL H. TODD, JR., CHIEF EXECUTIVE OFFICER, PLANNED PARENTHOOD-WORLD POPULATION

Mr. TODD, Jr. Mr. Chairman and members of the Senate Finance Committee, I am Paul H. Todd, Jr., chief executive officer of Planned Parenthood-World Population, a national organization of almost 150 local affiliates which, under medical supervision, provided voluntary family planning services in 1966 to more than 316,000 women, most of whom are of low income.

We appreciate being invited to comment on the provisions on the Social Security Amendments of 1967 (H.R. 12080) which relate to maternal and child health, and on the general provisions relating to public assistance. Our primary interest and competence centers on four programs encompassed in the bill which have a bearing on the provision of family planning services:

1. *The maternity and infant care* authorization which would designate family planning as a stated purpose of the program and which, beginning in fiscal 1969, would permit a $15 million allocation to finance voluntary family planning services.
2. *The maternal and child health* amendment which would mandate that the States develop demonstration projects in family planning as a condition of State plan approval.
3. *The public assistance* provisions which would require that the States offer family planning services to welfare recipients and initiate programs aimed at reducing illegitimacy and strengthening family life.
4. *The medical assistance* program which is of great potential significance for the provision of family planning services to some medically indigent families.

Until a few years ago, Planned Parenthood Affiliates were the primary source of competent medical advice to the poor in child spacing and family planning. More recently Federal, State, and local agencies have begun to assume some of this responsibility. Out of 5,300,000 potential low-income patients, however, only 700,000 are currently receiving family planning services from all public and private agencies combined. More than a third are served by our organization. It is estimated that of these 5,300,000 women, nearly 500,000 per year will have an unwanted pregnancy unless subsidized family planning services are available.

Clearly much remains to be done by both the public and private sector. The provisions in H.R. 12080 are a legislative landmark that will provide impetus to the development of voluntary family planning

services by State and local health departments and hospitals. They will help to get on with the job. We join with Secretary Gardner in saying we are "* * * particularly glad * * * that increased funds have been made available for child welfare services and maternal and child health."

We have stated, and research by the Department of Health, Education, and Welfare confirms, that the provision of competent family planning services is one of the most effective means available to reduce infant mortality. In addition, the introduction of family planning has resulted in significant decreases in the number of unwanted births and the number of abortion cases seen in many large metropolitan hospitals. In 1964, for example, when family planning services were first offered in the District of Columbia General Hospital, there were 6,210 recorded births and treatment for 685 abortions. In that first year family planning services were offered to about 56 percent of the patients. By the end of 1966 there were 5,555 births and 523 treatments for complications from abortions, and 80 percent of these obstetrical patients were receiving family planning services. Between the end of 1965 and 1966, the occupied obstetrical beds in D.C. General had decreased from 80 to 50 percent.

In Corpus Christi, Tex., at the Good Samaritan Hospital, deliveries have dropped 29 percent and abortion cases 69 percent since family planning was introduced in 1961.

In addition, rates of return for postpartum checkups have increased in many hospitals from perhaps a third of deliveries to two-thirds or more, following the introduction of family planning services. This demonstrates the desire of the patients to space and limit their families.

Thus we observe, Mr. Chairman, that in those programs serving predominantly low-income persons, the availability of voluntary family planning makes an important difference in their lives. These modern family planning programs depend to a most important degree on cooperation by the patients. Family planning services are not only accepted and wanted, but are one of the most popular components of health services.

In addition to direct benefits to the mother, child spacing has important benefits to the child, among many others, a fourfold reduction in birth defects, including mental retardation, if pregnancies are than 15 months apart; and a significant reduction in children suffering from the "battered child" syndrome. Thus the legislation carries the potential of increasing substantially the environmental assets associated with the wanted and accepted child.

I should now like to comment on each portion of the legislation:

1. MATERNITY AND INFANT CARE PROGRAM

The maternity and infant care programs of the Children's Bureau have made grants to 54 communities for comprehensive medical services, which have usually included family planning as one of their minor components. Approximately 37,500 patients have received family planning services under this program, or about 63 percent of the poor women who have delivered their babies through the projects. Significant improvements in the health of mothers and children have already been registered in the neighborhoods served, and significant

social and health benefits have accrued to the community at large, such as reductions in the rates of infant mortality.

Recognizing these important facts, the House Ways and Means Committee saw fit to make family planning, for the first time, a stated and separate purpose of the overall MIC program and to provide a generally increased authorization for these maternal and child health programs which would allow $15 million specifically to finance the expansion of family planning medical services in fiscal year 1969. This is a signficant step forward for our Nation, for our communities and for the parents and children in the families which will receive these services.

Yet we should be clear that this is only a modest beginning. Its potential will only be realized if Congress appropriates the full $250 million authorized for maternal and child health, if the percentage reserved for project grants is not decreased, and if the funds are not otherwise diverted from services to research, training or other efforts for which funds are available elsewhere. The $15 million allocation for family planning, when supplemented by local funds, should permit the expansion of services to an additional 750,000 families. This is a reasonable goal for fiscal year 1969 and would mean that we have doubled the present caseload of 700,000.

However, just as it is feasible to double the patient load in fiscal year 1969, it is also feasible and necessary to double the patient load in succeeding fiscal years until all families in need are being served. This will require added funds of about $30 million each year, for a total of $75 million in fiscal year 1971, fiscal year 1972, fiscal year 1973.

Given the will, which can be mobilized, and the money, which is a pittance compared with alternative costs which would have to be borne, we are confident this timetable is realistic.

We therefore urge this committee to designate more specifically the sum of $15 million for family planning services in fiscal year 1969 and to give consideration to substantially increased allocations for these services in fiscal year 1970 through fiscal year 1973. Only with this kind of a clearcut, forward projection can Federal, State, and local agencies plan properly for the orderly and economical expansion of these services.

2. MATERNAL AND CHILD HEALTH

The maternal and child health program was established 30 years ago to assist State and local health departments to provide services for needy mothers and children, especially in rural areas. The new amendments in H.R. 12080 mandate the provision of family planning demonstation projects by the States as a condition for State MCH plan approval. This is an excellent step to encourage State action but it must be kept in mind that demonstration projects are by definition token and isolated services and do not meet the State's responsibility to provide services wherever needed. This provision will also have little impact unless additional funds are specifically allocated for family planning. We again would urge this committee to give serious consideration to authorizing additional funds to be allocated specifically for the expansion of family planning services through the MCH program, in implementation of the mandate which Congress is giving to the States.

3. PUBLIC ASSISTANCE PROVISIONS

Under the new public assistance amendments passed by the House, States would be required "in all appropriate cases" to offer family planning services to welfare recipients. We support this objective. Indeed, we have long urged State and local welfare departments to make voluntary family planning services routinely and readily available to recipients, who constitute less than one-fifth of the 5.3 million couples in need of subsidized services. The experience of the last several years demonstrates that relief recipients, no less than other groups in the population, desire family planning services and will use them if they are made available in a realistic and dignified manner. It is our belief that the best way to extent family planning to relief recipients is to expand these services in health agencies and hospitals, as envisioned in the MIC and MCH provisions. The role of welfare departments should be supportive and ancilliary: to insure that the necessary medical services are indeed available and accessible to their clients, to pay for their cost and to make known to recipients where they may be obtained.

In this context, the new provisions of the public assistance section dealing with services to be furnished to families with dependent children should make clear that the 75 percent Federal matching provision for necessary family planning services covers both medical and social services.

Particularly in extending family planning to those who depend on public assistance, every effort must be made to avoid any actual or implied coercion. Not only does a coercive approach to family planning violate the right or individual privacy but it is self-defeating. We have seen in many communities how the punitive application of such regulations as the "man-in-the-house" rule results in frightening recipients away from taking advantage of family planning services which they want and need. We urge the committee to amend section 201B to require Federal, State, and local authorities to establish clear and unambiguous safeguards against coercion in carrying out the mandated family planning program.

We must express our deep concern that other provisions of H.R. 12080 may be implemented in some States and localities in such a punitive fashion as to foster exactly the worst context for patient acceptance of the expanded family planning program mandated by the bill. Many recipients, faced with harsh implementation of the new provisions on determination of paternity and child support, may well come to view family planning, not as a liberating means of helping them to solve some of their problems and to build a brighter future for their children, but as another punitive measure imposed on them by welfare authorities. There is no surer way to deter relief recipients from utilizing family planning services.

We are especially concerned with the provisions which would freeze the proportion of children on AFDC as of January 1967. The result of this provision predictably will be, not to reduce illegitimacy, but to render ineffective other constructive programs embodied in this legislation. If a major thrust of the bill is actually to reduce illegitimacy, these provisions should be removed and consideration should be

given to the variety of positive programs which are being tried in many communities. We would, for example, call your attention to a recent carefully controlled study at Yale providing comprehensive medical, social, and educational services, including family planning, to teenage girls pregnant for the first time. The study has shown that the rate of repeat illegitimacies dropped 90 percent and also that most of the girls took steps to complete their education and to become self-supporting.

The freeze will force the States to establish even more restrictive eligibility requirements or to lower the already inadequate support being paid. We share Secretary Gardner's belief that children should not "have to pay for the shortcomings and inequities of the society into which they are born [or] for the real or supposed sins of their parents."

4. MEDICAL ASSISTANCE PROGRAM

Finally, we believe that the changes made in the medical assistance program are regressive in general and will decrease the availability of family planning services to low-income parents in particular. To extend family planning to the 5.3 million poor couples who need it cannot be done by hospitals, health departments, and voluntary agencies alone but will require increasing participation by private physicians. Title XIX is the only significant Federal-State program which can potentially involve private physicians in the provision of these services. Both the cutback in eligibility and the weakening of the services which the States are required to provide will result in decreasing the family planning care which is made available to the poor through this program. We urge the committee to restore the maximum level of eligibility to 150 percent of the cash assistance level and the provision that the States must provide at least the five basic health services as a condition of plan approval. Additionally, we urge the committee to require that family planning services and supplies be made a mandated service under title XIX. In terms of assisting relief recipients in rural and urban areas who, for various reasons, cannot be reached by MIC and MCH programs, to practice modern family planning, it is our strong belief that mandating family planning in the medical assistance program is essential.

The potential importance of the private physician in a family planning program is demonstrated by the experience of Dr. Paul F. Maddox of Wolfe County, Ky., population 6,500, who has singlehandedly provided services to 1,800 patients as a means of improving maternal and child health. Pregnancies have declined from 194 to 97 per year in the county, following initiation of his voluntary program.

In conclusion, Mr. Chairman, the experience of the last 5 years demonstrates that the inability of the poor and the relief recipient to plan their families derives in very large measure from lack of access to competent guidance in modern family planning. The poor want fewer children than the middle class, but they have more. Opportunity, not lack of aspiration; knowledge, not irresponsibility, is the difference.

H.R. 12080 in many respects is a milestone in beginning a serious national effort to overcome this difference and to give the poor the same chance in family planning most other Americans have long enjoyed.

The maternity and infant care program amendments are excellent and are urgently needed; we believe the authorization should be increased in phases to facilitate orderly growth.

The maternal and child health program, to carry out its mandate in family planning, should receive additional funds from this Congress.

The public assistance amendments which are punitive may actually increase illegitimacy and should be eliminated. The legislation should make clear that family planning services are unrestricted and voluntary.

The eligibilty levels and required services under the medical assistance program should be restored, and family planning should be added as a mandated service.

Such steps, we believe, would greatly aid in bringing dignity to millions of families, and at the same time would reduce unwanted pregnancies, the incidence of abortion, and our appallingly high rates of infant mortality. In so doing, they would make a significant contribution to the reduction of poverty and dependency, and the strengthening of family life.

Thank you.

(An attachment to Mr. Todd's statement follows:)

RESOLUTION ON SOCIAL SECURITY AMENDMENTS OF 1967 (H.R. 12080), ADOPTED BY PLANNED PARENTHOOD-WORLD POPULATION EXECUTIVE COMMITTEE, SEPTEMBER 14, 1967

The PPWP Executive Committee welcomes the maternal and child health provisions of the Social Security Amendments of 1967 (H.R. 12080) as a legislative landmark which will provide considerable impetus to the development of voluntary family planning services by state and local health departments, hospitals and private agencies. By making family planning, for the first time, a stated purpose of these programs and providing an increased authorization which would allow $15 million specifically to finance the expansion of family planning medical services in FY 1969, the Bill will facilitate the extension of services to approximately 750,000 families. This is a significant step forward toward providing services to the 5.3 million poor parents who need and want them. If it is coupled with necessary additional authorizations in subsequent years, it will make possible the rapid, orderly and economical development of these services. Thus H.R. 12080 is a milestone in beginning a serious national effort to give the poor the same chance in family planning most other Americans have long enjoyed.

H.R. 12080 also requires that states must "in all appropriate cases" offer family planning services to public assistance recipients. We support this objective but believe that this should be coupled in the legislation with a requirement that Federal, state and local authorities establish clear and unambiguous safeguards against coercion in carrying out this program.

At the same time, we are deeply concerned that other provisions relating to public assistance may be implemented in some states and localities in such a punitive fashion as to foster exactly the worst context for patient acceptance of these family planning services. The cruel and inhumane provisions on determination of paternity and enforcement of child support, and particularly the "freezing" on the proportion of children on AFDC as of January 1967 will certainly not reduce illegitimacy and may render ineffective other constructive programs embodied in H.R. 12080. There is no surer way than harsh implementation of these provisions to deter relief recipients from utilizing family planning services. These punitive provisions should be removed from the legislation.

If these revisions are made, we believe H.R. 12080 would greatly aid in bringing dignity to millions of families by reducing unwanted pregnancies, the incidence of abortion and our appalingly high rates of infant mortality. In so doing, H.R. 12080 would make a significant contribution to the reduction of poverty and dependency and the strengthening of family life.

STATEMENT OF RUTH ATKINS, ON BEHALF OF THE NATIONAL COUNCIL OF NEGRO WOMEN, INC.

Miss ATKINS. Mr. Chairman and members of the Senate Finance Committee, Miss Height was unable to be with us today. With the kind indulgence of this committee, I will appear in her place. My name is Ruth Atkins. I am a member of the National Council of Negro Women, and I am able to speak from personal knowledge of the meaning of poverty. The National Council of Negro Women is an organization of 3,850,000 women begun by a great American, Mary McLeod Bethune. The daughter of slave parents, Mrs. Bethune organized the National Council of Negro Women in 1935, in the depth of the great depression, to provide a channel for united action against mankind's ancient enemies—poverty, disease, ignorance, and discrimination. At that time, and for a great many years thereafter, Negro women, trained or untrained; relatively well off or very poor, residing in the North, South, East, or West of these United States, were outside the mainstream of American opportunity and decisionmaking. For years we provided for ourselves services that our white sisters could take for granted. Serving alone in our communities we worked with our neighbors and our neighborhoods where we saw the need. Now we find ourselves deeply involved in myriad programs working with poor women and girls and children in communities throughout the Nation. We can speak with some authority about the "life style" and the needs of poor people.

In a real sense the knowledge of poverty is close to the Negro woman's life. There is ample statistical evidence which suggests that Negro women are the "poorest of the working poor," trying to maintain families under the handicap of the lowest median income of any group in the Nation. More than two-fifths of nonwhite women are poor. The Negro female worker is triply handicapped. Concentrated in nonunion employment, she is discriminated against on the basis of both race and sex, and inadequate education and training stand between her and successful competition in the marketplace. As a result, she is paid less, on the average, than Negro and white men and white women. The distinguished members of this committee are far too knowledgeable for me to labor this point with additional statistics. I believe we can agree that on the basis of her life experience the Negro woman is an "expert witness" on poverty. She has suffered more than any other group in the Nation from the many complex and interrelated factors out of which poverty rises and is maintained unto the fourth and fifth generation. While poverty and deprivation are problems of white as well as of Negro Americans, it is nonetheless true, that a larger percentage of Negro families are poor—over 40 percent of Negro families as contrasted with less than 20 percent of white families. A greater proportion of Negro people, therefore, live in poverty.

We are particularly concerned with the sections of H.R. 12080 which would freeze the number of children eligible for AFDC payments, erect numerous new eligibility requirements, and insist upon compulsory work programs for mothers of young children and teenagers.

FREEZE ON AFDC PAYMENTS

We have particular questions about the provision which would freeze Federal matching AFDC payments to States at the January 1967 levels. This would, in effect, establish a maximum quota for future welfare roles. State welfare officials faced with rising population needs would have the alternatives of setting increasingly restrictive standards, or would have to impose excessive and perhaps impossible burdens on existing fiscal resources.

There is, additionally, the constitutional question of whether such a provision does not, in effect, deny equality of treatment to one category of children through no overt act on their part or their parents. The overwhelming issue, from our point of view, and from yours as American lawmakers committed to the tradition of equal opportunity for all children, is the moral one of the right to Federal support for all children whose families are unable to provide for them. There is no escaping the ethical implications of arbitrary exemption of some children from benefits which are needed to maintain life and health.

NEW ELIGIBILITY REQUIREMENTS

There have been indications that State and local welfare officials will find the paternity determination support provision burdensome and expensive to administer. If this provision is adopted, there should be specific safeguards against loss of aid and support for children during the period of investigation and litigation. In fact, many of the provisions appear to us to increase the authority and intervention exercised by welfare workers over the lives of the recipients. This again is contrary to our democratic tradition which recognizes each citizen's right to self-respect and personal dignity. Poverty does not provide a license for administrative meddling or for stripping the last shreds of decency from human lives.

As a matter of fact, if we were to attempt to assess the most damaging aspects of poverty on the lives of young people, it would be that poverty is bad because it defiles the human spirit. It denies a person a chance to grow and develop. This is not solely because of lack of money, but because our society, through its welfare programs seems to ascribe to the poor a meanness of spirit and lack of sensitivity which in turn serve to stifle initiative and degrade the self.

COMPULSORY WORK PROGRAMS

The intent of the work program provision is to increase the individual's job potential. Accepted as such, there can be no quarrel with the approach. There are, however, serious questions about the effect of the specific provisions written into H.R. 12080.

Although there is no disagreement with the philosophy that people should be helped to become self-supporting, we do not feel that the best interests of children or of all mothers is served by the simplified solution of forcing welfare recipients, including some 16- and 17-year-olds into the labor market at any cost. Labor Secretary Wirtz has already testified to the difficulty of finding jobs for persons with limited education and the problems likely to be cause by "instant training" programs too hastily established.

Setting up compulsory work programs for mothers of young children introduces an element of coercion which is not likely to produce a sound learning climate. Nor is it consistent with the "freedom to choose your own life work" ethic on which our free enterprise economy prides itself.

There is no question that the arbitrary removal of mothers of young children from the home will have serious effects on wages, working conditions, and family life. The solo parent who has managed to maintain a home for her children and provide some measure of family stability and parental love in the face of overwhelming economic odds is to be admired and respected. Under the provisions of section 201, of this bill, she now can be arbitrarily ordered by local or State welfare agents to abandon her young children to a hastily established day-care center while she worries her way through a day of "work training." If she refuses to abandon her maternal role, "the authorities" may question her "fitness" to remain a mother to her children. I am certain that the gentlemen of this committee share with me a belief in a strong and loving family as the keystone to our American way of life. We had far better concentrate on building family strength and resiliency rather than on destroying the family as this legislation threatens to do.

The bill permits increased payments for foster care for children removed from their own homes, but does not increase the amount available to mothers to provide better care for their children at home, although this would cost far less financially and emotionally. The family as the basic social unit emerges badly bruised from this legislative mixing pot.

DAY CARE

To raise still another practical issue, the bill commendably provides for increased day-care facilities. This is, however, not a short-term undertaking, and the establishment of proper day-care centers should build upon the needs and wishes of the people in the community as well as the expertise of the specialists. In fact, the day-care provision could, in itself, provide an excellent training means and job source if the centers were established and operated by the mothers of young children with the advice and support of local, State, Federal, and university authorities. Headstart has proved the validity of this approach to training parents in child development, child care, and family living skills through involving them as paid participants in an actual program.

JOB TRAINING AND WAGES

The wastefulness of establishing job training with hastily organized programs under inexperienced State agencies has already been mentioned. There are other dangers inherent in this provision which cause us to have grave misgivings. Experience has shown that a great deal of so-called training, including that provided in many vocational high schools results in shoddy preparation of people for jobs that no longer exist. Where they do provide some minimal skills, these are often in fields already overcrowded and underpaid. The training provisions of this act may well serve to depress wages and retard labor organization in already low-paid, overcrowded industries such as agricultural

labor, food processing, and restaurant and hotel work. We, in the National Council of Negro Women, have actively participated in the fine programs to train and upgrade household employment. Our efforts have, however, been geared to upgrading skills and wages and working conditions in order to make this a proud and honored occupation—respected by employer and employee alike. Without this kind of very careful restraints and safeguards, the "job training" provision of H.R. 12080 may serve merely to add to the pool of frustrated, underpaid, unprotected workers whose "entry pay" becomes their final pay.

CONCLUSION

The National Council of Negro Women urges this committee to restore the administration proposals which were deleted from the original bill by the House as follows:

1. States should be required to bring actual welfare payments up to their own minimum levels. In at least one State, the AFDC payment amounts to $9 per month per child—less than one-third of that State's own minimum.
2. Income tax exemptions for the low-income aged should be revised to provide relief from taxes for this group.
3. Social security coverage should be extended to protect farmworkers—estimated at 500,000 additional workers.

In conclusion, I would ask the distinguished members of this committee to keep in mind the proud ideals of this Nation of ours—that government is the servant of the individual citizen, and that it derives its strength from the strength and dignity and worth of its individual citizens. The sections of this bill about which I spoke earlier run counter to current enlightened concepts that public welfare should be available to all who are in need; that it should be adequate to maintain life and health and decency; that it should permit the individual recipient to keep his dignity and self-respect. The right to live decently is a basic human and legal right. We live in a nation with abundant resources to provide a better future for all the people, let us determine to have the will to do it.

STATEMENT OF HON. HARRISON A. WILLIAMS, JR., A U.S. SENATOR FROM THE STATE OF NEW JERSEY

Senator WILLIAMS. Mr. Chairman, thank you for this opportunity to make a brief statement in support of the bill now before you. I wish to make only three points:

First, social security increases sought by the Administrator this year can be considered only as a temporary and totally inadequate step forward. Truly satisfactory OASDI levels will not be reached until general revenues are used to supplement payroll taxes.

The committee has already heard from Senator Robert Kennedy on this matter. As a cosponsor of his bill, I certainly agree with his basic premise that general revenues must be tapped within the fairly near future if we are really serious about providing decent retirement income to the millions of Americans who rely on social security for all or a major part of their needs in later years.

If anyone doubts the need for greater social security benefits, I urge him to scan the transcript of almost any hearing held before the Senate Special Committee on Aging. No matter what the subject—health, housing, consumer interests, or even the institution of retirement itself—the witnesses at our hearings always come around to one basic observation: insufficient income is either the cause of or a major contributing factor to other problems faced by older Americans.

I am sure that other witnesses have told this committee that a retired couple lives on approximately half of the income enjoyed before they left the work force. And I am sure that others have said that present social security benefits are far below the official poverty level. Such comments are heard at almost any hearing conducted by the Committee on Aging and its subcommittees. Social security has been accused again and again of perpetuating poverty and the accusation remains true simply because we stubbornly choose to declare that it was established as an insurance system and so should forever be denied funds from general revenues.

Mr. Chairman I will not burden the committee with a lengthy discussion of original intent by the designers of the social security system. I will say only that there is ample evidence that the pioneers in social security never intended that their final program should be rigid and rejective. I think that Dean Charles Schottland, of Brandeis University, made a few important points in testimony given before a subcommittee of the Committee on Aging fully 2 years ago:

> The fetish of not using general funds in the program has already been breached. We are using general funds now when we give credit for military service. We are going to use general funds in medicare for those who are blanketed in during this interim period. . . . After all, if we are going to use general funds in one way to support them, there is no reason why we should not use it for another. Many of the foreign countries have found it very feasible to have government contribution along with employer and employee contribution.

In other words, the social security system should be strong enough to be changed when it makes sense to change it. Now, as we come closer to the time when payroll taxes become acutely troublesome to low- and middle-income workers, shouldn't we be inventive rather than narrow-minded about OASDHI?

Second, even with support from general revenues, social security would not be adeqeate as it should be in decades to come unless other forms of retirement income are cultivated, too.

I am supporting the bill before this committee simply because it appears that it is about as far as Congress may be willing to go this year on social security benefits and improvements in medicare and medicaid. Passage of this bill will take us a little closer to a decent way of life for millions of Americans who beame poor because they reached 65 or thereabouts.

But even as I vote yes for the bill, I recognize its shortcomings. And I feel more and more strongly that after this year we can no longer vote for stopgaps in social security.

What we need now—and I, as chairman of the Senate Special Committee on Aging will do everything to encourage—is a deliberate and far-reaching analysis of the prospects for all forms of retirement income within the next two to four decades in this Nation.

What do we really know about the future of private pension plans, for example? And what should the Federal level be doing to promote plans that are reasonable in cost and attractiveness to middle- or low-income workers? I think it is safe to say that the best pension plans now available give the most help to those who need the least help. Are our feet dragging on this issue? We've had excellent reports from Federal departments about the future of pension systems, but the rate of gain in pension coverage is disheartening to say the least.

If we're really going to consider all courses of potential retirement income, we'll also have to give some thought to potential employment opportunities—full or part time—among those past the official "retirement age." But the plain truth is that we as yet haven't given sufficient thought to employment possibilities any more than we've really thought about pensions.

My point is that future discussions of social security increases will be neither realistic or productive if they center merely on the question of how many more dollars can be squeezed out of payroll taxes to provide minimal increases.

We need an overview of all sources of retirement income, and we need it for decades to come, and we need it before we make the next big changes in OASDHI.

Third, welfare recipients should not become victims of earnest, but misdirected, attempts to cut costs.

This year's discussion of the social security and welfare amendments took place in a feverish atmosphere. Critics of the welfare programs regarded such programs as targets rather than as vehicles intended to make life more bearable for the most unfortunate people in this Nation.

Mr. Chairman, I think that Secretary Gardner summed up the situation admirably when he made the following points:

A. That it is cruel to train an unwed mother or anyone else for a job that may not exist.

B. That the children in broken or fatherless homes would be the major victims of the new cutbacks.

C. And that the welfare program itself cannot end poverty; it can merely offer first aid to its victims. To end the conditions that cause abuses within welfare systems, we must grapple with poverty itself.

To conclude, I urge passage of the administration bill, together with reasonable amendments to broaden social security, medicare, and medicaid coverage. But I also feel that whatever we do this year will be inadequate, and we must begin to think in terms of progress by decades rather than in our present terms—which too often dictate that a person dependent upon social security for all or part of his income is doomed to stay several points below each rise in the cost of living.

STATEMENT OF HON. JOSEPH M. MONTOYA, A U.S. SENATOR FROM THE STATE OF NEW MEXICO

Senator MONTOYA. Mr. Chairman and distinguished members of the committee, I welcome this opportunity to appear before you to discuss what I believe to be a crucial gap in the coverage afforded older Ameri-

cans under medicare. There is no protection against the costs of prescription drugs and medicines written for patients who are outside of hospitals and extended care institutional facilities.

As you know, Mr. Chairman, the medicare program which we enacted 2 years ago was designed essentially to cover the costs of short-term institutional care provided in connection with an acute illness. Drugs and medicines essential to the treatment and care of inpatients were included in the hospital insurance portion of the program. Prescribed medicines, however, needed by patients who were no longer institutionalized were not covered under either the basic hospital plan or the voluntary medical insurance plan of the program.

Great strides in pharmacology and drug manufacture have enabled thousands of older people to remain ambulatory and to lead normal lives. I fear that many people might otherwise be institutionalized today, if it weren't for the fact that modern pharmacology permits them to remain outside of hospitals and homes. Moreover, to the extent that drugs and medicines keep older people from occupying hospital bedspace and care, they constitute a more economical method of dealing with acute and chronic illness, resulting in savings both to the individual and to the community.

It seems to me ironic that we have not helped older people meet the costs of these medicines which keep them alive and functioning outside of an institution. There seems to be substantial agreement on the part of most interested parties that prescription drugs and medicines represent a significant item of expense for older people. Data gathered from the National Health Survey shows that during the period July 1964 to June 1965, persons aged 65 and over spent, on the average, over $50 for medicines during the year. This amount was nearly three times the amount spent for medicines by persons under 65. The discrepancy is even more pronounced for the porportion spent for prescribed medicines. Persons age 65 and over spent, on the average, $41, or about 3.3 times the amount spent by younger persons for prescription drugs. The data also showed that costs for medicines rise sharply with the presence of chronic conditions or impairments and with the degree of activity limitation arising from such conditions and impairments.

Older people also acquire prescribed medicines more frequently than their younger counterparts—nearly three times as often—11.4 to 4 per person per year—and pay a higher cost per acquisition—$4 to $3.50. During 1965, it is estimated that persons over 65 spent over $600 million at the retail level for prescribed medicines. Expenses for medicines amounted to more than $100 a year for 3 million older Americans. For 600,000 older people, drug expenses exceed $250 annually.

Mr. Chairman, in the light of the limited and fixed income resources of most older Americans, there can be no doubt that the costs of prescriptions constitutes a heavy financial burden. We must move now to assist older people to meet these costs.

My amendment, essentially identical to S. 17 which I introduced on the opening day of this Congress, would amend title XVIII of the Social Security Act to provide benefits toward the costs of prescription drugs under the medical insurance part of Medicare. I have been joined by 22 of our colleagues in sponsoring this proposal to close this most important coverage gap in the Medicare program.

Mr. Chairman, my amendment would add as a new benefit payment toward the costs for drugs and medicines prescribed by physicians to patients who are not institutionalized in hospitals and extended care facilities. Each beneficiary who has elected to enroll in the supplementary program would be entitled to this benefit after incurring the first $25 of drug expense himself. The deductible feature tends to assure that benefits are paid to those who are confronted with very large drug expenses during the calendar year, and therefore the proposal would have the effect of helping those who need it most.

The amount of benefits payable to the beneficiary would be based upon a schedule of allowances prepared by a formulary committee. This committee would arrive at the allowance for a particular drug taking into account the acquisition costs of various drugs, including the generic name costs, to ultimate dispensers for more frequently prescribed quantities, plus a factor representing a reasonable professional fee to cover the professional services of the pharmacist. Allowances would be made only for qualified drugs as determined by the formulary committee.

Mr. Chairman, I wish to stress that my amendment does not in any way restrict or interfere with the manner in which a physician prescribes a drug, whether by trade or generic name. The physician can, as he now does, prescribe the drug he believes as a matter of medical judgment to be helpful in his treatment of the patient. Nor does my amendment in any way interfere with the procedures used by retail pharmacists in filling these prescriptions, or with the pricing mechanisms which govern the selling price of any particular drug. The patient can pay the pharmacist directly, as he now does, and then be reimbursed upon application for the amount of the allowance provided for the National Formulary Committee. The physician prescribes just as he always has and the pharmacist fills the prescription as he always has, receiving payment from the patient. In the event that the cost of the drug prescribed by the physician is more than that provided for in the schedule of allowance, the pharmacist in no way suffers financially.

The difference between the cost of the drug and the allowance would be made up for by the beneficiary. Like private insurance programs which provide for payments for drug expenditures, my amendment establishes a mechanism to limit the program's liability insofar as meeting the costs of prescription drugs is concerned. In no way does this proposal limit medical practice, or interfere with drug pricing.

Mr. Chairman, as you well know, there is a great deal of controversy connected with proposals to establish a formulary mechanism to evaluate drugs. Charges and countercharges have been made regarding the issue surrounding the quality and therapeutic equivalence of trade name and generic name drugs. Charges have been made that my amendment requires physicians to prescribe generically. Other claims have been made that my proposal would fix the prices of drugs, and that in the long run quality would be sacrificed in the interest of economy. None of these charges are true, if one studies exactly what the amendment would do. My amendment would create a formulary committee whose job it would be to evaluate drugs whose performance is expected to produce clinically equivalent results, and to select from

among these the least costly as the allowance which the beneficiary would be entitled to receive. And where one product regardless of its name is of demonstrable value in the treatment of patients the price of this product may be used to determine the maximum amount the program will pay by way of reimbursement to the beneficiary. The activities of the formulary committee would not require that the physician prescribe only the products it selects in arriving at an insurance allowance. The physician is, and should be, concerned with the medical significance of the drug he prescribes. My amendment endorses this concept entirely.

Mr. Chairman, you, the members of the committee, and the sponsors of this amendment are all deeply interested in assuring that older people are able to obtain the best quality drug product available to them today. The physician is the only one who is able to know what drug to prescribe. My amendment proposes to help older people pay the costs of the drugs so prescribed by the physicians. While the formulary mechanism does not imply that the costs of all prescription drugs will be met under the proposal, it will provide allowances which can help the elderly meet a good part of these costs. Schedules for drug allowances are being used today in a number of health plans to help those insured to meet drug costs. I have heard no reports that these schedules have interfered with the doctor's medical judgment, nor with the pharmacists' pricing mechanism. What is provided under these plans certainly should not be denied millions of older Americans whose drug costs are likely to be even greater than they are for the younger beneficiaries of these insurance plans. My amendment does not provide drugs to beneficiaries; it helps instead to meet the costs of drugs prescribed by the physician and filled by the pharmacist.

Therefore, Mr. Chairman, I am not as concerned about trying to resolve the generic trade name controversy by legislation, as I am concerned about helping older people pay for the drugs they now require, The administration witnesses who have testified before the committee point up the many varied and complex issues and problems surrounding proposals to pay for drugs. The administration has stated that they are reluctant to seek legislation at this time, but desire to study further some of these problems. However, Mr. Chairman, as I said on the floor of the Senate when I offered my amendment in August, the Congress is fully capable of originating workable solutions to real problems confronting our citizens. The effective date of my measure would be July 1, 1969. This would provide the executive branch with ample time to work out the administrative problems they foresee at this time, more time in fact than was afforded them in working out the whole complex medicare program itself. And even if circumstances are such that not all solutions are reached by that time, enactment of the amendment now will leave us in the position to provide this vitally needed benefit at the earliest possible moment.

The amendment would be accompanied by an increase in monthly premiums under the supplementary medical insurance program of approximately $1, only half of which, or 50 cents, would be contributed by the beneficiary. It seems to me that for the amount of protection this proposal represents to every older person, the elderly would welcome this opportunity to obtain such coverage at this cost. I might

also add, Mr. Chairman, the sponsors of the amendment are well aware of the need to control expenditures at this particular time. However, under the proposal, no Federal appropriations to finance this benefit would be required until the middle of 1969, and the full increase of the required appropriation probably would not be felt until 1970.

Finally, Mr. Chairman, my amendment, as I see it, is an adjunct to your proposal to assure that only drugs of proper quality are paid for under federally aided programs, particularly under public assistance programs. As you know, I have been happy to join with you in support of your proposal, originally contained in S. 1303, because I endorse completely the principle that the Government should strive for the greatest possible economy consistent with quality in the payment for drugs in which Federal funds are used. Our proposals do not compete with each other, rather they are complementary.

Mr. Chairman, I am disappointed, as I know you are, in the administration's continuous need to study, study, and study some of the areas I have touched upon today. Last year, the Senate adopted a proposal to include the costs of prescription drugs under medicare. I would have thought that the administration would have concentrated more of their energies toward finding solutions to the problems they now see in such a proposal. Yet, after another year, we are told that they need to study it some more.

The fact is that older Americans need help now. I believe that the Congress should act, therefore, to fulfill its obligation to these people this session. If we do not, the proposal may be "studied" for years and years to come. Mr. Chairman, I urge that the amendment be adopted by the committee. Thank you.

STATEMENT OF HON. GEORGE MURPHY, A U.S. SENATOR FROM THE STATE OF CALIFORNIA

Senator MURPHY. Mr. Chairman, I strongly urge the Senate Finance Committee to adopt amendment No. 296 to H.R. 12080, the social security bill. This amendment incorporates the provisions of S. 1071 introduced on February 24 by Senator Ribicoff and coauthored by me. The amendment would extend to State employees, if they so elected by a majority vote, and if an agreement were worked out between the Federal and State Governments, medicare hospitalization coverage.

Mr. Chairman, there is a great interest in this amendment in the State of California. To illustrate the need for the amendment, it will be helpful to examine the situation of the 172,000 public school teachers in the State of California. Unless the amendment is adopted these teachers, who are among the 650,000 instructional personnel affected nationally, will be denied the benefits of medicare. They are denied this coverage because they are employed by State and local governments and are not covered by the regular Social Security Act. While it is true that the present Social Security Act does allow State and local governments to enter into agreements extending regular social security coverage to public employees, in the case of the California teachers, they already enjoy a retirement system under the State teachers retirement program. The teachers own retirement system provides them with

retirement and survivorship benefits. However, their own system does not include hospitalization and the existing Social Security Act does not permit them to qualify for medicare coverage. This is the purpose of amendment 296. Amendment No. 296, of course, requires teachers and the other public employees to pay their own way, to contribute in order to participate in the program.

To summarize, Mr. Chairman, this amendment is a most meritorious one. It is financially sound. It presents no administration problem because part A of medicare is financed by a payroll tax separate from the social security payroll tax, and it is in the public interest. I know that I speak not only for the 160,000 members of the California Teachers Association, but also for the Associated California Employees, a council of independent government employees representing more than 375,000 city, county, and other school personnel in urging strongly the adoption of amendment No. 296.

Mr. Chairman, I ask unanimous consent that an excellent statement in support of 296 by the California Teachers Association be inserted.

I appreciate the committee's courtesy.

STATEMENT OF ROBERT E. McKAY, ASSISTANT EXECUTIVE SECRETARY, ON BEHALF OF THE CALIFORNIA TEACHERS ASSOCIATION

Mr. McKAY. The California Teachers Association, largest statewide professional organization in the United States, supports the provisions of amendment No. 296 and respectfully recommends that the Senate Finance Committee incorporate them into H.R. 12080, the social security bill.

On behalf of its more than 160,000 members and other public employees in California, the association urges this action as the most equitable and economical means of providing the hospitalization coverage under medicare available to other Americans, but denied them because they are employed by public agencies not covered by social security.

California teachers are among the more than 650,000 instructional personnel in the Nation who will be denied the benefits of medicare plan A unless the Social Security Act is amended to permit them and their employers to contribute to and receive the advantages of this separately financed insurance program. This is so because their retirement and survivorship benefits are provided by a State teachers retirement system rather than by social security and the existing law makes no provisions for them to qualify for the coverage available to nearly 20 million citizens over age 65.

The California Teachers Association believes, along with Senator Abraham Ribicoff who has offered this amendment, that teachers and other public employees to whom these benefits are not currently available should have been afforded the opportunity of deciding whether they wish to be included in the hospitalization coverage.

The provisions of the amendment would not impose any additional financial burden on the Federal Government. Subject to a voluntary agreement worked out by the State with the Secretary of Health, Education, and Welfare, the coverage would be made available to most

public employees, including teachers in California. Before the benefits would be made available, however, members of the State or local retirement systems would have to approve by a majority vote their inclusion in the program.

Many public employees in California in addition to schoolteachers are not included under the present law. Through their organizations they have voiced a strong desire to be covered by medicare plan A. The Associated California Employees, a council of independent government employees representing more than 375,000 city, county, school and other personnel, join in support of this amendment.

The California Teachers Association believes the proposal to be sound and workable and in the public interest. The Finance Committee's favorable consideration is solicited.

STATEMENT OF HON. GORDON ALLOTT, A U.S. SENATOR FROM THE STATE OF COLORADO

Senator ALLOTT. Mr. Chairman, I want to express my appreciation to you and the other members of the committee for giving me this opportunity to present my views and comments on the amendments to the Social Security Act which are now pending before this committee. I have profound respect for the complexity of the questions which these amendments present and the consideration which must be exerted to assure the adoption of meaningful amendments to the Social Security Act. As a former member of the Special Committee on Aging, I have a special regard for the problems and needs of our older citizens, the majority of whom must look to the social security system for the financial resources by which to live. As the beneficiaries of the Social Security Act, I am certain that these people are watching very closely the results of these hearings with anxious concern and hope.

Mr. Chairman, historically, Americans have tried to create adequate income for their retirement through such forms of investment planning as personal savings, private pension plans, and annuities. Congress recognized its role in the establishment of a floor of protection for the retirement period of older Americans when it passed the Social Security Act of 1935. Because of its involuntary nature, social security is an essential part of an individual's relationship with his Government. For some whose vigorous investment planning or frugal savings programs paid off, social security benefits supplement retirement income; for others, however, these benefits become the sole means of support in old age. For the former, social security is cast in the light of a return on investment; for the latter, it is looked to as a kind of essential welfare insurance and existence.

I believe this Government has a continuing responsibility to analyze the social security law to be certain its benefits are adequate for the job it was proposed to accomplish: involuntary old age insurance. The continuation of the social security system is like that of any other pension system in its dependence upon the willingness of those whose taxes support the program to continue to share the fruits of their labor. At the same time, however, we are witnessing the spectacle of a purposeful, planned inflationary economy, whose shadow casts real doubt upon the ability of ever attaining an adequate retirement income. Thus,

on the one hand, we find that a young man who takes his place in the work force today at age 21 stands to get back $12,000 less than he has invested in social security after he retires. And, on the other hand, we note that from Janaury 1965 to the present date, social security recipients have lost at least $1.5 billion in purchasing power to the ravenous hunger of inflation. That young man may well question the fact that he is forced to continue sharing the fruits of his labors when he realizes that if the payments from himself and his employer were allowed to accumulate in a trust fund during the same working period, at his retirement he would be able to draw $160 per month for the rest of his life on the interest alone—and never have to touch the principal of his investment.

We are in this position with regard to this young man's financial future in the social security system because of the willingness of too many in government to increase the benefits of the system without insisting on the means of financing the program. One simply cannot suggest these benefits in a complete financial vacuum with utter disregard for the consequences; to do so deprives every young man of his rightful expectancy from social security. It is time that we be honest with that young man.

We are in this position regarding our older Americans because of the unwillingness of this administration to stem the tide of inflation. Older Americans living on fixed incomes are at the mercy of the deteriorating purchasing power of the dollar.

It was with these concerns and realities in mind that on May 15, I introduced several amendments to the Social Security Act which I though were essential to alleviate the deficiencies of the system without resorting to additional payroll taxes. These amendments would have the following effect:

(1) The establishment of an automatic cost-of-living increase in social security benefits beginning January 1, 1969.

(2) An increase in the earnings limitations an OASDI beneficiary may earn without penalty to $2,220 per year.

(3) The creation of a new provision in the Social Security Act which will allow an increase in benefits for each year in which a man works after the age of 65.

(4) An increase in the minimum old age, survivors benefit to $50 per month.

(5) An increase in the aged widows and widowers monthly insurance benefits to 90 percent of the primary benefit.

In my opinion, these are the best amendments which can be enacted without resorting to an increase in taxes. As the members of this committee are well aware, there is an actuarial surplus in the social security trust account at the present time. The Social Security Administration's chief actuary, in a report published October 11, 1966, advised that the total old age, survivors, and disability trust accounts, when taken together, had a positive actuarial balance of 0.74 percent of taxable payroll on a long-range, level-cost basis. My proposed amendments can be enacted for 0.72 percent, well within the 0.74 percent positive actuarial balance of these two accounts. My amendments are aimed at providing meaningful assistance to those social security beneficiaries who need immediate help without imposing an additional burden on those whose current labor produce the income for the system.

In addition to my amendments, of course, numerous other proopsals have been introduced in this session of Congress dealing with suggested changes in the Social Security Act. Among these is H.R. 12080 which provides, among other things, for an across-the-board 12½-percent increase in benefits. The comprehensive program envisioned by H.R. 12080 would utilize the actuarial surplus, together with an increase in the amount of taxable earnings and an increase of 22 percent over the next 6 years in the payroll taxes. I was particularly hopeful, of course, that my amendments to the Social Security Act might be adopted by this committee since they did not require an increase in taxes to fund their benefits. I know the members of this committee and all Senators are most concerned and disturbed over the proposed tax surcharge. This latter question is one which will be confronting this committee all too soon, and demands a balanced approach to the questions of increasing payroll taxes to fund additional benefits to social security beneficiaires at this time.

I strongly believe that three of my amendments commend themselves to this committee.

Mr. Chairman, since inflation is the hidden tax on both the young man still working and the elderly retiree it is essential that our social security system provide constant protection against inflation. Automatic cost-of-living increases are an integral part of the protection which must be afforded. The need for an automatic cost-of-living provision is so acute in fact that I was greatly disappointed when the administration failed to include it in either of this year's proposals. I am equally disturbed not to find such a provision in H.R. 12080.

An automatic cost-of-living increase would have a twofold effect. First, it would assure the young man whose taxes support the system that his equity would never be destroyed by inflation. Second, it would insure the older person that his benefits will no longer be subject to the continued effects of inflation which have already robbed him of so much of his purchasing power.

Second only to the obligation of providing relief from this economic squeeze play caused by inflation is the need to assist those, who through no fault of their own, have not been able to provide an adequate income for their old age. I believe that the plight of these people requires immediate congressional attention. This Government has the capacity and the resources to assure every American, regardless of age, an opportunity for dignity. What he does with that opportunity is his own business; that we provide it is ours.

To achieve a truly sound and equitable social security system, my first amendment, S. 1773, would provide an automatic cost-of-living increase in benefits beginning in 1969. The year 1967 will be considered the base year for purposes of computing the amount by which living costs have risen. Under my proposal early in 1969 and in each year thereafter, the Secretary of Health, Education, and Welfare will determine the increase in the cost of living since the end of the calendar year of 1967. For each full 3-percent rise in the cost of living, social security benefits will be increased by a corresponding 3 percent in April of 1969. Thereafter, benefits will be increased by increments of 3 percent for each full 3-percent rise in the cost of living in each succeeding year after 1969. The increase in benefits would be payable

for months after March in each year. I should point out here, Mr. Chairman, that no increase will occur unless there is a full 3-percent increase. Thus a full 3-percent rise in the cost of living will result in a 3-percent rise in benefits, while a 5-percent increase in living costs would only result in a 3-percent increase in benefits. Of course, if a 6-percent increase were noted, there would be a full 6-percent increase in the benefits to be paid.

Under this proposal, no increase in social security tax rates would be necessary to finance the automatic increase because, according to Social Security Administration actuaries, inflation pushes up wages and salaries subject to the tax.

Mr. Chairman, another improvement which must be enacted concerns the present earnings limitation. At present, earnings in excess of $1,500 per year by an OASDI beneficiary results in a reduction of benefits. This means, of course, that a man may only earn $125 a month without incurring reduced benefits. My second amendment to the Social Security Act, S. 1774, would increase this earnings limitation to a more realistic figure of $2,220 per year which would mean that a man would be allowed to earn $60 more per month without being faced with reduced benefits. Of course, not all older Americans want employment. Some want a retirement enriched by service without remuneration. Other older Americans, however, are struggling to live on fixed incomes. I believe that a realistic increase in the amount a man may earn without being faced with a reduction of benefits will be a real encouragement for those citizens who need to find other employment to supplement their fixed incomes. This, I believe, can be accomplished with the enactment of my proposed amendment. I know that many of our Nation's citizens who now feel hamstrung by present restrictions on their earnings from employment will find in this amendment a real encouragement to seek out new sources of income without being faced with undue penalties.

One of the most glaring inequities of the present law involves the man who delays his retirement and continues working past the age of 65. Such a man now has to continue contributing part of his wages to social security despite the fact that he would be entitled to benefits if he were to quit working. The average numbers of years for which OASDI payment will be made to a group of people over 68, for example, is obviously less than the amount required for those of 65.

The social security account a man has established thus receives a double benefit if he elects to continue working past the age of 65: continued contributions and delayed distribution of benefits. There is a much more subtle impact here, however, and that is the effect this anomaly has upon the initiative of those elderly citizens who either need additional income or who are eager to continue contributing their skills to our economy. As the law now stands older Americans are discouraged from continuing their productive creativity after they have reached the "magic age" of 65.

Up to 1950 there was a provision in the Social Security Act which provided a 1-percent increase in benefits for every year a man worked after 65. I have always thought it was a mistake that this provision was repealed. In fact, I would have voted to increase it. This is the basis of my third amendment to the present social security law. My

amendment, S. 1775, proposes that benefits be increased by 4 percent per year or one-third of 1 percent for each month in which a man continues to work after 65, assuming he is eligible for old-age insurance benefits. Under my amendment, if a man continued to work for 1 year after the date on which he was eligible to begin receiving benefits, his monthly benefits would be increased by 4 percent from that month for as long as he draws social security. Thus, assuming a man were entitled to $100 per month in benefits at the age of 65, he could, by working and deferring his retirement to age 70, increase his benefits to $120 per month for the rest of his life. If a man should have to interrupt his working for any period and draw his benefits he may still resume working at any time and the amount his benefits would be increased would be determined by one-third of 1 percent for each month in which he continues to work. My proposal, of course, will not have any effect upon a man's right to apply for medicare protection, nor upon the present effect of the law which deletes all restrictions after age 72.

Under the present law a man may receive any amount of money from his investments or other nonemployment income. Almost any banking institution would allow that man at least a 4-percent return on the investment of his money. My amendment would allow the man who has to continue working to realize a 4-percent return on the investment of his time and effort.

Mr. Chairman, this Government has the obligation to deal fairly with both the individuals whose taxes support this program as well as the beneficiaries of social security whose previous efforts helped to establish the financial reserves of the system. I believe we deal most fairly with these individuals when we assure them a climate of dignity and independence in their relationship with social security without resorting to making promises we cannot afford to keep, or will not take action to keep. I also believe that these amendments would establish a creative program, the opportunities of which would provide the dignity and independence these people deserve.

Mr. Chairman, in urging the adoption of these amendments, I am only seeking to strengthen and improve the legislation which is pending before this committee. I believe that the adoption of my amendments would provide a greater degree of protection for the entire system. It may be that the adoption of automatic cost-of-living protection, which has been too long denied the social security system, would preclude the necessity for an immediate 12½-percent increase in payments. I think a realistic appraisal of the needs of the social security system must be reconciled with the present state of our economy. In this regard I feel that the amendments which I am urging before this committee provide the measure of protection, relief and opportunity which will enhance any social security legislation which this Congress may be called upon this year to adopt.

Again, Mr. Chairman, my thanks to you and to the members of the committee for the opportunity to offer these comments and recommendations regarding the social security legislation pending before you at this time.

STATEMENT OF JOHN H. MATHIS, CHAIRMAN, ON BEHALF OF THE COMMUNITY SERVICE SOCIETY

Mr. MATHIS. The Community Service Society of New York has served troubled families in New York City for over 100 years. Throughout the history of the society, its citizen committees have engaged in promoting social legislation. Out of this experience, three of our citizens' committee—the committee on aging, the committee on family and child welfare, the committee on health—have developed the views on H.R. 12080 set forth in this letter. Their detailed statements are appended. We offer these views and comments in the hope that they will be of assistance in your deliberations on this important social legislation.

We have examined H.R. 12080 and the Committee on Ways and Means report in detail. In preparation of this statement we have reexamined H.R. 5710 and H.R. 1977. We find, and note below, that several of the H.R. 12080 provisions dealing with the social security and health insurance system are commendable.

In contrast, we find the entire tone of title II, H.R. 12080, which contains the public welfare amendments, the legislative intent embodied in the Ways and Means Committee report and many provisions of this title to be retrogressive and punitive.

We believe that if the Senate Finance Committee intends to use a positive, not a punitive, approach to amending the Social Security Act, it would be far more constructive to start from the earlier bill, H.R. 5710, adopt its good features, amend its less-satisfactory ones and incorporate the acceptable provisions of H.R. 12080, than to use H.R. 12080 as the base.

PUBLIC ASSISTANCE AND CHILD WELFARE

We speak first to the public welfare amendments (title II) about which we have the greatest concern. We find this part of H.R. 12080 based on assumptions which are not valid. The provisions and the committee report assume:

1. That the 1962 Social Security Amendments to expand service to public assistance families have been adequately tested and found wanting. This is not true. Even in New York City, which is ahead of much of the Nation in efforts to provide service and experiment with new approaches, implementation of the 1962 amendments is limited due to staff shortages and practices which consume the workers' efforts to such extent there is no time for counseling. In many States and communities there has been only token implementation.

2. That the welfare system is the cause of social problems such as chronic unemployment, dependency, illegitimacy which could be cured if the welfare program was drastically changed. This is not true. There is no evidence that public assistance payments cause these social problems. There is evidence that attempts at social control through coercion based on the threat of denial of assistance have failed whenever attempted.

3. That the welfare caseload abounds with shiftless persons who prefer relief to employment. The facts do not support this assump-

tion. The vast majority of persons on public assistance are too old, too young, too sick, or disabled to be employed. As reported to you recently by Mayor John V. Lindsay, of the 600,000 persons on public assistance in New York City last year, 79 percent were children and adults caring for them; 15 percent were too old or sick to work; 4 percent lacked employment skills; and 2 percent were working but did not earn sufficient money to support their families.

These are families who are weighed down by a multiplicity of overwhelming problems many of which stem from serious educational deficiencies and low self-expectation, from ill health, poor housing, and lack of job opportunities.

Given adequate provision in the community for education, decent housing, employment, and skilled counseling most of them would respond to the opportunity to become self-supporting and independent of public assistance. It should be pointed out, however, that employment of the mother is not necessarily the desirable goal for all families and that this should be a matter of choice not of direct or indirect coercion.

H.R. 12080 authorizes substantial sums to expand day care, family planning, community work, and training programs. In themselves, these are socially desirable programs. We support the orderly expansion of these services. The vast increase in funds authorized over current expenditures does not, however, contemplate a gradual expansion related to availability of suitable facilities and properly trained personnel.

We are deeply concerned with the provisions of H.R. 12080 which couple expansion of these service programs with a freeze on Federal reimbursement for the AFDC–UP caseload based on the January 1967 ratio of children in one-parent families receiving assistance to the State's total child population and the provisions which would deny assistance to the mother, father, or child over 16 years of age not in school, who fails to accept community work or training. Whether the penalty is imposed directly upon the State or the parent, it is the children who would be most harmed by removal of the parent from assistance, or the removal of the children from the home by court order and placement in foster homes, or by resorting to the discredited system of voucher payments, or by a general freeze on the numbers of children eligible for assistance.

We are unequivocally opposed to subverting day care, family planning, community work, and training programs to coercive measures in order to reduce public assistance to families with dependent children (AFDC).

MEDICAL ASSISTANCE

In our opinion, several of the medical assistance provisions constitute a serious threat to the national effort begun with the enactment of medical assistance (title XIX) in 1965, to bring quality health care within the reach of large segments of the population who previously had access to little or inadequate health service.

We refer specifically to placing a ceiling in the Federal law on eligibility for medical assistance and fixing that ceiling in relation to a State's cash payments made in the AFDC program or the State's

per capita income, whichever is the lower. We can only assume that the purpose of this provision is to reduce drastically the Federal Government's commitment to provide health services to the medically needy.

Another provision which we believe would emasculate the entire concept of title XIX if it became law, is the choice given the States under H.R. 12080 of including any seven of the listed 14 health services rather than continuing the requirement that the program include the five basic health services. Under such a provision, it would be possible for a State to operate a health care program of little use to the medically needy.

These two provisions move far away from the original intent of the Congress which was declared to be the protection of a large segment of the population against the risk of destitution caused by ill health and high medical expenses and the guarantee of high quality medical care—its availability a matter of right to all citizens. Other unsatisfactory provisions are cited in the appended material.

SOCIAL INSURANCE

We believe that an increase in OASDI cash benefits is needed to alleviate the condition of poverty in which the vast majority of OASDI beneficiaries now live. We find the 12½-percent increase in H.R. 12080 insufficient; the 15-percent increase provided in H.R. 5710 was, itself, minimal.

We approve liberalization of the retirement test to permit persons between 65 to 72 years to earn larger amounts without sacrificing their retirement benefits—as provided in both H.R. 5710 and H.R. 12080.

HEALTH INSURANCE (MEDICARE)

We believe that medicare coverage should be extended to the disability insurance beneficiaries. Such coverage is provided in H.R. 5710 but not in H.R. 12080. We favor the provision in H.R. 12080 which would increase from 90 to 120 the number of covered hospital days.

CHILD HEALTH

The child health portion of H.R. 12080 makes provision for a sound program that includes both prevention and treatment. We approve with a reservation only about the future of these programs which is discussed in the appended material.

SOCIAL WORK EDUCATION

In view of our endorsement in 1966 of the bill introduced by Senator Ribicoff (S. 3432) we are pleased that both H.R. 5710 and H.R. 12080 provide Federal support for social work manpower and training. As initial legislation authorizing grants for expansion and development of graduate and undergraduate social work education, we prefer the more flexible features of H.R. 5710 to the H.R. 12080 imposition of a $5 million ceiling on any appropriation beyond the first year and the specification that not less than half of any appropriation be used for undergraduate programs.

Amendments to the Social Security Act have far-reaching consequences. We urge your support for constructive changes that will alleviate, not add to the burdens of the poor and otherwise severely disadvantaged members of our society.

We appreciate the opportunity to submit our testimony. The detailed position statements developed by our several committees are appended.

(The position statements referred to follow:)

APPENDIX I—COMPARATIVE ANALYSIS BY THE COMMITTEE ON AGING OF THE OLD AGE, SURVIVORS AND DISABILITY BENEFITS AND THE HEALTH INSURANCE BENEFITS IN H.R. 5710 AND H.R. 12080

OLD AGE, SURVIVORS AND DISABILITY INSURANCE

General Benefit Increase—HR 5710 (§ 101); HR 12080 (§ 101)

HR 5710 provided an across-the-board increase of at least 15%, an increase in the minimum benefit from $44 to $70 a month, and increases in the ultimate maximum benefit for a worker alone from $168 to $288 per month and for family benefits from a top of $368 to $650 per month. HR 12080 provides for a general increase of 12½%, an increase in the minimum benefit to $50 a month, and increases in the ultimate maximum benefit for a worker alone to $212 per month and for families to $423.60 per month.

The Committee on Aging believes that the benefit increases proposed in HR 12080 are insufficient to ensure that present and future beneficiaries will not fall further behind in their struggle to be independent and to maintain a decent standard of living. The provisions in HR 5710 are regarded as an attempt to bring Old Age, Survivors and Disability Insurance benefits more nearly into conformity with increases in the cost of living. It would provide no more than a minmum base to which other resources, such as private pensions, savings or public assistance, would have to be added to cover everyday living costs at a decent and dignified level for retired persons and for their dependents and survivors. For many without any resources of their own, life would continue to be spent in poverty because of a reluctance to expose themselves and their families to the indignities of the means test for public assistance.

The experience of the Community Service Society—not only in its Older Persons Service but also in a demonstration project, Senior Advisory Service for Public Housing Tenants in the South Bronx—indicates the serious effects on the aged of constant financial worry and deprivation.

The Committee on Aging, therefore, urges the Senate at least to restore the benefit increases to those proposed in HR 5710.

Special Minimum Primary Insurance Benefits—HR 5710 (§ 102); HR 12080 (——)

HR 12080 does not contain the proposal which was in HR 5710 to provide a special minimum primary monthly benefit equal to $4 multiplied by the number of years of coverage up to a maximum of 25 years ($100). The Committee on Aging believes that this provision would affect a group which over the years has contributed to the national economy through steady employment, but has suffered deprivation because of low wages.

The Committee on Aging, therefore, urges the Senate to restore this provision of HR 5710.

Increase in Benefits for Certain Individuals Age 72 and over—HR 5710 (§ 104); HR 12080 (§ 102)

HR 5710 provided an increase in the special payments to persons aged 72 and over who have not worked in covered employment long enough to meet the regular insured status requirements or who had no work covered under Social Security. This provision amounted to an increase from $35 to $50 a month for an individual and from $52.50 to $75 for a couple. HR 12080 proposes an increase to $40 a month for an individual and $60 for a couple. The recipients eligible for these payments include the most poverty-stricken citizens of the nation, who are penalized merely because Social Security coverage was not sufficiently broad during their working years.

The Committee on Aging supports the increase proposed in HR 5710.

Liberalization of Retirement Test—HR 5710 (§107); HR 12080 (§106)

The Committee on Aging supports the proposal of both bills which provide for an increase from $1,500 to $1,680 in the amount a beneficiary could earn in a year without a reduction in OASDI benefits. However, the Committee believes that the increase will not correct an inequity which has been inherent in the system since its inception, namely that a beneficiary who, for one reason or another, receives less than the maximum currently payable is nonetheless as restricted in his additional earnings as is the beneficiary receiving maximum benefits.

The Committee on Aging proposes a further liberalization of the retirement test for persons whose benefits are below the maximum in their category. Such persons should be permitted to earn an amount equal to the difference between the maximum currently payable and the actual benefits received in addition to the general limit—proposed to be $1,680 annually in both bills—before suffering any reduction in benefits. This formula should also be applied in determining each person's monthly earnings limit. This proposal is submitted because of its social desirability, with the knowledge that its cost can be estimated by the Social Security Administration.

HEALTH INSURANCE BENEFITS (MEDICARE)

Extension of Coverage to the Disabled—HR 5710 (§125); HR 12080 (§120)

The Committee on Aging supports the proposal in HR 5710 to extend health insurance protection—both hospital insurance and medical insurance under Parts A and B, respectively, of Title XVIII—to disabled beneficiaries regardless of age. The Committee believes this to be a logical and beneficial development which parallels past changes when Old Age and Survivors Insurance was broadened to become Old Age, Survivors and Disability Insurance.

HR 12080 excludes this provision and establishes an Advisory Council to study the problem. However, such a study has already been conducted by the Social Security Advisory Council which recommended coverage of the disabled.

The Committee on Aging, therefore, urges that action be taken to provide health insurance for the disabled.

Inclusion of Podiatrists' Services under Supplementary Medical Insurance Program—HR 5710 (§127); HR 12080 (§127)

Both bills propose the inclusion of non-routine foot care by a podiatrist within the medical insurance program (Part B).

The Committee on Aging supports this provision and views it as a means to reduce the immobility and consequent social isolation of older persons.

Hospital Reimbursement—HR 5710 (——); HR 12080 (§402)

HR 12080 provides that the Department of Health, Education, and Welfare would be authorized to experiment with alternative methods of reimbursing hospitals and related health care facilities, which would provide incentives to keep costs down while maintaining acceptable standards of care.

The Committee on Aging shares the concern of many individuals and groups about constantly spiraling health care costs. It supports the provision in HR 12080 for experiments with methods other than "reasonable cost" reimbursement, believing this approach holds promise of providing incentives for efficiency in operation without jeopardizing quality of care.

Outpatient Hospital and Diagnostic Specialty Benefit—HR 5710 (§120); HR 12080 (§129, 131)

The Committee on Aging supports the provision in both bills which would include services provided by hospital-based radiologists and pathologists under Part A (hospital insurance). This represents a partial return to the billing system in effect prior to the advent of Medicare when the services of the anesthesiologist, physiatrist, radiologist and pathologist had been included in the hospital bill. The need for separate billing caused by their coverage under Part B (medical insurance) causes widespread administrative problems and is a burden and source of confusion to patients. The Committee urges that this amendment be broadened to include hospital-based anesthesiologists and physiatrists in the calculation of inpatient costs.

However, the Committee on Aging opposes the provision in both bills that removes outpatient hospital diagnostic services from Part A and transfers such

services to Part B. The Committee believes the inclusion of outpatient diagnostic services under Part A provides needed service on an outpatient basis which otherwise might be given on an inpatient basis at higher cost. It would seem possible to resolve administratively the problem of differentiating between the outpatient diagnostic services (now chargeable to Part A) and treatment services by physicians in hospitals (now chargeable to Part B).

Elimination of Initial Certification by Physician—HR 5710 (§ 131); HR 12080 (§ 126)

The Committee on Aging considers that the elimination of the requirement that a physician certify as to the need for the initial hospitalization of a patient, as proposed in both bills, is unsound. A physician should be prepared to state that he believes hospital admission to be necessary. The Committee on Aging notes that the present law requires no more than the signature of the physician to a simple statement such as "I certify that the admission of the above patient was a medical necessity." This would appear not to be an onerous requirement; rather it constitutes a simple device which would help to control unnecessary hospitalization.

Extension of Maximum Duration of Benefits for Inpatient Hospital Services—HR 5710 (—); HR 12080 (§ 127)

HR 12080 extends the number of days which can be covered in a spell of illness from 90 to 120 days, retains the coinsurance of $10 now applying from the 61st to the 90th day, and adds a coinsurance of $20 from the 91st to the 120th day.

The Committee on Aging supports this extension of benefits and believes that it represents a desirable improvement in hospital coverage for the sick aged.

Method of Payment to Physicians under Supplementary Medical Insurance Program—HR 5710 (—); HR 12080 (§ 125)

HR 12080 proposes another alternative to the assignment and receipted-bill methods provided under the present law for the payment of physicians' bills for services under the Supplementary Medical Insurance Program (Part B). The proposal would permit the submission of an itemized bill to the insurance carrier by either the physician or the patient. As under present law, payment would be limited to 80 per cent of the physician's reasonable and customary charges.

Clearly, this proposal provides some help to financially pressed older persons when the physician has refused to accept the assignment method. There is flexibility, but complications also are present in that transmittal of payments either to the physician or to the patient is permitted. The fact that the itemized bill may exceed "reasonable charges" only defers the settlement date. Under these circumstances, the patient still is confronted by financial pressures or uncertainties about his obligations.

The Society's experience in its direct-service program and in its demonstrations underscores the need for simple procedures which can be easily understood by older persons who are not only frightened by illness but ignorant about the choices open to them, hesitant in their contacts with public and professional groups, and fearful about the impact of medical costs on strained resources.

The Committee on Aging supports the proposed alternative to the assignment and receipted-bill methods for the payment of physicians' bills, but believes it should be modified so that the patient is liable for no more than the payment of 25% over and above the Medicare payment. This maintains the principles of reasonable and customary charges and the current 20% coinsurance factor.

APPENDIX II—ANALYSIS BY THE COMMITTEE ON FAMILY AND CHILD WELFARE OF THE PUBLIC ASSISTANCE AMENDMENTS AND THE CHILD WELFARE AMENDMENTS IN H.R. 12080

§ 201—PROGRAMS OF SERVICES FURNISHED TO FAMILIES WITH DEPENDENT CHILDREN

We support the stated intentions and provisions of this section concerning programs to increase self-sufficiency, reduce illegitimacy and strengthen family life. We are particularly appreciative of the greatly increased financial support for family planning, day care and other family services. We have long urged that more funds be made available so that these important and necessary services could become a more integral part of a comprehensive welfare program.

We have serious concerns, however, about the effectiveness of these programs as they are outlined in H.R. 12080 because they are so closely associated with

the various repressive, coercive and punitive measures provided in this and other sections.

In § 201 we are referring to the strong tightening of the relationship between law enforcement agencies and welfare departments for the purposes of (1) more speedily and effectively establishing paternity and securing support payments; and (2) requiring that instances of neglect, abuse, or exploitation of a child be brought to the attention of the appropriate court or law enforcement agency.

While efforts to establish paternity and secure support payments are certainly often justifiable, such a concentrated effort as this legislation implies will frequently lead to denials and withholding of information; and it must also be remembered that there are many instances when there is nothing to be gained financially or psychologically by establishing paternity. Such efforts will further cause the caseworker to become a prying investigator and will impede efforts at family counseling which can only succeed if there is mutual trust and respect, and if the client believes that others want to help, not punish him. This applies equally to the strong threats of court action to remove a child (as #2 above and other provisions imply).

We want to reiterate our support of the greatly increased reimbursement for day care services. The Committee on Family and Child Welfare of Community Service Society has long been eager for increased day services. We do have some concern, however, with the vast amount of money being offered so quickly and have serious reservations about the ability of States to use the money well if they were expected to use it so rapidly. This could be particularly dangerous in view of the provision that allows for purchase of day care services from private groups; a result could be the springing up of jerry-built day care operations.

We recommend that the appropriation for day care services contain provisions for a planful progression in the establishment of centers and in the use of the money available. We would also like to see more safeguards built into the program to prevent the use of day care centers as mere repositories for children.

§ 202—EARNINGS EXEMPTION FOR RECIPIENTS OF AID TO FAMILIES WITH DEPENDENT CHILDREN

We endorse the concept of an earnings exemption that would offer a realistic incentive to recipients of welfare programs. Considerably higher exemptions have been recommended by the Administration ($50 plus ½ the remainder) and Social Services Commissioner Ginsberg of New York City ($85 and ⅓ the remainder) as being more realistic than the $30 a month plus ⅓ the remainder offered by H.R. 12080.

With respect to a *training* incentive, we endorse the concept of a monetary incentive as provided by H.R. 5710. The various penalties outlined in H.R. 12080 for a recipient's failure to prove good cause for his inability to enter (or preference against) a specific work and training program only leads us to the conclusion that coercion and harassment are to be used instead of incentives.

§ 203—DEPENDENT CHILDREN OF UNEMPLOYED FATHERS

We endorse the provision that allows for permanent inclusion in the AFDC program of families with unemployed fathers. We would like to see this provision made mandatory for each State.

We urge, however, the removal of the restrictive eligibility requirements imposed in H.R. 12080 by the new Federal definition of unemployment, i.e., unemployment for at least 30 days, and exhaustion of unemployment compensation benefits or evidence of a substantial connection with the work force (1½ years of work during a three-year period ending in the year before assistance is granted).

Certainly the first and second of these requirements would cause considerable havoc and deprivation for a family which, because of a marginal income, has been unable to set aside for the proverbial "rainy day." The last requirement is clearly designed to penalize those who have shown instability, lack of ambition and so on; thus, it would keep out the very people the program is designed to rehabilitate, would perpetuate the poverty invironment of the children in such families, and would cause them to be penalized because of the supposed sins of their fathers.

§ 204—COMMUNITY WORK AND TRAINING PROGRAMS

It is our belief that the provisions in H.R. 5710 in regard to Community Work and Training Programs offer a sound approach and machinery for an operable program. H.R. 5710 has the added advantage over H.R. 12080 of giving the responsibility for work and training programs to the Department of Labor which, in our view, is much better equipped to administer this than are State Departments of Welfare. We question the need for such an elaborate Welfare Department program when so much is already being done in this area via the Economic Opportunity and Manpower Development Acts. Also, other pertinent legislation is being proposed which again leave employment and training aspects with the Department of Labor. We also question whether there are enough available jobs to absorb the participants of such a vast work and training program. We submit that the problem of unemployment has to be attacked on many fronts and levels; it cannot be solved merely by a frontal attack at those who have been poorly educated and poorly trained, and those stereotyped as "shiftless" and "wanting to live off welfare."

We view the penalties for refusing to take training as inviting many opportunities for coercion and harassment. It opens up more avenues for subjective judgments upon the part of caseworkers and investigators, thus increasing the chances for abuse of welfare rights. The penalties themselves are extremely harsh and can only cause more hardship and poverty for the families and children the program is supposed to help. These penalties, along with the coercive nature of other provisions in H.R. 12080, could make it virtually impossible for a mother (whether she be unmarried, divorced, or deserted) to exercise any real degree of free choice in determining whether working or staying at home would be more beneficial to her children.

§ 205—FEDERAL PARTICIPATION IN PAYMENTS FOR FOSTER CARE OF CERTAIN CHILDREN

We have unceasingly urged that more Federal support be given to child welfare programs. We, therefore, endorsed H.R. 1977 which provided for Federal support of 75% for child welfare services, and we recommended that the provisions of H.R. 1977 be included in the Social Security Act.

We commend H.R. 12080 for offering such substantial support to foster care, and placing all the child welfare provisions within the Socal Securty Act. However, we wonder whether H.R. 12080, in differentiating between AFDC and non-AFDC children and offering more money to the former category, is indicating that foster care could and would be used as a threat. We must be vigilant in preventing placement that would be based more on a punitive approach to the parents than on the child's actual emotional and physical needs.

We also want to express here our endorsement of and pleasure with § 247, Permanent Authority to Support Demonstration Projects, which is designed to meet a long-standing need for research, training and demonstration projects in child welfare.

§ 207—PROTECTIVE PAYMENTS AND VENDOR PAYMENTS WITH RESPECT TO DEPENDENT CHILDREN

We urge that there be no change in the provisions of the existing Social Security Act which set 5% of the public assistance rolls as the maximum number of families to whom protective payments can be made with Federal sharing, and which also require States to meet full need in order to receive approval for such payments. We view protective payments as a device that should be used only in the most extreme situations; increasing the numbers allowable and abolishing the full-need requirement, would serve to leave open the possibility of severe abuse.

We deplore the provision in H.R. 12080 which authorizes voucher (vendor) payments. In 1961, the Board of Trustees of Community Service Society stated in a document entitled "Public Welfare—A Benefit to All," "It has been said that persons on relief are not capable of handling their own money affairs, and that vouchers, rather than cash, should be given them. . . . Nothing in our experience supports this proposal, and much speaks against it. If there is a problem of mismanagement, it is the occasion to help the family learn how to handle its own affairs. It helps not at all to take all responsibility from the family, especially if there is hope of returning the family eventually to independent living."

We submit that there has been no evidence since 1961 to warrant any alteration in this point of view. Protective and voucher payments cause a greater sense of degration and humiliation for recipients who were already seeing themselves as second-class citizens because they receive assistance. The use of such payments can only lead to more hopelessness, bitterness and anger.

§ 208—LIMITATION ON NUMBER OF CHILDREN WITH RESPECT TO WHOM FEDERAL PAYMENTS MAY BE MADE

We oppose this Section. We view this provision as one that will cause suffering and hardship either by actually withholding all assistance from a vast number of children (it has been estimated that this could affect a quarter of a million children by January 1968) or by severely depressing assistance standards. It completely ignores the possibility of in-migration to a particular state, and thus would penalize efforts people make to better themselves, for this is the primary reason behind a family's decision to move to another State. It is clear that what will emanate from this provision are coercive and harassing practices in welfare programs.

We wish also to call to your attention that H.R. 12080 does not make it mandatory that each State meet the full need as computed by the State's standard. We hailed such a provision in H.R. 5710 (§ 202), as having been sorely needed, but also recommended that this be augmented by a minimum budget standard with which all States would have to comply. We urge that the limitation prescribed in § 208 be deleted, and that meeting full need based on a Federal minimum budget standard be made mandatory. Only then can there be adequate assurance that our country's AFDC program is indeed meeting the needs of the people it was designed to serve.

APPENDIX III—ANALYSIS OF THE MEDICAL ASSISTANCE AMENDMENTS AND THE CHILD HEALTH PROVISIONS IN H.R. 12080

§ 220. LIMITATION ON FEDERAL PARTICIPATION IN MEDICAL ASSISTANCE

Federal reimbursement for Title XIX beneficiaries would be limited to 133⅓% of the highest cash payment made by a state to a family of the same size receiving help from the program for Aid to Families with Dependent Children. If 133⅓% of the State's per capita income is lower than the above figure the lesser amount would be used.

Objection was raised by the Committee on Health to a somewhat similar proposal in H.R. 5710 which used 150% as the base amount, and the highest standard of cash benefits set by a state in its federally assisted program. Objection was raised because of the linking of health care to welfare assistance eligibility. The substantial expenditures required to pay for medical care can soon exhaust the assets of individuals and families whose incomes may exceed the highest welfare standard set by a state by 100%, or more. To withhold medical assistance from such families is to invite future applications for cash assistance from demoralized families without the emotional or material resources to regain their independence. The limitation proposed would discourage preventive and early therapeutic treatment.

The young and elderly low income individuals and families would be those most affected—two groups most in need of health services. Sound health care policy dictates adequate preventive and early services to preclude the serious chronic conditions that can mean lifetime impairment. The economic implications if such policy is not followed are too evident to reqiure elaboration.

A further objection to medical assistance eligibility based on welfare standards or payments is the inflexibility that would result in adjusting to increases in costs. In recent years health services have risen more than any other component of the cost of living index. Cash assistance benefits, which would be the base for medical assistance, are raised at a painfully slow rate to meet the general increase in living costs. The strain on financially independent families would become greater and greater as the cost of health services continued to climb.

The Committee on Health objects to this amendment which would tie eligibility for the medically needy to cash assistance payments.

§ 221. MAINTENANCE OF STATE EFFORT

States would have options on how to calculate the expenditure to be maintained in order to meet the requirement that federal funds not be used to replace

state funds. The intent of Title XIX is to encourage states to establish medical assistance programs that would expand and improve existing services. The maintenance of state expenditures at the present level is a positive requirement to achieve this end. The proposed amendment would allow states to submit lower figures as the expenditure to be continued in order to obtain federal funds. This could result in diminished medical assistance programs and less health care for those in need, a direct contradiction to the intent of the 1965 amendment.

The Committee on Health opposes this amendment.

§ 223. COORDINATION OF TITLE XIX AND THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

Closer coordination of Title XIX and Part B of Title XVIII is claimed for this proposal. States that do not pay the Part B premium for all needy and medically needy persons 65 years of age or over would lose federal reimbursement on care for such persons given as Title XIX benefits if the service is included in Part B. The limitations on Part B services such as no drugs, eyeglasses, etc. result in most needy and medically needy Part B recipients turning to Title XIX for supplementary care. The administrative complications and confusion for the elderly persons who must cope with both Title XVIII and Title XIX throws doubt on the validity of the proposed amendment. Until such time as Part B of Title XVIII provides adequate coverage the justice of this proposal is open to question.

§ 224. REQUIRED SERVICES UNDER STATE MEDICAL ASSISTANCE PLAN

The requirement in existing law that the services in § 1905(a) (1) through (5) of Title XIX be included in any program of medical assistance would be amended to permit the inclusion of any seven of the fourteen services enumerated in § 1905(a). The Committee on Health registers the strongest possible objection to this proposal. It could well destroy the medical assistance program in some states, or substantially increase the costs of the program if it were limited to inpatient care. The five services now required represent the basis of an adequate health care program. The Committee believes that the federal government has a responsibility to set a pattern for states that will provide essential services and encouragement to expand the program. This proposal would do the opposite by leaving to the states the choice of services. The choice might be based on expediency, pressures from vested interests, deliberate withholding of care, unwarranted economies in state expenditures, or indifference to need.

The Committee on Health opposes this amendment.

§ 225. EXTENT OF FEDERAL FINANCIAL PARTICIPATION IN CERTAIN ADMINISTRATIVE EXPENSES

A defect in the original bill would be corrected by this proposal which has full Committee support. Federal reimbursement for skilled medical personnel and staff directly supporting such personnel would be available at the rate of 75% to any public agency implementing Title XIX, not just for such personnel in the single state administering the program.

§ 226. ADVISORY COUNCIL ON MEDICAL ASSISTANCE

An Advisory Council on Medical Assistance of twenty-one persons appointed by the Secretary of Health, Education, and Welfare would be established by this proposal. The Council would include representatives of state and local agencies, non-governmental organizations concerned with health and consumers of health services with a majority of the Council to be in the last category. Technical advisory committees could be appointed by the Secretary as needed either at the request of the Council or upon decision of the Secretary. The parallel advisory group established by Title XVIII has been most useful. The Committee on Health supports this proposal, while raising the possibility of an Advisory Council on Health Care that could serve the Secretary for all health programs.

§ 227. FREE CHOICE BY INDIVIDUALS ELIGIBLE FOR MEDICAL ASSISTANCE

Free choice of institution, agency or person qualified to provide Title XIX services would be assured by this amendment. A similar provision is in Title

XVIII. Since New York State has already implemented such a provision through the State Board of Social Services the Committee has no objection to the federal proposal.

§ 228. UTILIZATION OF STATE FACILITIES TO PROVIDE CONSULTATIVE SERVICES TO INSTITUTIONS FURNISHING MEDICAL CARE

By July 1, 1969 state Title XIX programs would have to provide for consultative services by state health and other agencies to hospitals, nursing homes, home health agencies, clinics, laboratories and other services the Secretary may specify. The purpose would be to help the services enumerated: qualify for participation in the Title XIX program; establish and maintain proper and efficient fiscal records; and provide information that could be used as the basis for determining payment for Title XIX services. This section seems directed toward improvement of standards and care. It has the support of the Committee on Health.

§ 230. DIRECT PAYMENTS TO CERTAIN RECIPIENTS OF MEDICAL ASSISTANCE

If this proposal becomes law reimbursement for paid or unpaid physicians' bills could be made directly to medically needy Title XIX recipients. The Committee objects to this provision which could result in physicians charging more than the Title XIX payment. Existing law requires that the physician accept the Title XIX reimbursement as payment in full; payment directly to the physician, as is now done, assures no supplementary charges to the patient. Question could be raised also as to a discriminatory policy that would prohibit direct payment to recipients of cash assistance who are Title XIX beneficiaries but allows such payment to beneficiaries not receiving cash assistance.

The Committee on Health objects to this amendment.

§ 231. DATE ON WHICH STATE PLANS UNDER TITLE XIX MUST MEET CERTAIN FINANCIAL PARTICIPATION REQUIREMENTS

The date by which states must assume 100% of the non-federal share of Title XIX costs would be advanced one year from July 1, 1970 to July 1, 1969. In view of the encouragement this would give local areas to use Title XIX and the better ability of the states to carry the cost, the Committee favors this proposal.

IMPROVEMENT OF CHILD HEALTH

The Committee supports the Child Health amendments proposed in H.R. 12080. The consolidation of all funds for these purposes and the standards set which states would have to meet to receive funds are positive steps toward improved services.

Maternal and infant care, pre-school and school health programs, dental care, family planning services, crippled children's services and other programs that may be developed can be planned and coordinated more efficiently. All of the programs and services are directed toward areas with concentration of low income families who would otherwise receive little or no care.

Provision is also made for research and training funds which will permit, among other things, experimentation in delivery of health services and in use of personnel with varying degrees of skill.

A definition of child health excludes mental health and mental retardation from these programs because funds for their support are provided by other federal legislation.

The Committee on health has one reservation it would like to note in connection with the Child Health amendments. Project grants to the states would be terminated beginning with the fiscal year 1973, on the assumption that primary responsibility for maternal and child care rests with the states. The total funds authorized would not be decreased so that the states would have increased funds available for formula grants. The Committee objects to any policy that eliminates maternal and child care as a federal concern and responsibility. The great maternal and child care programs in this country, almost without exception, have had their origin in federal initiative. It would be regrettable should the states lose this essential resource and stimulus.

STATEMENT OF DR. RICHARD D. BAUER, PRESIDENT, MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

Dr. BAUER. This message reflects the views of the Medical and Chirurgical Faculty of the State of Maryland on S. 17 and S. 2299 now under consideration by the Senate Finance Committee as amendments 265 and 266 to H.R. 12080. We regret that circumstances prevented us from offering oral testimony on questions raised by the measures which are of great concern to members of the medical profession and their patients. We respectfully ask that this expression be included in the printed record of the hearings.

As physicians primarily concerned with the highest quality of medical care for all citizens, we urge Congress to reject any proposal which would require, by direct or indirect means, the prescribing of drugs by their generic names.

From a medical point of view, brand name drugs often have properties in addition to the active chemical ingredient that make them especially valuable in the treatment of certain patients.

The carefully controlled and precisely stated characteristic of the drug product is something that the prescribing physician relies on when he specifies it for a patient. The patient's response to a particular medicine can be scientifically evaluated because the physician knows exactly what it was that he prescribed. If the doctor is forced to prescribe a generic drug, knowing little or nothing about the source, he may lose an important element of control over the treatment of his patient.

In the instances of successive refills, the physician would again be deprived of control over the patient's treatment unless a given drug were supplied by the same manufacturer and possessed the same variables—coating, solubility, disintegration time, base, et cetera—in each batch supplied to the pharmacist. We submit that this is possible only with brand name drugs and could not be possible with a generic product supplied by different manufacturers.

There is at the present time no limitation which prevents physicians from prescribing generically. We believe most physicians do so in cases compatible with the patient's needs. But, to take a random example, when digitalis is prescribed, the physician must know who made the medicine and have complete confidence in it. The range between a therapeutic dose and a toxic dose is too narrow for a chance to be taken on a product of indeterminate origin.

In particular, we are concerned over the proposal in both pending measures for the establishment of a national drug formulary from which physicians would be required to prescribe in order for their patients to be reimbursed for drugs under federally financed health programs. This, in our opinion, would be direct Government intervention in the practice of medicine. Under this procedure, it would no longer be a case of the patient's best interests being served according to individual needs, but rather one of a committee determining the prescription for the patient.

The measures also call for the prices of qualified drugs to be determined by the Government, thus effectively changing the present system of free enterprise now in existence. Experience has taught us that

whenever a price schedule is adopted, this price becomes the floor. Consequently, the competitive aspects of drug prescription pricing would be eliminated and the Government would be in the field of price control.

In addition, the establishment of two classes of citizens would also be written in the laws of the United States under these measures. To require physicians to use generic drugs for their less fortunate patients would create a double standard of therapy. One class would get those medications the physician knew were best and in which he had confidence; the other would get drugs the physicians hoped might be effective.

Unfortunately, the term "generic" has been widely misconstrued to indicate that it means a less expensive drug which will do the same thing as a more expensive drug. There is a conspicuous lack of scientific evidence to support any such contention. On the contrary, there is considerable evidence to suggest that marked differences exist among drug products containing the same active ingredient, even among generic drugs produced by different manufacturers.

A comprehensive study of the "generic equivalency" question is now being made by the Department of Health, Education, and Welfare at the direction of the President. Until it is completed and the results are known by the public and the scientific world, we respectfully urge the Senate Finance Committee to withhold any action on the drug measures now before it.

STATEMENT OF DR. BERWYN F. MATTISON, EXECUTIVE DIRECTOR, AMERICAN PUBLIC HEALTH ASSOCIATION

Dr. MATTISON. Only 14 months have elapsed since July 1, 1966, when the first of a series of provisions of title 18, Public Law 89-97 went into effect. The effective date for other provisions is even more recent. Despite this brevity of experience, we believe that certain problems have become evident, and that certain specific changes are indicated. The benefits of the medicare program in meeting the health needs of persons age 65 and over is clear. That it is imperfect is equally evident. That the program should be improved, continued, and broadened is, to the APHA, indisputable.

In considering amendments to Public Law 89-97, it is incumbent upon the Congress, and especially this committee, to weigh carefully both the experiences of the past and the prospects for the future while keeping in mind two especially pertinent factors. First, fiscal integrity must be preserved. Second, effective health care appropriate to need must be provided. These objectives are not mutually exclusive—they can and should be made compatible.

It is the view of the APHA that the justification for enactment of titles 18 and 19 was the provision of quality health services to beneficiaries in need of them. The goal of both Federal and State programs should be achievement of one uniformly high standard of medical care, not a system which will permit a high level for some and a second inferior grade of medical care for certain population groups. Other considerations must be secondary.

This ambitious new health legislation was not born from a need related to financial profit. Nor should its goal be merely to arrange

financial details, spend allotments, and reimburse vendors. There must be continuous attention to how the money is used, and with what effects. Every effort should be made to obtain as much effective health care as possible from the resources available.

The observations and recommendations of the APHA will be related to our sphere of competence—health—and they will be applicable to the two most basic factors—financing and effectiveness of care. This statement will not cover all of the points raised by H.R. 5710 or H.R. 12080, but it will deal with those which, in our view, are most critical in developing the best health program possible.

The APHA recommends amendment of title 18 Public Law 89-97, in order that all existing arrangements for providing physicians' services, including salaried physicians and group health plans, will be eligible for reimbursement.

Despite the intent of the Congress to in no way interfere either with the practice of medicine or with the manner in which medical services are provided, Public Law 89-97 has done just that. The rigidity of the required fee-for-service payment system has made necessary an artificial accounting for services rendered under other systems of reimbursement. It has been a direct interference with the best in medical practice. I has made necessary a complicated system of medical cost accounting maintained at an unnecessary expense. The results are frequently confusing, even ludicrous—patients reeciving a physician's bill for a few cents. This cumbersome and costly requirments should be eliminated.

The action of the House in H.R. 12080 relative to arrangements with radiologists and pathologists is supported by the APHA but this is only a step in the right direction. We urge this committee to complete the needed amendment, to authorize all existing arranagments as eligible for reimbursement.

The APHA recommends amendment of title 18 to eliminate the required 3-day hospital stay prior to admission to an extended care or nursing home facility.

The logic behind this requirement was to assure medical evaluation before placement, but the presently required 3-day hospital stay does not necessarily accomplish this objective. We suggest, in its stead, a prerequisite medical evaluation, with prescribed criteria, including a determination of rehabilitation potential, before admission to an extended care facility, a nursing home or release to a home health agency. In many instances, an unnecessary, expensive hospital stay would be eliminated and, in every instance, a plan for a continued regimen of needed service would result. Physicians' services, now possible under part B, makes possible an out-of-hospital evaluation which was nonreimburseable when this legislation was first conceived as dealing with institutional benefits only. The value of continuity of care, recognized by the requirement for a physician plan, should be constantly emphasized.

The APHA recommends amendment of title 18 to eliminate all deductibles.

The rationale for deductibles is essentially twofold. First, that they deter the hypochondriac or the merely lonely from seeking unnecessary care, thus preventing unnecessary overcrowding of facilities

and overburdening physicians; and second, some financial support of the program is realized. There is no proof that deductibles furnish any such deterrent. And there is indication that they may discourage patients from seeking care early in an episode of illness.

Disregarding completely the value of an early visit in an episode of illness, deductibles contribute to an administrative nightmare. And the labor and concomitant costs involved in the recordkeeping and in the incessant checking and rechecking on deductibles is tremendous. We are advised that overhead costs to intermediaries, a sizable portion of which is attributable to bookkeeping required to keep track of deductibles, is running between 10 and 18 percent. This, in our view, is inordinately excessive and further, is an unnecessary and unproductive charge against the program. Furthermore, it is an added complexity for the beneficiary himself.

The APHA recommends amendment of title 18 so that depreciation allowances to institutions, whether under voluntary or proprietary auspices, are predicated on funding such allowances.

It is important to keep in mind that this provision of the law is intended specifically for renewing or rebuilding—a depreciation allowance on capital expenditure—and that this return is in addition to (a) a 2-percent unidentifiable cost factor, and (b) a return on investment which, based upon the formula incorporated in the law, is presently running about 7.5 percent. The intent of section 129 in H.R. 5710 appears consistent with our recommendation, but we urge the committee to consider two modifications.

First, we believe it would be much simpler to retain the depreciation allowance in the medicare fund with arrangements whereby an institution would have a charge against said allowance when, in accordance with the State health facility planning authority, capital expenditures are to be made. This would eliminate the need for cumbersome recapture provisions.

Second, any capital expenditure by a provider of service should be required to be in conformity with the State plan for facility development. Without such approval, a depreciation allowance should not be made. And, the State agency of whom approval is required should be the State agency which has responsibility for total health facility planning, which is not necessarily the agency designated pursuant to section 1864(c), Public Law 89-97.

The APHA recommends amendment of title 18 to include as a reimbursable charge the cost of prescription drugs for out-of-institutional care where medically indicated.

Making drugs available to patients whose medical condition has been stabilized is sound preventive medicine which, in many cases, will obviate the need for more costly rehospitalization. Most beneficiaries would prefer to remain in their homes and if their health can be protected in this environment it is preferential to do so from both the choice and cost vantage points. The APHA has long supported the position that public expenditures for prescription drugs should be made on the basis of generic name wherever possible. This stand is based upon a belief that effective drugs should be provided at the lowest possible cost. Examples of price discrepancies between trade and generic name prescribing can be illustrated by three examples of wholesale prices selected at random.

Trade name	Cost per 100	Generic name	Cost per 100
Meticorten (5 mg.)	$17.90	Prednisone (5 mg.)	$1.00
Peritrate (10 mg.)	2.50	Pentaerythritol tetranitrate (10 mg.)	.50
Equanil	6.50	Meprobamate	3.00

It appears to us, and we hope this committee will be equally convinced, that in the interest of guarding the financial integrity of this program it should be required that drugs be prescribed generically whenever possible from a formulary in which only the products of approved manufacturers would be listed.

The APHA recommends amendment of title 18 whereby home health services would be expanded so as to provide comprehensive health care.

Section 127 of H.R. 12080 would add the services of podiatrists to those of the health disciplines presently included. This action is merited but additional services should be included. The home is the locale of preference if appropriate health care can be provided there. But whatever the needed speciality may be, it should be available. Section 1861 of Public Law 89–97 should be amended in order that the services of indicated specialists (for example, nutritionists and dietitians) can be reimbursed, hence made readily available.

The APHA is particularly pleased by the authority proposed in section 127, H.R. 12080, for the Secretary HEW to encourage and support demonstrations of innovative cost reducing methods and procedures. Presently there exist no incentives what ever to provide needed care in the most efficient manner. Much improvement must be made in the proper utilization of facilities. Eligibility for a stated number of days' care in a facility should not be the criterion of determination for length of stay. The ambulant patient should not be occupying a bed. We urge the Senate to approve this measure which has such a great potential to improve this program.

TITLE XIX

It is the opinion of the APHA that title 19 is not now meeting the demonstrated health needs of those for whom it is intended. Certainly the less economically fortunate States have not and probably will not be able to finance their share of this program. It is our further opinion that it never will.

While it is possible to anticipate, with a reasonable degree of accuracy, costs for food, clothing, and shelter, medical problems and their attendant costs are completely unpredictable. A family of modestly comfortable means can, in the face of a health catastrophe, be thrown into a tragic indebtedness. It is because of just such instances that the APHA favors prepaid health insurance protection. Unless and until public assistance recipients and the medically indigent are covered by the Federal health insurance program, title 19 should be improved.

Controls placed upon the title 19 program were primarily fiscal in nature. This situation has been intensified by H.R. 12080. Conceding

the fact that in this type program fiscal limiting elements are inherent, the APHA nonetheless deplores Federal support of a second-class medical care system. Changed methods of financing and payment have not resulted in bringing first-class medicine to the needy.

The fallacy in the operational concept of this program is patently clear. Intended to provide aid to the indigent and the medically indigent, the requirements of State financial participation practically guarantees that States with low per capita income will provide inadequate services at best and none in many instances. The resulting geographical inequity—it is no longer sufficient to be medically indigent, one must choose the correct State in which to enjoy the condition—is totally unsatisfactory.

We have serious reservations as to the workability of the welfare system in this country. It is apparent to any objective observer that it is a system of perpetuation rather than one of solution. We have grave doubts, however, as to the effectiveness of some of the proposals of H.R. 12080 to improve this situation. There seems no justification for heaping punishment upon the heads of children for the sins of their parents. Within the sphere of our competence, we are concerned for instance, over the health conditions of the AFDC child not eligible for service under the restrictions of H.R. 12080. Would these children be eligible for care under title 19? Will, as we fervently hope they will be, health agencies be involved in the health evaluation and medical rehabilitation ordered by H.R. 12080? And while the effect of allowing free choice of physician and health facility to the title 19 beneficiary is intended to bring that person into the mainstream of medical practice, is the Congress cognizant of the magnitude of the additional cost and the administrative nightmare which will result? These are pertinent questions which remain to be resolved but two provisions of H.R. 12080 are definitely retrogressive. The first is the ceiling placed upon the Federal contribution to the title 19 program. If viewed as a brake on Federal expenditures, it is a marked improvement. If viewed from the standpoint of meeting health needs of the indigent and medically indigent, it is a disaster. A second undesirable feature is substituting any seven of the 14 health services for the mandated basic five. This would allow a State, with more than 50 percent Federal support, to provide health services which would be more a charade than the needed commodity. We vigorously protest these provisions of H.R. 12080 as well as elimination of the required comparability of services now a part of title 19.

We agree with the House and urge upon this committee amendment of title 19 to provide 75 percent Federal reimbursement for the compensation and training of professional medical personnel and supporting staff engaged in the administration of this program, irrespective of the State agency so administering.

The present arrangement is, in our view, not consistent with the intent of the Congress nor of this committee when Public Law 89-97 was enacted.

The APHA recommends amendment of title 19 to vest in State health departments authority to certify providers of service financed under this title.

In order to insure that a uniformly high level of medical care is provided, the qualifications and competence of providers must be certified

all along the line—from practitioner through facility. Just as certification of beneficiaries' eligibility is mandated to the unit with the expertise, the State welfare authority, certifying providers should be mandated to the unit with that expertise, the State health authority.

In the interest of curtailing unnecessary administrative work and confusion, we believe it would be helpful if the Department of Health, Education, and Welfare adopted a policy whereby proof of civil rights compliance furnished, as required, under title 18 would be considered valid for title 19. Neither certifying State agencies nor institutions should be required by a second Federal agency to furnish proof of compliance already submitted to another agency of the same Department.

MATERNAL AND CHILD HEALTH PROGRAMS

Several amendments are proposed in H.R. 5710 and in H.R. 12080 to accelerate our total effort to improve the health status of our Nation's youth. In our view, there are few if any ventures of comparable worth. These programs, the early casefinding and treatment of handicapping conditions of children, the special grants for maternity and infant care, and the training of competent personnel all merit increased support. In the face of ample proof that we can do better, we must. The APHA strongly supports the proposed increases in the authorizations for these programs.

We support the new grant arrangement for maternal and child health and crippled children grants. However, the complications posed by a combined MCH–CC grant are considerable in the face of the recent HEW reorganization where these two programs are administratively separated in the Federal department. We wish to apprise this committee of our conviction that the crippled children program, 87 percent of whose child beneficiaries are 16 years of age or less can hardly be considered one where the vocational potential is the paramount element. This service should be under competent medical supervision, not administered by agencies whose competence is education or vocational training. The prospect of relatively early termination of project grants for child health programs in areas of great need is viewed with caution. We believe this provision should be reviewed 2 years prior to the date of termination to make sure that the health needs of children will be met.

In the interest of maximum accomplishment from programs within States and communities, we urge a requirement that these grant programs be coordinated with the State planning agency required by Public Law 89–749 enacted in October 1966. These vital programs should be made an integral part of the total Federal-State-local health effort.

We support too, the innovative and long-overdue authority for a careful evaluation of the results of Federal support and direction of operating health programs. The APHA is persuaded that this should be a part of every Federal grant program and heartily endorses inclusion of this provision. We must state that such evaluation will, in our view, be more objective if made by other than the program administrators. Hence, we hope that the Secretary of HEW will, in every

instance possible, seek evaluation through a grant or contract arrangement with organizations outside the Federal Government.

DENTAL HEALTH OF CHILDREN

Dental diseases and their complications number more victims, adults and children alike, than any other chronic condition. Dental disease attack is particularly vicious in childhood. It begins almost at birth—usually no later than the second year—destroying first the primary or baby teeth and then, as soon as they erupt, the secondary or permanent teeth and continuing into adulthood for as long as there are teeth left to be attacked. Dental disease can be prevented, but once it is present in the mouth of a child, it can be controlled only through continuous professional care.

The proposed emphasis on a national dental health program for children offers a first real opportunity to break this seemingly endless cycle of disease, neglect, and destruction. It offers a progressive program of comprehensive dental care to children across the country who would not otherwise receive such care. It is a program which, if extended to all the Nation's children, could within a generation virtually eliminate decay as a major cause of tooth loss and bring the other major destructive dental diseases under effective control. We consider this proposal of utmost importance to the health protection of our children, and we urge favorable action by this committee. We further believe that this program should be administered by the agency within the department most experienced and qualified to do so, the dental health program of the Public Health Service.

NURSING HOMES

Before leaving title XIX we wish to indicate APHA's support of two amendments proposed to H.R. 12080. Both are direct results of extensive hearings by the Long-Term Care Subcommittee, Senate Special Committee on Aging. Both address themselves to improving health care in nursing homes, specifically that financed under title XIX. Each would, in our view, materially improve this program.

The complete statement of the APHA on Institutional Care of the Chronically Ill Aged can be found on pages 149–152, part 2, hearings before the Joint Subcommittee on Long-Term Care, May 6, 1964. Our evaluation of the problem at that date remains essentially valid today. Likewise, the remedial action proposed then is still pertinent today.

Amendment No. 294, proposed by Senator Moss, would require States which provide nursing home services to provide home health services. The latter is an essential element of the total spectrum of health care. Without this element, abuse of nursing home facilities is practically guaranteed. Health care appropriate to need is both sensible and economical. Amendment 294 would place additional requirements upon the title 19 program each intended to elevate the quality of care provided in nursing homes. Every effort to this end should be taken. But, as we have stated before, one of the most effective ways to encourage adequate nursing home services is to reduce the need for such services. This points up the very practical approach of Senator Moss'

amendment—elevate the standard of care in nursing homes, and make home health services available so that persons who no longer need nursing home care can receive needed health care in their own homes.

Amendment No. 298, proposed by Senator Kennedy of Massachusetts, would require a State licensing system of nursing home operators. We have long urged education programs for nursing home operators and staffs focused on improving the quality of health care provided. Only those who will, can be educated. The responsibility of nursing home operators is very important to the well-being of the home's clients; his preparation should meet adequate standards. We support inclusion of amendment No. 298 in H.R. 12080.

NEW PROGRAM

Finally, the APHA recommends serious consideration by this committee and the Congress of the need for a new federally supported program to aid in the financing of nonmedical homes, residences, or institutions for beneficiaries of programs for the aged who do not need constant medical or nursing care. These facilities would, for example, provide a home for the ambulatory patient who needs only occasional medical attention. Such a program would help prevent overutilization of hospital and nursing home facilities while providing a site for needed care at less cost than if the patient were institutionalized.

Your favorable consideration of these several suggestions will, we believe, do much to improve these valuable health programs.

○